Authorization Update

Genetic Testing

Authorization Process Change: Beginning Feb 1, 2017, prior authorization will be required for genetic testing. Prior authorization is required before services are rendered for the following CPT codes:

18314	81266	81355	81436
81162	81272	81400	81437
81170	81273	81401	81438
81201	81276	81402	81440
81203	81280	81403	81442
81210	81281	81404	81445
81211	81282	81405	81450
81212	81287	81406	81455
81213	81291	81408	81460
81214	81292	81410	81465
81215	81294	81411	81470
81216	81295	81412	81471
81217	81297	81415	81493
81218	81298	81416	81504
81219	81300	81417	81519
81222	81311	81425	81525
81223	81313	81426	81528
81225	81314	81427	81528
81226	81317	81430	81535
81227	81319	81431	81536
81228	81321	81432	81538
81229	81323	81433	81540
81246	81324	81434	81545
81265	81325	81435	81595
81266	81401	81445	88377

MOLINA® HEALTHCARE

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DME Items

Beginning Jan 17, 2017, the following DME items will no longer require prior authorization:

DME Item	Code
Hospital Bed (standard)	E0290
Trapeze Bar	E0912
Fracture Frame	E0946
Stationary Oxygen System	E0424
Portable Oxygen System	E0431
Portable Oxygen System	E0434
Stationary Oxygen System	E0439
Respiratory Assist Device	E0470
Respiratory Assist Device	E0471
Respiratory Assist Device	E0472
I-PPB Machine	E0500
CPAP	E0601
Oxygen Concentrator	E1390
Oxygen Concentrator	E1392
Controlled Dose Inhalation System	K0730
Patient Lift	E0630
Patient Lift	E0637
Patient Lift	E0638
Patient Lift	E0641
Patient Lift	E0642
Segmental Pneumatic Appliance	E0656
Segmental Pneumatic Appliance	E0657
Pneumatic Compression Device	E0675
Limb Compression Device	E0676
Neuromuscular Stimulator	E0744
Neuromuscular Stimulator	E0745
Nerve Stimulator	E0765
Electrical Stimulation Device	E0766
Wheelchair Seat Cushion (standard)	E2602
Wheelchair Seat Cushion (standard)	E2603
Wheelchair Seat Cushion (standard)	E2604
Positioning seat (standard)	T5001
Wheelchair Accessory (standard)	E2632
Wheelchair Accessory (standard)	E2633
Wheelchair (standard)	K0003
Wheelchair (standard)	K0004

Wheelchair (standard)	K0005
Wheelchair (standard)	K0006
Wheelchair (standard)	K0007
Repair of DME	K0739

Bariatric surgery

Effective April 1, 2017, HCS will be prior authorizing the following services:
43644, 43645, 43770, 43771, 43772, 43773, 43774, 43886, 43887, 43888, 43775, 43842, 43843, 43632, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865

Reminders

Appointment Availability Standards

Providers shall comply with the following minimum appointment availability standards, as applicable.

i. For emergency care: immediately upon presentation at a service delivery site.
ii. For urgent care: within twenty-four (24) hours of request.
iii. Non-urgent "sick" visit: within forty-eight (48) to seventy-two (72) hours of request, as clinically indicated.
iv. Routine non-urgent, preventive appointments: within four (4) weeks of request.
v. Specialist referrals (not urgent): within four (4) to six (6) weeks of request.
vi. Initial prenatal visit: within three (3) weeks during first trimester, within two (2) weeks during the second trimester and within one (1) week during the third trimester.
vii. Adult Baseline and routine physicals: within twelve (12) weeks from enrollment. (Adults >21 years). [Applicable to HIV SNP Program only]: Adult Baseline and routine physicals: within four (4) weeks from enrollment. (Adults >21 years).
viii. Well child care: within four (4) weeks of request.
ix. Initial family planning visits: within two (2) weeks of request.
x. Pursuant to an emergency or hospital discharge, mental health or substance abuse follow-up visits with a Participating Provider (as included in the Benefit Package): within five (5) days of request, or as clinically indicated.
xi. Non-urgent mental health or substance abuse visits with a Participating Provider (as included in the Benefit Package): within two (2) weeks of request.
xii. Initial PCP office visit for newborns: within two (2) weeks of hospital discharge; [Applicable to HIV SNP Program only]: Initial PCP office visit for newborns within forty-eight (48) hours of hospital discharge or the following Monday if the discharge occurs on a Friday.
xiii. Provider visits to make health, mental health and substance abuse assessments for the purpose of making recommendations regarding a recipient's ability to perform work when requested by a LDSS: within ten (10) days of request by an MMC Enrollee, in accordance with Section 10.7 of this Agreement.

Calling for an authorization

If a prior authorization was required, and an authorization was not obtained, the provider may bill for these services to obtain a claim denial. Upon receipt of the Explanation of Payment (EOP) the provider will have information on how to appeal the claim denial.

Maternity care providers

Molina Healthcare of NY follows Medicaid guidelines and uses a global rate to reimburse for maternity care. Maternity care includes antepartum care, delivery services, and postpartum care and should be submitted for reimbursement according appropriate codes. When a service is eligible for a global maternity care payment, the antepartum and postpartum care visits will not be paid separately. These ante and post-partum care claims must still be submitted for quality/tracking purposes. In certain circumstances, provision of antepartum care, delivery or postpartum care that is not part of a global service may be considered for separate reimbursement. You can find additional information in the Medicaid NCCI Manual at medicaid.gov/medicaid/data-and-systems/ncci/index.html or by visiting www.emedny.org.