MOLINA HEALTHCARE

# PROVIDER BULLETIN

A bulletin for the Molina Healthcare of Ohio provider networks

## Telehealth Place of Service (POS) 02 and GT Modifier

***Information for all Medicaid and MyCare Ohio providers***

As of Nov. 15, 2020, the Ohio Department of Medicaid (ODM) fee-for-service no longer accepts Place of Service (POS) 02 on telehealth claims where Medicaid is the primary payer. The ODM Telehealth Billing Guidelines are posted on their website.

Effective Nov. 15, 2020, Telehealth place of service (POS) 02 should **NOT** be billed on claims submitted to Molina Healthcare, and claims must be billed with the GT modifier, unless stated otherwise in ODM's telehealth billing guidelines.

Molina encourages providers to adopt this change as soon as possible. Claims billed with POS 02 will be denied where Molina Medicaid is the primary payer for date of service (DOS) Jan. 1, 2021 and after. The POS on the claim must reflect the physical location of the practitioner at the time the telehealth service was delivered and not POS 02.

Behavioral Health (BH) providers should continue to follow the most current ODM BH Provider Manual guidance for Telehealth billing as noted in the "10/19/2020 – Medicaid Billing Requirements for Telehealth Services MITS BITS, located at https://bh.medicaid.ohio.gov/" under "MITS Bits & Newsletters."

For Home Health services, Registered Nurse (RN) Assessment service and RN Consultation service, POS 02 should continue to be billed for these services provided using telehealth.



**Questions?**

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

Email us at OHProviderRelations@MolinaHealthcare.com

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## 2021 Provider Manual Annual Update: Significant Updates by Section/Chapter

***Information for all Medicaid and MyCare Ohio providers***

By Jan. 1, 2021, the updated Combined Medicaid and MyCare Ohio Provider Manual will be posted on our website under the "Manual" tab for a Jan. 1, 2021 effective date.

The items listed below outline content section-by-section where significant updates have been made to the Molina Healthcare of Ohio Medicaid and MyCare Ohio Combined Provider Manual (Combined Provider Manual). Format changes, removal of redundant information and/or streamlining of language have been made throughout the Combined Provider Manual. Additionally, content has been added to the Combined Provider Manual that has been previously communicated in Provider Bulletins and posted to the Molina Provider Website.

**Table of Contents**

- Refreshed section to align to chapters in the Provider Manual.
- New "Address and Phone Number" chapter listed.
- Removed "Background and Overview of Molina Healthcare Inc. (Molina Healthcare)" chapter.
- Replaced "Claims and Encounters Data" chapter with new name "Claims and Compensation."
- Replaced "Covered Services" chapter with new name "Benefits and Covered Services."
- Removed "Provider Portal" chapter.

**Addresses and Phone Numbers**

- Added new "Addresses and Phone Numbers" chapter to replace "Background and Overview of Molina Healthcare, Inc. (Molina Healthcare)" chapter.

**Eligibility, Enrollment, Disenrollment**

- Added "Effective Date of Enrollment" section to chapter.
- Added language defining when a Primary Care Provider (PCP) change request will become effective.

**Benefits and Covered Services**

- New "Member Cost Sharing" section. This section is noting provider's responsibility to collect the copayment and other Member Cost Share from member, as applicable, to receive full reimbursement for a service.
- New "Services Covered by Molina" and "Link(s) to Summary of Benefits" sections. These sections call out where this information is posted on the applicable line of business member websites for reference.
- New "Obtaining Access to Certain Covered Services" section. This section calls out certain categories of services for quick reference.
- New "Health Management Programs" section. This section captures information found throughout the manual and includes it all under one heading for ease of reference.
- New "Telehealth and Telemedicine Services" section to explain telehealth and telemedicine benefits.

**Claims and Compensation**

- Created separate sections for "Medicaid Third Party Liability (TPL)," "MyCare Ohio Third Party Liability (TPL)" and "Ohio Medicaid, MyCare Ohio Medicaid Secondary and MyCare Ohio Opt Out Third Party Liability (TPL)" to add clarity to the processes.
- Added language to "Reimbursement Guidance and Payment Guidelines" section with "Updates from Centers for Medicare & Medicaid Services (CMS) or state Medicaid agencies." The Manual states CMS and state Medicaid agencies issue periodic updates, additions, and revisions to their fee schedules, payment policies, payment rates, payment methodologies, regulations and other provisions for services furnished under the various fee schedules. The update or revision will be applied upon implementation to all claims received after the implementation.
- New "Telehealth Claims and Billing" section. This section details billing requirements for Medicaid as primary payer in alignment with the Nov. 15, 2020 Ohio Department of Medicaid (ODM) guidance, as well as Medicare billing requirements following CMS for Medicare as primary payer.
- Updated information in the "General Coding Requirements" section "Place of Service (POS) Codes" to note the following in the list of invalid POS codes: 02: Telehealth (Only for Medicare as Primary Payer; POS 02 will be denied for Medicaid as Primary Payer, unless stated otherwise in ODM's telehealth billing guidelines) and 03: School (only valid for Medicaid BH services).
- New "National Drug Code (NDC)" section.
- New "Medicaid Timely Claim Processing" section to consolidate information in separate areas of prior Provider Manuals.
- Added "MyCare Ohio Provider Reconsideration of Delegated Claims – Contracted Provider" section to consolidate information found in other Molina-published sources.

**Health Care Services**

- Added new "Requesting Prior Authorization," "Inpatient at Time of Termination of Coverage" and overview "Care Management (CM)" sections. The overview Care Management section consolidates separate line of business sections from prior Provider Manuals.
- Added language in the "Readmissions" section directing providers to the current, web-posted Readmission Payment Policy.

**Managed Long-Term Services and Support**

- Added a new "Managed Long-Term Services and Support (MLTSS)" chapter to replace the previous MLTSS Manual on Molina's Provider Website.

**Credentialing and Recredentialing**

- Removed detailed language in the "Types of Practitioners Credentialed & Recredentialed" section now noting that Nurse Practitioners, Physical Therapists and Physician Assistants are required to be credentialed.
- Updated requirements for "Fellowship Training" to remove restriction that Molina only recognizes fellowship training programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States.

**Delegation**
- Added a new "Delegation" overview chapter.

**Quality Improvement**
- Removed language regarding random audits under the "Medical Records" section.
- Added additional bullet points under "Medical Record Keeping Practices" section.
- Removed "Information Filed" section.
- Removed "Identifying and Implementing Appropriate Safety and Error Avoidance Initiatives" high-level overview section.
- Simplified language previously under "Access to Care" section. Timeframes regarding Appointment and Availability Standards did not change.
- Removed "Appointment Scheduling" section.
- Updated language in the "Administration & Confidentiality of Facilities" section.
- Removed "Care Management" section from this chapter.
- Updated "Clinical Practice Guidelines" by combining Clinical Practice Guidelines with the Behavioral Health Clinical Practice Guidelines and added the following Clinical Practice Guidelines: Acute Stress and Post-Traumatic Stress Disorder (PTSD), Anxiety/Panic Disorder, Perinatal/Prenatal/Postnatal Care and removed Attention-Deficit/Hyperactivity Disorder (ADHD) and Schizophrenia.
- Updated citations in "Preventive Health Guidelines" section to include Bright Futures/American Academy of Pediatrics and the Centers for Disease Control (CDC).
- Added "Medicare Health Outcomes Survey" section.
- Added "Merit-Based Incentive Payment System (MIPS)" section.
- Removed "Improving the Health Status of Health Plan Membership" section.

**Cultural Competency and Linguistic Services**
- Updated the "Nondiscrimination of Health Care Service Delivery" section with language from Section 1557 of the Affordable Care Act.

**Compliance**
- Added additional resources for reporting in the "Reporting Fraud, Waste and Abuse" section.
- Removed the "Sample Authorization for the Use and Disclosure of Protected Health Information form."

**Member Rights and Responsibilities**
- Removed "Molina Members' Rights" section and added link to Member Handbook.
- Removed "Molina Membership Responsibilities" section and added link to Member Handbook.

**Provider Responsibilities**
- Added "National Plan and Provider Enumeration System (NPPES) Data Verification" section.
- Added language in the "Member Eligibility Verification" section to remind providers that Member eligibility is the responsibility of the provider.

**Provider Portal**
- Chapter removed.

**Pharmacy**
- Added "Step Therapy" section.

**Risk Adjustment Management Program**
- Clarified the language in the "Why is Risk Adjustment Important?" section.
- Updated the "Your Role as a Provider" section.

**Appendix A**
- Changed B4157 to B4150 under "National Drug Codes (NDC)" section.
- Replaced the Modifier table for MLTSS under the "MyCare Ohio Billing Guidelines" with a link to the external, posted modifier document.
- Telehealth and Telemedicine Services have been modified to incorporate updated regulatory guidance from ODM and CMS.

**Appendix B**
- Updated "Transition of Care – Medicaid" section as follows and removed outdated content:

Transition of Care (TOC) for members transitioning from the below programs to Molina Healthcare of Ohio:
- Ohio Medicaid Fee-For-Service (FFS)
- Other Ohio Managed Care Plans (MCPs)
- Newly Enrolled in the Ohio Medicaid Program

**Molina will allow a new member to receive services from network and out-of-network providers, as indicated, if any of the following apply:**
- If Molina confirms that the Adult Extension member is currently receiving care in a nursing facility on the effective date of enrollment with Molina, Molina will cover the nursing facility care at the same facility until a medical necessity review is completed and, if applicable, a transition to an alternative location has been documented in the member's care plan.
- Upon becoming aware of a pregnant member's enrollment, Molina will identify the member's maternal risk and facilitate connection to services and supports in accordance with ODM's *Guidance for Managed Care Plans for the Provision of Enhanced Maternal Care Services.* These services and supports include delivery at an appropriate facility and continuation of progesterone therapy covered by Medicaid FFS or another MCP for the duration of the pregnancy. In addition, Molina will allow the pregnant member to continue with an out-of-network provider if she is in her third trimester of pregnancy and/or has an established relationship with an obstetrician and/or delivery hospital.
- **If a prior authorization (PA) is on file:** Molina will honor any PA approved prior to the member's transition to Molina through the expiration of the authorization period, based on the member's effective date with Molina; regardless of whether the authorized or treating provider is in or out-of-network with Molina.
  - The MCP may conduct a medical necessity review for previously authorized services if the member's needs change to warrant a change in service. Molina will render an authorization decision pursuant to Ohio Administrative Code (OAC) rule 5160-26-03.1.
  - Molina may assist the member to access services through a network provider when any of the following occur
    - The member's condition stabilizes, and Molina can ensure no interruption to services;
    - The member chooses to change to a network provider; or
    - If there are quality concerns identified with the previously authorized provider.
  - Scheduled inpatient or outpatient surgeries approved and/or pre-certified shall be covered pursuant to OAC rule 5160-2-40 (surgical procedures would also include follow-up care as appropriate).
  - Organ, bone marrow, or hematopoietic stem cell transplant shall be covered pursuant to OAC rule 5160-2-65 and Appendix G of the Agreement between Molina and ODM.
- **If no prior authorization (PA) is on file:** Molina will provide the following services to the member regardless of whether services were prior authorized/pre-certified, or the treating provider is in or out-of-network with the MCP. Timeframes for the services are below:

- Chemotherapy or Radiation – within 30 days of the member's effective date with Molina.
- Durable Medical Equipment (DME) – within 30 days of the member's effective date with Molina. DME shall be covered at the same level with the same provider as previously covered until Molina conducts a medical necessity review and renders an authorization decision pursuant to OAC rule 5160-26-03.1.
- Home Care and Private Duty Nursing (PDN) Services – within 30 days of the member's effective date with Molina. Private Duty Nursing and home care services shall be covered at the same level with the same provider as previously covered until Molina conducts a medical necessity review and renders an authorization decision pursuant to OAC rule 5160-26-03.1.
- Hospital Discharge – Molina will continue with treatment if the member was discharged 30 days prior to Molina's enrollment effective date within 30 days of the member's effective date with Molina.
- Medicaid Community Behavioral Health Services – Members can see out-of-network providers within 30 days of the member's effective date with Molina. If a member is unable to obtain medically necessary services from a Molina network provider, Molina will adequately and timely cover the services out-of-network until Molina is able to provide the services from a network provider. For continuity of care purposes, Molina will:
  - Work with the service provider to add the provider to their network;
  - Implement a single case agreement with the provider; or
  - Assist the member in finding a provider currently in Molina's network.
- Physician Services – within 30 days of the member's effective date with Molina, then must be transitioned to a network provider or medical necessity for seeing an out-of-network provider must be established
- Prescribed drugs shall be covered without PA for at least the first 90 days of membership, or until a provider submits a PA and the MCP completes a medical necessity review, whichever date is sooner. The MCP shall educate the member that further dispensation after the first 90 days will require the prescribing provider to request a PA. If applicable, the MCP shall offer the member the option of using an alternative medication that may be available without PA. Written member education notices shall use ODM-specified model language. Verbal member education may be substituted for written education but shall contain the same information as a written notice. Written notices or verbal member education shall be prior approved by ODM.
- Upon notification from a member and/or provider of a need to continue services, the MCP shall allow a new member to continue to receive services from network and out-of-network providers when the member could suffer detriment to their health or be at risk for hospitalization or institutionalization in the absence of continued services.

- **Change in Enrollment During Hospital/Inpatient Facility Stay: Process between the Managed Care Plans (MCP):**
  - When the MCP learns of a currently hospitalized member's intent to disenroll the eligibility files exchanged between ODM and the MCPs, the disenrolling MCP shall notify the hospital/inpatient facility and treating providers as well as the enrolling MCP, if applicable, of the change in enrollment. The disenrolling MCP shall notify the inpatient facility that it will remain responsible for the inpatient facility charges through the date of discharge; and shall notify the treating providers that it will remain responsible for provider charges through the date of disenrollment. The disenrolling MCP shall not request and/or require that a disenrolled member be discharged from the inpatient facility for transfer to another inpatient facility. Should a discharge and transfer to another inpatient facility be medically necessary, the disenrolling MCP shall notify the treating providers to work with the enrolling MCP or ODM as applicable to facilitate the discharge, transfer and authorization of services as needed.
  - When the enrolling MCP learns through the disenrolling MCP, through ODM or other means, that a new member who was previously enrolled with another MCP was admitted prior to the effective date of enrollment and remains an inpatient on the effective date of enrollment, the enrolling MCP shall contact the hospital/inpatient facility. The enrolling MCP shall verify that it is responsible for all medically necessary Medicaid covered services from the effective date

of MCP membership, including professional charges related to the inpatient stay; the enrolling MCP shall inform the hospital/inpatient facility that the admitting/disenrolling MCP remains responsible for the hospital/inpatient facility charges through the date of discharge. The enrolling MCP shall work with the hospital/inpatient facility to facilitate discharge planning and authorize services as needed.
When the MCP learns that a new member who was previously on Medicaid FFS was admitted prior to the effective date of enrollment and remains an inpatient on the effective date of enrollment, the MCP shall notify the hospital/inpatient facility and treating providers that the MCP is responsible for the professional charges effective on the date of enrollment, and shall work to ensure discharge planning provides continuity using MCP-contracted or authorized providers.

If a member has been admitted to a hospital prior to the first day of Medicaid eligibility and no retroactivity occurs, the MCP is responsible for reimbursement of the inpatient claim for the days the member is enrolled in the MCP only. The days prior to eligibility would be considered non-covered days, and the claim will be processed on a per diem payment basis as partial eligibility. In addition, if a member loses Medicaid coverage during and inpatient stay prior to discharge, payment will be made on a per diem basis up to and including the termination date with Molina.