MOLINA HEALTHCARE

Provider Bulletin

A bulletin for the Molina Healthcare of Ohio Medicaid network • November 2011

Important Payment and Billing Policy Updates

We are committed to providing timely updates and helpful tools to assist with appropriate billing to support accurate and timely claims payment. This edition of the Provider Bulletin outlines several important payment policy updates.

New HCPCS Codes – Effective September 1, 2011

The Medicaid Fee Schedule, Appendix DD of the Ohio Administrative Code Rule 5101:3-1-60, published by the Ohio Department of Job and Family Services (ODJFS) now includes updates effective September 1, 2011. The following new codes require prior authorization:

HCPCS Code	Description
L7368	Lithium ion battery charger
Q2040	Injection, incobotulinumtoxinA, 1 unit
Q2041	Injection, von Willebrand factor complex (human), Wilate, 1 IU VWF:RCo
Q2044	Injection, belimumab, 10 mg

The Molina Healthcare CPT Codes Requiring Prior Authorization list, available at www.MolinaHealthcare.com by selecting Provider, Ohio, Forms, will be updated to include these additional codes and is available for your reference.

Sterilization and Delivery Services - Claim Processing Guidelines

Claims received for sterilization services are paid only if the required criteria are met and the appropriate Consent to Sterilization form (JFS 03198) is received, according to the Ohio Administrative Code (OAC). In addition, reimbursement will not be made for associated services such as anesthesia, laboratory tests, or hospital services if the sterilization service itself cannot be reimbursed. However, sterilization claims received without a valid consent form attached that includes services unrelated to the sterilization (e.g., delivery services) will be processed as follows:

- Inpatient hospital claims on a UB-04 will be denied.
  - Reimbursement can be made for charges unrelated to the sterilization procedure when a corrected claim is received removing all of the sterilization related charges and ICD9 diagnosis/procedure codes
- Outpatient hospital claims on a UB-04 will be denied.
- Physician services on the HCFA-1500 claim form will deny the line items for the sterilization services and process the line items unrelated to the sterilization services for payment.
  - No corrected claim form is required.

Consent to Sterilization form is available at www.MolinaHealthcare.com or on the ODJFS website.

Changes to the Electronic Remittance Advice (ERA) Format to 5010 Version

Effective January 1, 2012, Molina Healthcare will transition the format of the 835 remittance files from the current 4010 version and will begin issuing all 835 transactions in 5010 version as mandated by the Health Insurance Portability and Accountability Act (HIPAA). Molina Healthcare will no longer be in dual

use mode. As a result, no 835 transactions will be sent in the 4010 version as of January 1. To prepare, we encourage you to make necessary changes to be compliant with the Centers for Medicare and Medicaid (CMS) 5010 version. A full description of requirements and educational resources for 5010 are available at www.cms.gov/Versions5010andD0.

As a reminder, you may view your Explanation of Payments (EOPs) at the ProviderNet website, https://providernet.adminisource.com. You will be able to access PDFs of EOPs and the associated 835 files on the ProviderNet website up to 13 months from the time of issuance. After such time, providers can request EOP images and files from Molina Healthcare for up to seven years. If you have not done so already, visit the ProviderNet website to register today so you can access your information electronically and begin experiencing the convenience and efficiency of electronic processes.

If you have questions or technical issues related to the ProviderNet website, contact FIS, the ProviderNet owners, directly by email (Provider.Services@fisglobal.com) or by phone at 1-877-389-1160.

Billing Guidelines for Bilateral Services and Use of Modifiers 50, LT and RT

Bilateral services are procedures performed on both sides of the body during the same operative session. Do not use modifiers LT and RT when modifier 50 applies. Multiple procedure reduction applies to all bilateral procedures subject to multiple procedure guidelines as noted in the appendix to OAC 5101:3-4-22, Surgical Services.

Molina Healthcare billing guidelines are as follows:

- Modifier 50 should only be reported for bilateral surgical procedures performed.
  - A bilateral surgical procedure is reported on one line using modifier 50.
  - The unit entry to use when modifier 50 is reported is “1.”
  - Do not submit two line items to report a bilateral procedure using modifier 50.
  - 150 percent payment adjustment for bilateral procedures applies.

- Modifier 50 should **NOT** be used to report:
  - Diagnostic and radiology facility services.
  - Institutional claims received for an outpatient radiology service appended with modifier 50 will be denied.
  - Procedures that are bilateral by definition or their descriptions include the terminology as “bilateral” or “unilateral.”

- Modifiers LT or RT are required when appropriate to identify:
  - Hospital procedures performed on identical anatomic sites on the right and left sides of the body (e.g., ears, eyes, nostrils, kidneys, lungs, and ovaries).
  - A procedure is performed on only one side.
  - Hospital diagnostic test and radiology services performed on the right and left sides of the body.

Please note modifier 50 is not listed in appendix A, Outpatient Hospital Modifiers, to rule 5101:3-2-21 of the OAC. Please reference the appendix to OAC 5101:3-4-22, Surgical Services, for physician claims that specifies if modifier 50, LT and/or RT is applicable by indicating an “x” in the corresponding column.

Advanced Practice Nurses (APN)

When billing for any service provided by an APN, in accordance with OAC 5101:3-8-27: Advanced Practice Nurses Modifiers, all services must be billed with the appropriate modifier to denote the type of APN that provided the service.

- Bill the modifier “SA” (e.g. 99201SA), if the APN is a nurse practitioner;

- Bill the modifier "SB" (e.g. 99201SB), if the APN is a nurse mid-wife; or
- Bill the modifier "UC" (e.g. 99201UC), if the APN is a clinical nurse specialist.

In accordance with the OAC 5101:3-8-23: Advanced Practice Nurses: Coverage and Limitations, APNs are subject to the following coverage and limitations:

- APNs are not eligible to bill or be reimbursed for CPT code 99223.
- Emergency room visit codes 99284 and 99285 are not covered if billed by an APN who is in an independent practice as defined in rule 5101:3-8-22 of the Administrative Code.

Molina Healthcare recently corrected the claims payment configuration to appropriately deny these three codes.

Advanced practice nursing services will be reimbursed, in accordance with OAC 5101:3-8-22: Advanced Practice Nurses Practice Arrangements and Reimbursement, the lesser of the provider's billed charge or one of the following:

- 85 percent of the provider contracted rate when services are provided by an APN in the following places of service: inpatient hospital, outpatient hospital, or hospital emergency department; or
- 100 percent of the provider contracted rate when services are provided by an APN in any non-hospital setting.

Molina Healthcare will notify you regarding any overpayments related to the above Ohio Medicaid payment policy as they are identified.

Early Periodic, Screening, Diagnosis, and Treatment (EPSDT) Services Requirement

Molina Healthcare requires the EPSDT data reported in block 24H be submitted on all EPSDT claims. If this field is left blank, the claim will be denied. ODJFS is federally required to annually report the number of EPSDT visits and referrals for follow-up or corrective treatment for Medicaid-eligible recipients 0-20 years of age. The EPSDT services should be reported as follows:

Paper Claims

Per ODJFS Instructions for Completing the CMS-1500 Claim Form (CMS 1500), the referral field indicator should be reported in field 24H for Healthchek/EPSDT services as follows:

Lower, Unshaded Area

Enter an E in the lower, unshaded area in field 24H if the service was related to Healthchek (EPSDT). Enter B in the lower, unshaded area in field 24H if the service was related to both Healthchek (EPSDT) and family planning.

Upper, Shaded Area

If either E or B is entered in the lower, unshaded area, then add the appropriate condition indicator in the upper, shaded area in field 24H using one of the following:

- NU (No Healthchek (EPSDT) referral was given)
- AV (Referral was offered but the individual refused it)
- ST (New Services Requested)
- S2 (Under Treatment)

Electronic Claims

Per ODJFS 837 Health Care Claim: Professional Companion Guide (http://jfs.ohio.gov/OHP/tradingpartners/pdfs/837P.pdf), completion of CRC02 and CRC03 are required for electronic claims.

Providers must select the appropriate response in Loop 2300 Segment CRC02, "Was an EPSDT referral given to the patient?" as follows:

- Enter Y in Loop 2300 Segment CRC02 if the service is Healthchek and follow-up is required and a referral is made.
- Enter N in Loop 2300 Segment CRC02 if the service is a Healthchek and no follow-up services are required.

Providers must select the appropriate condition indicators in Loop 2300 Segment CRC03.

- If response to CRC02 is Yes, use one of the following:
  - AV (Referral was offered, but the individual refused it)
  - ST (New Services Requested)
  - S2 (Under Treatment)
- If response to CRC02 is No, use the following:
  - NU (No Healthchek (EPSDT) referral was given)

EPSDT Services:

- Preventive Medicine Services
  - New Patient under one year 99381
  - New Patient (ages 1-4 years) 99382
  - New Patient (ages 5-11 years) 99383
  - New Patient (ages 12-17 years) 99384
  - New Patient (ages 18-39 years) 99385
  - Established patient under one year 99391
  - Established patient (ages 1-4 years) 99392
  - Established patient (ages 5-11 years) 99393
  - Established patient (ages 12-17 years) 99394
  - Established patient (ages 18-39 years) 99395
- Evaluation and Management Codes
  - New Patient 99201-99205
  - Established Patient 99211-99215

  Note: These CPT codes must be used in conjunction with codes V20-V20.2 and/or V70.0 and/or V70.3-70.9.

National Drug Code (NDC) Number Billing Requirements

As a reminder and follow up to the July 2011 Provider Bulletin, federal law requires that any code for a drug covered by Medicaid must be submitted with the NDC, with the exception of hospital claims. Effective November 21, 2011, Molina Healthcare will deny claims if the NDC information is missing or is invalid to comply with the federal requirement. The NDC/HCPCS crosswalk, which provides a listing of each NDC assigned to a HCPCS, is updated monthly and is available for your reference at www.dmepdac.com/crosswalk.

HCPC codes J0120-J9999, Q0138-Q0139, Q0515, Q2009-Q2010, Q2017, Q2026-Q2027, Q3025, Q4081, Q4096-Q4099, S0145, S0148, S0166, B4157-B4162, and CPT codes in the 90281-90399 series require the NDC and should be reported as follows:

Paper Claims

- CMS 1500 - NDC is billed on shaded area of field 24A to include:
  - NDC qualifier
  - NDC number
  - Unit of measure qualifier
  - Unit of measure quantity

- UB-04 - NDC is billed on shaded area of Field 43 to include:
  - NDC qualifier
  - NDC number
  - Unit of measure qualifier
  - Unit of measure quantity

  Note: NDC information is required for End-Stage Renal Disease Clinic claims but is not required on hospital claims. Hospitals that are able or are already submitting NDCs are encouraged to continue this practice.

Electronic Claims
The NDC number is reported in the LIN segment of Loop 2410 only.

- 837 Health Care Claim: Professional (837P):
  - Loop 2400
    - SV101-1: Qualifier of 'HC'
    - SV101-2: HCPCS Code
    - SV101-3: Modifier
    - SV101-4: Quantity
  - Loop 2410
    - LIN02: Qualifier of 'N4'
    - LIN03: NDC
    - CPT04: Quantity
      - CPT05: Unit of measurement qualifier F2 – International Unit
      - GR – Gram
      - ML – Milliliter
      - UN – Unit

- 837 Health Care Claim: Institutional (837I):
  - Loop 2400
    - SV202-1: Qualifier of 'HC'
    - SV202-2: HCPCS code
    - SV202-3: Modifier
    - SV204: Unit (DA, F2, UN)
    - SV205: Quantity
  - Loop 2410
    - LIN02: Qualifier of 'N4'
    - LIN03: NDC
    - CPT04: Quantity
      - CPT05: Unit of measurement qualifier F2 – International Unit
      - GR – Gram
      - ML – Milliliter
      - UN – Unit

Questions?

If you have any questions, please call Molina Healthcare's Provider Services at 1-800-642-4168. Representatives are available to assist you from 8 a.m. to 5 p.m. Monday through Friday.