Senior Whole Health Claims and Billing Orientation

Plan Year 2025

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Claims Submission

- We recommend that you submit claims through the Electronic Data Interchange (EDI) for efficient processing and payment. We work with multiple clearinghouses including SSI Claimsnet and claims may also be submitted utilizing Availity.

- SWH has partnered with ECHO Health, Inc. (ECHO), for payment delivery and 835 processing. To register for the ECHO platform please see the Claims & Authorizations section on our website. This page includes information on electronic claims submissions, FAQs, and registration information.

- Electronic Payer ID-**SWHMA**

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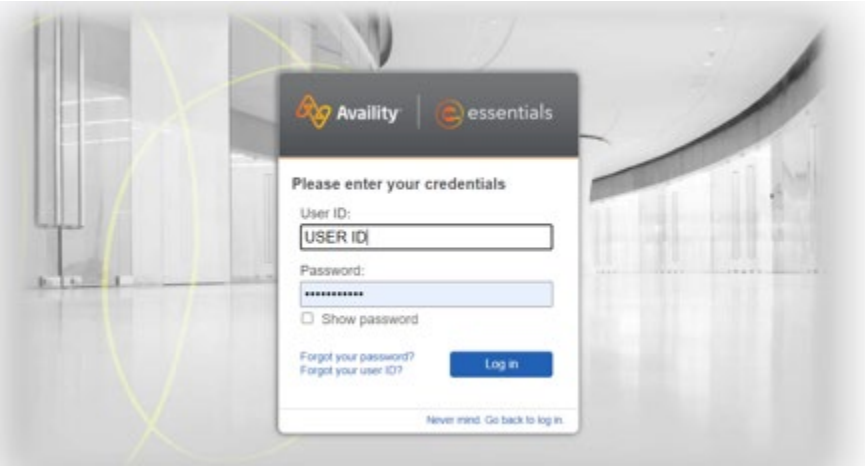
Availity Essentials Provider Portal

SWH utilizes the Availity Provider Portal for providers to:

- Verify benefits and eligibility
- Submit claims / view claim status
- Submit Authorizations
- Appeal/Reconsider Claims
- Upload supporting documentation for claims
- Submit HEDIS documentation



We continue to expand these offerings and will communicate any additional services as they become available

- To register for an account on the Availity Provider Portal, please visit:
  Availity Registration

Additional information on Availity including upcoming trainings can be found on the SWH website.

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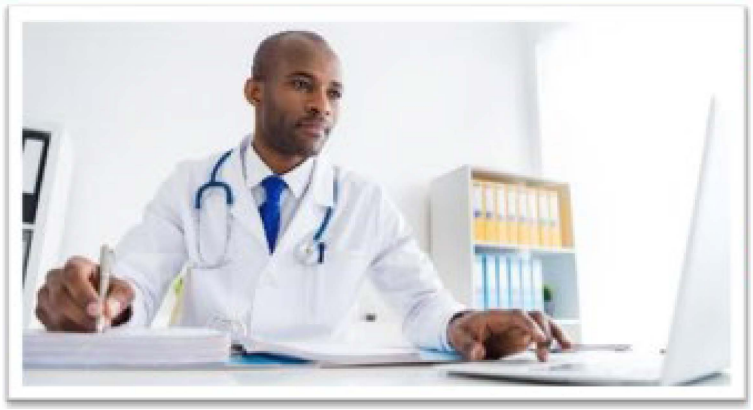
Availity Essentials Portal

The Availity Essentials Provider Portal is secure and available 24 hours a day, seven days a week. Self-service Provider Portal options include:

- Online Claim Submission
- Claims Status Inquiry
- Corrected Claims
- Member Eligibility Verification and Benefits
- Secure Messaging
- Check Status of Claim Dispute



- Manage Overpayment Request
- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Claim Appeal/ Reconsideration Requests
- Care Coordination Portal
- Remittance Viewer
- View PCP Member Roster
- Submit and Check Status of PA Requests

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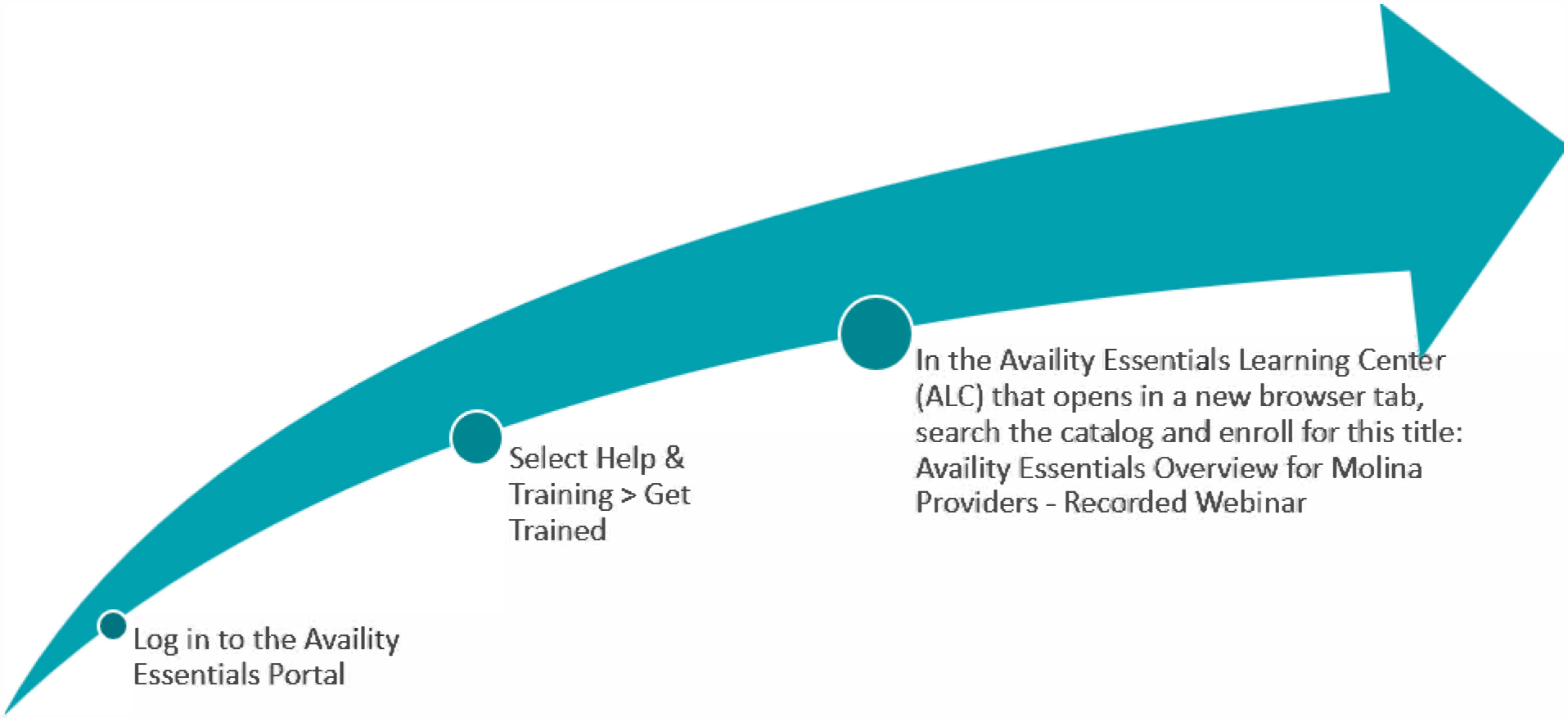
Availity Essentials Portal

Once registered providers will have access to the Availity Essentials Portal training by following these steps:



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Requirements on every Claim

- Member name, date of birth and Senior Whole Health Member ID number
- Member's gender
- Member's address
- Date(s) of service
- Valid International Classification of Diseases diagnosis and procedure codes
- Valid revenue, CPT or HCPCS for services or items provided
- Valid Diagnosis Pointers
- Total billed charges
- Place and type of service code
- Days or units as applicable (anesthesia Claims require minutes)
- Provider tax identification number (TIN)
- 10-digit National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Rendering Provider information when different than billing
- Billing/Pay-to Provider name and billing address
- Place of service and type (for facilities)
- Disclosure of any other health benefit plans
- National Drug Code (NDC), NDC Units, Units of Measure and Days or Unites for medical injectables
- E-signature
- Service facility location information
- Any other state-required data
- Any applicable authorization number approved for the service

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Professional and Institutional Claim Forms

The two claim forms used for billing Molina include:

Providers should follow standard guidance for accurate completion of UB-04 and CMS-1500 claims prior to submission

The two form types do not always stand alone. For example, if a surgeon performs a procedure in a facility such as a hospital or Ambulatory Surgery Center (ASC), a CMS-1500 will be submitted for the surgeon's services only, while a separate UB-04 form will be submitted for the use of the facility. Both forms will be needed to fully bill out for a procedure.

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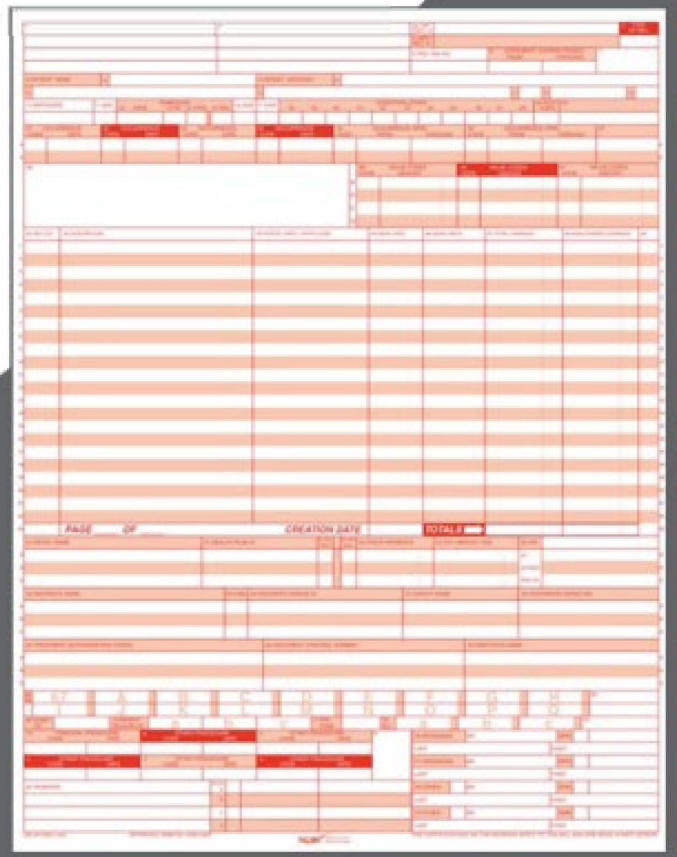
UB-04 Claim Form

The National Uniform Billing Committee (NUBC) UB-04 claim form is used by facility providers, including:



Molina strongly encourages providers to submit claims electronically, including secondary claims.

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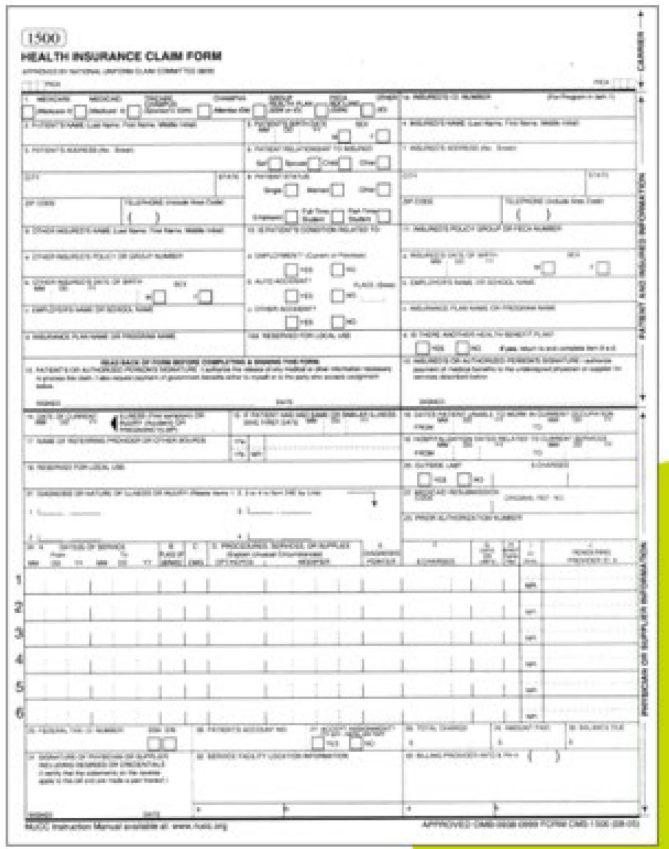
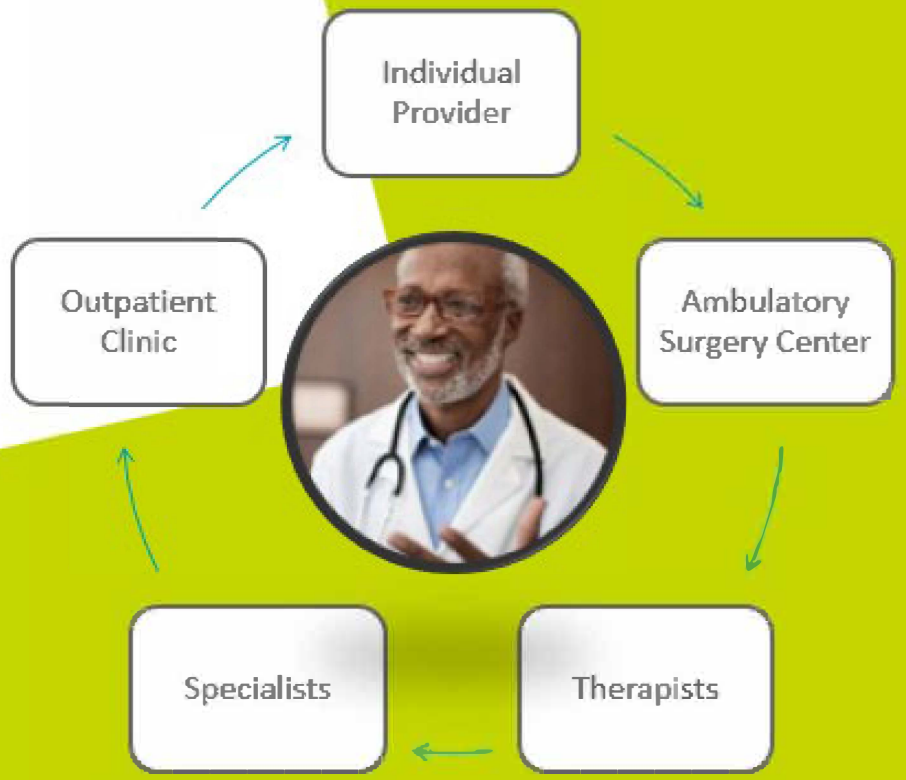
CMS-1500 Claim Form

The National Uniform Billing Committee (NUBC) CMS-1500 claim form is used by non-institutional providers, up to and including:


1500

HEALTH INSURANCE CLAIM FORM



Molina strongly encourages providers to submit claims electronically, including secondary claims.

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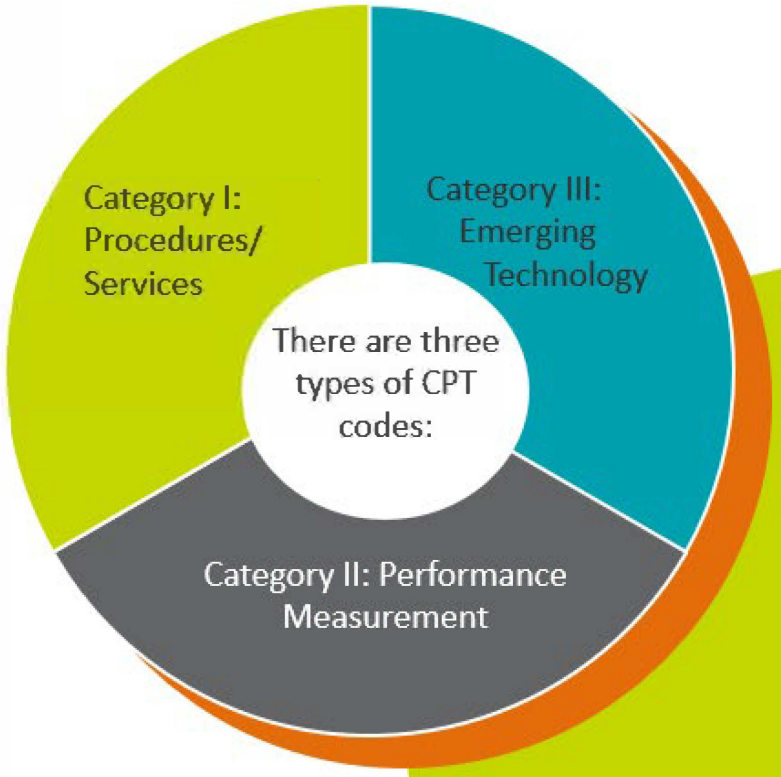
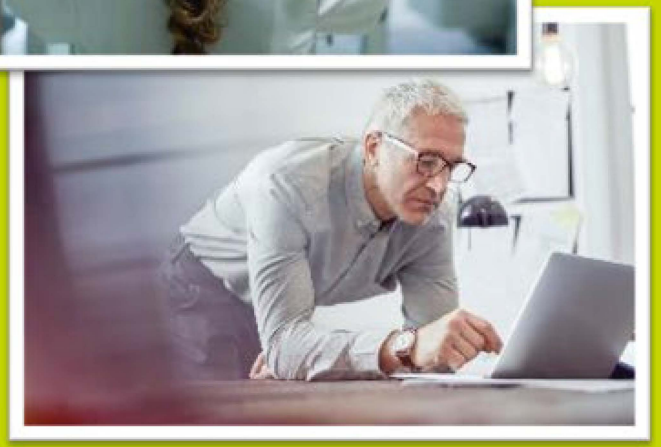
Coding Sources: CPT

CPT is an American Medical Association (AMA) maintained uniform coding system.

CPT codes are five-digit numeric codes used to identify medical services and procedures furnished by physicians and other health care professionals.





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Coding Sources: HCPCS

Health Care Common Procedure Coding System (HCPCS) is a CMS-maintained uniform coding system.

HCPCS codes are five-digit numeric codes used to identify procedure, supply and Durable Medical Equipment (DME) codes furnished by physicians and other health care professionals.

There are two types of HCPCS codes:

Level I:
Comprised of CPT codes

Level II:
Used to identify products, supplies and services not included in CPT codes (ex. ambulance services and DME)

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Coding Sources: ICD-10 Diagnosis

ICD-10-CM –
International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM) diagnosis codes are maintained by the National Center for Health Statistics (NCHS), Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).

ICD-10-PCS –
International Classification of Diseases, 10th revision, Procedure Coding System (ICD-10-PCS) are used to report procedures for inpatient hospital services.

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11-Digit National Drug Code (NDC)

The 11-digit National Drug Code (NDC) number must be reported on all professional and outpatient claims when submitted on the CMS-1500 and UB-04 claim forms, or electronic equivalent.

Providers will need to submit claims with both HCPCS and NDC codes with the exact NDC that appears on the medication packaging in the 5-4-2 digit format (i.e., xxxxx-xxxx-xx) as well as the NDC units and descriptors.

If the NDC information is missing or invalid, the claim line(s) will be denied.

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10-Digit National Drug Code (NDC)

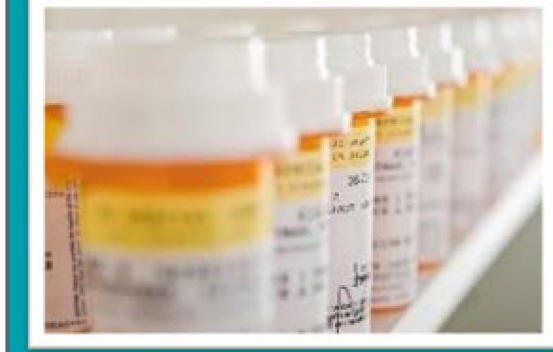
When the package of a drug only includes a 10-digit NDC number, the 10 digits must be converted to 11 digits by adding a leading zero to only one segment as indicated below:

Ex.
09999-9999-99

If the first segment contains only four digits, add a leading zero to the segment

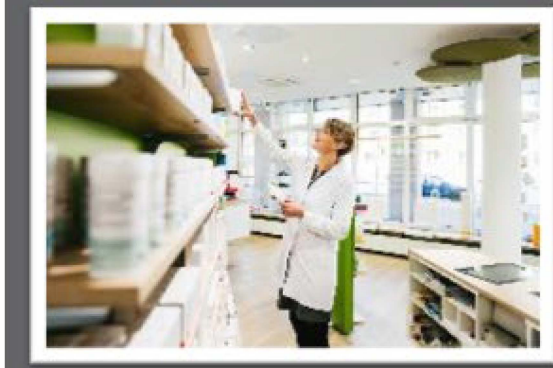
Ex.
99999-0999-99

If the second segment contains only three digits, add a leading zero to the segment



Ex.
99999-9999-09

If the third segment contains only one digit, add a leading zero to the segment



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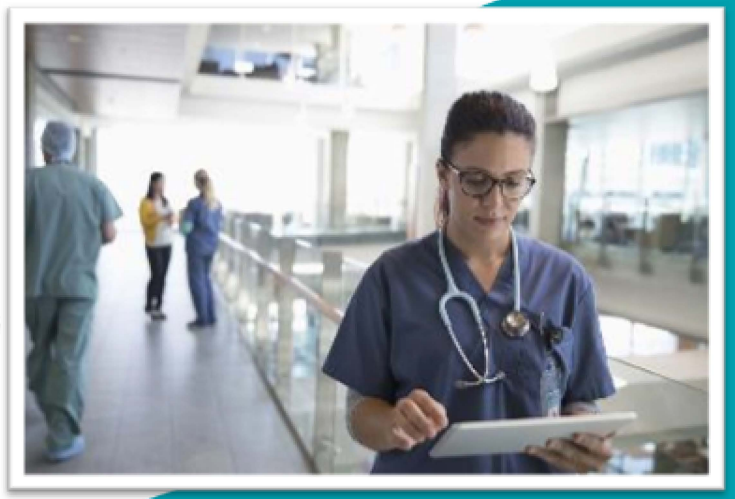
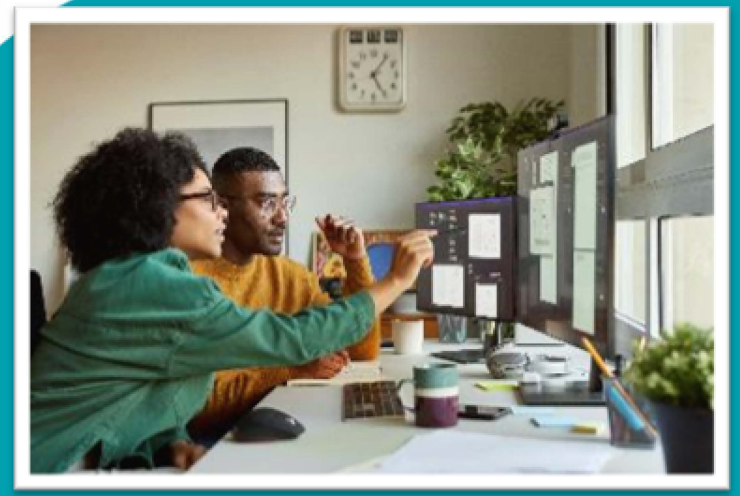
National Correct Coding Initiative (NCCI)

CMS has directed all federal agencies to implement National Correct Coding Initiative (NCCI) as policy in support of Section 6507 of the Patient Affordable Care Act of March 23, 2010. Molina uses NCCI standard payment methodologies.

NCCI Procedure to Procedure edits prevent inappropriate payment of services that should not be bundled or billed together, and to promote correct coding practices.

Based on NCCI Coding Manual and CPT guidelines, some services/procedures performed in conjunction with an Evaluation and Management (E&M) code will bundle into the procedure when performed by same physician and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures.





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NCCI, Continued

NCCI editing also includes Medically Unlikely Edits (MUEs), which prevent payment for an inappropriate number/quantity of the same service on a single day. A MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same provider for the same patient on the same date of service.

Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

For additional information on CMS guidelines for NCCI edits, visit the CMS NCCI page.

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Evaluation and Management (E&M)

Providers should report E&M services in accordance with the AMA CPT Manual and the CMS guidelines for billing E&M service codes: Documentation Guidelines for E&M.

- The level of service for E&M service codes is based primarily on the member's medical history, examination and medical decision-making.
- Counseling, coordination of care, the nature of the presenting problem and face-to-face time are considered contributing factors.
- Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.
- It would not be medically necessary or appropriate to bill a higher level of E&M service when a lower level or service is warranted.
- The volume of documentation should not be the primary influence upon which a specific level of service is billed and should support the level of service reported.

CMS Regulations and Guidance 30.6.1/Selection of Level of Evaluation and Management Services, A – Use of CPT Code (cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r178cp.pdf).

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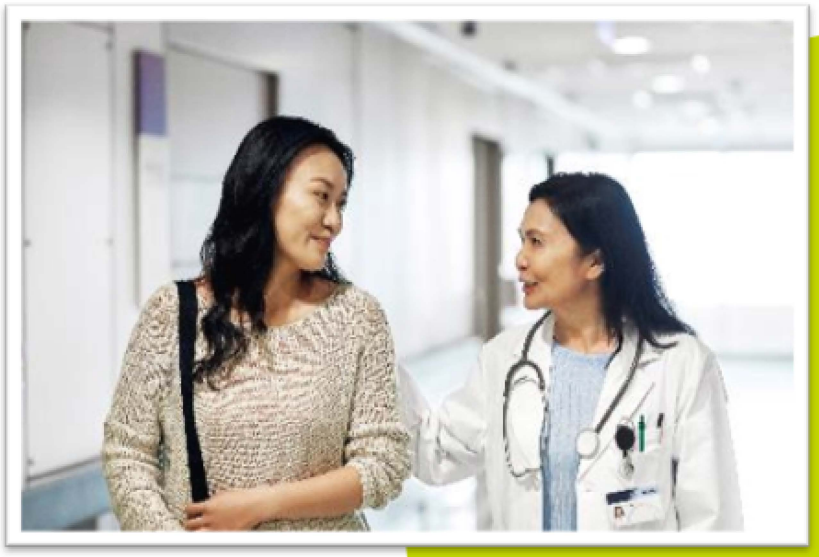
Diagnosis Related Group (DRG)

Diagnosis Related Group (DRG) (both Medicare Severity-Diagnosis Related Group [MS-DRG] and All Patient Refined-Diagnosis Related Group [APR-DRG]) clinical validations are performed by Molina and a vendor.

The DRG and principal diagnosis are to be determined upon discharge and should not be based on the clinical suspicions at the time of admission.

The DRG clinical validation determination will be made using the medical record documentation available at the time of review, or upon request, and must support all diagnoses and procedures billed, including Major Complication or Comorbidity (MCC) and Complication or Comorbidity (CC).



Correct DRG assignment is in accordance with industry coding standards:

- Coding Clinics
- ICD Coding Manual
- ICD-10-CM Coding Guidelines
- Uniform Hospital Discharge Data Set

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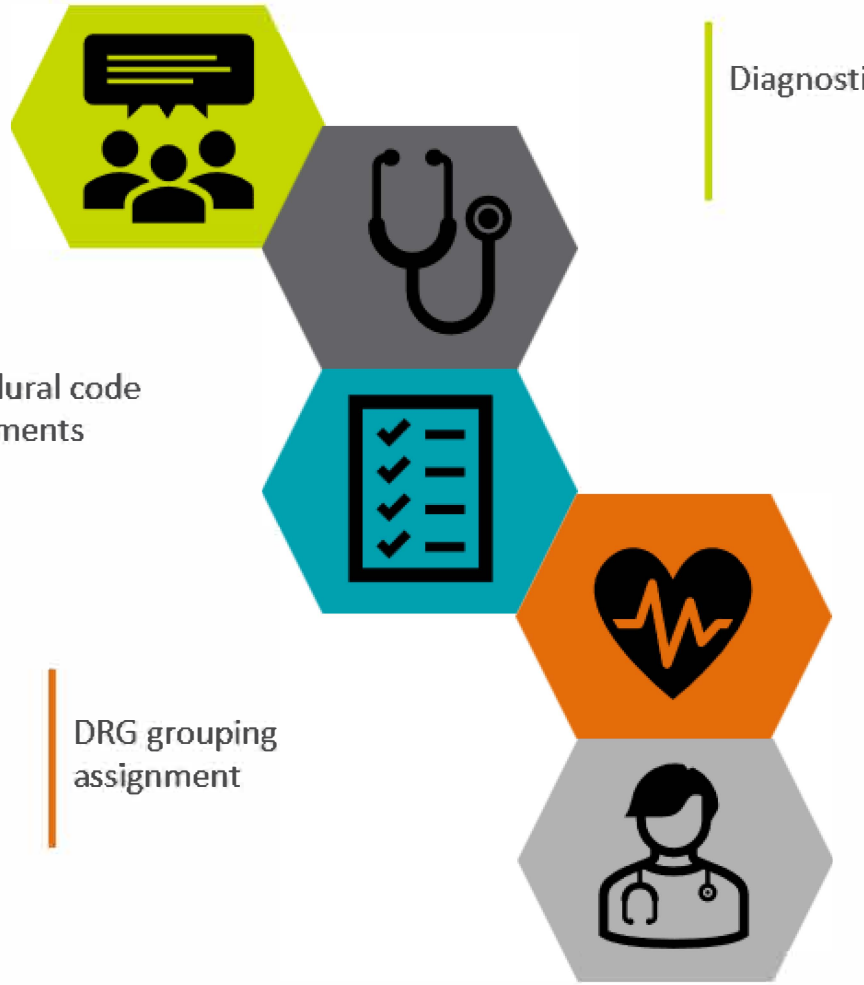
DRG, Continued

DRG clinical validation includes, but is not limited to, verification of the following:



- Diagnostic code assignments
- Procedural code assignments
- Sequencing of codes
- DRG grouping assignment
- Major Complication or Comorbidity (MCC) and Complication or Comorbidity (CC), if reported

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DRG, Continued

In the event that DRG clinical validation does not substantiate the billed DRG, or it is inconsistent with standards and requirements, Molina will:

- Update the incorrect DRG to the correct DRG assignment
- Adjust payment or request refunds as appropriate
- Send a notification of the result

In the event providers do not submit requested documentation within 30 days, or the documentation submitted does not support the DRG clinical validation review, Molina may deny, reduce or recover claim payment consistent with the documentation provided.

Molina will send a notification explaining the results of the validation review.

Providers retain their right to dispute the results of these reviews as outlined in the letter or in the Provider Manual.

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Optum Prepay Audit

Molina, in partnership with Optum, performs prepayment reviews utilizing widely acknowledged national guidelines for billing practices and to support uniform billing for all payers.

The prepayment claim reviews will ensure claims are billed accurately and coded correctly by reviewing state and federal policies sourced from Medicaid and Medicare rules utilized industry-wide.

The concepts utilized for the pre-pay reviews align with correct coding practices and incorporate a review of medical records to determine whether they support the services and codes billed.

*SWH also utilizes Cotiviti as a pre-pay solution

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NCDs and LCDs

Through implementation of claims edits, Molina's claims payment system is designed to audit claims concurrently, in order to detect and prevent paying claims that are inappropriate.

In the absence of state specific guidelines, Molina applies additional guidelines to their claims' payment logic, including:

- National Coverage Determinations (NCDs)
- Local Coverage Determinations (LCDs)

NCDs and LCDs are decisions by Medicare and their administrative contractors that provide coverage information and determine whether services are reasonable and necessary on certain services offered by participating providers.

Note: NCDs supersede LCDs, but **LCDs** expand on coverage policies for each jurisdiction, and these coverage policies may vary, including information regarding appropriate coding, credentialing, diagnostic testing and treatment.

Code Edit Policy Disputes

When submitting a Claim Reconsideration related to a code edit it is important to include the information below:

- Include any supporting clinical documentation
- Include trip documentation for ambulance services
- Explanation of why the provider does not agree with Molina's current correct coding policy or interpretation
- Include the supporting alternative policy information and the source where it can be found

A provider can request a Claim Reconsideration regarding a code edit policy in situations where the provider's and Molina's correct coding policy sources conflict, or where they may have different interpretations of a common correct coding policy source.

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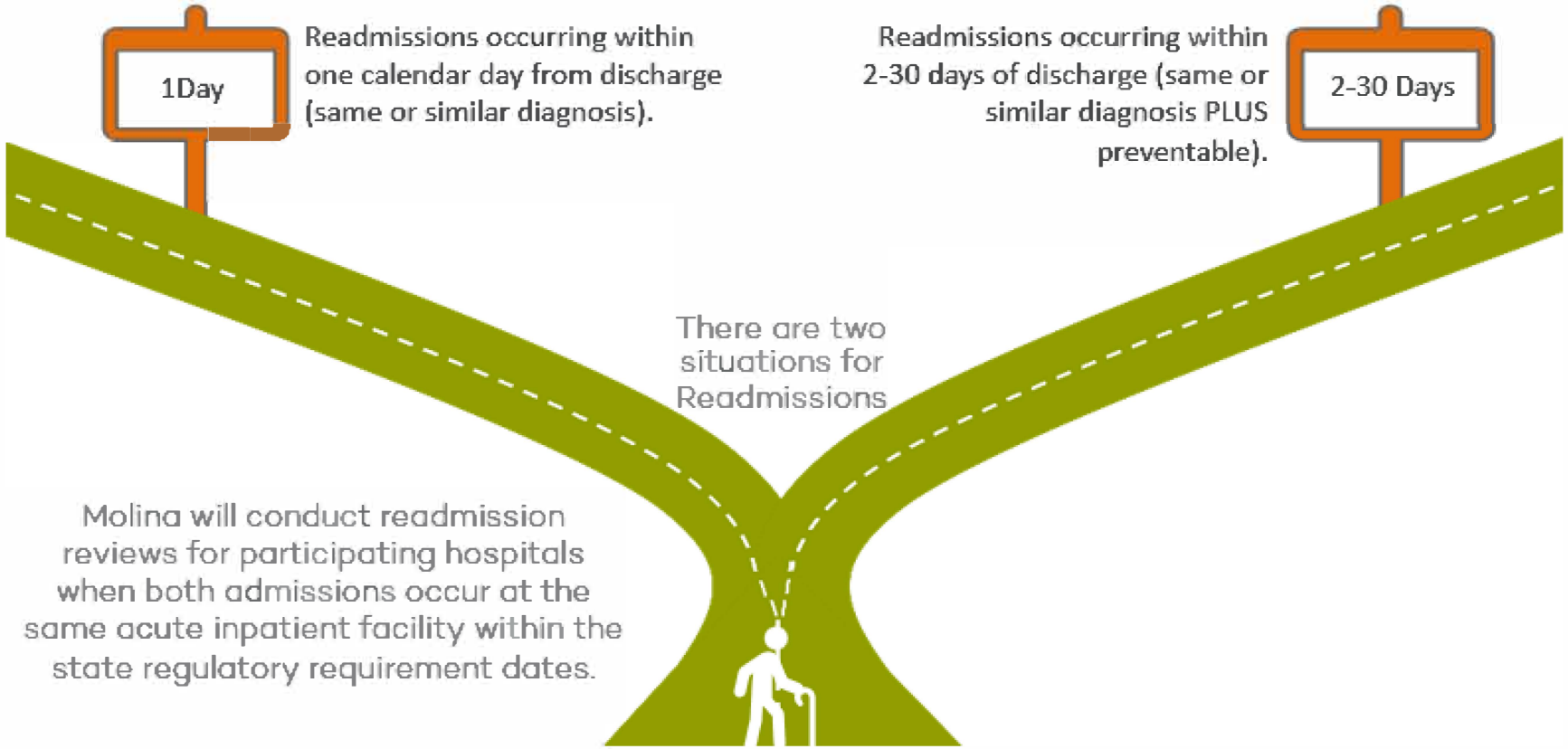
Readmissions

Readmission review is an important part of Molina's Quality Improvement Program to ensure that Molina members are receiving hospital care that is compliant with nationally recognized guidelines as well as federal and state regulations.



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Readmissions, Continued

One Calendar Day

When a subsequent admission to the same facility with the same or similar diagnosis occurs within one calendar day of discharge, the hospital will be informed that the readmission should be combined with the initial admission and will be processed as a continued stay.

2-30 Days

When a subsequent admission to the same facility occurs within 2-30 days of discharge, if it is determined that the readmission is related to the first admission (readmission), or if it is determined to be preventable, then a single payment may be considered as payment in full for both the first and subsequent hospital admissions.

Provider can dispute with supporting documentation if they believe the readmission is unrelated or unpreventable based on published guidelines.

For additional information see the Readmission Payment Policy on the Provider Website.

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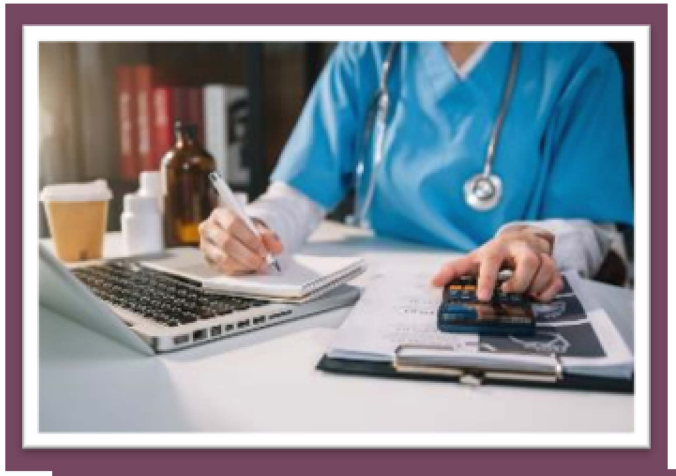
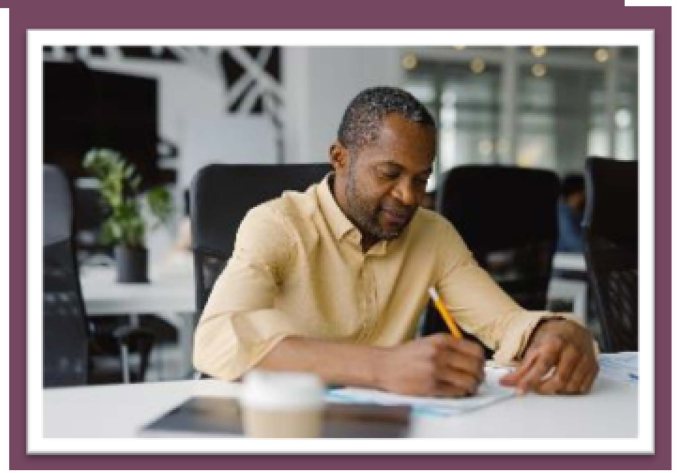
Corrected Claims

Corrected claims are considered new claims for processing purposes. Corrected claim submissions are not adjustments and should be directed through the original submission process marked as a corrected claim or it may result in the claim being denied.





- Corrected claims must be submitted electronically with the appropriate fields on the 837I or 837P completed.
- The Provider Portal includes functionality to submit corrected Institutional and Professional Claims.
- Corrected claims must include the correct coding to denote if the claim is a replacement of prior claim or corrected claim for an 837I, or the correct resubmission code for an 837P, and include the original claim number.
- Claims submitted without the correct coding will be denied.

Claim Frequency Code	Description	Action
7	Use to replace an entire Claim.	Senior Whole Health will adjust the original Claim. The corrections submitted represent a complete replacement of the previously processed Claim.
8	Use to eliminate a previously submitted Claim.	Senior Whole Health will void the original Claim from records based on request.

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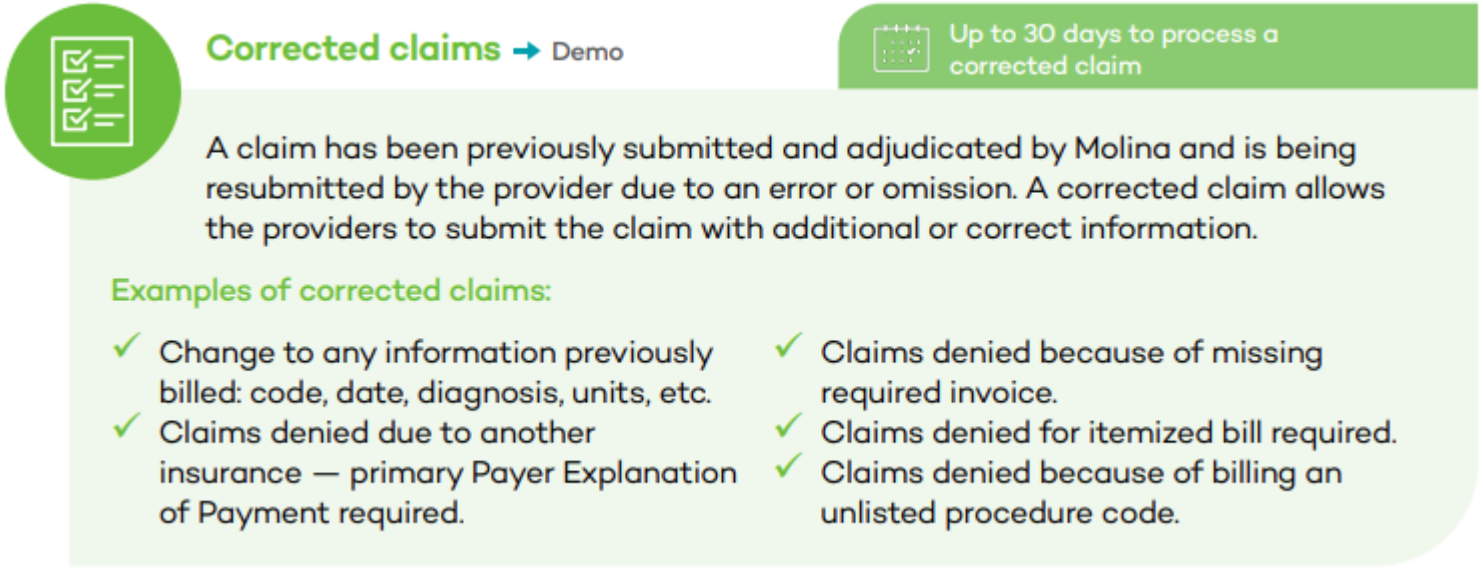
Corrected Claims, Continued

Corrected claims can be submitted and managed through Availity



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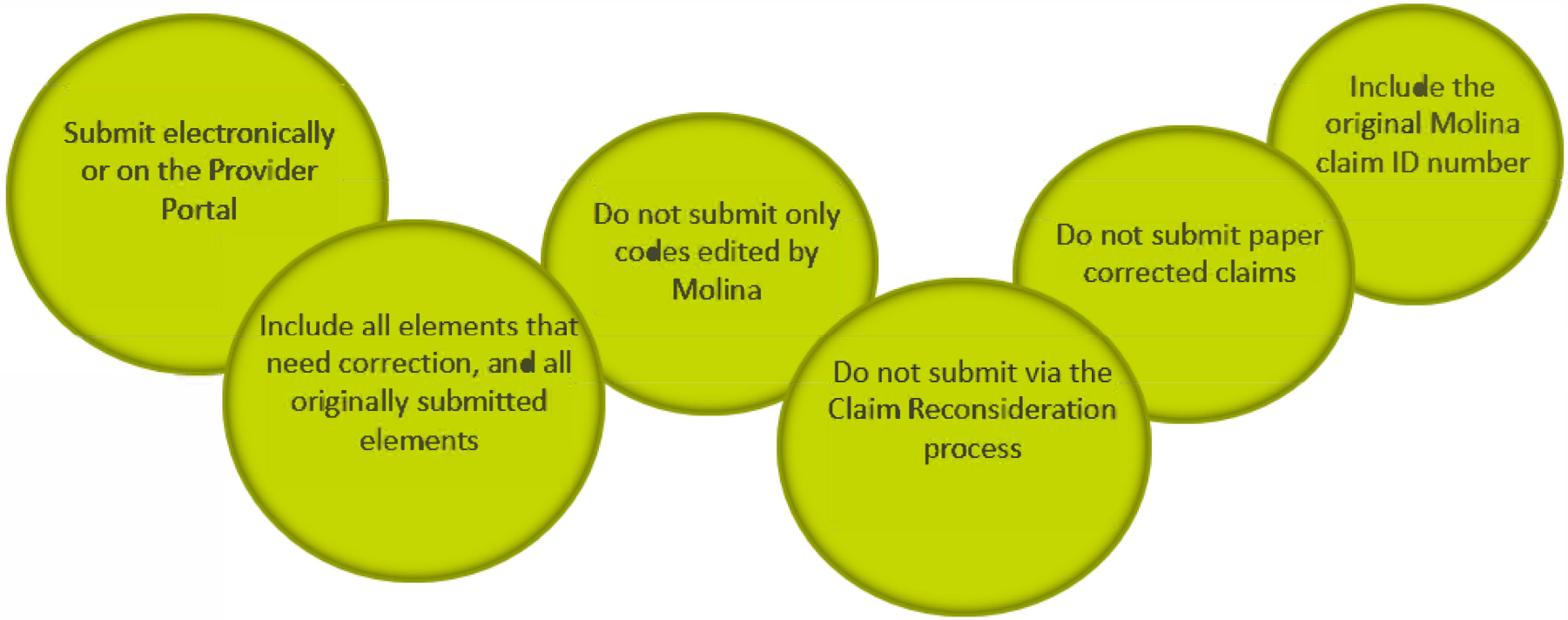
Corrected Claims, Continued

Corrected Claims must be received by Molina no later than the filing limitation stated in the provider contract or within 365 days of the original remittance advice. Claims submitted after the filing limit will be denied.

Reminders for the corrected claim process:



Corrected claims must be submitted with the Molina claim ID number from the claim being corrected, and with the appropriate corrected claim indicator based on claim form type.

Corrected Claim Requirements

All Corrected Claims:
- Must be free of handwritten or stamped verbiage (paper Claims).
- Must be submitted on a standard red and white CMS-1450 (UB-04) or CMS-1500 Claim form (paper Claims).
- Original Claim number must be inserted in field 64 of the CMS-1450 (UB-04) or field 22 of the CMS-1500 of the paper Claim, or the applicable 837 transaction loop for submitting corrected claims electronically.
- The appropriate frequency code/resubmission code must also be billed in field 4 of the CMS-1450 (UB-04) and 22 of the CMS-1500.

Note: The frequency/resubmission codes can be found in the NUCC (National Uniform Claim Committee) manual for CMS-1500 Claim forms or the UB Editor (Uniform Billing Editor) for UB-04 Claim forms.

Corrected Claims must be sent within thirty (30) calendar days of the original claim's Remittance Advice (RA) date.

Corrected Claims submission options:
- Submit Corrected Claims directly to Senior Whole Health via the Availity portal.
- Submit Corrected Claims to Senior Whole Health via your regular EDI clearinghouse.

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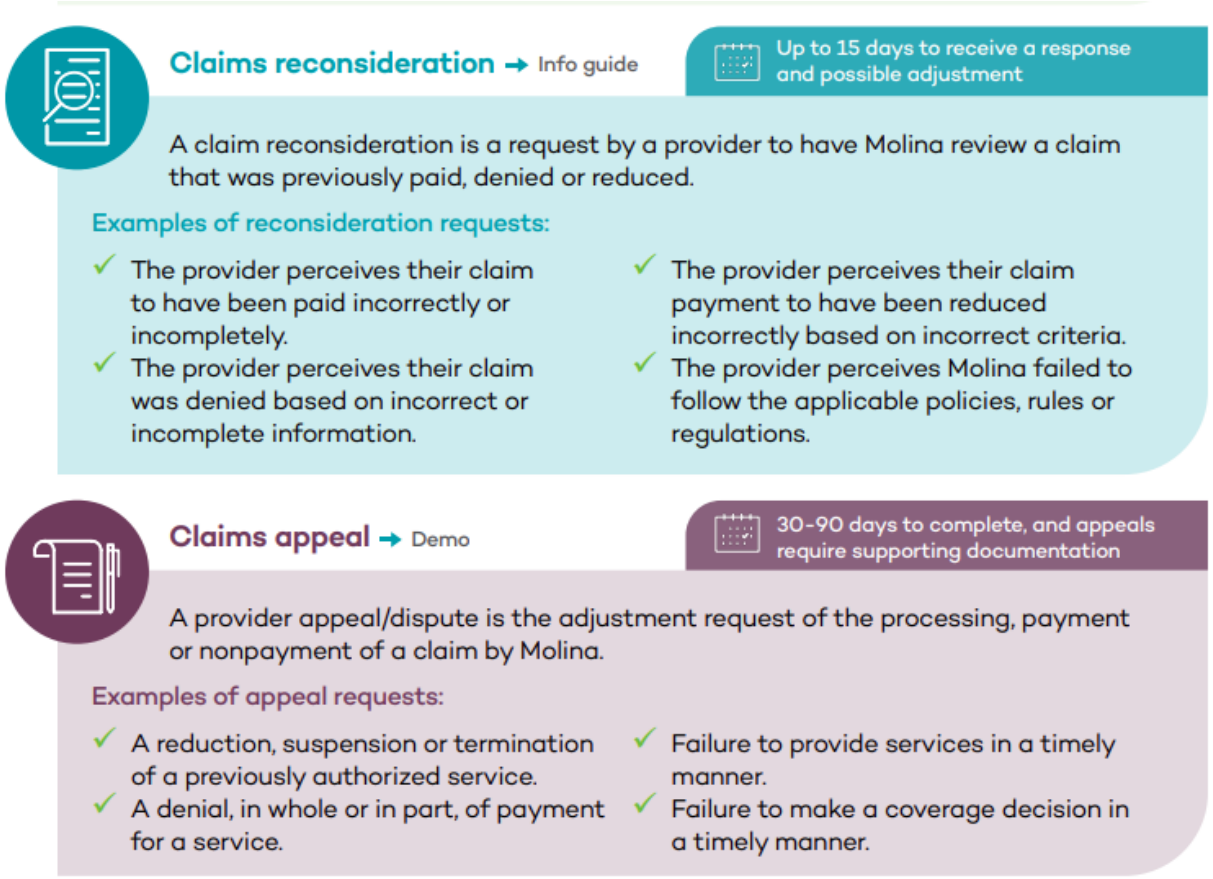
Availity Reconsiderations/Appeals

Claim Reconsiderations/Appeals can be managed through Availity. The claims workflow including demos can be found here. Providers would submit a reconsideration/appeal via claim status and complete the dispute request in the designated appeal's standalone function in the provider portal.



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Provider Claim Dispute

A Provider Claim dispute is a reconsideration review of a Claim previously adjudicated related to a denial of payment/partial payment (example: timely filing, duplicate, code edit, NCCI Edit, non-covered service, benefit exhaustion, rate of payment/contracted rate issue) with documentation to support your dispute, such as coding requirements (AAPC/Novartis), contracts, state and/or federal regulations, and payment policies. The Claim dispute reconsideration must be requested within the contractual timeframes outlined in your Provider Agreement with Senior Whole Health. This will be directed to the Appeals department for review of the dispute. The dispute will be investigated, addressed and the Provider will be notified of the outcome in writing within 60 calendar days from the date the dispute is received by Senior Whole Health.

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Provider Claim Appeal

A Provider Claim appeal is a written request for medical necessity review of a Claim denial or partial denial. All requests must include the necessary documentation, such as labs, hospital history and physical (H&P), discharge summaries, progress notes, radiology images/information for the date of service pertaining to the Claim in question for the appeal review to be completed. The appeal must be requested within the contractual timeframes outlined in your Provider Agreement with Senior Whole Health. The appeal will be investigated, addressed and the Provider will be notified of the outcome in writing, within 60 calendar days from the date the appeal is received by Senior Whole Health.

- The denial or limited authorization of a requested service, including the type or level of service.
- The authorization did not meet medical necessity.
- Partial Denials.
- The reduction, suspension or termination of a previously authorized service.
- The denial of whole payment for services rendered.
- Timely submission of authorization.

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Claims Requiring Itemized Bills

All Claim/Claim lines that deny for itemized bill on the Explanation of Provider Payment (EPP) remit, must be sent with a corrected Claim to the address below. The corrected Claim and the itemized bill must match for the reconsideration to be completed.
Mailing address:
Senior Whole Health
PO Box 22630
Long Beach, CA 90801
Electronic Data Interchange (EDI) Number: 61799

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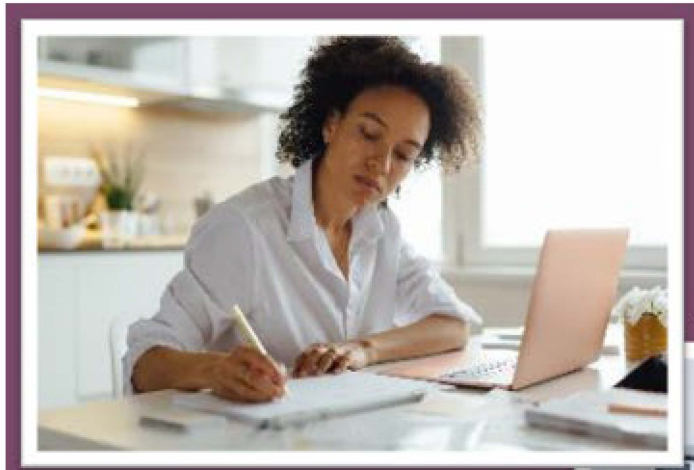
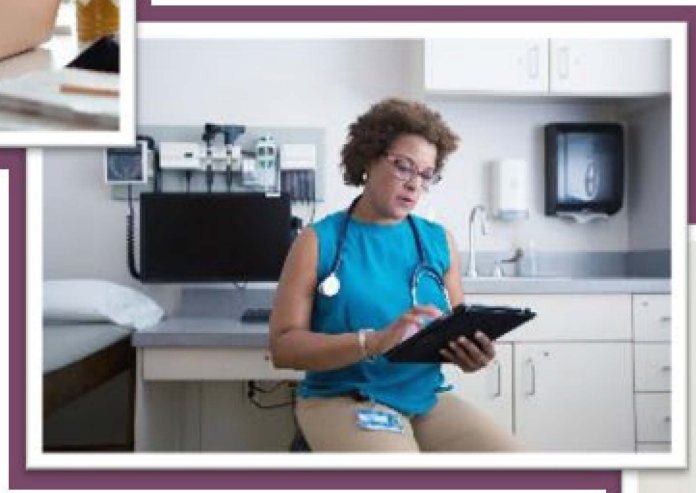
Attachments

Providers should include supporting documentation as an attachment with the initial claim, or with a corrected claim once the initial claim has been finalized.



Providers have the ability to upload documents to claims:

- In the Provider Portal at the time of the claim submission
- Attach to a claim that was submitted through Electronic Data Interchange (EDI) while it is in adjudication using the PWK Indicator process



Note: Once the claim is in adjudication it is too late to add attachments.

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NDC Claim Denials

If your Claim denies for “missing /invalid NDC National Drug code” please review the NDC billed on your Claim prior to submitting the dispute to make sure it is a correct/valid NDC for the HCPCS code you are submitting which is included on the Claim.
Recommendations when submitting disputes/appeals for multiple Claims for different Members or multiple Claims for the same Member:

- Each Member must have a separate dispute/appeal submitted - do not consolidate multiple Members into one request.
- Molina will accept multiple Claims for one Member on one appeal/dispute request, but please list all applicable Claim numbers you want addressed.
- Please include all supporting documentation with the original submission for the service in question. If we receive partial documentation, we will review based on the documentation received.
- If no documentation is received and you are requesting a medical necessity review, we will send a letter, unable to process due to lack of information.

Please review your authorization prior to submitting Claims to make sure the authorization is matching services billed (date of service/service provided).

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Balance Billing

Pursuant to law and CMS guidance, Members who are dually eligible for Medicare and Medicaid and classified as Qualified Medicare Beneficiaries (QMB) shall not be held liable for Medicare Part A and B cost sharing when the State or another payor is responsible for paying such amounts. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Senior Whole Health to the Provider. Balance billing a Member for covered services is prohibited, except for the Member's applicable copayment, coinsurance and deductible amounts.

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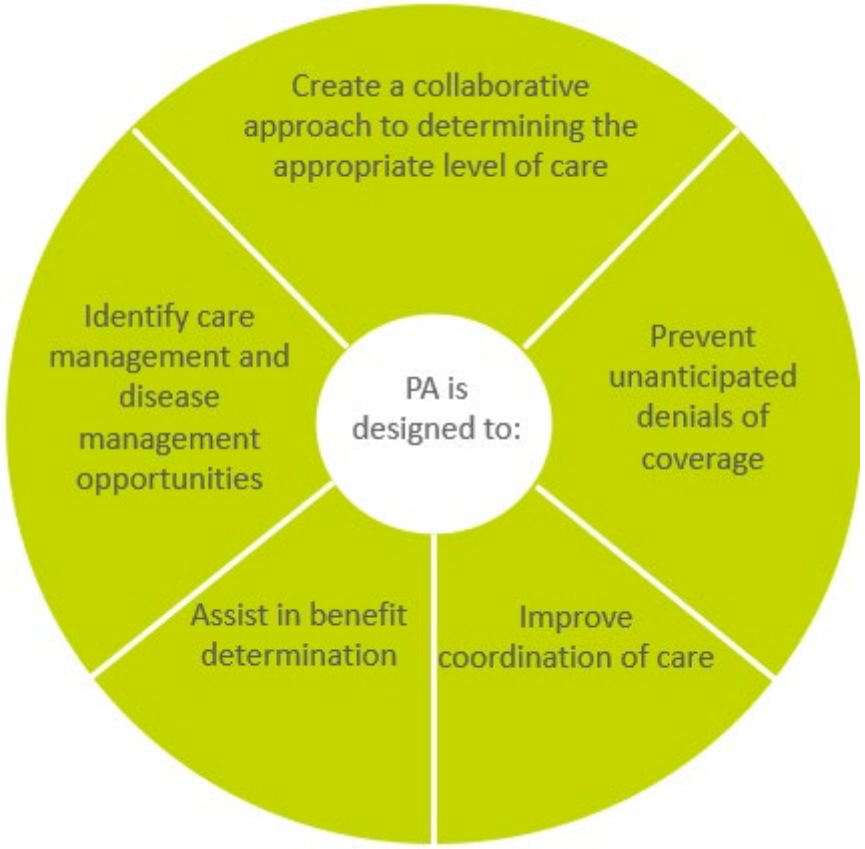
Prior Authorization (PA)

Prior Authorization (PA) is a request for prospective review. Requests for services on the SWH PA Code List are evaluated by licensed nurses and trained staff. The PA Code LookUp Tool can be found is in the middle of the SWH Provider page. Please note that Prior Authorization requirements for dual-eligible members (Medicare and Medicaid beneficiaries) should be evaluated at the individual line of business.

Need a Prior Authorization?

Code LookUp Tool



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SWH Provider Website

Please visit our website at:
molinahealthcare.com/providers/ma/swh/home.aspx

What Can be Found:

- Important Communications
- Valuable Resources
- Provider Forms
- Contact Information
- Payment Integrity Policies
- Dedicated Quality Section
- Clinical and Preventive Health Guidelines
- Behavioral Health Toolkit
- MOC Annual Training
- Availity Materials
- PA Guides

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Provider Data Accuracy

Maintaining an accurate and current Provider Directory is a state and federal regulatory requirement, as well as a National Committee for Quality Assurance (NCQA)-required element.

Providers may update provider data through CAQH Direct Assure or by submitting a PIF form to SWH. If you choose to close your panel to new members, you must give SWH 30 days' advance written notice.

Important Reminders:

- Providers must validate their information at least quarterly for correctness and completeness.
- Notice of changes must be made at least 30 days in advance of any of the following:
- Change in office location, office hours, phone, fax, or email
- Addition or closure of an office location
- Addition or termination of a provider
- Change in Practice Name, Tax ID and/or National Provider Identifier (NPI)
- Open or close your practice to new patients (PCP only)

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CAQH

CAQH for Participating Providers

- Go to your CAQH Provider Directory Snapshot at CAQH ProView - Sign In
- Update provider data elements as necessary and attest to the accuracy
- When updating your CAQH profile, it is important to select “Global” for your access to ensure SWH can review these changes to your data.
- For questions about CAQH, please contact CAQH directly at **888-599-1771**. Chat support is also available.

- CAQH Provider Data Portal for Practice Managers User Guide

- Your **CAQH (Council for Affordable Quality Healthcare)** profile provides SWH with important information on you and your practice, including whether you are currently accepting new patients, demographic information (such as languages other than English that are spoken in your practice).

- To ensure you stay compliant, we recommend updating your profile on a quarterly basis. You may access your CAQH profile at CAQH ProView - Sign In

- If you are with a Group Practice, you can also request Add/Changes by completing the Provider Information Update Form.

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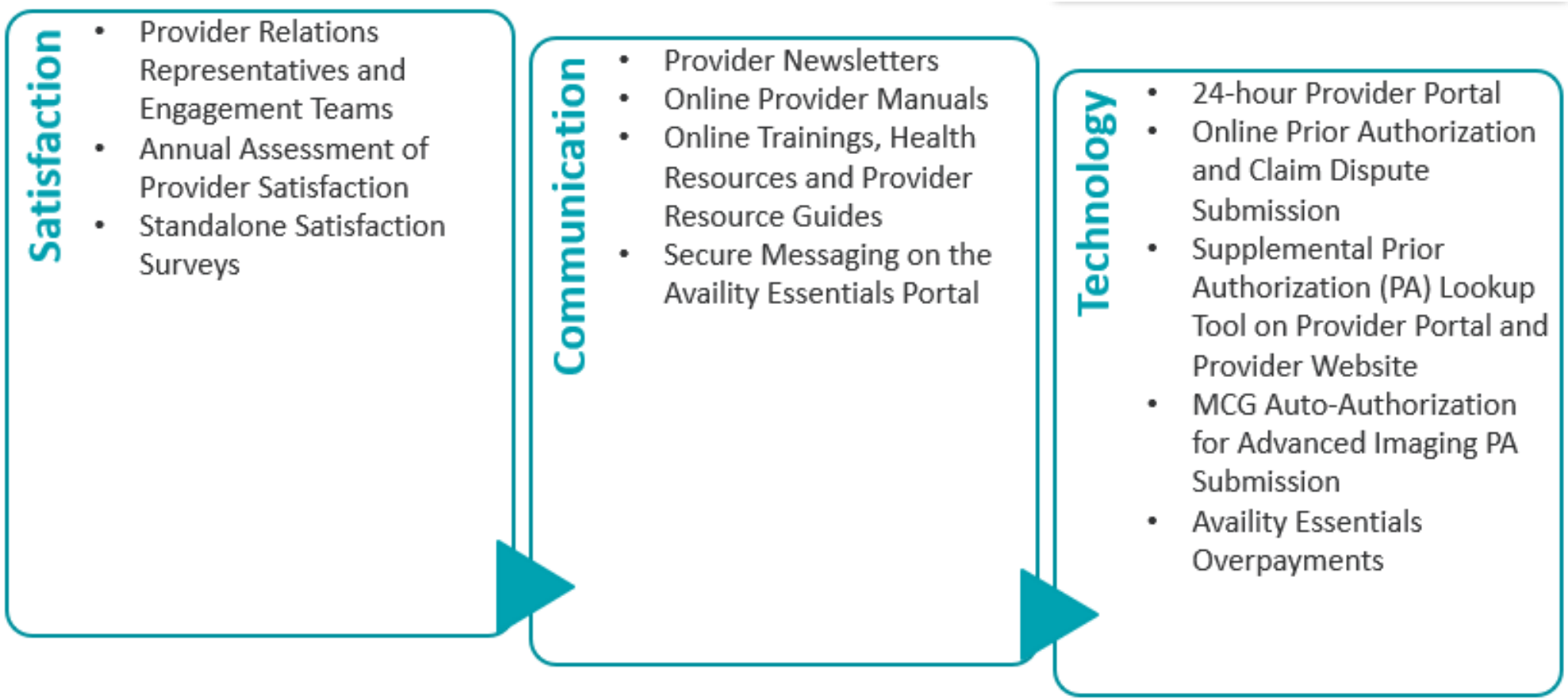
SWH Provider Relations



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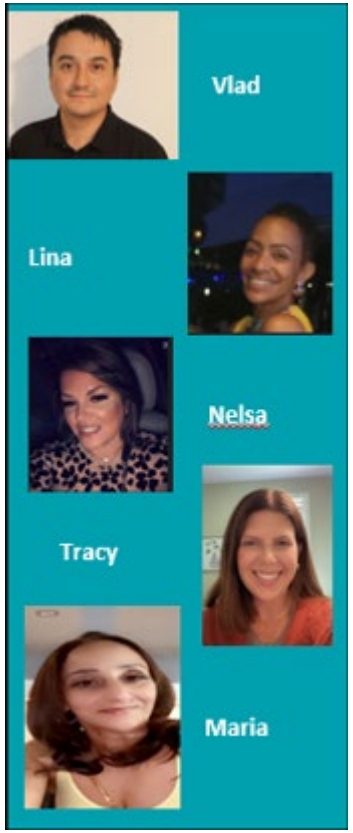
Senior Whole Health Provider Relations Contact Information



Contact information for providers, facilities, groups:

MA County	Representative	Email Address
Barnstable, Berkshire, Franklin, Hampden, Norfolk, Hampshire	Vladimir Ustariz	Vladimir.Ustariz@molinahealthcare.com
Suffolk	Lina Ribeiro	Lina.Ribeiro@molinahealthcare.com
Middlesex, Worcester	Nexalix Acevedo	Nexalix.Acevedo@molinahealthcare.com
Essex, Plymouth	Tracy Daly	Tracy.Daly@molinahealthcare.com
Bristol	Maria Lopes	Maria.Lopes@molinahealthcare.com

For general inquiries, questions or to identify your specific representative:

Email Address
SWHProviderRelations@molinahealthcare.com

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Provider Resources/Engagement

Telephone: SWH Provider Service Center- (855) 838-7999

Email: SWHProviderRelations@MolinaHealthCare.com

Dedicated Account Manager: Assigned by County/Provider Specialty

Provider Website: https://www.molinahealthcare.com/providers/ma/swh/home.aspx

Senior Whole Health has developed an online subscription service for providers to automatically receive our critical updates directly to your inbox. These important updates will include quarterly provider newsletters, operational updates, claims and pre-authorization information. If you are interested in signing up, please visit our website at molinahealthcare.com/providers/ma/swh/resources/comm.aspx.

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Senior Whole Health Provider Surveys and Feedback

The Senior Whole Health Provider Relations Team hopes you have found this training session beneficial. Please share your feedback here with us so we can continue to provide you with excellent customer service!

Take our SWH Provider Communications Survey Here

SWH Provider Website feedback can be submitted here

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Questions

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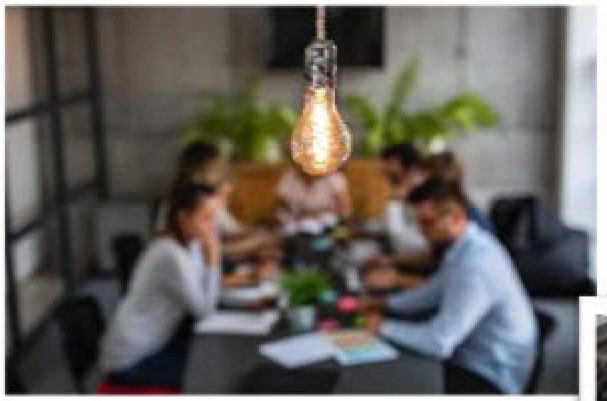
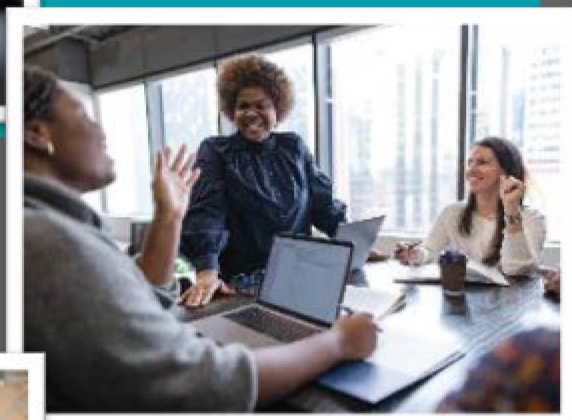
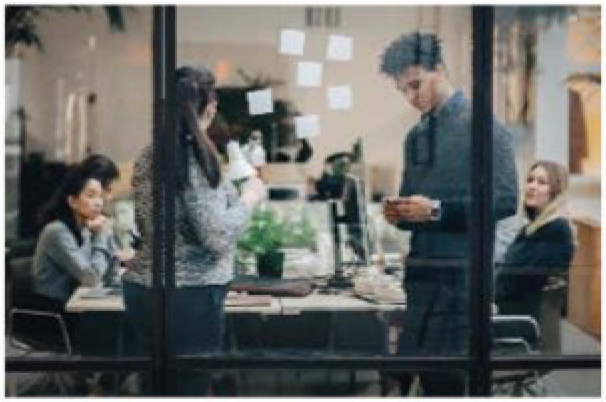
Thank You







Questions

Open Discussion

Thank you for participating in today's meeting!

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