Inpatient Authorization Request Update

Information for providers in all networks

Effective April 11, 2016, providers must submit prior authorization (PA) requests for inpatient emergency admission (including emergency room) and outpatient service via the Web Portal or fax. Molina Healthcare will no longer accept these requests via phone or email.

Requests must include a valid working diagnosis at the time of the submission. This can include signs and symptoms, but not “rule out.”

This update will improve efficiency and turnaround time by ensuring requests and supporting documents are received at the same time.


To fax, send the Service Request Form (www.MolinaHealthcare.com/Providers/OH under the “Forms” tab) and supporting documents to:

Medicaid (includes MyCare Ohio Medicaid): (866) 449-6843
Medicare (includes MyCare Ohio Medicare): (877) 708-2116
Marketplace: (855) 502-5130

Effective April 11, 2016 – Prior Authorization Update

Information for providers in all networks

Effective April 11, 2016, the following codes will be added to Molina Healthcare’s current list of codes that require PA:

- 27279 – Arthrodesis sacroiliac joint
- 36299 – Vessel injection procedure
- 81210 – Braf gene
- 81225 – Cyp2c19 gene com variants
- 81281 – Long qt synd known fam var
- 81324 – Pmp22 gene dup/delet
- 81504 – Oncology tissue of origin
- 86152 – Cell enumeration
- 86153 – Cell enumeration phys interp [reported w/ modifier 26]
- 36299 – Vessel injection procedure
- 99199 – Special service or report

An updated PA Code List will soon be posted to www.MolinaHealthcare.com/Providers/OH under the “Forms” tab.

New Billing Information for Hospice and Nursing Facilities

Information for participating hospice providers in the Medicaid, MyCare Ohio and Marketplace networks

Effective for dates of service March 1, 2016 and after, participating hospice providers cannot bill directly for hospice room and board (revenue code 065X and HCPCs code T2046). The participating nursing facility must bill room and board on a UB using revenue code 065X with HCPCs code T2046 and bill only for overnight stays. The facility will be reimbursed 100 percent of the Medicaid fee schedule. Molina Healthcare is not responsible for reimbursing room and board.

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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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ItMatters@MolinaHealthcare.com
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Join Our Email Distribution List

To learn how to receive this bulletin via email or view our bulletin archives, visit www.MolinaHealthcare.com/Providers/OH and click “Provider Bulletin” in the “Communications” tab.

Website Roundup

Recently updated at www.MolinaHealthcare.com/Providers/OH:

- Prior Authorization Code List
- Consent to Sterilization Form
- Guides to Participating Providers
- Transportation Training
- Transportation Guide

Clear Coverage™ Corner

Start using Clear Coverage™ for an authorization system that may provide an automatic decision. To learn more, join the next training session.

Fri., April 15 from 9 to 10 a.m.,
Meeting Number: 808 734 469
Fri., May 20 from 9 to 10 a.m.,
Meeting Number: 800 815 312

2. Enter the meeting number.
3. If asked, enter name and email.
4. Give your number for a call back.
5. Follow the instructions.

Request on-site training from your Provider Services Representative or by email OHProviderRelations@MolinaHealthcare.com.
Corrected Claims Submission Requirements

Information for providers in all networks

- **Include** all elements that need correction **and** all other elements originally submitted.
- **Do not** submit only codes edited by Molina Healthcare.
- **Do not** submit via the claims reconsideration process.

CMS 1500

- In 2300 Loop, the CLM segment (claim information) CLM05-3 (claim frequency type code) must indicate one of the following:
  - “7” – REPLACEMENT (replacement of prior claim)
  - “8” – VOID (void/cancel of prior claim)
- In 2300 Loop, the REF segment (claim information) must include the original claim number, found on the remittance advice.

UB04

- Bill type for UB claims are billed in loop 2300/CLM05-1. In bill type for UB, the 7 or 8 go in the third digit for “frequency.”
- In 2300 Loop, the REF segment (claim information) must include the original claim number, found on the remittance advice.

Primary payment details on both professional and facility claims

- Loop 2320 will have other payer information. Page 18 and 19 of the companion guide shows how to report the other payer loops.
- AMT*D will have the other payer paid amount.
- Line level payment amount should be reported at 2430 loop.

SBIRT – Identification of At-risk Patients in Primary Care

Information for providers in the Medicaid network

Ohio Medicaid now reimburses for screening, brief intervention, referral and treatment (SBIRT) to identify at-risk patients for alcohol and substance abuse. Codes G0396 and G0397 allow Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), physicians, physician assistants and advance practice nurses to:

- Use a validated screening instrument for screening
- Perform a brief intervention in the primary care setting
- Refer, as needed, those who need more extensive treatment

Refer members to Molina HealthCare’s Care Management program, a free service that supports the care and treatment you provide.

Codes Added to ODM Fee Schedules

Information for providers in the Medicaid network

New codes added to the Provider Administered Pharmaceuticals fee schedule include J7297 and J7298 (replacing J7302) and 2016 procedure codes. New coverage for procedures 96127 and 99420 are listed in the CPT and HCPCS Level 2 Procedure Code Changes. To learn more: [http://medicaid.ohio.gov/Providers/FeeScheduleandRates](http://medicaid.ohio.gov/Providers/FeeScheduleandRates).