Claims and Billing Orientation

2022 | Molina Healthcare

MOLINA HEALTHCARE

MHO-PROV-0021
0722

Agenda

- Provider Resources
- Types of Claim Forms
- Claim Submission
- Coordination of Benefits
- Code Editing
- Corrected Claim
- Claim Attachments
- Claim Reconsideration
- Potentially Preventable Readmissions
- Sepsis
- Contact Molina

Provider Resources

MOLINA HEALTHCARE

Provider Services

Satisfaction

- Provider Services Representatives and Engagement Teams
- Annual Assessment of Provider Satisfaction
- The It Matters to Molina Program that Includes Monthly Forums, surveys, and an Information Page on the Provider Website

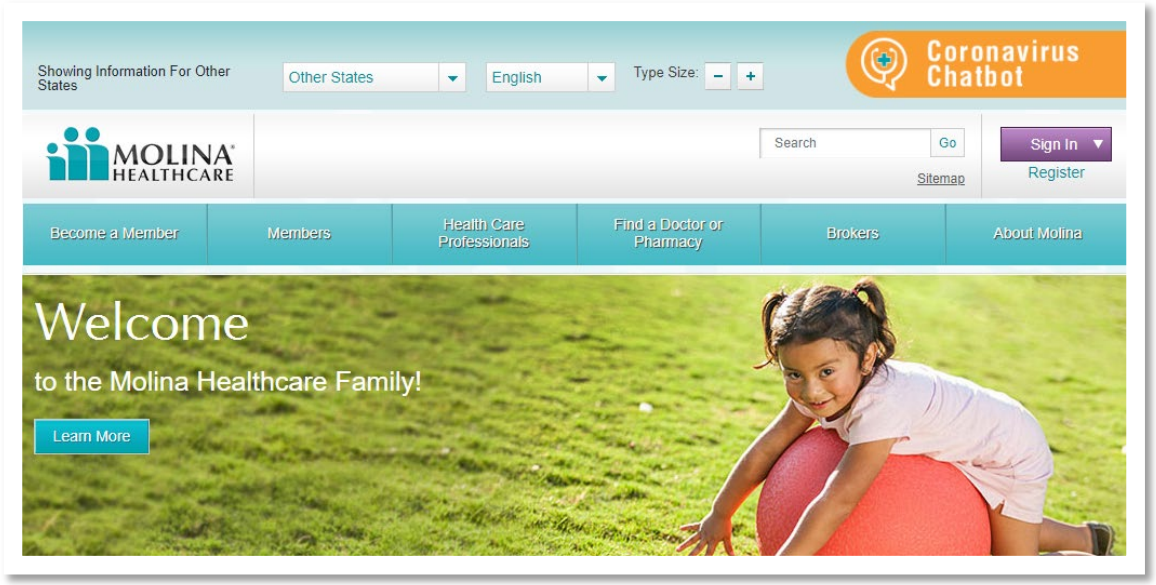
Communication

- Provider Bulletin and Provider Newsletters
- Online Provider Manuals
- Online Trainings, Health Resources, and Provider Resource Guides
- Interactive Voice Response (IVR) Phone System

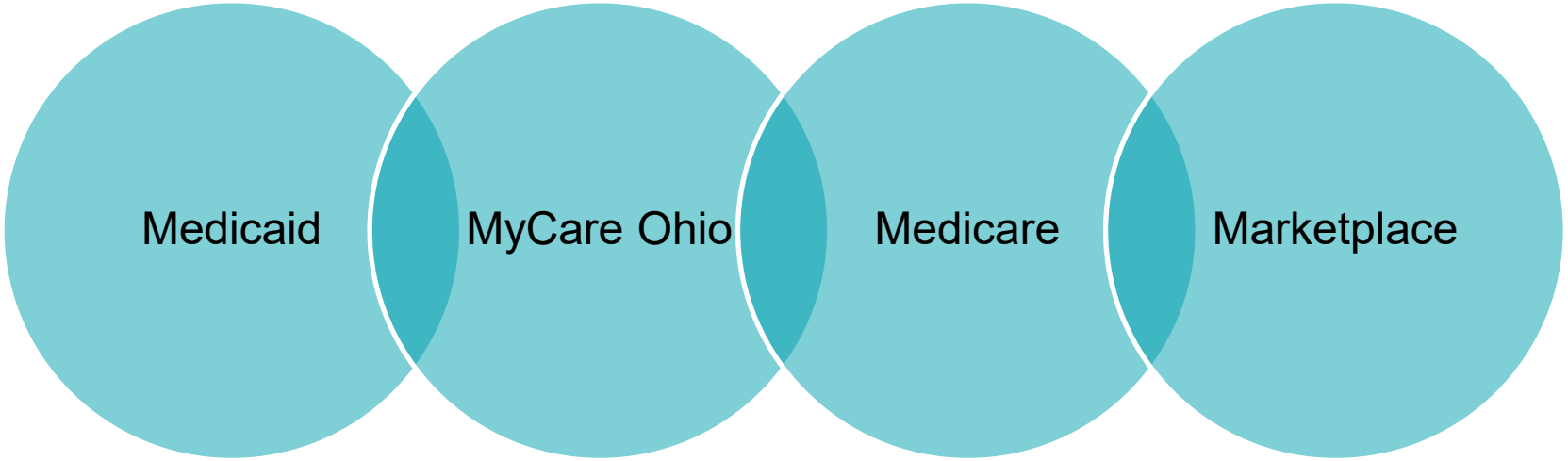
Technology

- 24-hour Provider Portal
- Electronic Funds Transfer and Electronic Remittance Advice
- Online Prior Authorization and Claim Dispute Submission
- Supplemental Prior Authorization Lookup Tool on Provider Portal and Provider Website

Provider Website



Molina has a Provider Website for each line of business.



Find the Provider Website at MolinaHealthcare.com.

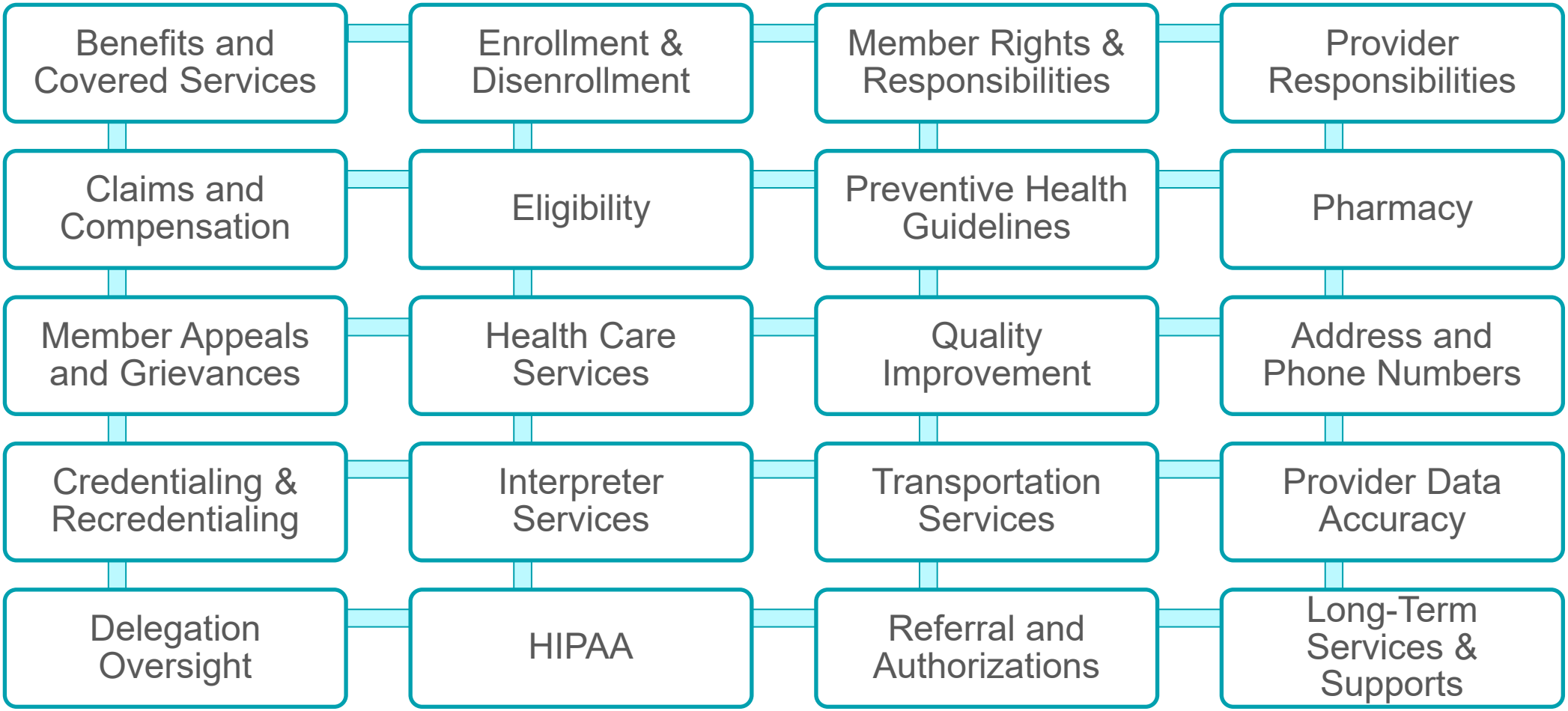
Provider Online Resources

Molina's Provider Website has a variety of online resources:

- Provider Manual
- Dental Manual
- Provider Portal
- It Matters to Molina Page and a Claims Payment Systemic Errors (CPSE) Page
- Provider Online Directory
- Contact Information
- Preventive and Clinical Care Guidelines
- Claims Information
- Health Insurance Portability and Accountability Act (HIPAA)
- Advanced Directives
- Frequently Used Forms
- Pharmacy Information
- Prior Authorization Information
- Claim Reconsiderations
- Provider Communications: Provider Bulletins and Provider Newsletters
- Fraud, Waste and Abuse Information
- Member Rights and Responsibilities
- Molina Policies

Provider Manual Highlights

The Provider Manual is customarily updated annually, but may be updated more frequently. Information in the Provider Manual includes:



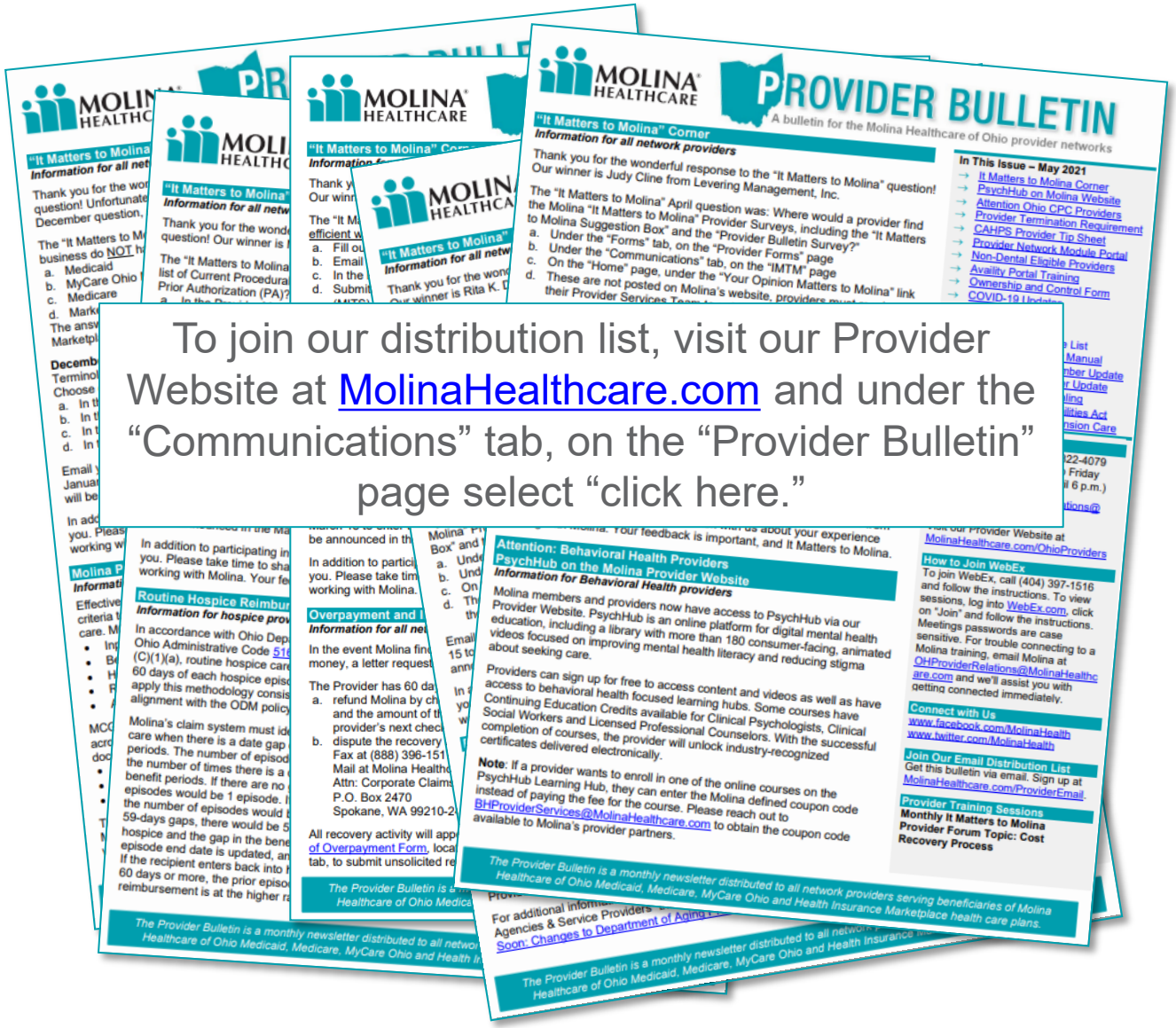
Provider Manuals are specific to each line of business.

Provider Bulletin

A monthly Provider Bulletin is sent to Molina's provider network to report updates.

The Provider Bulletin includes:

- Prior authorization changes
- Training opportunities
- Updates to the Provider Portal
- It Matters to Molina Corner
- Changes in policies that could affect:
  - Claim submissions
  - Billing procedures
  - Payment
  - Appeals



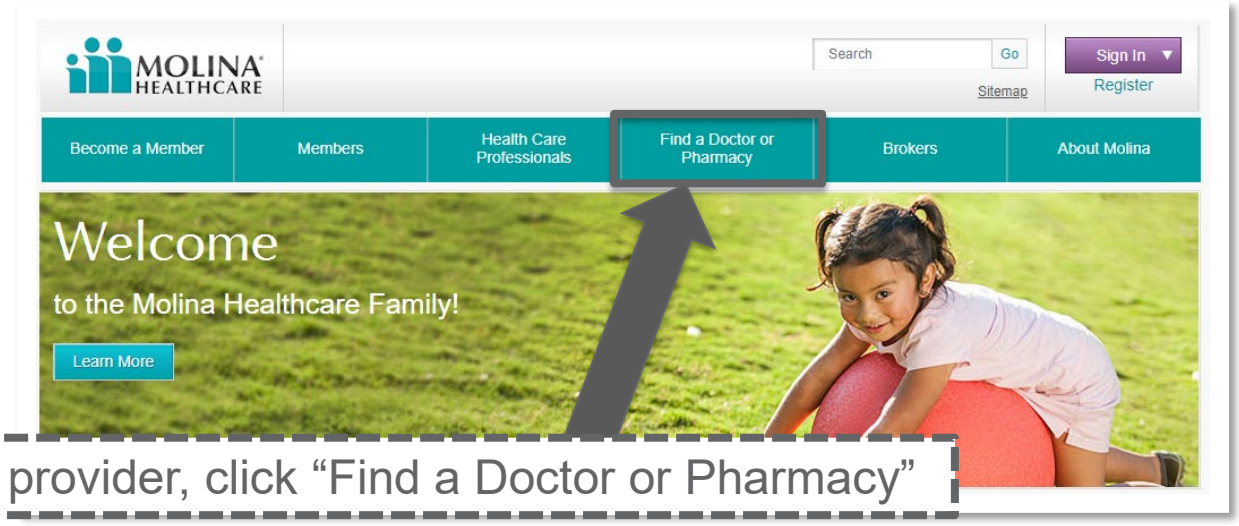
To join our distribution list, visit our Provider Website at MolinaHealthcare.com and under the "Communications" tab, on the "Provider Bulletin" page select "click here."

Provider Online Directory

The Provider Online Directory now offers enhanced search functionality so information is available quickly and easily. Molina providers are encouraged to use the Provider Online Directory linked on our Provider Website to find a network provider or specialist.

Key Benefits Include:				
User-friendly and intuitive navigation	Provider profile cards for quick access to information	Browsing by category, search bar, and common searches	Expanded search options and filtering for narrowing results	Provider information that can be saved to use later

Members should be referred to participating providers.



To find a Molina provider, click “Find a Doctor or Pharmacy”

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.

Important Reminder: Providers must validate the Provider Online Directory information at least quarterly for correctness and completeness.

Please notify Molina at least 30 days in advance for 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 Tax ID and/or National Provider Identifier (NPI)
- Open or close your practice to new patients (PCP only)

Please use the Provider Information Update Form to make these changes.

Reminder: The Ohio Department of Medicaid (ODM) is migrating to the new Provider Network Management (PNM) system in 2022 for provider information and updates.

Medicaid ID Number Requirements and Enrollment

Reminder: The Ohio Department of Medicaid (ODM) is migrating to the new Provider Network Management (PNM) system in 2022 for provider information and updates.

It is imperative that providers confirm their information is correct in the Medicaid Information Technology System (MITS). This will ensure they do not encounter issues once the data is transferred to the new PNM system.

ODM requires provider groups and individuals to be enrolled and active with Ohio Medicaid, and to have an active Medicaid Identification (ID) Number for each billing National Provider Identifier (NPI).	A single Medicaid ID cannot be affiliated with more than one NPI.	If you are currently enrolled and active with Ohio Medicaid, you must maintain your active status or risk future claim denials.

For additional information view the "Medicaid Enrollment of Group Practices" memo at medicaid.ohio.gov.

Please note that Medicaid enrollment is also required by the Code of Federal Regulations (CFR) rule 42 CFR 438.602.

Molina ID Cards

Providers are encouraged to review the most up-to-date version of the Molina Member Cards available on our Member Website.

- Medicaid Member Card
- MyCare Ohio (Medicare-Medicaid) Member Card
- MyCare Ohio (Medicaid) Member Card
- Medicare Member Card
- Marketplace Member Card: In the Marketplace Provider Manual

Prior Authorization (PA)

Prior Authorization (PA) is a request for prospective review. Requests for services on the Molina PA Code List are evaluated by licensed nurses and trained staff.

PA is designed to:				
Assist in benefit determination	Prevent unanticipated denials of coverage	Create a collaborative approach to determining the appropriate level of care	Identify care management and disease management opportunities	Improve coordination of care

The PA Code List is a list of the services that require a provider to submit a PA request and if there are limitations to the code.

View the PA Code List on our Provider Website, under the “Forms” tab

Utilize the PA Lookup Tool on our Provider Website and Provider Portal to determine if a PA is required

Provider Responsibilities

Molina expects our contracted providers will respect the privacy of Molina members (including Molina members who are not patients of the provider) and comply with all applicable laws and regulations regarding the privacy of patient and member Protected Health Information (PHI).

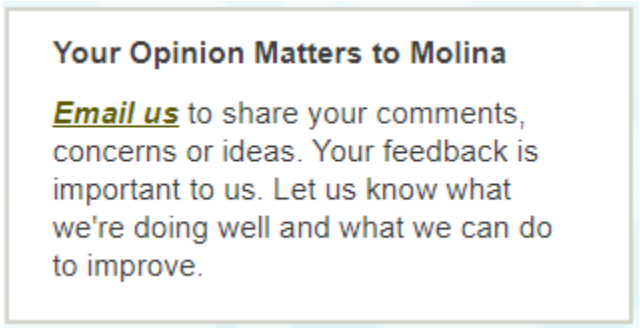
For additional information view the “Provider Responsibilities” section of the Provider Manual, located at MolinaHealthcare.com under the “Manual” tab. Topics include:

- Non-Discrimination of Health Care Service Delivery
- Provider Data Accuracy and Validation
- National Plan and Provider Enumeration System (NPPES) Data Verification
- Electronic Solutions/Tools Available to Providers
- Primary Care Provider (PCP) Responsibilities

It Matters to Molina

Molina wants your feedback! Please take time to share feedback with us about your experience working with Molina. Let us know what we are doing well, and what we can do to improve your experience. Please share training ideas that would benefit your practice, references/resources we can develop.

Your feedback is important, and It Matters to Molina.



Ways to provide feedback includes:

- Click on the “Email us” link under “Your Opinion Matters to Molina” at the top of our Provider Website
- Email your Provider Services Team
- Take one of our post-training or general feedback surveys located on the It Matters to Molina page
- Join our Provider Advisory Committees

Monthly It Matters to Molina Provider Forum:

Molina offers monthly It Matters to Molina Provider Forums with either a set presentation topic, or as an open question and answer session between our provider partners and Molina subject matter experts. Find a list of upcoming trainings on the It Matters to Molina page.

Types of Claim Forms

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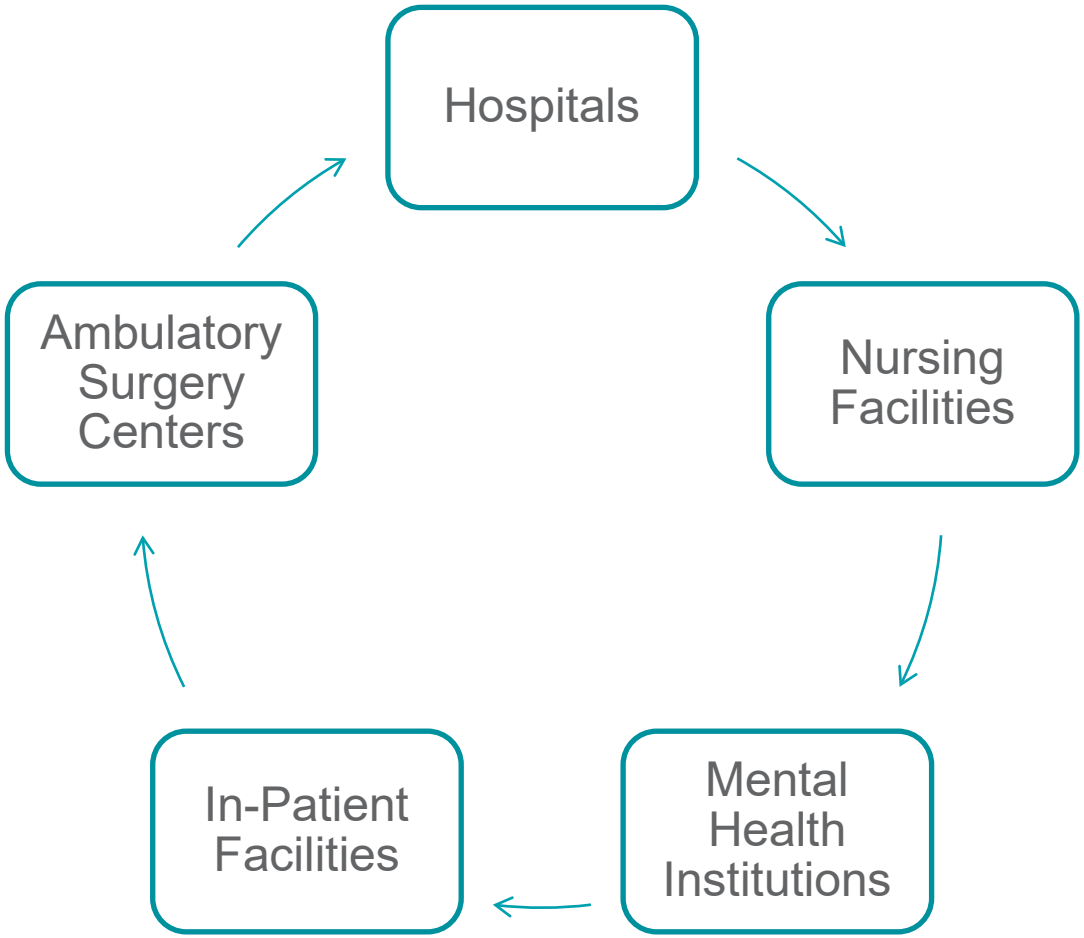
Professional and Institutional Claim Forms

The two claim forms used for billing Molina include:

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.

UB-04 Claim Form

The National Uniform Billing Committee (NUBC) UB-04 claim form includes 81 fields and is used by facility providers, including:



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

UB-04 Claim Form Required Fields

Conditional Fields:

- 2
- 3 a-b
- 15-16
- 18-29
- 31-36
- 38 a-d
- 39-41 a-d
- 43
- 46
- 48
- 52-54
- 58-59
- 61-65
- 70 a-c
- 71
- 72 a-c
- 74 a-e
- 76-80

Required Fields:

- 1
- 4-6
- 8 a-b
- 9 a-d
- 10-14
- 17
- 42-45
- 47
- 50-51
- 55-57
- 60
- 66
- 67 a-q
- 69

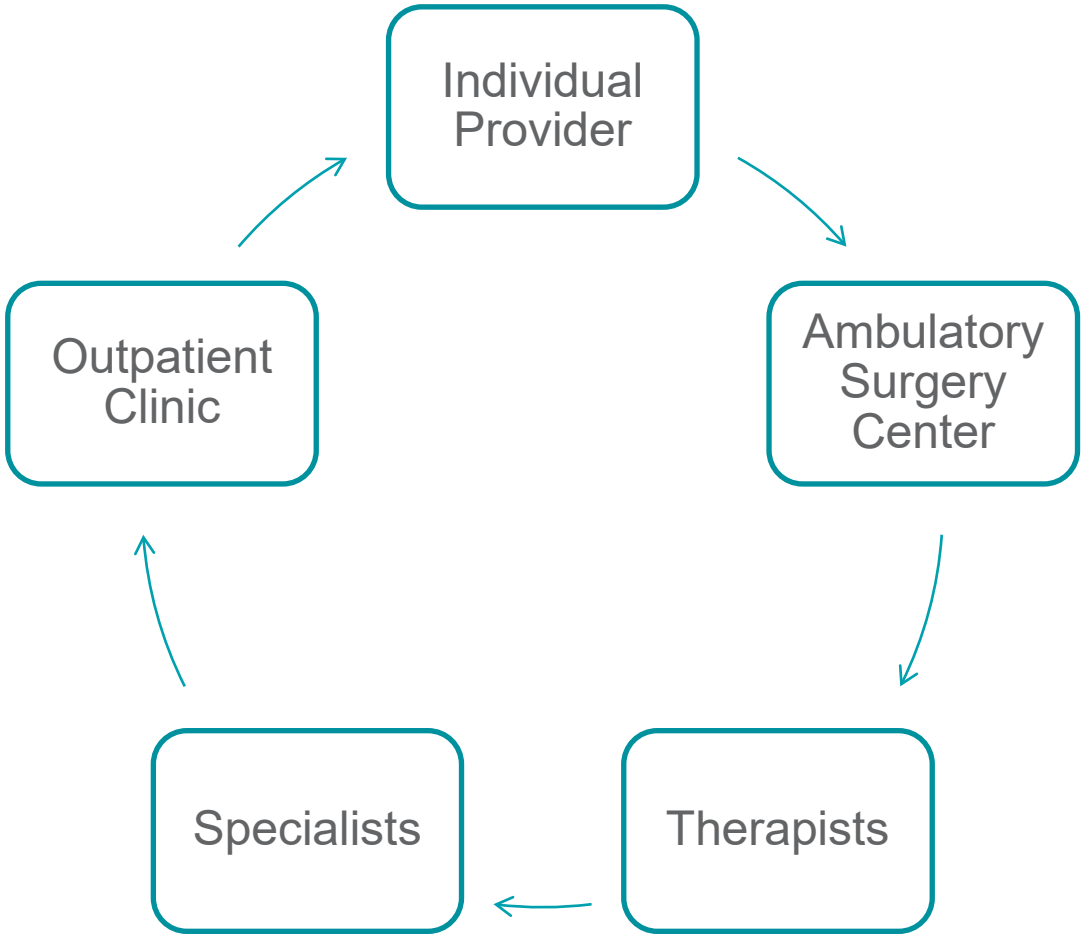
Not Used:

- 7
- 30
- 37
- 49
- 68
- 73
- 75
- 81

Find additional information in the CMS Claims Processing Manual.

CMS-1500 Claim Form

The National Uniform Billing Committee (NUBC) CMS-1500 claim form includes 33 fields and is used by non-institutional providers, up to and including:



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

CMS-1500 Claim Form Required Fields

Conditional Fields:

- 1
- 4-8
- 9 a-d
- 10 d
- 11a-d
- 12-16
- 17 a-b
- 18-20
- 22-23
- 24 a
- 24 c
- 24 h
- 24 k
- 26-27
- 29
- 32 a

Required Fields:

- 1 a
- 2-3
- 10 a-c
- 21
- 24 a-b, d-g, i-j
- 25
- 28
- 30-31
- 33 a-b

Not Used:

- N/A

Find additional information in the CMS Claims Processing Manual.

Claim Submission

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Provider Portal: Transition from Molina Provider Portal to Availity

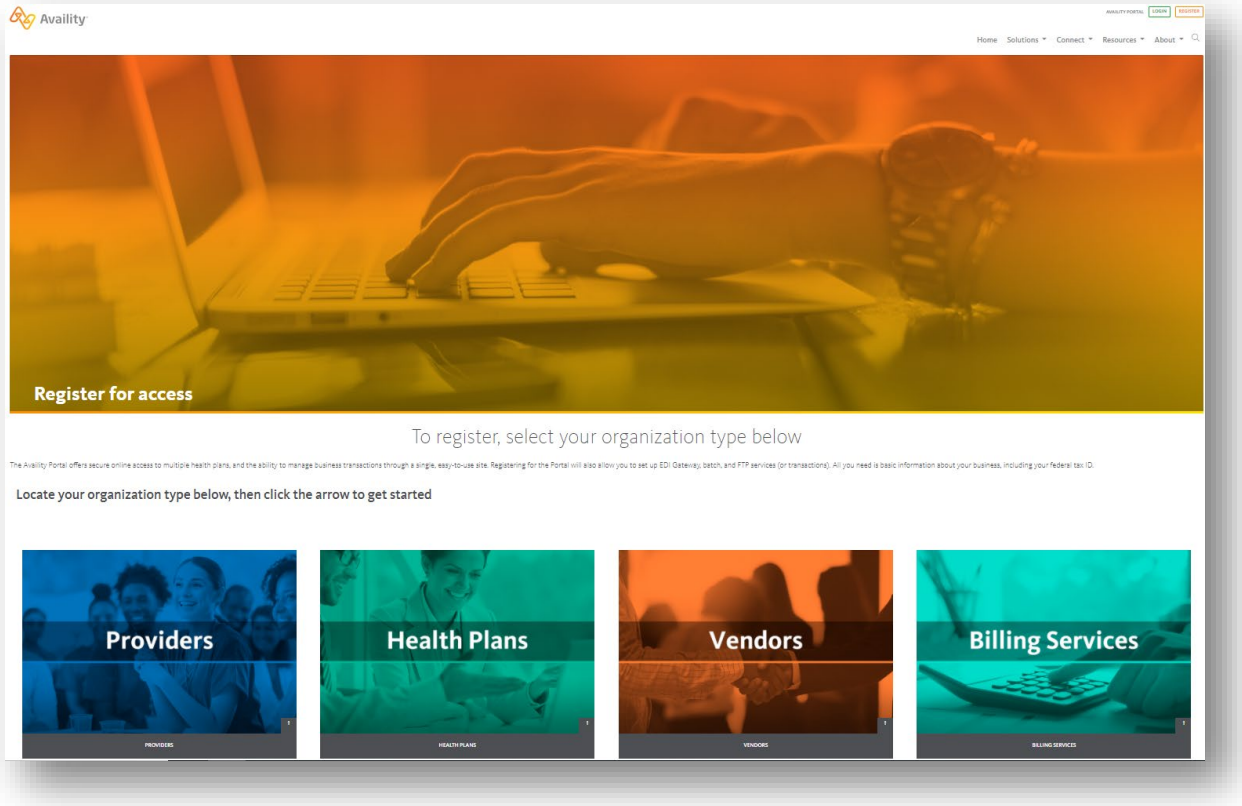
Availity is Molina's exclusive Provider Portal provider.

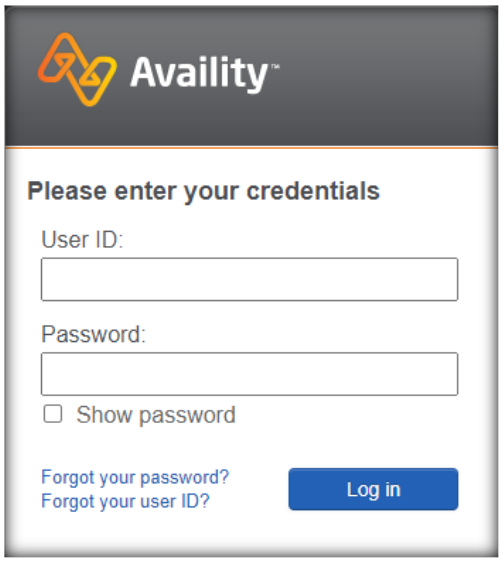
- The Molina Provider Portal, including all features, functionality, and resources will continue transitioning to Availity in 2022.
- This is a phased transition, with access to both the Molina Provider Portal and the Availity Portal being available via single sign-on as features and functionality are deployed on the Availity Portal.
- Features currently available on the Availity Portal include submitting new claims, correcting claims, accessing claims reports and claim status, adding attachments, eligibility verification, secure messaging with Molina, and Electronic Remittance Advice (ERA).

Providers should register for the Provider Portal at Availity.com.

Availity Provider Portal

Register for Availity at availity.com/provider-portal-registration and select your organization type.

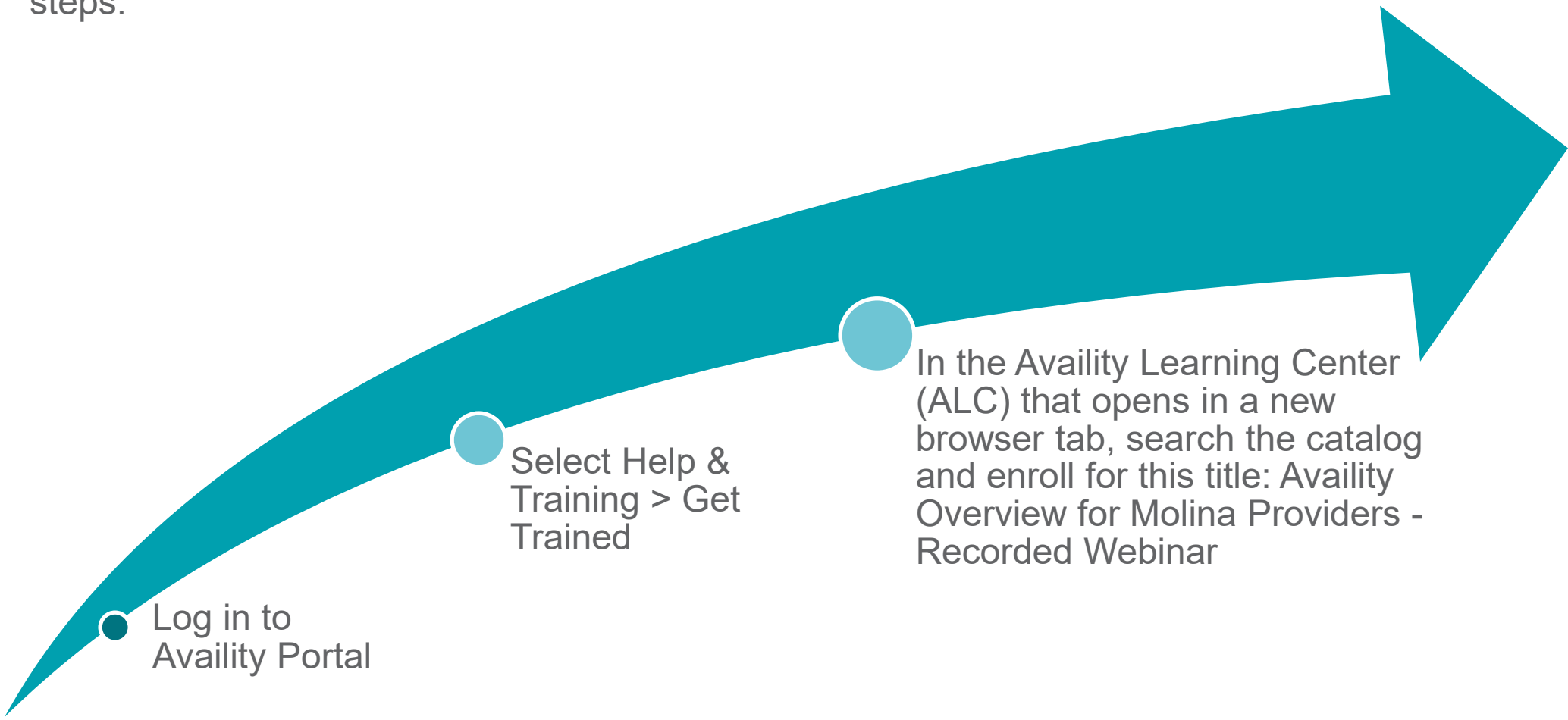




Log into Availity at: apps.availity.com/availity/web/public.elegant.login.

Availity Provider Portal

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



Atypical Providers:
Under “News and Announcements” select “Atypical Providers: Here’s your Ticket to Working with the Availity Portal” to view training sessions.

Provider Portal

The 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
- Online Claim Reconsideration Requests
- Member Eligibility Verification and History
- Update Provider Profile
- Member Nurse Advice Line Call Reports
- Secure Messaging
- Check Status of Authorization Request
- Coordination of Benefits (COB)
- View PCP Member Roster
- Submit PA Requests

Coordination of Benefits

MOLINA HEALTHCARE

Primary Insurance

A Medicaid beneficiary may have a third-party resource (health insurance, another person, or entity) that is liable to pay for the beneficiary's health care.

Third Parties could include		
Health Insurers (include private or employer-based coverage, Medicare and TRICARE)	Other government programs	Other liable people or entities

Coordination of Benefits (COB) ensures that payment is not more than required and helps recover payments when a third party is responsible to pay for all or some of the health care received by a member.

Primary and Payer of Last Resort

When a person has a Medicaid and there is another liable third party

- Health insurance, including Medicare and TRICARE generally pays first, to the limit of coverage liability
- Other third parties generally pay after settlement of claims

Medicaid is payer of last resort for services covered under Medicaid, except in those limited circumstances where there is a federal statute making Medicaid primary to a specific federal program.

Deficit Reduction Act of 2005: Impact on Claims

Consistent with the Deficit Reduction Act of 2005 and the Ohio Administrative Code, Molina Healthcare has an established process to identify third party liability through review and coordination of benefits (COB).

This process may identify and coordinate benefits pre-claim or post-claim payment.

Pre-claim:

Provider receives Molina remittance advice denying the claim for other coverage/primary EOB as noted in the following grid.

Claim remit number	Claim remit message
377	EOB not received on Claim
216	No COB entered with a Secondary Enrollment

Deficit Reduction Act of 2005: Impact on Claims

Post-claim within 120 days:

If Molina identifies commercial third party liability within 120 days (increased to 270 days for Molina claim payment dates on and after July 1, 2021) from provider's payment date from Molina:

- Molina will issue a letter to the provider stating the details of the third party payor identified by Molina as well as a request for refund of the impacted claims within 60 days.
- Provider to perform COB and bill the third party payor identified.
- Provider should refund Molina for the amount paid on the impacted claim(s) within 60 days.
- If no refund is received from the provider within 60 days, Molina will recover the amount paid from future claim payments.
- Upon receipt of third party payment, provider should submit the claim and third party remittance to Molina for COB, subject to timely filing requirements.

Deficit Reduction Act of 2005: Impact on Claims

Post-claim more than 120 days for MyCare Ohio and Medicare:

If Molina identifies commercial third party liability more than 120 days (increased to 270 days for Molina claim payment dates on and after July 1, 2021) from provider's payment date from Molina for MyCare Ohio and Medicare lines of business:

- Molina will issue a letter to the provider stating the details of the third party payor identified by Molina as well as a request for refund of the impacted claims within 60 days.
- Provider to perform COB and bill the third party payor identified.
- Provider should refund Molina for the amount paid on the impacted claim(s) within 60 days.
- If no refund is received from the provider within 60 days, Molina will recover the amount paid from future claim payments.
- Upon receipt of third party payment, provider should submit the claim and third party remittance to Molina for COB, subject to timely filing requirements.

Deficit Reduction Act of 2005: Impact on Claims

Post-claim more than 120 days for Medicaid and Marketplace:

If Molina identifies commercial third party liability more than 120 days (increased to 270 days for Molina claim payment dates on and after July 1, 2021) from provider's payment date from Molina for Medicaid and Marketplace lines of business:

- Molina will submit the provider's claim to the third party payor following the Claim Reclamation process.
- OPT-OUT PROCESS: Providers may choose to opt-out of the Molina Claim Reclamation process. To do so, providers must submit a request to opt-out. The request will include the following elements:
    - Submitted on the provider's letterhead
    - List the specific tax identification number(s) to opt out
    - Email to: OHProviderRelations@MolinaHealthcare.com

Risks of opt-out:

For providers who opt-out of Claim Reclamation, Molina will recover claim payment via provider refund or recovery from future claim payments. In the event the third party payor denies the provider's claim due to timely filing or lack of medical necessity, Molina will also deny the claim as the secondary payer. Molina will also confirm the provider's claim meets Molina timely filing requirements for any additional payment as the secondary payer.

Code Editing

MOLINA HEALTHCARE

Claim Editing Process

Coding edits are based on Current Procedural Terminology (CPT), Medicaid Purchasing Administration (MPA) guidelines, industry standard NCCI policy and guidelines, and industry payment rules and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB).

Molina has a claims pre-payment auditing process that identifies frequent correct coding billing errors such as:

- Bundling and unbundling coding errors
- Duplicate claims
- Services included in global care
- Incorrect coding of services rendered

If you disagree with an edit, please follow the Claim Reconsideration process guidelines located in the Provider Manual.

Coding Sources: CPT

Current Procedural Terminology (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.

There are three types of CPT codes:

- Category I Code: Procedures/Services
- Category II Code: Performance Measurement
- Category III Code: Emerging Technology

Coding Sources: HCPCS

Health Care Common Procedure Coding System (HCPCS) is a Centers for Medicare and Medicaid Services (CMS) maintained uniform coding system.

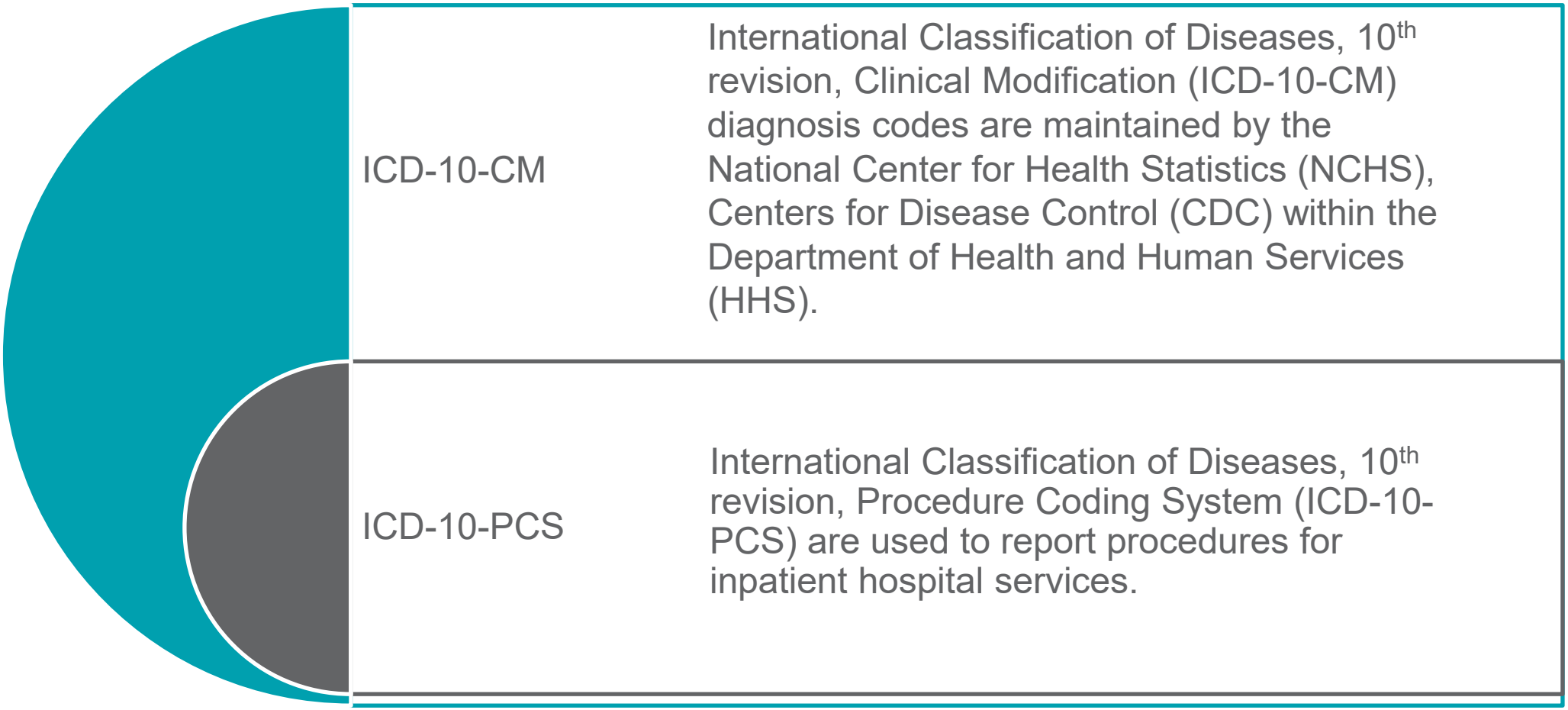
HCPCS codes are five-digit numeric codes used to identify procedure, supply, and Durable Medical Equipment (DME) codes furnished by physicians and other health care professionals.

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)

Coding Sources: ICD-10 Diagnosis



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 Health Care Common Procedure Coding System (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.

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:

If the first segment contains only four digits, add a leading zero to the segment	If the second segment contains only three digits, add a leading zero to the segment	If the third segment contains only one digit, add a leading zero to the segment
Ex. 09999-9999-99	Ex. 99999-0999-99	Ex. 99999-9999-09

Covered and Non-Covered Days

Value code 80 (Covered Days) must be present on inpatient and long-term care claims, or the claims will be denied.

- Units billed with value code 80 are the number of covered full days and must correspond with units billed on the room and board claim line
- Value Code 80 and corresponding units exclude non-covered days, leave of absence days, or the day of discharge or death

Claims with non-covered days must bill value code 81 (Non-Covered Days) to indicate the total number of full days that are not reimbursable.

- Units billed with value code 81 are the number of non-covered full days and must correspond with units billed on the room and board claim line
- Charges related to the non-covered days would be reported under Total Charges and Non-Covered Charges on the room and board claim line
- The discharge date or day of death should not be included as a non-covered day in the value code or the room and board line
- Claims reporting non-covered days must report an occurrence code of 74 with the date span of the non-covered days

Find additional information in the CMS Claims Processing Manual

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.

National Correct Coding Initiative (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 at cms.gov/Medicare/Coding/PTP-Coding-Edits.

Evaluation and Management (E&M)

Providers should report Evaluation and Management (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).

E&M Pre-Payment Review

Molina evaluates and reviews high-level E&M services for all lines of business.

The evaluation and review process will include claims that appear to have been incorrectly coded based on diagnostic information that appears on the claim and peer comparison

Service codes included in the scope of this review include 99204, 99205, 99214, and 99215

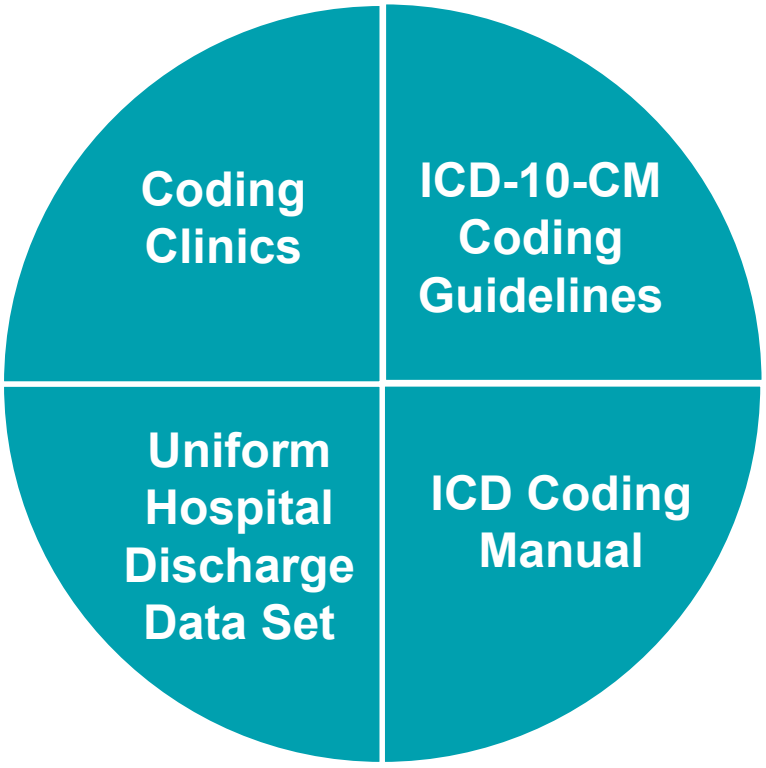
Claims that have been identified as incorrectly coded will include a remittance message that indicates that it was identified as incorrect coding

If a provider disagrees with a claim finding, the provider can file a claim reconsideration following the published guidelines.

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.

Correct DRG assignment is in accordance with industry coding standards:



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).

Diagnosis Related Group (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
- MCC and CC, if reported

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 letter to the provider explaining 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 provide a letter explaining the results of the validation review. Providers retain their right to dispute the results of these reviews as outlined in the Provider Manual.

Optum Pre-Claim Audit

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

The prepayment claim reviews will look for over-utilization and other incorrect billing practices by reviewing state and federal policies sourced from Medicaid and Medicare rules utilized industry wide, and then applying appropriate analytics.

The concepts utilized for the pre-pay audit are in alignment with correct coding practices and incorporate a review of medical records to determine if they support the services and codes billed.

Optum Prepayment Audit: Services Impacted

- NCCI Modifier Override (CPT Definition)
- NCCI Modifier Override (Procedure Overlap)
- NCCI Modifier Override (Misuse of Col 2 with Col 1)
- Surgical Procedures Exceeding Targeted Threshold
- Providers Identified with Atypical Historical Billing Patterns
- Cross coder – Professional vs Outpatient Facility Surgical Claims
- J Codes – Excessive Quantity Billed – Professional
- Invalid Provider Specialty for Allergy Services
- ER Upcoding – Professional
- Coding Verification of Custom Fitted or Fabricated Orthotics
- DME Claims Overlapping Inpatient Stay
- Preventive Scoring Model

National Coverage Determinations (NCDs) and Local Coverage Determinations (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 the following to their claims' payment logic:

- 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

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.

Reminder: When submitting a claim reconsideration related to a code edit it is important to include the information below:

- 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
- Include any supporting clinical documentation
- Include trip documentation for ambulance services

Corrected Claim

MOLINA HEALTHCARE

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 returned to the provider for resubmission.

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:					
Submit electronically or on the Provider Portal	Include all elements that need correction, and all originally submitted elements	Do not submit only codes edited by Molina	Do not submit via the claim reconsideration process	Do not submit paper corrected claims	Include the original Molina claim ID number

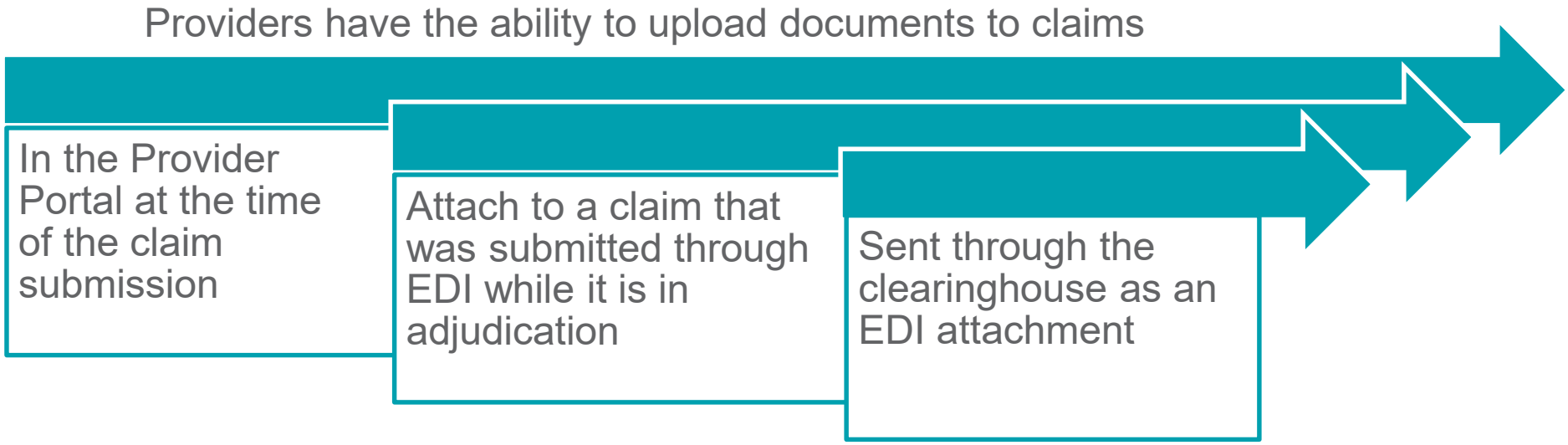
Corrected claims must be submitted with the Molina claim ID number from the original claim being corrected, and with the appropriate corrected claim indicator based on claim form type.

Claim Attachments

MOLINA HEALTHCARE

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.



Once the claim is in final status (pay/deny/paid/hold/wait pay/wait deny) it is too late to add attachments.

For additional information on the types of services or claims that require attachments for processing view the Reference Guide for Supporting Documentation for Claims resource on the Provider Website.

Medicaid and MyCare Ohio Consent Forms

The sterilization, hysterectomy, and abortion consent forms must be submitted with the claim when the service is billed. If the form is missing or incomplete the claim will be denied.

Claims for these services are paid only if the following required criteria is met:

Consent to Sterilization Form:
Required except in unique circumstances of an unscheduled clinical event that requires sterilization because of a life-threatening emergency

ODM Abortion Certification Form:
Not covered, except when medically necessary to save the life of the member or in instances of reported rape or incest

Consent to Hysterectomy Form:
Required except in unique circumstances of an unscheduled clinical event that requires a hysterectomy because of a life-threatening emergency

Note: CPT codes 58661, 58700, 58720 and 58940 require an operative report.

For specific procedure codes where a Consent Form is required see OAC 5160-21 Reproductive Health Services.

Find additional information in the Provider Manual. The Provider Manual and consent forms are available on the Provider Website.

Claim Reconsideration

MOLINA HEALTHCARE

Claim Reconsiderations Not Related to an Authorization

Submit a claim reconsideration only when disputing a payment denial, payment amount, or code edit. Claim reconsiderations are applicable for disputes unrelated to clinical appeals or reconsiderations associated with pre-service and post-service authorization.

Primary insurance Explanation of Benefits (EOB), corrected claims, and itemized statements are not accepted via claim reconsideration. Please refer to the Supporting Documents or Claim Submission process guidelines.

The Claim Reconsideration Request Form (CRRF) must be filled out entirely and include the claim number, or it will not be processed and the provider will be notified. Paper submissions received by mail will not be processed and the provider will be notified.

The form and supporting documents can be submitted through our Provider Portal or the form can be faxed to (800) 499-3406.

Claim Reconsideration Form

The Request for Claim Reconsideration Form must be filled out entirely or it will not be processed and the provider will be notified required to process the reconsideration.

Claim Reconsideration Request Requirements:			
A claim reconsideration must be submitted for any dispute that is related to a claim denial that is not due to an authorization	A claim reconsideration must be submitted within 120 calendar days from the disputed claim remit date	Requests must be fully explained as to the reason for reconsideration	Must include previous claim and remittance advice, any other documentation to support the request and a copy of the referral/ authorization form (if applicable)

This form is available on our Provider Website under the “Forms” tab. Please be sure you are accessing the current version of the form or your request will be returned unworked.

Paper submissions received by mail will not be processed and the provider will be notified.

Note: According to Ohio regulations, health care providers are not permitted to balance bill Medicaid members for services or supplies provided.

Claim Reconsiderations Additional Resources

Please refer to the:

- **MyCare Ohio and Medicare**:
  MyCare Ohio and Medicare Authorization and Claim Reconsideration Guide on the MyCare Ohio website under the “Manual” tab, under “Quick Reference Guides & FAQs”
- **Medicaid and Marketplace**:
  Medicaid and Marketplace Authorization and Claim Reconsideration Guide on the Medicaid website under the “Manual” tab, under “Quick Reference Guides & FAQs”

Please confirm the line of business the member is eligible under, and reference the correct guide for the reconsideration process and appeal rights.

Potentially Preventable Readmissions

MOLINA HEALTHCARE

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.

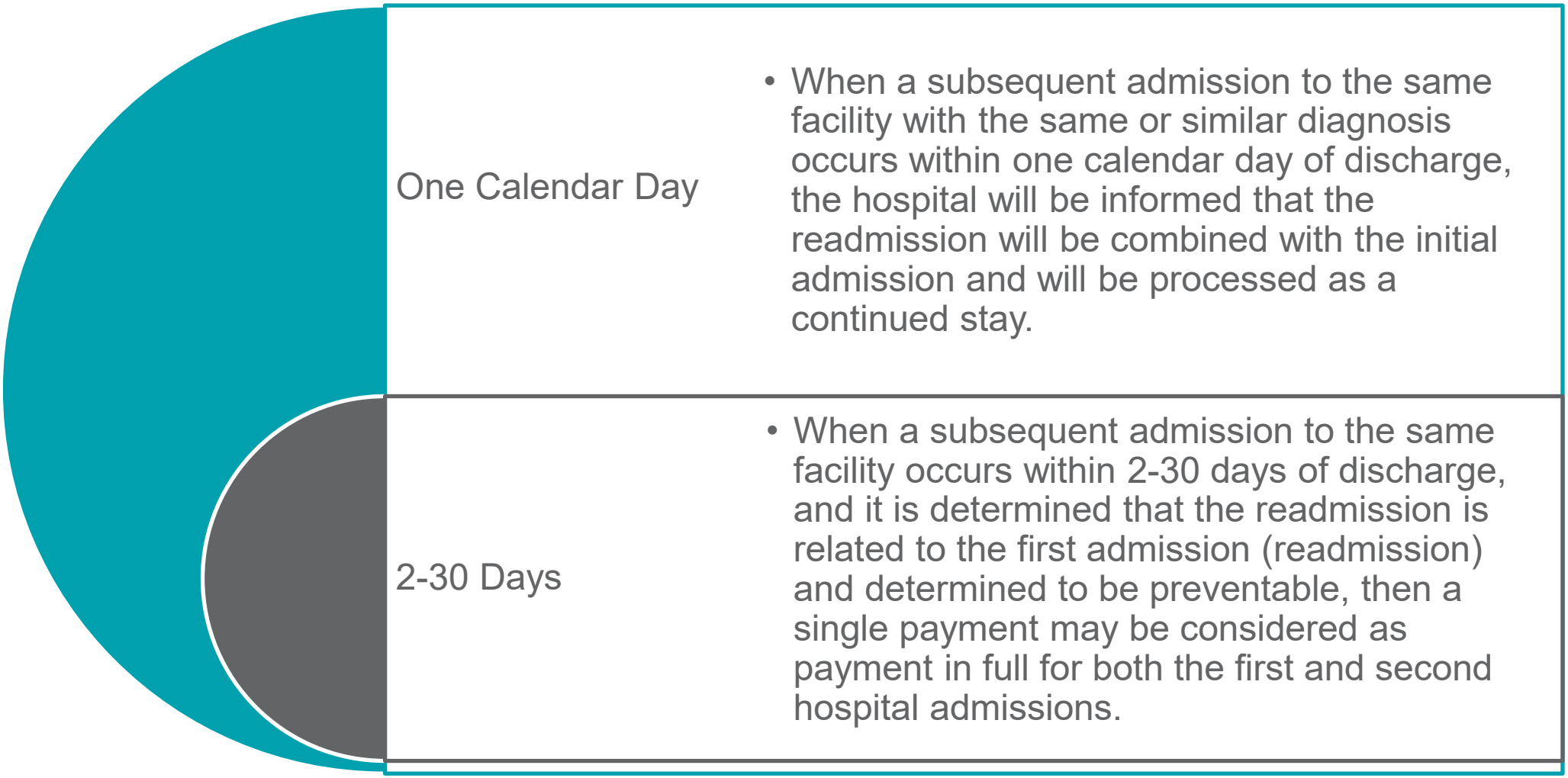
There are two situations for Readmissions:

Readmissions occurring within one calendar day from discharge (same or similar diagnosis)

Readmissions occurring with 2-30 days of discharge (same or similar diagnosis PLUS preventable)

Molina will conduct readmission reviews for participating hospitals when both admissions occur at the same acute inpatient facility within the state regulatory requirement dates.

Readmissions, Continued



For additional information see the Readmission Payment Policy on the Provider Website, under the “Policies” tab.

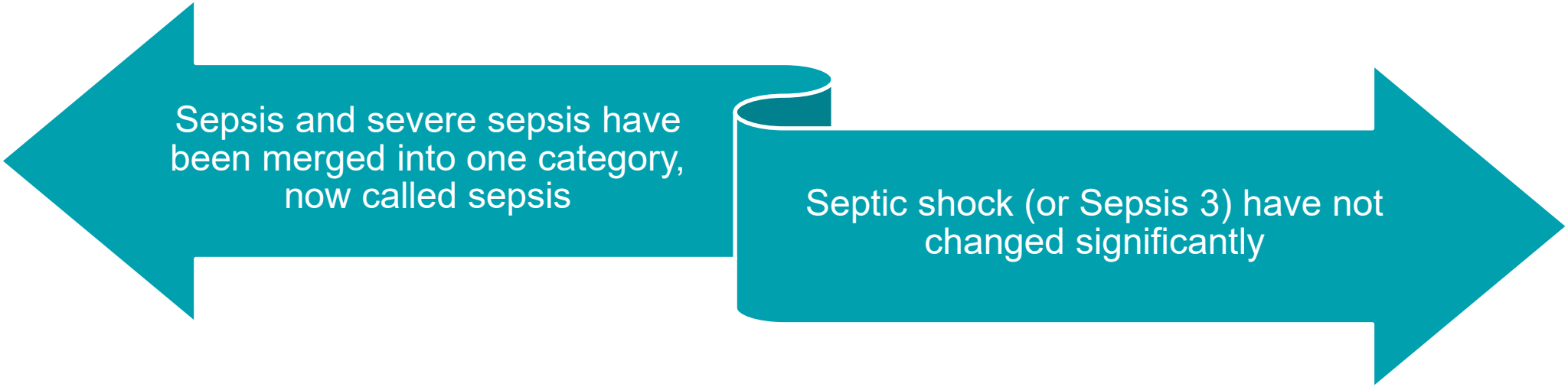
Sepsis

MOLINA HEALTHCARE

Sepsis and Septic Shock Payment Policy

Molina uses the revised sepsis guidelines issued by the Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3).

The Sepsis-3 guidelines have consolidated three sepsis categories into two categories:

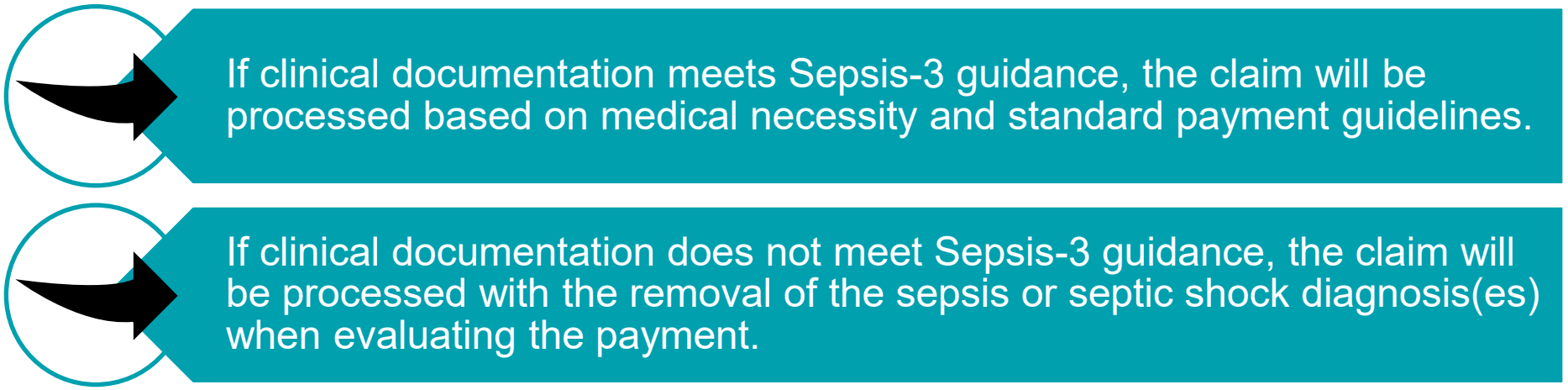


The Sepsis-3 definition will be used in clinical claim reviews to validate that sepsis was present and that related services were appropriately submitted as part of the member's claim.

If clinical documentation provided to and reviewed by Molina does not support Sepsis-3 definitions and associated services, hospital payments will be adjusted appropriately.

Sepsis and Septic Shock Payment Policy: Claims

Molina will review the clinical at the time of the claim receipt to determine if any diagnosis (primary or secondary) of sepsis or septic shock meet the Sepsis-3 guideline:



If a sepsis or septic shock diagnosis is determined to be inappropriate, providers will have standard reconsideration timelines via the Claims Reconsideration Process for Molina to perform review of the additional documentation from providers.

Contact Molina

MOLINA HEALTHCARE

Frequently Used Email Addresses

Molina of Ohio Provider Services Contact Information:

Molina has designated email addresses based on provider types to help get your questions answered more efficiently or to connect you to training opportunities.

- Behavioral Health questions: BHProviderServices@MolinaHealthcare.com
- Hospital or hospital-affiliated physician group questions: OHProviderServicesHospital@MolinaHealthcare.com
- MyCare Ohio LTSS and Medicaid Ancillary questions: OHMyCareLTSS@MolinaHealthcare.com
- Nursing Facilities questions: OHProviderServicesNF@MolinaHealthcare.com
- Physician practice questions: OHProviderServicesPhysician@MolinaHealthcare.com
- General questions: OHProviderRelations@MolinaHealthcare.com

For additional contact information view the “Contact Information” section of the Provider Manual, located at MolinaHealthcare.com.

Molina Provider Training Survey

The Molina Provider Services Team hopes you have found this training session beneficial.

Please take a few minutes to complete the Molina Provider Training survey to provide feedback on this session.

The survey is located on the It Matters to Molina Page of our Provider Website, under the “Communications” tab.

Molina wants to hear about what other topics you’d like training on in the future.

Please share your feedback with us so we can continue to provide you with excellent customer service!