



CLAIMS AND ENCOUNTER DATA

BILLING AND CLAIMS SUBMISSION

As a contracted provider, it is important to understand how the claims process works to avoid delays in claims payment. The following items are covered in this section:

- Claim Submission
- Claim Corrections/Adjustments
- Overpayments/Refund Requests
- Third Party Liability
- Coordination of Benefits
- Billing the Member

Molina Healthcare of Ohio, Inc. (Molina Healthcare) generally follows the Ohio Department of Job and Family Services (ODJFS) guidelines for claims processing and payment for the Covered Families and Children (CFC) and Aged, Blind or Disabled (ABD) programs.

- General billing information can be found on the ODJFS website: <http://emanuals.odjfs.state.oh.us/emanuals>.
- The HIPAA EDI Transaction and Code Set Rule can be found at: <http://jfs.ohio.gov/ohp/infodata/hipaa.stm>.
- More information about Molina Healthcare and the claims and billing processes is available on the Molina Healthcare website at www.MolinaHealthcare.com.

CLAIM SUBMISSION (HARD COPY)

All claims should be submitted to Molina Healthcare with appropriate supporting documentation by mail or electronically. Claims must be submitted on the proper claim form (e.g. CMS-1500 or UB-04).

- Molina Healthcare accepts the CMS-1500 claim form and the UB-04 claim form.
- Claims for services that require prior authorization, but were not prior approved by Molina Healthcare, will be denied for no authorization.
- Providers must bill Molina Healthcare for services with the most current coding available, using HIPAA-compliant modifiers.
- Please see ODJFS BIN.1001.4.

The following information must be included on every claim:

- Member name, date of birth and social security number
- Date(s) of service
- ICD-9 diagnosis and procedure codes
- HIPAA-compliant revenue, DRG, CPT, HCPCS codes
- Billed charges for service provided
- Place and type of service code
- Days or Units as applicable
- Provider tax identification

- Medicaid ID number and/or NPI number
- Rendering provider name
- Service facility location information
- Pay-to provider name and address
- Individual provider and group Medicaid number. When the billing provider is a group practice, the provider number assigned to the individual who performed the service is noted in the PIN# field, and the group number is noted in the space marked GRP# in box 33 of the CMS-1500 form.

Claims must be legible and the information must be located in the appropriate fields on the claim form. Therefore, illegible claims will be returned to the provider, and claims lacking the information described above will be denied as incomplete.

In some cases, additional information may be requested in order to accurately process the claim. If the requested information or documentation is not received within 60 days of the request date, the claim may be denied as incomplete or inaccurate.

Providers billing Molina Healthcare directly should send their claims to:

Molina Healthcare of Ohio, Inc.
 PO Box 22712
 Long Beach, CA 90801

CLAIM SUBMISSION (ELECTRONIC)

Molina Healthcare encourages electronic claim submission through one of the following clearinghouses:

- Emdeon Practice Insight
- Zirmed, Inc.
- Availity (formerly THIN)
- Practice Insight

Providers billing Molina Healthcare electronically should use payer number 20149. Track your electronic transmissions using acknowledgement reports to ensure that claims are received for processing in a timely manner. When your claims are filed electronically you will:

- Receive an acknowledgement from the clearinghouse.
- Receive an acknowledgement from Emdeon within 5-7 business days of your transmission.

If you experience any problems with your transmission, please contact your local clearinghouse representative.

For additional information, go to Molina Healthcare's EDI website - www.MolinaHealthcare.com.

Miscellaneous Drug Codes

Claims billed with HCPCS J3490 or other miscellaneous drug codes must include the NDC number in order for services to be paid.

Maternity Care

Molina Healthcare requires the last menstrual period (LMP) date on all pregnancy-related claims. If the field is left blank, the claim will be denied. The Ohio Department of Job and Family Services (ODJFS) requires the LMP date on all pregnancy-related encounters to ensure that pregnancy-related clinical performance measures are calculated correctly. Ohio Medicaid managed care plans are required to report encounter data in accordance with Ohio Administrative Code rule 5101:3-26-06.

CMS-1500

- The LMP should be reported as Item 10a-c - Patient's Condition - Check "YES" or "NO" to indicate whether employment, auto, or other accident involvement applies to one or more of the services described in Item 24.
- Item 14 - Date of Current Illness, Injury or Pregnancy - Complete this field for pregnancy only. Enter the six digit (MMDDYY) or eight digit (MMDDCCYY) date of the LMP.

UB-04

- The LMP should be reported as Form Locator 31-34 - Occurrence Code – Populate occurrence code 10 - LMP. The date of the LMP is applicable when the patient is being treated for a maternity-related condition.
- Form Locator 35-36 - Occurrence Span Code and Dates – Populate the LMP date.

Early Periodic, Screening, Diagnosis, and Treatment (EPSDT) Services

Molina Healthcare requires the EPSDT data reported in block 24h be submitted on all EPSDT claims. If this field is left blank, the claim will be denied. ODJFS is federally required to annually report the number of EPSDT visits and referrals for follow-up or corrective treatment for Medicaid-eligible recipients 0-20 years of age. The EPSDT services should be reported as:

Field: 24h - EPSDT/Family Planning HEALTHCHECK/EPSDT

- Enter an "**E**" in this block if the service is a Healthchek and no follow-up services were required.
- Enter an "**R**" in this block if the service was Healthchek and follow-up is required and a referral is made.

EPSDT Services:

- Preventive Medicine Services 99381
- New Patient under one year 99382
- New Patient (ages 1-4 years) 99383
- New Patient (ages 5-11 years) 99384
- New Patient (ages 12-17 years) 99385
- New Patient (ages 18-39 years) 99391
- Established patient under one year 99392
- Established patient (ages 1-4 years) 99393
- Established patient (ages 5-11years) 99394
- Established patient (ages 12-17 years) 99395
- Established patient (ages 18-39 years) 99431
- Newborn care (history and examination) 99432
- Normal newborn care Evaluation and Management Codes 99201-99205
- New Patient 99211-99215 Established Patient

NOTE: These CPT-4 codes must be used in conjunction with codes V20-V20.2 and/or V70.0 and/or V70.3-70.9.

Anesthesia Services

Molina Healthcare requires all anesthesia services be billed with the number of actual minutes in the units field (Item 24G) of the CMS-1500 form. The minutes will be calculated by 15 minute increments to determine the appropriate units to be paid. If the claim is submitted without the minutes in field 24G, the claim will be denied.

Urgent Care Services

Molina Healthcare requires all services rendered at an urgent care facility be billed with Place of Service 20. This is required for claims to process accurately against urgent care benefits in the Molina Healthcare claims processing system.

TIMELY CLAIM FILING

Claims for covered services rendered to Molina Healthcare members must be received by Molina Healthcare no later than the filing limitation stated in the provider contract, or within 120 days from the date of service(s). Claims submitted after the filing limit will be denied.

Claims received with explanation of benefits (EOBs) from the primary carrier attached will not be subject to the timely filing restriction, but must be submitted to Molina Healthcare within 60 days of the date listed on the EOB from the other carrier.

The provider may request a review for claims denied for untimely filing by submitting justification for the delay. See the Appeals and Grievances section of this manual for information regarding review of denied claims.

TIMELY CLAIM PROCESSING

Claim payment will be made to contracted providers in accordance with the provisions set forth in the provider's contract.

A clean claim is a claim that has no defect or impropriety, contains all required substantiating documentation and does not involve circumstances that require special treatment that could prevent timely payment.

- Ninety (90%) percent of the monthly volume of clean claims will be adjudicated within 30 calendar days of receipt by Molina Healthcare.
- Ninety-five (95%) percent of the monthly volume of claims shall be paid or denied within sixty (60) calendar days of receipt by Molina Healthcare.
- Ninety-nine (99%) percent of all claims shall be paid or denied within ninety (90) calendar days of receipt by Molina Healthcare.

The receipt date of a claim is the date that Molina Healthcare receives either written or electronic notice of the claim. All hard copy claims received by Molina Healthcare will be stamped with the date of receipt.

CLAIM ADJUSTMENTS

Providers seeking an adjustment of a previously adjudicated claim must request such action within 120 days of the original remittance advice. Requests for claim adjustments submitted after the 120 day period cannot be considered. The request for a claim adjustment must include the following documentation to allow for a thorough review of the request:

- A completed Request for Claim Reconsideration Form or a cover letter that includes the claim number and clearly explains the reason for the adjustment request.
- Additional documentation related to the claim, including the previous claim and remittance advice, a copy of the referral/authorization form (if applicable) and any other documentation to support the adjustment.
- The item(s) being resubmitted should be clearly marked as a request for an adjustment.

Forms are available at www.MolinaHealthcare.com. Select Providers, Ohio, Forms.

Requests for claim adjustments can be mailed or faxed to:

Molina Healthcare of Ohio, Inc.
Attn: Provider Services
PO Box 349020
Columbus, Ohio 43234-9020
Fax: (614) 781-1537

Requests for adjustments of claims paid by a delegated medical group/IPA must be submitted to the group responsible for payment of the original claim.

CLAIM CORRECTIONS

Providers seeking a correction or reprocessing of a previously adjudicated claim must request such action within 120 days of the original remittance advice. Requests for correction of a claim submitted after the 120 day period cannot be considered.

The request for correction must include the following documentation:

- A cover letter clearly explaining the reason for the correction.
- The item(s) being resubmitted for correction should be clearly marked.
- The previous claim and remittance advice, any other documentation to support the adjustment, and a copy of the referral/authorization form (if applicable) must accompany the adjustment request.

Forms are available at www.MolinaHealthcare.com. Select Providers, Ohio, Forms.

Requests for claim corrections should be mailed to:

Molina Healthcare of Ohio, Inc.
PO Box 22712
Long Beach, CA 90801

Requests for correction of claims paid by a delegated medical group/IPA must be submitted to the group responsible for payment of the original claim.

CLAIM RECONSIDERATIONS

Requests for review of a denied claim must be received within 120 days from the date of the denial. The request should be mailed or faxed to:

Molina Healthcare of Ohio
Attn: Provider Services
PO Box 349020
Columbus, Ohio 43234-9020
Fax: (614) 781-4464

Forms are available at www.MolinaHealthcare.com. Select Providers, Ohio, Forms.

Please refer to the Appeals and Grievances (Complaints) section of this manual for additional information regarding appeals of denied claims.

OVERPAYMENTS AND REFUND REQUESTS

In the event Molina Healthcare finds an overpayment on a claim or must recoup money, a letter requesting the refund will be mailed to the provider. The provider has sixty (60) days to refund Molina Healthcare by check, or an accounts receivable will be established and the amount of the overpayment will be deducted from the provider's next check(s).

If you have any questions regarding a refund request letter, please call the Claims Recovery Unit at 1-800-423-9899 or (509) 459-6690 or Molina Healthcare Provider Services at 1-800-642-4168. In the event the provider receives a check that is not theirs or finds an overpayment, please send the refund with a copy of the Remittance Advice and claim information to:

Please direct payment and any correspondence to:

Molina Healthcare of Ohio
P.O. Box 715257
Columbus, Ohio 43217-5257

If returning a Molina Healthcare check, please send to:

Molina Healthcare of Ohio
P.O. Box 349020
Columbus, Ohio 43234-9020

THIRD PARTY LIABILITY (TPL)

Molina Healthcare is required to notify ODJFS and/or its designated agent within fourteen calendar days of all requests for the release of financial and medical records to a member or representative pursuant to the filing of a tort action. Notification must be made via the Notification of Third Party (tort) Request for Release Form (JFS 03246).

Molina Healthcare must submit a summary of financial information to ODJFS and/or its designated agent within thirty calendar days of receiving an original authorization to release financial claim statement letter from ODJFS pursuant to a tort action. Molina Healthcare must use the Tort Summary Statement Form for ODJFS (JFS 03245). Upon request, Molina Healthcare must provide ODJFS and/or its designated agent with true copies of medical claims.

Molina Healthcare is prohibited from accepting any settlement, compromise, judgment, award or recovery of any action or claim by the enrollee.

Molina Healthcare will pay claims for covered services when third party benefits are not available. Molina Healthcare will attempt to recover any third party resources available to members and shall maintain records pertaining to TPL collections on behalf of members for audit and review.

COORDINATION OF BENEFITS (COB)

Medicaid pays secondary to all private insurance. Private insurance carriers and Medicare must be billed prior to billing Molina Healthcare. Providers must include a copy of the primary insurance explanation of benefits with the claim. Molina Healthcare will pay the difference between payment made by the primary insurance carrier and the Molina Healthcare maximum contracted allowable rate. If the primary insurance paid more than Molina Healthcare's maximum contracted allowable rate, the claim will pay zero dollars.

Molina Healthcare will pay claims for covered services when probable COB has not been established to pay a claim. Molina Healthcare shall maintain records pertaining to COB collections on behalf of members for audit and review.

BILLING MOLINA HEALTHCARE MEMBERS

A provider may bill a Molina Healthcare member only for *non-covered* services if both the member and the provider sign a payment agreement prior to the services being rendered. The agreement must be specific to the services being rendered and clearly state:

- The service is not covered by ODJFS or Molina Healthcare.
- The member is choosing to receive the service and agrees to pay for it, even though the service may have been determined by Molina Healthcare to be not medically necessary.
- The member is under no obligation to pay the provider if the service is later found to be a covered benefit, even if the provider is not paid because of non-compliance with Molina Healthcare's billing and/or prior authorization requirements.
- For members with limited English proficiency, the agreement must be translated or interpreted into the member's primary language to be valid and enforceable. This interpretation/translation service is the responsibility of the provider.

CLAIMS SUBMISSION GUIDE

Hard Copy Claims	Molina Healthcare of Ohio, Inc. PO Box 22712 Long Beach, CA 90801
EDI Claims	Molina Healthcare Payer ID: 20149 Electronic claim submissions are accepted from Emdeon, Practice Insight, Availity and Zirmed, Inc. for all types of claims.
Claim Inquiries	Molina Healthcare Provider Services 1-800-642-4168
Timely Filing Requirements	Claims must be received by Molina Healthcare within 120 days from date of service, unless outlined otherwise in the provider's contract with Molina Healthcare. A request for adjustment/correction of a claim must be received within 120 days of the date the original claim was processed.
Requests for Additional Information	Additional information requested by Molina Healthcare to process a claim must be received within 60 days of the date of request.
Appeals	Request for review of a denied claim must be received within 120 days of the date of denial. Mail requests to: Molina Healthcare of Ohio, Inc. Attn: Provider Services PO Box 349020 Columbus, Ohio 43234-9020 Fax: (614) 781-4464
Payment	Checks are mailed weekly to providers.
Refunds/ Overpayments/ Incorrect Checks	Send refunds for overpayments with copy of the Remittance Advice (RA) and claim information to: Please direct payment and any correspondence to: Molina Healthcare of Ohio PO Box 715257 Columbus, Ohio 43217-5257 If returning a Molina Healthcare check, please send to: Molina Healthcare of Ohio PO Box 349020 Columbus, Ohio 43234-9020