



CLAIMS AND ENCOUNTER DATA

BILLING AND CLAIMS SUBMISSION

The following items are covered in this section:

- Claim Submission
- Billing Guidelines
- Timely Claim Filing/Processing
- Claims Editing Process
- Claim Corrections and Reconsiderations
- Overpayments and Refund Requests
- Third Party Liability
- Coordination of Benefits
- Billing the Member
- Invalid Place of Service Codes
- HIPAA Compliant Modifiers that Impact Claims Payment
- Claims Submission Guide

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 Molina Healthcare EDI Companion Guides can be found at: [Ohio Web Sites Companion Guide Links](#).
- More information about Molina Healthcare and the claims and billing processes is available on the Molina Healthcare website at www.MolinaHealthcare.com.

CLAIM SUBMISSION

All claims (medical and behavioral health services) should be submitted to Molina Healthcare with appropriate supporting documentation by mail or electronically.

- Molina Healthcare accepts the following claim forms:
 - CMS 1500 - AMA universal claim form also known as the National Standard Format (NSF)
 - CMS 1450 - UB-04 (for hospitals)
- 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 transaction and code sets.

The following information must be included on every claim:

- Member name, date of birth and ID number
- Date(s) of service for each service rendered
- Other insurance information, as applicable
- ICD-9 diagnosis and procedure codes
- ICD-9 diagnosis pointer
- HIPAA-compliant CPT, HCPCS and modifier code sets
- Billed charges for each service line
- Total billed charges for the claim
- Place and type of service code

- Units, as applicable (anesthesia claims require minutes)
- Provider federal tax identification number
- National Provider Identifier (NPI) for rendering and billing/pay-to provider in the appropriate fields
- Rendering provider name
- Service facility location information
- Billing/pay-to provider name and address
- For prenatal or delivery services, the last menstrual period (LMP) date is required
- The National Drug Code (NDC) number is required for HCPCS codes in the J series; HCPCS codes in the Q or S series that represent drugs; CPT codes in the 90281-90399 series (immune globulins); and Enteral Nutritional B Code Products that price AWP (B4157-B4162)

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.

Providers billing Molina Healthcare directly should send paper claims to:
 Molina Healthcare of Ohio, Inc.
 PO Box 22712
 Long Beach, CA 90801

ELECTRONIC CLAIM SUBMISSION

Providers billing Molina Healthcare electronically should use **payer number 20149**. Please note that secondary claims may also be submitted electronically.

Molina Healthcare encourages electronic claim submission as it provides your office with the following benefits:

- Reduces operational costs associated with paper claims
- Reduces time for Molina Healthcare to receive a claim by eliminating mailing time
- Increases accuracy of data
- Ensures HIPAA compliance

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 and a list of current clearinghouses, go to Molina Healthcare's EDI website - www.MolinaHealthcare.com.

HIPAA 5010 Transaction Compliance Standards Implementation Effective January 1, 2012

On January 1, 2012, Molina Healthcare began accepting and issuing all Electronic Data Interchange (EDI) HIPAA transactions in Version 5010 format, regulated by CMS. The 4010A1 transaction standards are no longer permitted.

Molina Healthcare recommends all providers reference the appropriate ODJFS Companion Guide (837I, 837P) to ensure all 5010 requirements are being met to avoid any unnecessary claim rejections.

Visit <http://jfs.ohio.gov> to reference the appropriate ODJFS 5010 Companion Guide for additional information. For HIPAA transaction and code set (TCS) questions or concerns, please call our toll-free HIPAA Provider Hotline at 1-866-MOLINA2 (1-866-665-4622).

BILLING GUIDELINES

Advanced Practice Nurses (APN)

When billing for any service provided by an advanced practice nurse (APN), in accordance with Ohio Administrative Code (OAC) 5101:3-8-27: Modifiers, all services must be billed with the appropriate modifier to denote the type of APN that provided the service:

- Bill the modifier "SA" e.g. 99201SA, if the APN is a nurse practitioner;
- Bill the modifier "SB" e.g. 99201SB, if the APN is a nurse mid-wife; or
- Bill the modifier "UC" e.g. 99201UC if the APN is a clinical nurse specialist.

In accordance with the Ohio Administrative Code (OAC) 5101:3-8-23: Advanced Practice Nurses: Coverage and Limitations, advanced practice nurses (APNs) are subject to the following coverage and limitations:

- APNs are not eligible to bill or be reimbursed for CPT code 99223.
- Emergency room visit codes 99284 and 99285 are not covered if billed by an APN who is in an independent practice as defined in rule 5101:3-8-22 of the Administrative Code.

Advanced practice nursing services will be reimbursed, in accordance with OAC 5101:3-8-22: Advanced Practice Nurses Practice Arrangements and Reimbursement, the lesser of the provider's billed charge or one of the following:

- Eighty-five percent of the provider contracted rate when services are provided by an APN in the following places of service: inpatient hospital, outpatient hospital, or hospital emergency department; or
- One hundred percent of the provider contracted rate when services are provided by an APN in any non-hospital setting.

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 and rounded to the nearest tenth to determine the appropriate units to be paid. If the claim is submitted without the minutes in field 24G, the claim will be denied.

Anesthesia services will not be paid for surgeries that are non-covered.

Chronic Conditions

In order for Molina Healthcare to accurately identify members with chronic conditions that may be eligible for one of the Disease Management or Case Management programs please see the suggested billing tips listed below:

- For members with chronic illness, always include appropriate chronic and disability diagnoses on all claims.
- Document chronic disease (please note Molina Healthcare has identified asthma as the most common diagnosis code not reported) whenever it is appropriate to do so (this includes appointments when prescription refills are written for chronic conditions).
- Be specific on diagnosis coding; always use the most specific appropriate diagnosis code available.

Diagnosis Pointers

A single encounter may frequently correlate with multiple procedures and/or diagnosis codes. Diagnosis pointers are required if at least one diagnosis code appears on the claim and must be present with the line item it is associated. This is a single digit field used to “point” to the most appropriate ICD-9 codes by linking the corresponding diagnosis reference number (1, 2, 3, and/or 4) from the diagnosis indicated in item number 21. Do not enter the actual ICD-9 codes or narratives in item number 21.

A pointer should be submitted to the claim diagnosis code in the order of importance. The remaining diagnosis pointers are used in declining level of importance to the service line. The diagnosis pointer should be reported in the following fields:

Paper Claims

Item Number 24E

Electronic Claims

Loop 2400

- SV107-1: Diagnosis code pointer
- SV107-2: Diagnosis code pointer
- SV107-3: Diagnosis code pointer
- SV107-4: Diagnosis code pointer

Dialysis Services

Molina Healthcare requires one service line per a date of service with a maximum unit of one for dialysis services. If a claim is received with a date span billing multiple units on a single charge line, the charge line will be denied.

Durable Medical Equipment

Molina Healthcare follows the DME guidelines as referenced in the **Ohio Medicaid Supply List and the Orthotic and Prosthetic List**. It is imperative that appropriate billing be used to identify the services provided and process claims accurately.

[5101:3-10-03 - Appendix A, Medicaid Supply List](#)

[5101:3-10-20 - Appendix A, List of Orthotic and Prosthetic Procedures](#)

Molina Healthcare follows all of the indicators published on the ODJFS Medicaid Supply List, including the following:

- "Prior auth" indicator
 - "Y" indicates prior authorization is required for reimbursement (see rule 5101:3-10-06 of the Administrative Code).
 - "N" indicates prior authorization is not required for reimbursement up to the maximum allowable units.
- "Max Units" indicator - A maximum allowable (MAX) indicator means the maximum quantity of the item that may be reimbursed during the time period specified unless an additional quantity has been prior authorized. If there is no maximum quantity indicated, the quantity authorized will be based on medical necessity as determined by Molina Healthcare.
- "RNT/P" indicator
 - "RO" means item is always rented - A DME code with this indicator should be billed with the RR modifier for the applicable rental period.
 - "PP" means item is always purchased – A DME code with this indicator should NOT be billed with a modifier.

- "R/P" means item is designated as rent to purchase as described in rule [5101:3-10-05](#) of the Administrative Code - A DME code with this indicator MUST be billed with a modifier.

Beginning July 1, 2011, claims payment on rent to purchase DME codes billed without the NU modifier will be paid as a monthly rental. This change will ensure monthly rental DME items are reimbursed as such and reduce your administrative work to post recoveries.

Durable Medical Equipment (DME), Medical Supplies and Parenteral Nutrition

Molina Healthcare billing requirements are:

- Submit one service line per each date of service.
- Use the shipping date as the date of service on the claim if a shipping service or mail order is utilized.
- Always include the appropriate modifier on all DME claims for rent to purchase items listed in the Ohio Medicaid Supply List.
 - RR modifier is required when item is rented.
 - NU modifier is required when item is purchased.

Emergency Room Evaluation & Management with Modifier 25

When circumstances warrant the billing of a modifier 25 for physician claims that include an Emergency Room Evaluation & Management code (ER E/M) when billed with a surgical procedure code, Molina Healthcare requires medical records with the initial claim submission.

Enteral Nutrition Formula - B Code Products

Molina Healthcare billing requirements are:

- 1 unit = 100 calories (calories / 100)
- NDC number must be present on claim
- Submit one service line per each date of service.
- Use the shipping date as the date of service on the claim if a shipping service or mail order is utilized.

Please see the below examples and refer to the Ohio Medicaid Supply list and OAC [5101:3-10-05](#) Reimbursement for Covered Services for further details.

Example:

A4221 SUPPLIES FOR MAINTENANCE OF A DRUG INFUSION CATHETER - PER WEEK 1 SET 4/MO

DOS	Service Code	Billed Charges	Units
11/28/10-11/28/10	A4221	\$120.00	2

B4220 PARENTERAL NUTRITION SUPPLY KIT; PREMIX, COMPLETE - PER DAY 1/DAY PP

Incorrect Billing

DOS	Service Code	Billed Charges	Units
11/28/10-11/30/10	B4220	\$60.00	3

Appropriate billing is as follows:

DOS	Service Code	Billed Charges	Units
11/28/10-11/28/10	B4220	\$60.00	3

E0565 COMPRESSOR, AIR POWER SOURCE FOR EQUIPMENT NOT SELF-CONTAINED OR CYLINDER -EACH 1/4 YRS R/P

DOS	Service Code/Modifier	Billed Charges	Units
11/28/10-11/28/10	E0565 RR	\$100.00	1 (1st month rental)
12/28/10-12/28/10	E0565 RR	\$100.00	1 (2nd month rental)
01/28/11-01/28/11	E0565 RR	\$100.00	1 (3rd month rental)
02/28/11-02/28/11	E0565 NU	\$600.00	1 (purchased)

B4160 - PEDIASURE LIQUID VANILLA (NDC # 70074-0558-98) for 29,900 calories

DOS	Service Code	Billed Charges	Units (Calorie units)
11/28/10-11/28/10	B4160	\$450.00	299

Early Periodic, Screening, Diagnosis, and Treatment (EPSDT) Services/Family Planning

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 follows:

Paper Claims

Per [ODJFS Instructions for Completing the CMS-1500 Claim Form](#), the referral field indicator should be reported in field 24H for Healthchek/EPSDT services as follows:

Lower, Unshaded Area

Enter 'E' in the lower, unshaded area in field 24H if the service was related to Healthchek (EPSDT).
Enter 'F' in the lower, unshaded area in field 24H if the service was related to family planning.
Enter 'B' in the lower, unshaded area in field 24H if the service was related to both Healthchek (EPSDT) and family planning.

Upper, Shaded Area

If either E or B is entered in the lower, unshaded area, then add the appropriate condition indicator in the upper, shaded area in field 24H using one of the following:

- NU (No Healthchek (EPSDT) referral was given)
- AV (Referral was offered but the individual refused it)
- ST (New Services Requested)
- S2 (Under Treatment)

Electronic Claims

Per ODJFS [837 Health Care Claim Professional](#) Companion Guide, completion of CRC02 and CRC03 are required for electronic claims).

Select the appropriate response in Loop 2300 Segment CRC02, “Was an EPSDT referral given to the patient?” as follows:

Enter ‘Y’ in Loop 2300, Segment CRC02 if the service was Healthchek and follow-up is required and a referral is made.

Enter ‘N’ in Loop 2300, Segment CRC02 if the service is a Healthchek and no follow-up services were required.

Select the appropriate condition indicators in Loop 2300, Segment CRC03.

If response to CRC02 is Yes, use one of the following in Loop 2400, Segment SV111:

AV (Referral was offered but the individual refused it)

ST (New Services Requested)

S2 (Under Treatment)

If response to CRC02 is No, use the following:

NU (No Healthchek (EPSDT) referral was given)

Enter ‘Y’ in Loop 2400, Segment SV112 if the service involved family planning.

EPSDT Services:

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

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

Billing for E&M and Preventive Services On the Same Date of Service

Did you know that Molina will pay for both a new/established patient E&M and new/established patient preventative visit for the same member on the same date of service if the diagnosis codes billed support payment of both codes? Be sure to bill the correct diagnosis codes and bill the new/established patient E&M with modifier 25 to ensure accurate payment.

Home Health Services

- Per OAC 5101:3-12-01, a face-to-face encounter with the qualifying treating physician must be done 90 days prior to start of care or within thirty days following the start of care. The treating physician must complete a certificate of medical necessity, Form JFS 07137, documenting this visit and the reasons for requesting home care.

- Effective 2/1/11, reimbursement will not be made for home health care services when the certificate of medical necessity on the appropriate JFS 07137 form, has not been received.

Home Health Services for Mom and Baby after Delivery

- No prior authorization is required for up to two home health care visits (G0154) for Mom and baby within the baby’s first 28 days of life only, provided the appropriate diagnosis code(s) are billed on the claim(s) as listed below.
- HQ modifier must be appended to both mom and baby’s claim, indicating a group visit.
- Pursuant to OAC 5101:3-12-05 Reimbursement: Home Health Services, the amount of reimbursement for each visit shall be the lesser of the provider’s billed charge or seventy-five percent of the provider’s contracted rate when billing with the modifier HQ "group setting" for group visits conducted in accordance with 5101:3-12-04 of the Administrative Code.

Diagnosis	Description
V24.1	Lactating mother
V24.2	Routine postpartum follow-up
651.03	Twin pregnancy, antepartum
651.13	Triplet pregnancy, antepartum
651.23	Quadruplet pregnancy, antepartum
651.33	Twin pregnancy with fetal loss and retention of one fetus, antepartum
651.43	Triplet pregnancy with fetal loss and retention of one or more, antepartum
651.53	Quadruplet pregnancy with fetal loss and retention of one or more, antepartum
651.63	Other multiple pregnancy with fetal loss and retention of one or more fetus(es), antepartum
651.73	Multiple gestation following (elective) fetal reduction, antepartum condition or complication
651.83	Other specified multiple gestation, antepartum

Inpatient Emergency Room (ER) Admissions

Molina Healthcare requires medical records with the initial claim submission. This is required so the claim can be reviewed for an inpatient authorization if an authorization is not on file due to the emergency situation.

Interim Claims – Type of bill (TOB) 112, 113, and 114

Upon discharge of a Molina Healthcare member, the inpatient hospital claim should be submitted with the complete confinement on a corrected claim with TOB 117 if interim claims were previously processed. Molina Healthcare requires a corrected claim with the complete confinement to ensure accurate claims payment.

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.

Molina Healthcare will reimburse providers for a prenatal risk assessment (PRA) by billing HCPCS code H1000 and completing the appropriate PRA form. The PRA form is a checklist of medical and social factors used as a guideline to determine when a patient is at risk of a preterm birth or poor pregnancy outcome. Both the [Molina Healthcare PRA form](#) and [JFS 03535](#) PRA form will be accepted. The PRA form must be completed on each obstetrical patient during the initial antepartum visit in order to bill for the prenatal at-risk assessment code.

- Forms are available at <http://www.MolinaHealthcare.com>, select Providers, Ohio, Forms or on the ODJFS website.

Well Care through the Perinatal Period - Consider providing an annual well exam for your patients in addition to prenatal or postpartum care. The services required for a well exam (health and developmental history, both physical and mental, a physical exam, and health education/anticipatory guidance) are often provided as part of the prenatal or postpartum exam, but may not have been coded in the past.

- Preventive services may be rendered on visits other than specific well care visits, regardless of the primary intent of the visit.
- Well visit and postpartum visit can be paid for the same office visit, provided that the appropriate procedure and diagnosis codes are included for both services.

To ensure accurate encounter reporting for HEDIS and ODJFS requirements, the following ICD-9 codes should not be billed for a *non-delivery* event.

ICD-9 Diagnosis Codes:	
V24.0	Postpartum care and examination immediately after delivery
V27.x	Outcome of delivery (must be used in conjunction with one of the ICD-9 codes and/or CPT codes listed below)
650	Normal delivery

OR

any of the following codes that includes a 5th digit equal to 1 or 2:	
640-649	Complications mainly related to pregnancy
651-659	Normal delivery and other indications for care in pregnancy, labor, and delivery
660-669	Complications occurring mainly during the course of labor and delivery
670-676	Complications of the puerperal
CPT Codes:	
59400-59410	Vaginal Delivery, Antepartum and Postpartum Care
59510-	Cesarean Delivery

59515	
59610-59622	Delivery After Previous Cesarean Delivery

ICD-9 Procedure Codes:	
72.x	Forceps, vacuum, and breech delivery
73.09	Other artificial rupture of membranes at the time of delivery
73.22	Internal and combined version with extraction
73.51	Manual assisted delivery - manual rotation of fetal head
73.59	Manually assisted delivery - other manually assisted delivery
73.8	Operations on fetus to facilitate delivery
73.9x	Other operations assisting delivery
74.x	Cesarean section and removal of fetus

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.

Effective 8/2/11, in accordance with Ohio Medicaid payment policy, the NDC will be required at the detail level when a claim is submitted with a Healthcare Common Procedure Coding System (HCPCS) code that represents a drug. With the exception of hospital claims, federal law requires that any code for a drug covered by Medicaid must be submitted with the NDC. HCPCS codes J0120-J9999, Q0138-Q0139, Q0515, Q2009-Q2010, Q2017, Q2026-Q2027, Q3025, Q4081, Q4096-Q4099, S0145, S0148, S0166, B4157-B4162, and CPT codes in the 90281-90399 series require the NDC number.

This change will apply to the following claim types:

Paper Claims

- CMS 1500 – Professional claims will be denied if the NDC information is missing or is invalid. The NDC number should also correspond with the CPT/HCPCS code.
 - Populate the NDC number on the shaded area of field 24A.
- UB-04 - End-Stage Renal Disease Clinic claims will be denied if the NDC information is missing on the line item detail or is invalid. The NDC number should also correspond with the CPT/HCPCS code.
 - Populate the NDC number, if applicable, on shaded area of field 43.
 - NDC information is not required on hospital claims. Hospitals that are able or are already submitting NDCs are encouraged to continue this practice.

Electronic Claims - The NDC number is reported in the LIN segment of Loop 2410 only.

- [837 Health Care Claim: Professional \(837P\)](#):
 - Loop 2400
 - SV101-1: Qualifier of 'HC'
 - SV101-2: HCPCS Code
 - SV101-3: Modifier
 - SV101-4: Quantity
 - Loop 2410
 - LIN02: Qualifier of 'N4'

- LIN03: NDC
 - CPT04: Quantity
 - CPT05: Unit of measurement qualifier (F2, GR, ML or UN)
 - F2 – International Unit
 - GR – Gram
 - ML – Milliliter
 - UN – Unit
- [837 Health Care Claim: Institutional \(837I\)](#):
 - Loop 2400
 - SV202-1: Qualifier of ‘HC’
 - SV202-2: HCPCS code
 - SV202-3: Modifier
 - SV204: Unit (DA, F2, UN)
 - SV205: Quantity
 - Loop 2410
 - LIN02: Qualifier of ‘N4’
 - LIN03: NDC
 - CPT04: Quantity
 - CPT05: Unit of measurement qualifier (F2, GR, ML or UN)
 - F2 – International Unit
 - GR – Gram
 - ML – Milliliter
 - UN – Unit

Newborn Claims

Molina Healthcare requires providers to report the birth weight on all newborn institutional claims. Newborn claims will group into DRG’s 385 – 391 or 892 – 898. To report this data, the appropriate value code must be used:

- Paper UB-04: Report in block 39, 40 or 41 using value code “54” and the newborn’s birth weight, in grams.
- Electronic: Report birth weight in C02205, Monetary Amount in Loop 2300, Segment HI as follows:
 - HI01-01: Qualifier of ‘BE’
 - HI01-02: Value code ‘54’
 - HI01-05: Birth weight in grams

Obstetrical Care

Molina Healthcare is committed to promoting primary preventive care for members. In an effort to ensure that female members receive all needed preventive care, Molina Healthcare encourages OB/GYNs to provide preventive care services in conjunction with obstetrical/gynecological visits.

When providing care to Molina Healthcare members, consider performing an annual well exam in addition to obstetric/gynecological services.

Services required during a well exam that should be documented in the medical record are:

- A health and developmental history (physical and mental)

- A physical exam
- Health education/anticipatory guidance

Note that:

- Preventive services may be rendered on visits other than well care visits, *regardless of the primary intent of the visit.*
- The appropriate diagnosis and procedure codes must be billed to support each service.
- A well exam and an ill visit can be paid for the same office visit, provided that the appropriate procedure and diagnosis codes are included for both services.

Coding for Well Care Services

Well Care Visit	CPT	ICD 9
Adolescent/Adult Well Care Visits (12-39 years)	99384-99385, 99394-99395	V 20.2, V 70.0, V 70.3, V 70.5, V 70.6, V 70.8, V 70.9
Well Care Visits	99201-99205, 99211-9215, 99241-99245	640.x3, 641.x3, 642.x3, 643.x3, 644.x3, 645.x3, 646.x3, 647.x3, 648.x3, 649.x3, 651.x3, 652.x3, 653.x3, 654.x3, 655.x3, 656.x3, 657.x3, 658.x3, 659.x3, 678.x3, 679.x3, V22-V23, V28

Outpatient Hospital Services

In accordance with OAC 5101:3-2-21 Policies for Outpatient Hospital Services, additional payment will be made for dates of service on or after March 31, 2010 for the following:

- Stand alone revenue codes billed with IV therapy
 - Line items that carry revenue center code 025X (with no CPT code present) and/or revenue center code 0636 (with a valid HCPCS J code) when the claim carries IV therapy CPT code 96365, 96366, 96367, or 96368 that does not include dialysis, chemotherapy, or surgical services.
- Independently billed pharmacy or medical supplies
 - Line items that carry revenue center code 025X (with no CPT code present), 0636 (with a valid HCPCS J code) and/or revenue center code 027X (with no CPT code present) that does not include dialysis, chemotherapy, surgical, clinic, emergency room, radiology, ancillary, laboratory, or pregnancy related services.

Sterilization/Delivery Services

Pursuant to OAC 5101:3-21-02.2 Medicaid Covered Reproductive Health Services: Permanent Contraception/Sterilization Services and Hysterectomy, claims received for sterilization services are paid in only if the required criteria are met and the appropriate Consent for Sterilization form (JFS 03198, HHS-687 or HHS-687-1) has been received per the Ohio Administrative Code. In addition, reimbursement will not be made for associated services such as anesthesia, laboratory tests, or hospital services if the sterilization service itself cannot be reimbursed. However, sterilization claims received without a valid consent form attached that includes services unrelated to the sterilization i.e., delivery services, will be processed as follows:

- Inpatient hospital claims on a UB-04 will be denied.
 - Reimbursement can be made for charges unrelated to the sterilization procedure when a corrected claim is received removing all of the sterilization related charges and ICD9 diagnosis/procedure codes.

- Outpatient hospital claims on a UB-04 will be denied.
- Physician services on the HCFA-1500 claim form will deny the line items for the sterilization services and process the line items unrelated to the sterilization services for payment.
 - No corrected claim form is required.

Consent to Sterilization form is available at www.MolinaHealthcare.com or on the ODJFS website.

For additional information on sterilization services or information for hysterectomy services, please refer to the Benefits and Covered Services section of the manual.

Transplants

In accordance with OAC 5101:3-2-03 Conditions and Limitations, services related to covered organ donations are reimbursable when the recipient of a transplant is Medicaid eligible.

Transplant services will be reimbursed according to OAC 5101:3-2-07.1 Hospital Services Subject to and Excluded from DRG Prospective Payment.

In order to receive reimbursement for organ acquisition charges the following guidelines are applied:

- The charges must be reported using revenue center code "810 - Organ Acquisition, General Classification." Please note that kidney transplants are not subject to additional reimbursement for organ acquisition.
- The organ recipient must be Medicaid eligible for acquisition costs to be reimbursed.
 - When both donor and recipient are Medicaid eligible, the recipient claim must be filed and paid first before submitting the donor claim. The donor claim must have the donor's Medicaid recipient name and ID number on the claim.
 - When the donor is not Medicaid eligible, the donor's claim must have the Medicaid recipient's name and ID number on the claim.

Unlisted Codes

Molina Healthcare encourages providers to bill with the most accurate and specific CPT or HCPCS code. If an unlisted code is used, documentation is required for all unlisted codes submitted for reimbursement. Documentation should include, but is not limited to:

- Complete description of the unlisted code
- Procedure/operative report for unlisted surgical/procedure code
- Invoice for unlisted DME/supply codes
- NDC #, dose and route of administration for the drug billed

Documentation will be reviewed for appropriate coding and existence of a more appropriate code. Claims submitted with unlisted codes that do not have documentation with them and no prior authorization on file 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 must be submitted to Molina Healthcare within the greater of the above timeframe or the following:

- 60 days of the date listed on the EOB from the other carrier for DOS prior to 8/1/11.
- 90 days of the date listed on the EOB from the other carrier for DOS 8/1/11 and after.

The provider may request a review for claims denied for untimely filing by submitting justification for the delay. See the Claim Reconsiderations section below 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. Further, payment is subject to the following minimum standards as set forth by the Ohio Department of Job and Family Services (ODJFS):

- 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.

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. 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.

CLAIMS EDITING PROCESS

Molina Healthcare has a business arrangement with Verisk Health (formerly HealthCare Insight/ HCI) for the screening and reviewing of professional and outpatient facility claims. Molina Healthcare 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

Coding edits are based on Current Procedural Terminology (CPT), Medicaid Purchasing Administration (MPA) guidelines, industry standard National Correct Code Initiative (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).

The National Correct Coding Initiative (NCCI) developed by CMS helps promote national correct coding methodologies for ensuring that claims are coded appropriately according to State and Federal coding guidelines. The coding policies developed are based on:

- Coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual;
- National and local policies and edits;
- Coding guidelines developed by national societies;
- Analysis of standard medical and surgical practice; and

- Review of current coding practice.

CLAIM RECONSIDERATIONS

Providers seeking an adjustment of a previously adjudicated claim must request such action within 120 days of the original remittance advice unless otherwise stated in the provider contract. Requests for claim adjustments submitted after the 120 day period or the timeframe specified in the provider contract 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 Molina Healthcare Claim Reconsideration Request 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 <http://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) 781-4464

90% of requests will be resolved within 30 days of receipt. Molina Healthcare will return a response to the provider on the decision of the reconsideration request via fax, whenever this number is provided. All other responses will be sent via mail to the billing address on file.

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 unless otherwise stated in the provider contract. Requests for correction of a claim submitted after the 120 day period or the timeframe specified in the provider contract cannot be considered.

CMS 1500

The request for correction to a CMS 1500 claim form must include a Molina Healthcare Corrected Claim Form or a cover letter clearly explaining the reason for the correction. Forms are available at <http://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

UB 04/CMS 1450

The request for correction to a UB 04 claim form can be submitted by paper or electronically and must include the correct bill type of xx7. Please see section below for a complete list of valid Type of Bill Codes.

OVERPAYMENTS AND REFUND REQUESTS

In the event Molina Healthcare finds an overpayment on a claim or must recoup money, a letter requesting the refund may 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). All recovery activity will appear on your Remittance Advice. Use the Return of Overpayment Form to submit unsolicited refunds or check returns. Go to <http://www.MolinaHealthcare.com>. Select Providers, Ohio, Forms.

If you have any questions regarding a refund request letter, please call the Claims Recovery Unit at 1-866-642-8999 and follow the prompts to Ohio 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 43271-5257

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 does not recover TPL related overpayments but will notify the ODJFS vendor to 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 commercial insurance and Medicare. Commercial insurance carriers and Medicare must be billed prior to billing Molina Healthcare.

Primary insurance information can be populated on electronic claims. COB primary information can be used to pay a claim as secondary without a paper copy of the primary carrier's explanation of benefit (EOB). The following data elements must be provided on the EDI claim file:

UB-04 Claims	CMS-1500 Claims
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PRIMARY PD AMT	PRIMARY PD AMT
PRIMARY ALLOWABLE	PRIMARY ALLOWABLE
TOTAL BILLED CHARGES	PATIENT RESPONSIBILITY
NON COVERED CHARGES	PATIENT PAID
TOTAL DENIED CHARGES	
PATIENT RESPONSIBILITY	

Molina Healthcare requires COB claims to be submitted as hard copy along with a copy of the primary carrier EOB if the primary carrier either line item denied or denied the entire claim. If the claim is submitted electronically and has a line item denial or the entire claim was denied by the primary carrier, Molina Healthcare will deny for paper copy.

COB claims can be accepted electronically if the primary carrier shows an allowable and/or paid amount on the claim. Also, if the primary carrier's allowed amounts were applied to deductible, copayment or coinsurance, this information needs to be included in the data elements submitted and will be accepted electronically.

When billing paper claims, providers **must** include a copy of the primary insurance EOB with the claim.

Providers will not require members who have a primary carrier to submit secondary claims to Molina themselves. Per OAC 5101:3-26-05 Managed Health Care Programs: Provider Panel and Subcontracting Requirements, providers may not bill members the difference between what a primary carrier paid and the covered amount, even if that balance involves a copayment, coinsurance or plan deductible unless a signed waiver is on file for a non-covered Medicaid service. Should providers choose not to bill Molina as secondary, the balance due after primary carrier has paid must be written off by the provider, which includes a member copayment, coinsurance and plan deductible.

Molina Healthcare will pay the difference between the payment made by the primary insurance carrier and the Molina Healthcare maximum contracted allowable rate at the header level. If the primary insurance total paid is more than Molina Healthcare's total maximum contracted allowable rate, the claim will pay zero dollars. Molina Healthcare will pay the patient's responsibility when coordinating payment secondary to Medicare, regardless if the payment exceeds Molina Healthcare's maximum contracted allowable. Include a Notice of Exclusions from Medicare Benefits (NEMB) form for a Medicare service or item that is excluded from coverage in order to process the claim.

Provider Takes Reasonable Measures to Obtain Third Party Payment

Molina Healthcare shall consider COB claims for payment when a primary carrier has not processed the claim in full when reasonable measures to obtain payment have been completed. In accordance with OAC 5101:3-26-09.1 Managed Health Care Programs: Third party Recovery, reasonable measures are defined as follows:

- Claim submission date to the primary carrier prior to 08/01/11
 - Provider submits a claim first to the primary carrier no less than three times within a ninety-day period and does not receive a payment remit or other communication from the primary carrier within ninety days of the last submission date. Provider must provide documentation of each claim submission and date of the submission.
 - Provider submits a claim first to the primary carrier and receives a remit that states claim is awaiting payment due to non-responsiveness of member. Provider must submit documentation showing submission first to the primary carrier and at least two attempts to contact member regarding information requested from the primary carrier within a 90 day period. Provider must provide documentation of each attempt and date of the attempt.

- Claim submission date to the primary carrier 08/01/11 and after
 - Provider submits a claim first to the primary carrier and does not receive a payment remit or other communication from the primary carrier within ninety days after the submission date. Provider must provide documentation of the claim and date of the submission to the primary carrier.
 - Provider submits a claim first to the primary carrier and receives a remit that states claim is awaiting payment due to non-responsiveness of member and provider then submits the documentation within ninety days of the remit denial from the primary carrier.

Acceptable documentation will include a screen print from provider's billing system. Contractual timely filing provisions still apply.

If payment from the primary carrier is received after Molina Healthcare has made payment, the provider is required to repay Molina Healthcare any overpaid amount. The provider must not reimburse any overpaid amounts to the consumer.

Coordination of Benefits for Global Obstetrical Claims

If a primary carrier EOB is received with a global obstetrical delivery code, Molina Healthcare requires an itemized statement showing dates of service and CPT codes for:

- Prenatal visits (E&M codes – append TH modifier, if appropriate)
- Delivery
- Postpartum visits

The payment will be manually calculated to determine secondary payment. Manual calculation is necessary because global OB codes are not an Ohio Medicaid covered service. The ODJFS allowable for each CPT listed on the itemized statement (as long as member was covered with Molina Healthcare at the time of service) will be multiplied by the provider's contracted rate to determine what Molina Healthcare's payment would have been if Molina Healthcare would have been primary. The primary carrier's payment is subtracted from Molina Healthcare's calculated allowable.

- If the primary carrier paid more than the Molina Healthcare allowable, no additional payment will be made.
- If the primary carrier paid less than the Molina Healthcare allowable, Molina Healthcare will pay the difference up to Molina Healthcare's allowable.

BILLING MOLINA HEALTHCARE MEMBERS

In accordance with OAC 5101:3-26-05 Managed Health Care Programs: Provider Panel and Subcontracting Requirements, a provider may bill a Molina Healthcare member only for *non-covered* services OR those services determined not to be medically necessary by Molina Healthcare's Utilization Management Department 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 OR services determined not to be medically necessary by Molina Healthcare's Utilization Management Department.
- 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 to supply.

Please note billing members for missed appointments is prohibited.

INVALID PLACE OF SERVICE CODES

The following place of service codes are not valid and should not be used.

00	Unassigned
01	Pharmacy
02	Unassigned
03	School
04	Homeless Shelter
05	Indian Health Service - Free standing Facility
07	Tribal 638 - Free standing Facility
08	Tribal 638 - Provider based Facility
09	Unassigned
10	Unassigned
17-19	Unassigned
27-30	Unassigned
35-40	Unassigned
43-48	Unassigned
57	Non-residential Substance Abuse Treatment Facility
58-59	Unassigned
63-64	Unassigned
66-70	Unassigned
73-80	Unassigned
82-98	Unassigned

HIPAA COMPLIANT MODIFIERS THAT IMPACT CLAIMS PAYMENT

For a complete list of modifiers, please refer to the HCPCS/CPT books, or EncoderPro online.

<p>Ambulance Modifiers signifying to or from a Nursing Facility (NF) will no longer be directly reimbursed for consumers residing in a NF. Claims should be directed to the Nursing Facility for reimbursement.</p> <ul style="list-style-type: none"> Ohio Administrative Code (OAC) 5101:3-15-02.8 Medical Transportation Services: Eligible Providers <p>DN,ND,EN,NE,GN,NG,HN,NH,IN,NI,JN,NJ,NN,PN,NP,RN,NR,SN,NS,NX,XN</p>

Anesthesia Service Modifiers	
<ul style="list-style-type: none"> Ohio Administrative Code (OAC) 5101:3-4-21 Anesthesia Services 	
AA	Anesthesia services personally furnished by anesthesiologist
AD	Medical supervision by a physician; more than four concurrent anesthesia procedures
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified

	individuals
QX	CRNA with medical direction by a physician or anesthesia assistant with medical direction by an anesthesiologist
QY	Medical direction of one CRNA by an anesthesiologist
QZ	CRNA without medical direction by a physician

Behavioral Health Service Modifiers

- **OAC 5101:3-4-29- Services Provided for the Diagnosis and Treatment of Mental and Emotional Disorders**

AH	A clinical psychologist
AJ	A clinical social worker
HN	A bachelor's level clinical staff person
HO	A master's degree level trained professional
HP	A doctoral level trained professional

Durable Medical Equipment (DME) Modifiers

BO	Enteral nutrition that is given orally
NU	New equipment is purchased
QE	Prescribed amount of oxygen is one liter per minute or less
QF	Prescribed amount of oxygen is greater than four liters per minute continuous and portable oxygen is also prescribed
QG	Prescribed amount of oxygen is greater than four liters per minute continuous and portable oxygen is not prescribed
RP	Repair/Replaced
RR	Short term rental
U1	Shall be used when oxygen services are provided via the use of a stationary oxygen concentrator to a consumer in a private residence <ul style="list-style-type: none"> • OAC 5101:3-10-13 Oxygen: Covered Services and Limitations in a Private Residence
UE	Used equipment

Home Health Modifiers

- OAC 5101:3-1-39 Verification of Home Care Service Provision to Home Care Dependent Adults
- OAC 5101:3-12-04 Home Health and Private Duty Nursing: Visit Policy
- OAC 5101:3-12-05 Reimbursement: Home Health Services
- OAC 5101:3-12-06 Reimbursement: Private Duty Nursing Services

U1	Infusion Therapy	Must be used when code T1000 is used for the purpose of home infusion therapy
U2	Second Visit	Must be used to identify the second visit for the same type of service made by a provider on a date of service per consumer
U3	Third Visit or More	Must be used to identify the third or more visit for the same type of service made by a provider on a date of service per consumer
U4	12 hours to 16 hours per visit	Must be used when a visit is more than twelve hours but not does not exceed sixteen hours
U5	Health check	Must be used to identify the consumer receiving services due to Health check
U6	PDN Authorization	Must be used to identify consumer receiving increased services
HQ	Group Visit	Indicates that a group visit was done

Additional Modifiers

22	Increased Procedural Service requiring work substantially greater than typically required
24	Unrelated evaluation and management service by the same physician during the postoperative period <ul style="list-style-type: none"> • OAC 5101:3-4-06 Physician Visits
26	Professional component of a procedure that has both a technical and professional component <ul style="list-style-type: none"> • OAC 5101:3-4-11 Diagnostic and Therapeutic Procedures comprised of Professional and Technical Components • OAC 5101:3-4-17 Gastroenterology, Otorhinolaryngology, Endocrinology, Neurology, Photodynamic Therapy and Special Dermatology Services • OAC 5101:3-1-60 Medicaid Reimbursement • OAC 5101:3-4-25 Laboratory and Radiology Services
50	Bilateral procedures performed; Reference OAC 5101:3-4-22 Surgical Services for physician claims and appendix A, Outpatient Hospital Modifiers, to OAC rule 5101:3-2-21 for institutional claims. Modifier 50 should not be used to report: <ul style="list-style-type: none"> • Procedures that are bilateral by definition or their descriptions include the terminology as “bilateral” or “unilateral”. • Diagnostic and radiology facility services. Institutional claims received for an outpatient radiology service appended with modifier 50 will be denied.
51	Multiple procedures performed; OAC 5101:3-4-22 Surgical Services
73	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia <ul style="list-style-type: none"> • OAC 5101:3-2-21 Policies for Outpatient Hospital Services (F)(3)
74	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia; hospital billing only <ul style="list-style-type: none"> • OAC 5101:3-2-21 Policies for Outpatient Hospital Services (F)(3)
80,81	Assistant-at-Surgery Services, valid only for physicians <ul style="list-style-type: none"> • OAC 5101:3-4-22 Surgical Services
EP	Services provided as part of Medicaid EPSDT program <ul style="list-style-type: none"> • OAC 5101:3-14-04 Reimbursement of EPSDT services
GC	GC Services performed in part by a resident under the direction of a teaching physician OAC 5101:3-4-05 Teaching Physician Services
QW	Waived laboratory procedure performed in accordance with CLIA guidelines
GE	Services performed by a resident without the presence of a teaching physician under the Primary care exception rule <ul style="list-style-type: none"> • OAC 5101:3-4-05 Teaching Physician Services
SA	Nurse Practitioner rendering service in collaboration with physician <ul style="list-style-type: none"> • OAC 5101:3-8-27 APN modifiers
SB	Nurse Mid-wife; OAC 5101:3-8-27 APN modifiers
SG	Facility charge for free standing Ambulatory Surgery Center (ASC) surgery center
TC	Technical component of procedure performed in a non-hospital setting <ul style="list-style-type: none"> • OAC 5101:3-4-11 Diagnostic and Therapeutic Procedures Comprised of Professional and Technical Components • OAC 5101:3-4-17 Gastroenterology, Otorhinolaryngology, Neurology and Special Dermatology Services • OAC 5101:3-1-60 Medicaid Reimbursement

	<ul style="list-style-type: none"> OAC 5101:3-4-25 Laboratory and Radiology Services
TH	Obstetrical treatment/services, prenatal or post-partum <ul style="list-style-type: none"> OAC 5101:3-4-08 Covered Obstetrical Services
UB	Transport of critically ill or injured patient over 24 months of age <ul style="list-style-type: none"> OAC 5101:3-4-06.1 Physician Attendance During Patient Transport
UC	Clinical nurse specialist; OAC 5101:3-8-27 APN Modifiers
UD	Physician assistant <ul style="list-style-type: none"> OAC 5101:3-4-03 Physician Assistants

Modifiers That Will Deny Per Medical Policy as these services are not Ohio Medicaid covered benefits	
AS, 60, 61, 62, 66, 81 (Co-surgeon, Minor Assistant at Surgery, and Physician Assistant) <ul style="list-style-type: none"> OAC 5101:3-4-03 Physician Assistants 	

TYPE OF BILL CODES - This is a three-digit code; each digit is defined below.

1st Digit – Type of Facility	Code
Hospital	1
Skilled Nursing Facility	2
Home Health	3
Christian Science (Hospital)	4
Christian Science (Extended Care)	5
Intermediate Care	6
Clinic	7
Specialty Facility or Hospice	8

2nd Digit – Bill Classifications (Excluding Clinics & Special Facilities)	Code
Inpatient	1
Outpatient	3
Other (For Hospital Referenced Diagnostic Services, or Home Health Not Under a Plan of Treatment)	4
Intermediate Care, Level I	5
Intermediate Care, Level II	6
Intermediate Care, Level III	7
Swing Beds	8

2nd Digit – Bill Classifications (Clinics Only)	Code
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Rural Health	1
Hospital Based or Independent Renal Dialysis Center	2
Free Standing	3
Other Rehabilitation Facility (ORF)	4
Other	9

2nd Digit – Bill Classifications (Special Facility Only)	Code
Hospice (Non-Hospital Based)	1
Hospice (Hospital Based)	2
Ambulatory Surgery Center (ASC)	3
Freestanding Birthing Center	4

3rd Digit – Frequency	Code
Admit through Discharge Claim	1
Interim – First Claim	2
Interim – Continuing Claims	3
Interim – Last Claim	4
Late Charge Only	5
Adjustment of Prior Claim	6
Replacement of Prior Claim	7
Void/Cancel of Prior Claim	8

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, 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 correction of a claim must be received within 120 days of the date the original claim was processed, unless outlined otherwise in the provider's contract with Molina Healthcare.
Claim Reconsiderations	Request for reconsideration of a denied claim must be received within 120 days of the date of denial, unless outlined otherwise in the provider's contract with Molina Healthcare. Fax/Mail requests to: Fax: (614) 781-4464 Molina Healthcare of Ohio, Inc. Attn: Provider Services PO Box 349020 Columbus, Ohio 43234-9020
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 43271-5257 If returning a Molina Healthcare check, please send to: Molina Healthcare of Ohio PO Box 349020 Columbus, Ohio 43234-9020