Claims

Please submit claims for Molina Healthcare Medicaid, Healthy Michigan Plan and MIChild to the following billing address:

Molina Healthcare
P.O. Box 22668
Long Beach, CA 90801

Please do not submit initial claims to the Troy address as this will delay the processing of your claims, and your claim may be returned. Please contact the Provider Call Center for claims status information at (855) 322-4077, Monday – Friday 8:00 a.m. – 5:00 p.m. EST; you may inquire about three (3) claims per call.

Please have the following available when calling to ensure timely assistance:

- Member ID;
- Date of Service;
- Tax ID; and/or,
- Claim Number

Claims Submission Guidelines

Filing Limit

- Claims should be sent to Molina Healthcare within 365 days from the date of service.
- For resubmission of secondary claims, Molina Healthcare must receive the claim within 180 days from the primary carriers' explanation of benefits remit date.
- If a claim is submitted to Medicaid or another HMO in error prior to the claim being submitted to Molina Healthcare, the submission limit is not extended. Eligibility must be verified prior to rendering services.
- Molina Healthcare responds to claims within State processing guidelines. The Claims determination will be reported to the provider on a Remittance Advice (RA).
- If no response is received within 45 days on a submitted claim, please call Molina Healthcare of Michigan at (855) 322-4077, or use WebPortal to status your claim(s).
- All claims received beyond the filing limit will be rejected and members are not to be billed for the service(s).

Electronic Claims Submission

Molina Healthcare accepts claims electronically, including secondary claims. Electronic submission allows claims to be directly entered into Molina Healthcare's processing system, which results in faster payment and fewer rejections.

- WebPortal (www.molinahealthcare.com) Provider Self Services
    - Submit claims
    - Status claims
    - Print claims reports
- Molina Healthcare also accepts electronic claims submissions through a variety of clearing houses:
- Molina Healthcare of Michigan Payor Number is 38334

Contact Information

- For WebPortal access contact Molina Healthcare's Help Desk at 1-866-449-6848 or contacts your Provider Services Representative directly.
- For EDI claim submission issues contact Molina Healthcare's Help Desk at 1-866-409-2935 or submit an e-mail to EDI.Claims@MolinaHealthcare.com. Please include detailed information related to the issue and a contact person's name and phone number.

Claims Form

- Professional charges must be submitted on a CMS1500 form
- Facility UB04 Form

Paper Claim Submission Guidelines

- Must use original forms
- Must be typewritten or computer generated
- Do not use highlighters, white-out or any other markers on the claim
- Avoid script, slanted or italicized type. 12 point type is preferred
- Do not use an imprinter to complete any portion of the claim form.
- Do not use punctuation marks or special characters
- Use a six digit format with no spaces or punctuation for all dates (ex 060101).
- Securely staple all attachments. Attachments should identify patient's name and recipient ID number

Claims Policies

Adjudication

Molina Healthcare adjudicates claims according to the State of Michigan Medical Services Administration (MSA) policies and procedures. Reference the Uniform Billing Guidelines, ICD-9 Diagnosis Code Book, CPT Code Book, HCPCS and Michigan Department of Community Health (MDCH) website www.michigan.gov when submitting a claim.

Payment

- Contracted providers will be paid according to the terms of the agreement between the provider and Molina Healthcare
- Non-Contracted Providers will be paid for covered services according to the MDCH Medicaid fee schedule in effect at the time of service.

Resubmission

- Providers may resubmit claims with correction(s) and/or change(s), either electronically or paper.
- For Paper CMS 1500 claim form: Enter "RESUBMISSION" on the claim in the Remarks section. Box 22: Medicaid resubmissions only enter the resubmission code and the original reference number as directed.

- 1 - Original (admission through discharge)
- 7 - Replace (replacement/correction of prior claim)
- 8 - Void (void/cancel of prior claim)

For Paper UB04 claim form: The correct bill type in box 4 must be indicated on the form.

Please send to Original/Resubmission to the address above, or submit electronically when appropriate and with appropriate bill type on UB 04 forms. Faxed copies are not accepted.

Newborn Care

Newborn care must be submitted on the appropriate claim form using the newborn's Medicaid ID number. The mother's Medicaid ID number may not be used to bill for services provided to a newborn.

National Drug Code (NDC)

Effective immediately per the MSA 10-15 and MSA 10-26 Bulletin regarding the billing of drug codes along with the appropriate NDC code for reimbursement. Submitting claims with a missing or invalid NDC drug code will result in delay of payment or denied claim. Please refer to newest NDC coding guidelines for direction regarding appropriate codes. Also refer to the Michigan Department of Community Health's (MDCH) bulletins MSA -7-33 and MSA 07-61 from 2007 and 2008 directing providers to bill accordingly. Drug manufacturers do change the NDC periodically throughout the year; keep in contact with the manufacturer or distributor for the most current NDC number.

This requirement is mandated to ensure MDCH compliance with the Patient Protection and Affordable Care Act (PPACA), P.L. 111-148.

Provider National Identification Number (NPI)

Molina Healthcare Required Fields:

CMS 1500	Required?	Field Location
Billing Provider NPI	Yes	Box 33a
Billing Provider Medicaid Number	Yes	Box 33b
Rendering Provider NPI	Yes	Box 24j
Rendering Provider Medicaid Number	Yes	Box 24j
Referring Provider NPI	If Applicable	Box 17b
Facility Provider NPI	If Applicable	Box 32a
Taxonomy Code	No	Boxes 24j; 33b and 32b

UB04	Required?	Field Location
Billing Provider NPI	Yes	Box 56
Billing Provider Medicaid Number	Yes	Box 57a
Attending Provider NPI	If Applicable	Box 76
Operating Provider NPI	If Applicable	Box 77j
Other Provider NPI	If Applicable	Box 78
Other Provider NPI	If Applicable	Box 79
Taxonomy Code	No	Boxes 57, 76,77,78 and 79

Coordination of Benefits

As a provider treating Molina Healthcare members, your cooperation in notifying Molina Healthcare when any other coverage exists is appreciated. This includes other health care plans or any other permitted methods of third party recovery for coordination of benefits, worker's compensation and subrogation.

- Claims involving coordination of benefits with primary insurance carriers should be received by Molina Healthcare within 150 days from the date of the primary carrier's explanation/denial of benefits.
- If Molina Healthcare reimburses a provider and then discovers other coverage is primary, Molina Healthcare will recover the amount paid by Molina Healthcare.
- Regardless of the primary payer's reimbursement, Molina Healthcare should be billed as a secondary payer for all services rendered. A copy of the primary payer's EOB showing payment or denial must be attached to the claim when submitting payment, or the claim can be submitted electronically for secondary coordination.
- The claims core processing system is configured according to MDCH guidelines. This method calculates what Molina Healthcare of Michigan (MHM) would pay as primary and subtracts the primary carrier's payment from this amount. The MHM payment is the lesser of this difference, *or* the Medicaid allowable per line. In other words, we can pay up to the patient responsibility, but **never more than** the MHM allowable.
- Molina Healthcare members cannot be billed for any outstanding balance after Molina Healthcare makes payment.
- Molina Healthcare members do not have deductibles, co-pays or co-insurance.

Claims submission guidelines for dual eligible Members

Services provided to patients who are covered by both Molina Medicare Options Plus and Molina Medicaid should follow the guidelines below:

- Submit one authorization request to the Molina Medicare team fax 888-295-7665 - Molina Healthcare will coordinate authorization requirements, benefits and services between the two products
- Submit one claim to Molina Healthcare to the Molina Medicare team - Upon receipt of the claim, we will process under Molina Medicare Options Plus then Molina Medicaid. There is no need to submit two claims. Claims processing information will be reported on two Remittance Advice (RA) forms

- **Molina Medicare, PO Box 22811, Long Beach CA 90801**
- The 1st will come from Molina Medicare indicating how the claim was processed and informing you that the claim was forwarded to Molina Medicaid for secondary processing
- The 2nd RA will show how the claim was processed for Molina Medicaid. Using the same claim number as the Medicare claim but with an "S" on the end to indicate secondary payment by Medicaid.

Interim Billing

Molina Healthcare does not accept claims billed with an interim bill type for outpatient services, containing a 2, 3, or 4 in the 3rd digit. All claims must be billed with the "admit through discharge" information. In the case of continuing or repetitive care, such as with physical therapy, facilities must bill on a monthly basis with all services occurring billed on one claim, with service from and to dates listed separately per line, and as an admit through discharge bill.

Claims Dispute/Appeal Request Form Instructions

Please indicate the Line of Business

SECTION 1: General Information

1. If preferred, save the form to your own computer
2. Complete each box in Section 1
3. Use one form per claim number
4. If submitting multiple claim disputes for the same dispute type, then complete only one Claims Dispute/Appeal Request Form, and leave the following fields blank (these fields will be on each of the claims):
   Claim Number (can be indicated on each claim or submit the RA)
   Member Name
   Member ID #
   Date of Service
5. Please do not alter this form, as it will not be accepted

SECTION 2: Type of Claim Adjustment

PLEASE CHECK THE MOST APPROPRIATE BOX

1. **Appeals:**
   CCI Edits and Timely Filing appeals must be submitted with supporting documentation.
2. **COB:**
   - Requires a copy of primary payer EOP (explanation of payment).
   - Requires effective date and/or term date, contract/policy number, and name of primary carrier.
   - Or send electronically with completed fields according to the EDI file layout.
3. **Member:**
   Indicate processed under incorrect member of the provider practice.
4. **Payment Amount**

- Requires supporting documentation of the calculation/formula used to determine amount of under/overpayment.
- Indicate if a request for a reversal is to be completed for overpayments.
- Requires a copy of the claim and supporting documentation for all duplicate claims.
- Requires a copy of authorization for all authorization related issues.

Please use additional paper attachments if necessary to document comments.
Fax form and documentation attention: **Claims Department** at (248) 925-1768 or mail to:

Molina Healthcare of Michigan
100 W. Big Beaver Rd, Suite 600
Attention: **Claims Department**
Troy, MI 48084-5209

Claim Dispute/Appeal Form can be found on the website at http://www.molinahealthcare.com/medicaid/providers/mi/forms/Pages/fuf.aspx

Provider Denied Claim Appeal Guidelines

If a Provider disagrees with a denied claim or denied claim line determination for reasons *other than a Medical Necessity/Administration Appeal for Authorization*, the Provider may appeal in writing within 90 days of the claims original determination. The appeal must include:

- A letter requesting and detailing the reason for the appeal.
- A copy of the claim.
- Any other supporting documentation
  - Record of timely filing.
  - Record of provider calculations or screen prints of pricing tool provider used to calculate claim.
  - Reference documentation.
  - Contract section of payment agreement.
  - Completed Claim Dispute/Appeal Request Form-Michigan (one form per one claim appeal). *Instructions on completing the form and copy of the form are in located under the Claims Dispute/Appeal Request Form Instructions section of this manual.*

Appeal letters and supporting documentation must be submitted to:

Molina Healthcare of Michigan
100 W. Big Beaver Stuite 600
Attn: PIRR Department-Claim Redeterminations
Troy, MI 48084
OR
Fax to:
Attn: PIRR-Claim Redeterminations
(248) 925-1768

Upon receipt of the appeal letter and supporting documentation, the appeal will be date stamped and logged within 5 days of receipt. All appeals for denied claims will be responded to within 30 days of receipt.

Provider Claim Redetermination/Disputes Guidelines

A redetermination/dispute request, which differs from Provider Medical Necessity/Administration Appeals for Authorization request, must be submitted within 365 days from the original Molina Medicaid Remittance Advice in order to be considered. Providers may request a claim redetermination when the claim was incorrectly paid due to over/underpayments, or to Claim's examiner or data-entry error. Additionally, the item(s) being resubmitted should be clearly marked as a "**redetermination"** and must include the following:

- Providers must include the reason for redetermination.
- Previous claim and remittance advice, any other documentation to support the request and a copy of the referral/authorization form (if applicable) must accompany the request.
- Requests for claim redetermination should be mailed to:

Molina Healthcare of Michigan
100 W. Big Beaver Rd. Suite 600
Attn: PIRR-Claim Redeterminations
Troy, Michigan 48084
OR
Fax to:
Attn: PIRR-Claim Redeterminations
(248) 925-1768

- Molina will contact the Provider if the claim denial is upheld.
- Providers may **not** "bill" the member when a denial for covered services is upheld per review.
- Providers will receive a Remittance Advice with payment/corrected payment if favorable to the provider.
- Corrected claim submissions are not adjustments and should be directed through the original submission process marked as a corrected claim or it will result in the claim being denied.

MOLINA HEALTHCARE

Claim Dispute/Appeal Request Form – Michigan

This is not a status form, please contact Molina at 855-322-4077 or use WebPortal to status your claims(s)

NOTE: FAILURE TO COMPLETE THIS FORM WILL RESULT IN A DELAY OF PROCESSING YOUR REQUEST

Please allow 45 days to process this adjustment request

☐ Medicaid Line of Business (includes CSHCS) ☐ Medicare Line of Business ☐ Marketplace

Please return this complete form and any supporting documentation to:
Molina Healthcare of Michigan, 100 W. Big Beaver Road, Suite 600 Attn: Claims, Troy, MI 48084-5209 Or Fax to: (248) 925-1768

Section 1: General Information

Today's Date	No. of Claims	Claim Number	
Member Name		Member Id#	
Provider Name		Date of Service	
Provider ID (TIN)	Provider Fax #	Provider Phone #	Contact Person

Section 2: Type of Claim Adjustment

Based upon the following reasons, we are requesting reconsideration of this claim.
Provider: Please check applicable reason(s) and attach all supporting documentation.

Appeals

☐ **CCI Edits (documentation required)**
Attn: CCI Edits Appeal
Fax to: 248-925-1768

☐ **Timely Filing:**
Use to appeal claims denied past one year filing limit.
Must be submitted within 90 days of denial date
Attach claim & supporting documentation showing claim was filed in a timely manner.
Newborn timely filing denials will not be reviewed if proper documentation was not included with original claim submission.
Attn: Timely Filing Appeal
Fax to: 248-925-1768
MEDICARE Fax 888-295-7665

Coordination of Benefits Information

☐ COB-Related Adjustment **Fax to 248-925-1768**

Alternate Insurance Information to **add or term** from a member file **Fax to 877-860-7751.** Please include Primary Insurance Carrier Information EOB

_____

Refunds or Return Checks:

☐ Mail to:
Molina Healthcare of Michigan Inc.
25874 Network Place
Chicago, IL 60673-1258

Coding Changes - Corrected Claim

☐ **Faxed copies are not accepted.**
Mail to PO Box 22668 Long Beach, CA 90801 or submit corrected claim electronically (Molina's payor Id #38334)

Authorization

☐ Authorization now on file – Please contact the call center to have the claim(s) reprocessed.

For an authorization, change information on an existing authorization or to appeal a denied authorization, do not use this form. Authorization form & instructions are available on Molina Healthcare website or WebPortal.
MEDICAID Fax 800-594-7404
MEDICARE Fax 888-295-7665.

Payment Amount

☐ Overpayment – Explain use COMMENTS below.
☐ Underpayment – Explain use COMMENTS below.
☐ Paid Wrong Provider, processed under incorrect tax identification number.
☐ Other (please note reason in comment section)

Comments: _____

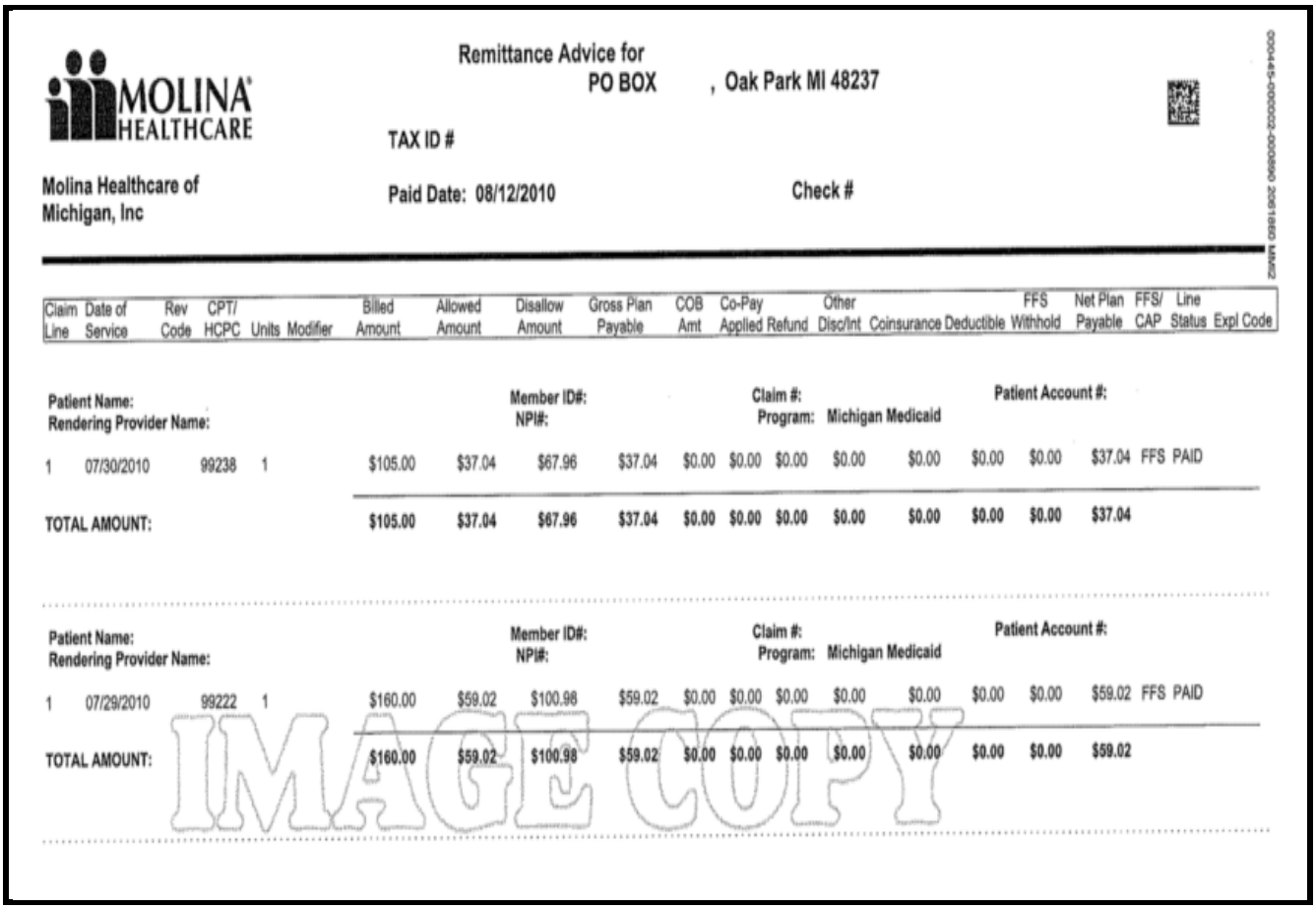
_____

_____

Revised on: 1/29/14

Sample Remittance Advice (RA)

Attachment C



MOLINA HEALTHCARE

Remittance Advice for
PO BOX , Oak Park MI 48237

TAX ID #

Molina Healthcare of Michigan, Inc

Paid Date: 08/12/2010 Check #

Claim Line	Date of Service	Rev Code	CPT/ HCPC	Units	Modifier	Billed Amount	Allowed Amount	Disallow Amount	Gross Plan Payable	COB Amt	Co-Pay Applied	Refund	Other Disc/Int	Coinsurance	Deductible	FFS Withhold	Net Plan Payable	FFS/ CAP	Line Status	Expl Code
Patient Name:								Member ID#:				Claim #:				Patient Account #:				
Rendering Provider Name:								NPI#:				Program: Michigan Medicaid								
1	07/30/2010		99238	1		$105.00	$37.04	$67.96	$37.04	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$37.04	FFS	PAID	
TOTAL AMOUNT:						$105.00	$37.04	$67.96	$37.04	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$37.04			
Patient Name:								Member ID#:				Claim #:				Patient Account #:				
Rendering Provider Name:								NPI#:				Program: Michigan Medicaid								
1	07/29/2010		99222	1		$160.00	$59.02	$100.98	$59.02	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$59.02	FFS	PAID	
TOTAL AMOUNT:						$160.00	$59.02	$100.98	$59.02	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$59.02			

IMAGE COPY

No check voucher
Cash Advance – Balance ($1.91)

000712-000001-001423 2065358 1060CK012
Molina HealthCare of Michigan
100 West Big Beaver, Suite 600
Troy, MI 48084

Temporary Return Service Requested

[redacted]

MOLINA HEALTHCARE

Page 1 of 4

DATE: 09/28/2010
TAX ID #[redacted]
CHECK NO.: No Check

MEDICAL REMITTANCE ADVICE

SUMMARY OF CHECK

Billed Amount:	$14.00	Refunds:	$0.00
Contract/Allowed Amt:	-$1.91	Interest:	$0.00
Disallow Amount::	$15.91	Coinsurance:	$0.00
Gross Plan Payable:	-$1.91	Deductible:	$0.00
COB Amt:	$0.00	FFS Withhold:	$0.00
Co-Pay:	$0.00	Total Paid Amount:	-$1.91

Advance Recovery

Advance Date:	09/28/2010
Advance Amount:	$1.91
Total Amount Recovered From This Payment:	$0.00
Remaining Balance:	$1.91

Total Check Amount: -$1.91

Confidential Protected Health Information

This document contains confidential Protected Health Information that is protected under HIPAA and other applicable federal and state laws. This information should be safeguarded at all times and should be securely destroyed when no longer needed. This information is intended only for use by the authorized recipient. Any unauthorized use or disclosure of this information should be reported to Molina Healthcare.

To file a provider claim reconsideration, please see the reconsideration procedure on the back of this page.

Exciting COB Enhancement: Molina can now accept COB claims through the standard 837 EDI file format.

Detail of no check voucher
Cash advance of ($1.19)

MOLINA HEALTHCARE

Remittance Advice for [redacted]

TAX ID # [redacted]

Molina Healthcare of Michigan, Inc

Paid Date: 09/28/2010

Check # No Check

Claim Line	Date of Service	Rev Code	CPT/ HCPC	Units	Modifier	Billed Amount	Allowed Amount	Disallow Amount	Gross Plan Payable	COB Amt	Co-Pay Applied	Refund	Other Disc/Int	Coinsurance	Deductible	FFS Withhold	Net Plan Payable	FFS/ CAP	Line Status	Expl Code
Patient Name: [redacted] Member ID#: [redacted] Claim #: [redacted] Patient Account #: [redacted] Rendering Provider Name: [redacted] NPI#: [redacted] Program: Michigan Medicaid																				
1	09/14/2010	73562	1	LT	$44.00	$17.04	$26.96	$17.04	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$17.04	FFS	PAID	
2	09/14/2010	R0070	1		$174.00	$0.00	$174.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS	PAID	BAC01
3	09/14/2010	Q0092	1		$21.00	$0.00	$21.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS	PAID	BAC01
TOTAL AMOUNT:					$239.00	$17.04	$221.96	$17.04	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$17.04			
Patient Name: [redacted] Member ID#: [redacted] Claim #: [redacted] Patient Account #: [redacted] Rendering Provider Name: [redacted] NPI#: [redacted] Program: Michigan Medicaid																				
1	07/02/2010	71010	-1		-$34.00	-$14.65	-$19.35	-$14.65	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	-$14.65	FFS	PAID	
2	07/02/2010	Q0092	-1		-$21.00	$0.00	-$21.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS	PAID	BAC01
3	07/02/2010	R0075	-1	UP	-$170.00	-$4.30	-$165.70	-$4.30	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	-$4.30	FFS	PAID	
TOTAL AMOUNT:					-$225.00	-$18.95	-$206.05	-$18.95	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	-$18.95			

Message: Reversal of Claim # is 10221833254
Member has no active enrollment on DOS

$17.04 - $18.95=

Voucher Summary and Check

0000445-0000001-0000889 2061860 MMI2
Molina HealthCare of Michigan
100 West Big Beaver, Suite 600
Troy, MI 48084

Temporary Return Service Requested

NAME
ADDRESS
STATE

MOLINA HEALTHCARE

Page 1 of 3

DATE: 08/12/2010
TAX ID #:
CHECK NO.:

MEDICAL REMITTANCE ADVICE

SUMMARY OF CHECK

Billed Amount:	$265.00	Refunds:	$0.00
Contract/Allowed Amt:	$96.06	Interest:	$0.00
Disallow Amount::	$168.94	Coinsurance:	$0.00
Gross Plan Payable:	$96.06	Deductible:	$0.00
COB Amt:	$0.00	FFS Withhold:	$0.00
Co-Pay:	$0.00	Total Paid Amount:	$96.06

Total Check Amount: $96.06

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IMAGE COPY

MOLINA HEALTHCARE
Molina HealthCare of Michigan
100 West Big Beaver, Suite 600
Troy, MI 48084

USBank
Havre, MT
usbank.com
93-455/929

08/12/2010

VOID AFTER 90 DAYS

PAY Ninety-Six and 06/100 **$96.06

TO THE ORDER OF
PROVIDER
PO BOX
Oak Park MI 48237