Molina Healthcare of California
Provider/Practitioner Manual

Claims and Encounter Data

CLAIMS

As a contracted Provider/Practitioner, it is important to understand how the claims process works to expedite the processing of your claims. The following items are covered in this section for your reference and convenience:

- Claim Filing Timeframe
- Complete Claim Definition
- Claim Review
- Claims Acknowledgement
- Claims Submission Instructions
- Claims Submission
- Claims Documentation
- Misdirected Claims
- Claims Receipt Verification
- Electronic Claims Transactions
- Provider Disputes
- Submission of Provider Inquiry Request
- Overpayment of Claims
- Claim Processing Timeframes
- Coordination of Benefits
- Third-Party Tort Liability
- Claim Auditing Fee-For-Service Providers
- Shared Risk Claims

Claim Filing Timeframe

Molina Healthcare of California (MHC) will accept complete claims from Providers/Practitioners for processing if received within one hundred and eighty (180) days following the date of service.

Provider shall promptly submit to MHC, claims for covered services rendered to MHC members. All claims shall be submitted in a form acceptable to and approved by MHC, and shall be complete including any applicable medical records pertaining to the claim as required by MHC's policies and procedures.

Any claims that are not submitted by the Provider/Practitioner to MHC within one hundred eighty (180) days of providing the covered services that are the subject of the claim shall not be eligible for payment, and Provider/Practitioner hereby waives any right to payment therefore.

Complete Claim Definition
MHC will adjudicate complete claims, which is a claim or a portion of a claim that provides reasonably relevant information or information necessary to determine payer liability and that may vary with the type of service or provider. In select circumstances, MHC may require additional information from a Provider/Practitioner for errors such as where the Plan has reasonable grounds for suspecting possible fraud, misrepresentations, or unfair billing practices.

Claim Review
A claim will be subject for appropriate billing review to determine if services are billed in accordance to the American Medical Association guidelines and review of unbundling services. MHC reviews provider claims for appropriateness in accordance with industry standard billing rules, including, but not limited to, current UB manual and editor, current CPT and HCPCS coding, CMS billing rules, CMS bundling/unbundling rules, National Correct Coding Initiatives (NCCI) Edits, CMS multiple procedure billing rules, and FDA definitions and determinations of designated implantable devices and/or implantable orthopedic devices. MHC conducts such review and audit on a line-by-line basis or on such other basis as MHC deems appropriate billing.

Claims submitted via paper
MHC will acknowledge receipt of paper claims, whether or not complete, within fifteen (15) working days of receipt. You may confirm receipt of your paper claims via telephone or via our Provider Self-Services WebPortal. We encourage you to use our WebPortal as you may routinely access claims status twenty four (24) hours a day, seven (7) days a week.

- To check via telephone, please call our Claims Call Center staff at (888) 665-4621 between the hours of 8:00 a.m.-5:00 p.m., Monday through Friday.

- To check the status of your claims via the Molina Healthcare website, please visit our Provider Self-Services Web Portal system at www.molinahealthcare.com.

Claims submitted electronically
For electronically submitted claims, MHC will similarly acknowledge receipt electronically within two (2) working days.

- If you submit your claims electronically via a clearinghouse, you will receive a 997 acknowledgement and a 277FE within two (2) working days.

- Providers/Practitioners registered on our Provider Self Services WebPortal can submit professional claims online. After you successfully submit a professional claim via the Provider Self-Services WebPortal, the next screen will display a message notifying you that your claim was successfully submitted, along with the claim number.

MHC will adjudicate each complete claim or portion thereof according to the agreed upon contract rate, no later than forty five (45) working days after receipt unless the claim is contested or denied. If a claim is contested or denied, the provider will receive a written determination stating the reasons for this status no later than forty five (45) working days after receipt.

Claims Submission Instructions (Production Environment)
Claims should be submitted to the PO Box listed below:

Molina Healthcare of California
P.O. Box 22702
Long Beach, CA 90801

Claims Submission
MHC will adjudicate complete claims, which is a claim or portion of a claim that provides reasonably relevant information or information necessary to determine payer liability and that may vary with the type of service or provider. MHC may require additional information from a Provider/Practitioner where the plan has reasonable grounds for suspecting fraud, misrepresentations, or unfair billing practices.

Claims will be submitted to Molina Healthcare or affiliated IPA/Medical Group with the appropriate documentation. The requirements for documentation are designed to streamline the claims payment process. Submission of complete, timely claims allows the payer to process the claims with a minimum of manual handling.

The following information must be included on every claim:

- Provider/Practitioner name and address
- Provider/Practitioner Federal Tax ID number
- Member name, date of birth and Medi-Cal Benefits Identification Card (BIC) number
- Date(s) of service
- ICD9 diagnosis code(s)
- Revenue, CPT, or HCPCS code for service or item provided
- Billed charges for service provided
- Place of service or UB-04 bill type code
- Submitting provider tax identification and/or social security number
- Name and state license number of attending provider

Documents that do not meet the criteria described above will be returned to the Provider/Practitioner indicating necessary information missing. In addition, claims must be submitted on the proper claim form, i.e., a UB-04, CMS-1500, or Universal Drug Claim Form. These forms are available from office supply stores and medical form vendors. Molina Healthcare and affiliated IPAs will only process legible claims received on the proper claim form that contains the essential data requirements.

Claims Documentation
To ensure timely claims processing, Molina Healthcare requires that adequate and appropriate documentation be submitted with each claim filed.

Documentation required with a CMS-1500 claim form:

Provider Type	Documentation
All Providers/Practitioners	Medicare/other coverage explanation of benefits
Dialysis service	Dialysis log
Home health	Doctor's orders
	Nurses notes
Physician (specialist)	Consult report
	Flow Sheet for OB Care
	Copy of referral form
Physician (emergency medicine)	Emergency room report
Surgeon	Operative report
	Sterilization consent form when applicable
Authorization number	
Discharge summary	
Emergency room report	
History and physical	
Medicare/other coverage Explanation of Benefits	
Referral form	

Providers/Practitioners who are billing Molina Healthcare must follow these guidelines.

Providers/Practitioners who are contracted through an affiliated IPA/Medical Group must follow the requirements outlined by the IPA/Medical Group when billing for services that are the responsibility of the IPA/Medical Group.

The following information must be included on every inpatient UB-04 claim:

- Patient name, BIC identification number, and date of birth. If subscriber is different from patient, also include subscriber name and identification number
- Provider name and address
- Bill Type
- Tax identification number (Box 5)
- Provider's Medi-Cal identification number (Box 51)
- Accommodation codes (Revenue Codes)
- Attending provider name and Medi-Cal identification number/State License number (Box 82)
- Date(s) of service
- Admit Type (Box 19)
- Discharge Status (Box 22)
- ICD9
- Principal procedure code(s) (Box 80-81)
- Authorization number (Box 63)

If a claim is sent directly to Molina Healthcare, rather than the IPA/Medical Group, and the claim includes both Plan-risk services and capitated-risk services, the Plan will process the appropriate Plan-risk services. Services which are the responsibility of the IPA/Medical Group will be forwarded to the IPA/Medical Group for processing.

Claims for capitated services that are misrouted to Molina Healthcare will be routed back to the appropriate IPA/Medical Group.

Misdirected Claims

In accordance with Title 28, California Code of Regulations (CCR) Section 1300.71, all misdirected claims received by MHC from an IPA/Medical Group/Hospital's sub-contracted provider(s) in error must be forwarded to the proper payor within ten (10) working days of receipt. To comply with this standard, MHC forwards all misdirected claims via hardcopy within ten (10) working days of receipt on a daily basis (as received) to the financially responsible IPA/Medical Group/Hospital for proper adjudication.

To help ensure timely claims adjudication, MHC requests that our contracted IPA/Medical Group/Hospital's delegated for claims payment continuously educate their contracted providers regarding the correct billing address in order to bill the IPA/Medical Group/Hospital directly instead of billing MHC.

Claim Receipt Verification

For verification of claims receipt by MHC please contact:

MHC Claims Customer Service
(888) 665-4621

Electronic Claims Transactions
Below is information to use when submitting Molina Healthcare of California (MHC) Electronic Claims Transactions through the Emdeon (formerly WebMD) Clearinghouse. MHC accepts both professional (CMS-1500) and institutional claims (UB-04) electronically.

MHC's Emdeon Payer ID is: 38333 (MHC pays the claims transaction fee)

Methods to initiate submission of EDI claims:

- You can call 1 (877) 469-3263
- If you are already connected to Emdeon, you can simply use the MHC Emdeon Payer ID
- You can call the HIPAA Hotline at 1 (866) 665-4622

Methods to initiate claims submission status transactions:

- You can call 1 (877) 469-3263
- If you are already connected to Emdeon, you can simply select MHC on menu of Emdeon Empower payors
- You can call the HIPAA Hotline 1 (866) 665-4622

HIPAA required the Department of Health and Human Services (HHS) to adopt national standards for electronic health care transactions. All covered entities must be in compliance with the electronic transactions and code sets standards by October 16, 2003. Covered entities include:

- Health plans
- Health care providers who transmit health information in electronic form in connection with a transaction covered by HIPAA, &
- Health care clearinghouses

Provider Disputes
A Provider Dispute is defined as a written notice prepared by a provider that:

Challenges, appeals, or requests reconsideration of a claim that has been denied, adjusted, or contested.

Challenges a request for reimbursement for an overpayment of a claim

Seeks resolution of a billing determination or other contractual dispute

For claims with dates of service on or after January 1, 2004, all provider disputes require the submission of a Provider Dispute Resolution Request Form or a Letter of Explanation, which serves as a written first level appeal by the Provider/Practitioner. For paper submission, MHC will acknowledge the receipt of the dispute within fifteen (15) working days. If additional information is needed from the Provider/Practitioner, MHC has forty five (45) working days to request necessary additional information. Once notified in writing, the Provider/Practitioner has thirty (30) working days to submit additional information or the claim dispute will be closed by MHC.

Providers/Practitioners may initiate a first level appeal by submitting and completing a Provider Dispute Resolution Request Form or a Letter of Explanation within three hundred sixty five (365) days from the last date of action on the issue. The written dispute form must include the Provider/Practitioner name, identification number, contact information, date of service, claim number, and explanation for the dispute. In addition, the following documentation is required to review and process a claims appeal:

Provider Dispute Resolution Request Form

- A copy of the original claim(s)
- A copy of the disposition of the original claim (s) in the form of the Explanation of Benefit or Remittance Advice
- Documented reason for appeal
- A copy of the medical record/progress notes to support the appeal, when requested

Provider Disputes and supporting documentation (via paper) should be submitted to:

Molina Healthcare of California
P.O. Box 22722
Long Beach, CA 90801
Attn: Provider Dispute Resolution Unit

The Provider Dispute Resolution Request and Provider Inquiry Request forms can be found in the exhibits at the end of this chapter and on our website at www.molinahealthcare.com.

If you need further information regarding the changes required under Title 28, CCR, Sections 1300.71 and 1300.71.38 related to claims processing and provider disputes please contact MHC at (888) 665-4621.

Submission of Provider Inquiry Requests:
Please use the Provider Inquiry Request Form for routine claim or payment follow-up and to resubmit claims contested with missing information, mailing them to:

Molina Healthcare of California
P.O. Box 22722

Long Beach, CA 90801
Attn: MHC Correspondence Unit

Overpayment of Claims
If MHC determines that a claim was overpaid, then MHC will notify the Provider/Practitioner in writing within three hundred sixty five (365) calendar days of the date of payment. Notification of an overpaid claim to the Provider/Practitioner requires the following information: member name and ID number, date of service, and an explanation why MHC believes the claim was overpaid. The Provider/Practitioner has thirty (30) working days to dispute an overpayment notification, which then becomes a provider dispute and follows the applicable procedures listed above under Provider Disputes.

Claims Processing Timeframes

Unless the Subcontracting Provider/Practitioner and Contractor have agreed in writing to an alternate payment schedule, ninety percent (90%) of "clean" claims will be adjudicated within thirty (30) calendar days of receipt. A "clean" claim is one that may be processed without obtaining additional information from the Provider/Practitioner of service or from a third party. However, "clean" claims do not include claims under investigation for fraud or abuse, or claims under review for medical necessity. All claims submitted for which no further written documentation or substantiation is required, are to be processed within forty five (45) working days of receipt.

Coordination of Benefits
Molina Healthcare and affiliated IPAs/Medical Groups have the liability for payment of authorized claims after all other third parties.

Private insurance carriers, including Medicare, must be billed by the Provider/Practitioner prior to billing Molina Healthcare, or affiliated IPAs/Medical Groups. The Provider/Practitioner must include a copy of the other insurance's explanation of benefits (EOB) with the claim.
Proof of third party billing is not required for:

- Services provided to Members with Other Health Coverage (OHC) codes A, M, X, Y, and Z
- Services defined by DHCS as prenatal or preventive pediatric services
- Child-support enforcement cases

Third-Party Tort Liability
Molina Healthcare must identify and notify the Department of Health Care Services within ten (10) days of the discovery of cases in which action by the member involving the tort or Worker's Compensation liability of a third party could result in recovery by the member of funds to which the Department has lien rights.

Molina Healthcare or affiliated IPAs/Medical Groups must be notified in writing of all potential and confirmed third party tort liability cases that involve a Molina Healthcare Medi-Cal Member. Notification must include:

- Member name
- Member identification number and Medi-Cal number
- Date of birth
- Provider name and address
- Date(s) of service
- ICD9 code and/or description of injury
- CPT code and description of service(s) rendered
- Billed charges for service(s)
- Any amount paid by other coverage (if applicable)
- Date of denial and reason(s) for denial

Any requests received by subpoena from attorneys, insurers, or members for bill copies must be reported to Molina Healthcare or affiliated IPAs/Medical Groups. Copies of the request and responses must be forwarded to Molina Healthcare.

Notification and information should be sent to the following addresses:

Molina Healthcare of California
Third Party Liability Coordinator
1500 Hughes Way, Pod A 2nd FloorLong Beach, CA 90810

For verification of claims receipt by MHC please contact:

MHC Claims Customer Service
(888) 665-4621

If the Provider/Practitioner of service is part of an IPA/Medical Group, please contact the IPA/Medical Group for the appropriate mailing address.

When Molina Healthcare receives a request for information from the Department of Health Care Services (DHCS) on an individual case, a response is required within ten (10) to thirty (30) days of the DHCS request. Molina Healthcare will be contacting the Provider/Practitioner of service for assistance if needed. The information requested must be returned within ten (10) days.

All claims for services rendered in relation to a third-party tort liability case should be submitted for processing as described in the “Claims Submission” section of this Manual. The claims will follow normal processing guidelines.

Claims Auditing: Fee-For-Service Providers

To verify the accuracy of fee-for-service Provider/Practitioner billings, a Molina Healthcare representative will conduct random Provider/Practitioner audits.

A sample of claims paid will be pulled and verified against the member's medical record maintained by the Provider/Practitioner. This audit may occur in the Provider/Practitioner's office or in the offices of Molina Healthcare. Where the billing substantially differs from the medical record, the information will be forwarded to the Claims Manager for follow-up and/or screening for fraud and abuse, with subsequent reporting to the DHCS.

Shared Risk Claims

Shared Risk claims should be sent to Molina Healthcare for adjudication. Additionally, the claims should be separated and batched into Plan or shared risk services and claim types. All claims submitted to Molina Healthcare must be on CMS-1500, LTC form 25-1, or UB-04 claim forms and indicate the date of receipt by the IPA/Medical Group. Claims for plan or shared risk services must be submitted to:

Molina Healthcare of California
P.O. Box 22702
Long Beach, CA 90801

If a claim is sent directly to Molina Healthcare, rather than the IPA/Medical Group, and the claim includes both Plan-risk services and capitated-risk services, the Plan will process the appropriate Plan-risk services. Services which are the responsibility of the IPA/Medical Group will be forwarded to the IPA/Medical Group for processing.

Claims for capitated services that are misrouted to Molina Healthcare will be routed back to the appropriate IPA/Medical Group.

ENCOUNTER DATA

Encounter Data Incentives, CHDP Incentives

ENCOUNTER REPORTING

The collection of encounter data is vital to Molina Healthcare. Encounter data provides the Plan with information regarding all services provided to our membership. Encounter data serves several critical needs. It provides:

- Information on the utilization of services
- Information for use in HEDIS studies
- Information that fulfills state reporting requirements

DHCS has implemented standards for the consistent and timely submission of Medi-Cal encounter data. These guidelines will also require heightened accuracy when completing and submitting PM 160 INF forms in order to meet the State of California CHDP Program requirements. Molina Healthcare is required to submit encounter information to DHCS on a monthly basis.

HIPAA Standards for Electronic Transactions

HIPAA required the Department of Health and Human Services (HHS) to adopt national standards for electronic health care transactions. All covered entities must be in compliance with the electronic transactions and code sets standards by October 16, 2003. Covered entities include:

- health plans,
- health care providers who transmit health information in electronic form in connection with a transaction covered by HIPAA, &
- health care clearinghouses

The electronic health care transactions covered under HIPAA that may affect provider organizations are:

Transaction Description	HIPAA Transaction Standard
Claims or Encounter Information	ASC X12N 837, Professional, or Institutional Health Care Claims (004010X096A198A1)
Eligibility for a Health Plan	ASC X12N 270/271 Health Care Eligibility Benefit Inquiry and Response (004010X092A1)
Referral Certification and Authorization	ASC X12N 278 Health Care Services Review Request for Review and Response (004010X094A1)
Claims Status	ASC X12N 276/277 Health Care Claim Status Request and Response (004010X093A1)
Payment and Remittance Advice	ASC X12N 835 Health Care Claim Payment/Advice (004010X091A1)

HIPAA Provider Hotline Contact Information

For HIPAA TCS questions please call the Toll Free HIPAA Provider Hotline at: ***1(866) 665-4622***. You may also obtain information on the Molina Healthcare website at: **www.molinahealthcare.com**

Policy

Molina Healthcare requires all Providers/Practitioners to submit encounter data reflecting the care and services provided to our members.

This policy applies to all Primary Care Practitioners (PCPs), contracted either directly with Molina Healthcare or through an IPA/Medical Group. It is important to note the encounter data must also reflect services provided by any ancillary personnel that are under the direction of the PCP, including any physicians (specialists) providing care and services to our patients as defined in their contract with Molina Healthcare.

Procedure

Single encounter (for our purposes) is defined as all services performed by a single Provider/Practitioner on a single date of service for an individual member.

The following guidelines are provided to assist our Providers/Practitioners with submission of complete encounter data:

- Reporting of services must be done on a per member, per visit basis
- A reporting of all services rendered by date must be submitted to Molina Healthcare
- Encounter Data must reflect all the same data elements required under a fee-for-service program
- All encounter data reporting is subject to, and must be in full compliance with, the Health Insurance Portability and Accountability Act and any other regulatory reporting requirements

Electronic Encounter Reporting is Subject to the Following Requirements

- Data must be submitted via our File Exchange Services (FES) site in the HIPAA compliant 837 format (ASC X12N 837).

- DHCS mandated values must be used when appropriate (e.g., procedure code modifiers).
- Electronic encounter data must be received within ninety (90) days from the end of the month following the encounter (e.g., by October 31st for all encounters occurring in July).
- Only encounter records that pass Molina Healthcare edits will be included in the records evaluated for compliance. Encounters that fail Molina Healthcare edits will be rejected and error reports will be made available via our File Exchange Services (FES) site or our ePortal Services at HYPERLINK "http://www.molinahealthcare.com" www.molinahealthcare.com. If the failed encounter is corrected and resubmitted within the required timeframe, it will then be included in the calculation for performance standards. Please note that ONLY the corrected encounters are to be resubmitted.
- In no event will incomplete, inaccurate data be accepted.

Tips for Successful Submission

- Encounter data must include the rendering Practitioner/Provider's name and state license number, and the National Provider Identifier (NPI) number whether contracted or non-contracted with an IPA/Medical Group.
- The billing Practitioner/Provider's tax identification number (TIN) and NPI must be included whether contracted or non-contracted with an IPA/Medical Group.
- We encourage multiple/frequent submissions of encounter data on a daily, weekly, or monthly basis to ensure timely submission.

Important Information on Hard Copy Submissions

- Hard copy encounter data for all Medi-Cal and Healthy Families capitated services must be submitted on a CMS 1500 or UB04 form only.
- CHDP encounter data must be submitted on a PM160 "INF Only" form. In addition, on-line submission is also available to submit your PM 160s via ePortal Services at: www.molinahealthcare.com.
- Hard Copy encounter data must be received by the 5th day of the second month following the date of the encounter (e.g., by September 5th for all encounters occurring in July).

Threshold Requirement

151.8 encounters per one thousand (1000) members per month. Twenty percent (20%) of CHDP submissions will be applied towards the threshold.

All hard copy encounter data must be submitted to the following address:

Molina Healthcare of California

P.O. Box 22807

Long Beach, CA 90801

Sanctions

Providers/Practitioners will be sanctioned for noncompliance. These sanctions may include ineligibility for the encounter incentive program, freezing new enrollment, capitation withhold, and/or ultimately terminating the capitation contract.

Encounter Data Incentive Requirements

Applicable to Los Angeles County, Riverside/San Bernardino Counties and Sacramento County only, as stated in the providers contract.

- Encounter Data must reflect all the same data elements required under a "fee-for-service" program.
- Encounter data must include the rendering Practitioner/Provider's name and state license number, and the National Provider Identifier (NPI) number.
- The billing Practitioner/Provider's tax identification number (TIN) and NPI must be included.
- Current and valid ICD9 and CPT codes and appropriate modifiers.
- Electronic encounter data must be submitted in the HIPAA compliant 837 format only. (ASC X12N 837) **Electronic encounters not submitted in the HIPAA compliant 837 format will not be eligible to receive the encounter data incentive.**
- Hard Copy encounter data must be submitted on a CMS 1500 or UB04 form only.
- All encounter data must be submitted timely and meet the threshold requirements.
- The threshold requirement is 151.8 encounters per 1000 members per month, for each line of business.
- Electronic encounter data must be received within 90 days from the end of the month following the date of the encounter (e.g., by October 31st for all encounters occurring in July.)

- Hard Copy encounter data must be received by the 5th day of the second month following the date of the encounter (e.g., by September 5th for all encounters occurring in July.)
- CHDP encounter data must be submitted on a PM160 "INF Only" form. In addition, on-line submission is also available to submit your PM 160s via ePortal Services at: www.molinahealthcare.com.
- **Duplicate, rejected and late/untimely submitted encounters will not be allowed towards the threshold requirements nor included in the incentive.**

Note: If you are contracted with an IPA / Medical Group please follow your IPA / Medical Group's Encounter Data Submission guidelines keeping the above standards in mind.

PM 160 INFORMATION ONLY FORM COMPLETION AND SUBMISSION

The California Department of Health Care Services (DHCS) requires that all Medi-Cal Members 0 through their 20th year and 11 months receive periodic health screening exams. Exams performed must meet the requirements of this program utilizing components of the Children's Health and Disability Prevention (CHDP), a part of Children's Medical Services State Program, the American Academy of Pediatricians (AAP) Periodicity Table for Wellness Exams, and the American Academy of Pediatrician Periodicity and Recommendations for Immunizations.

All Wellness (CHDP) exams for Molina Healthcare Medi-Cal members must be documented on the PM 160 Information Only Form (PM 160). The PM 160 form is used for Medi-Cal members enrolled in a managed care plan.

Order Desk

The State of California provides the PM 160 to each managed care plan contracted with Medi-Cal. All forms used to report services for Molina Healthcare members, MUST be ordered directly from Molina Healthcare.

PM 160 Form Order Desk (800) 5268196 ext. 127371 or 127350

CHDP Submissions

All Providers/Practitioners assigned a pediatric population must submit a PM 160 form for all Wellness services rendered to Molina Healthcare Medi-Cal members 0 through their 20th year

and 11 months and according to the screening guidelines on the AAP Periodicity Table.

CHDP Incentive Program

Applicable to Los Angeles County, Riverside/San Bernardino Counties and Sacramento County only, as stated in the providers contract.

Molina Healthcare offers a CHDP Incentive Program for certain eligible physicians in participating counties for the timely submission of clean PM 160 Information Only Forms for the provision of CHDP services to Members ages zero (0) through twenty (20). Payment is also subject to compliance with the American Academy of Pediatrics ("AAP") recommendation for Preventive Pediatric Health Care and Immunizations, Guide to Clinical Preventive Service, a report of the U.S. Preventive Service Task Force.

Eligible physicians must submit a completed Molina Healthcare Reimbursement Incentive (MRI) Program packet to be considered for the program. The MRI Program packet sets forth the county-by-county eligibility criteria. A completed MRI Program packet includes, but is not limited to, the following documentation:

- Provider Acknowledgement (Completed and signed)
- Provider Assignment of Benefits form (Completed and signed)
- W9 Form
- A CHDP Provider and Site Certification (L.A. area only)

For providers approved by Health Plan for the CHDP Incentive Program, Health Plan pays an incentive payment for the timely submission of clean PM 160 Information Only Forms for the provision of CHDP services to Members ages zero (0) through twenty (20) commensurate with the amount equivalent to 100% of the amount DHCS reimburses providers pursuant to the CHDP Fee Schedule Rates in effect as of the date(s) of service. For eligible capitated providers, CHDP services are capitated as Wellness Visits within your standard capitation payments, and any CHDP Incentive Program payments by Molina for the CHDP data are in addition to those standard capitation payments for the services.

Required Submission Standards

The following information is required for the processing of PM 160 INF submissions. If these

fields are not completed, Molina Healthcare will contact your office.

- Patient Complete Name
- Patient Date of Birth
- Name of Guardian or Responsible Person
- Date of Service
- The Next Visit date
- Ethnic Code
- Vital Signs, Height, Weight and MBI
- Blood Pressure for children 3 years and up
- The appropriate services noted for the type of screen given
- The type of screen
- The prepaid project code
- Test Results
- Immunization and test codes
- An ICD9 for every problem diagnosed and follow up code; if no problems are detected then the appropriate Wellness exam code **MUST** be used
- Completion of the Tobacco Questions
- The patient eligibility section including the County Code, Aid Code, and patient's identification number
- The rendering provider's name, service address and Medi-Cal/NPI number
- All PM 160 form submissions **MUST** be signed by the physician rendering service
- If the child is under 2 months of age you may be able to use the Mother's Medi-Cal number

Online submission is preferred to submit your PM 160 INFs via ePortal services at:

www.molinahealthcare.com

Routing Instructions for the PM 160 Version Forms

Send Copy 1 (Brown/White) to:

Molina Healthcare of California
P.O. Box 16027
Mailstop "HFW"
Long Beach, CA 90806
Attn: CHDP Department

Copy 2 (Yellow)	*Send to the local CHDP Community Office for your area*
Copy 3 (White)	*Keep in the patient's file in the provider's office*
Copy 4 (Pink)	*Give to the patient*

On-Line PM160 Version 8

Print a copy	For patient's chart and Parent/Guardian at time of visit
Print a copy	Sign and send to the CHDP Community Office for your area