MOLINA HEALTHCARE

PROVIDER BULLETIN

A bulletin for the Molina Healthcare of Ohio provider networks

Effective Jan. 1, 2016 – New PA List and Form

Information for providers in all networks

Effective Jan. 1, Molina Healthcare will remove several prior authorization (PA) requirements and update the PA Code List and PA Service Request Form to reflect these changes. A user guide will also be added to the PA Code List. Look for the updated documents to be posted on Dec. 31 at www.MolinaHealthcare.com/Providers/OH under the "Forms" tab.

Effective July 1, 2015 – Nurse & Aide Service Rate Changes

Information for providers in Medicaid and MyCare Ohio networks

The Ohio Department of Medicaid (ODM) created a new rate system for nursing and aide services to increase access to home- and community-based services and improve the rates and billing process. The new rates were effective **July 1, 2015**.

To view the updated rates, visit the ODM website:
http://medicaid.ohio.gov/Portals/0/Providers/rate-changes-2015.pdf.

The change adds two new distinct services:

- RN Assessments: Must be completed before start of service and when a patient's service package changes.
- RN Consultations: May be completed in person or over the phone and required when a patient's condition changes significantly.
    - As of July 1, LPNs no longer have to make their own payment arrangements for a consulting RN. RN Consultations are a Medicaid reimbursable service.

Rate Calculation

A new calculation ensures services are provided for at least 35 minutes to receive the base rate and recognizes advanced skill levels and registered nurses. The base rate is only paid when at least three units are billed. If only two units are billed, the unit rate will be paid.

- Two or fewer units on line – multiply units by the unit rate
- Greater than two but less than five units on line – base rate paid
- Greater than four units on line – subtract number of units by four and multiply by the unit rate, then add the base rate

The new calculation applies when billing for: G0154, G0156, T1000, T1002, T1003, T1019, S5125, G0151, G0152, G0153.

PT, ST and OT services performed in a Home Health setting are paid using the new calculation. The fee for these services did not change. This applies to: G0151, G0152, and G0153.

Modifier Changes

Providers billing G0154 or T1000 must now include the modifier to indicate if an RN or an LPN is providing the services. Refer to Ohio Administrative Code (OAC) 5160-12-05 for modifiers for *home health services* and OAC 5160-12-06 for modifiers for *private duty nursing services*.

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Questions?

Provider Services – (855) 322-4079
8 a.m. to 5 p.m., Monday to Friday
(MyCare Ohio available until 6 p.m.)

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Effective Jan. 1, 2016 – New Home Health Codes for Medicare

Information for Medicare and MyCare Ohio networks

The Centers for Medicare and Medicaid Services (CMS) established two new procedure codes to differentiate levels of nursing services provided during a hospice stay and a home health episode of care.

The codes (and retirement of the previous code, G0154) are effective for hospice service dates on and after Jan. 1 and home health episodes of care ending on or after Jan. 1.

- Services provided by an RN are coded as G0299.
- Services provided by an LPN are coded as G0300.

The new codes are for Medicare services only. ODM has not adopted the codes. Continue to bill G0154 for Medicaid services.

Effective Feb. 1, 2016 – Expanded NDC Requirements

Information for Medicaid network

As of Feb. 1, 2016, outpatient hospital claims will deny if billed without a valid/active 11-digit National Drug Code (NDC) number reported without

Effective Feb. 1, 2016 – Encounter Requirements to Prevent Claim Rejection

Information for providers in all networks

Missing/Invalid Covered Days

- Value code 80 (covered days) must be present on inpatient claims and the number of units must correspond with the inpatient units billed on the claim, *or the inpatient claim will be denied*.
- Non-covered days must be reported with a value code of 81. If the covered and non-covered days values (80 and 81) are not reported on separate lines, *the claim will deny*.
- The sum of the covered days and non-covered days billed units on the line level should be equal to the sum of value code 80 and 81 amounts at the header level.

Invalid Admit Source

Admit Source 9 is invalid for inpatient claims for Medicaid patients. Claims billed with this admission source *will be denied*.

Newborn Facility Claims

The type of admission for newborn inpatient claims should be 4. The admit source should be either 5 or 6.

CODE	Code Structure for Newborn	IP	OP
5	Born Inside this Hospital: use, as applicable, with Priority (Type) of Visit 4 (Newborn)	YES	Required only if Priority (Type) of Visit = 4
6	Born Outside of this Hospital: use, as applicable, with Priority (Type) of Visit 4 (Newborn)	YES	Required only if Priority (Type) of Visit = 4

Newborn Claims

Providers must report birth weight on all newborn institutional claims using the appropriate value code:

- Paper UB-04: Report in block 39, 40 or 41 using value code 54 and the birth weight in grams. Include decimal points. For example, birth weight of 1000 grams is reported as 1000.00.
- Electronic: Report birth weight as a Monetary Amount. Reference ODM Companion Guide (837I) at http://medicaid.ohio.gov/PROVIDERS/MITS/HIPAA5010Implementation.aspx for the appropriate loop and segment.

Inpatient Interim Claims

Claims have an invalid discharge status when:

- They are UB Claims, *and*
- The Type of Bill = 11x [x=2 or 3], *and*
- The Discharge Status Code (FL 17) is not equal to 30 (still patient), then the value should be considered as invalid.

Discharge status code 30 is defined as Still Patient. When billing for inpatient services, using this code with type of bill other than 112, 113, 122, or 123 *will result in a denied claim*.

Reference

For more information, refer to http://emanuals.odjfs.state.oh.us/emanuals/dataimages.srv/emanuals/pdf/pdf_forms/UB04HOSPITALINST.PDF.

dashes or spaces. An NDC number is required for:

- HCPCS codes in the J series
- HCPCS codes in the Q or S series that represent drugs
- CPT codes in the 90281-90399 series (immune globulins)
- Enteral Nutritional B Code Products that price AWP (B4157-B4162)

Also, the list of codes that require NDCs for both physician and hospital claims has expanded. The following codes require an NDC number:

- HCPCS J0120-J9999
- HCPCS Q0138-Q0139
- HCPCS Q0515
- HCPCS Q2009-Q2010
- HCPCS Q2017
- HCPCS Q2026-Q2027
- HCPC Q2050
- HCPCS Q3025
- HCPCS Q4081
- HCPCS Q4096-Q4099
- HCPCS S0145
- HCPCS S0148
- HCPCS S0166
- HCPCS B4157-B4162
- CPT codes 90281-90399 series
- HCPC B4164-B4216
- HCPC B4220-B4224
- HCPC B4240

Prevent Claim Denial – EPSDT

Information for Medicaid and MyCare Ohio networks

Don't forget to complete the referral field indicator (field 24) on Early Periodic Screening, Diagnosis and Treatment (EPSDT) claims, or *your claim will be denied*. To learn more, visit www.MolinaHealthcare.com/Providers/OH and select "Provider Training" under the "Manual" tab.

Provider Spotlight

Congrats to gift basket winners in the monthly Clear Coverage™ drawing: Genesis Primary Care Physicians.

Fighting Fraud, Waste & Abuse

Do you have suspicions of member or provider fraud? The Molina Healthcare AlertLine is available 24 hours a day, 7 days a week, even on holidays at (866) 606-3889. Reports are confidential, but you may choose to report anonymously.