Section 9. Claims

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

- Claim Submission
- Corrected Claim
- Claims Disputes/Adjustments
- Overpayments/Refund Requests
- Coordination of Benefits (COB)/Third Party Liability (TPL)
- Billing the member

Claim Submission

Claims may be submitted to Molina Healthcare with appropriate documentation by mail or filed electronically (EDI) for CMS-1500 and UB-04 claims. For members assigned to a delegated medical group/IPA that processes its own claims, please verify the "Remit To" address on the member's Molina Healthcare ID card (Refer to Section 2). Providers billing Molina Healthcare directly should send claims to:

Molina Healthcare of Utah, Inc.
PO Box 22630
Long Beach, CA 90806

Providers billing Molina Healthcare electronically should use current HIPAA compliant ANSI X12N format (e.g., 837I for institutional claims, 837P for professional claims, and 837D for dental claims) and use electronic payor ID number: SX109 for HCFA and 12X09 for UB.

Providers must use good faith effort to bill Molina Healthcare for services with the most current CMS approved diagnostic and procedural coding available as of the date the service was provided, or for inpatient facility claims, the date of discharge. The following information must be included on every claim:

- Institutional Providers:
    - The completed UB 04 data set or its successor format adopted by the National Uniform Billing Committee (NUBC), submitted on the designated paper or electronic format as adopted by the NUBC. Entries stated as mandatory by NUBC and required by federal statue and regulations and any state designated data requirements included in statues or regulation.

- Physicians and Other Professional Providers:
    - The Centers for Medicare and Medicaid Services (CMS) Form 1500 or its successor adopted by the National Uniform Claim Committee (NUCC) submitted

on the designated paper or electronic format. Current Procedural Terminology (CPT) codes and modifiers and International Classification of Diseases (ICD) codes. Entries states as mandatory by NUCC and required by federal statute and regulation and any state designated data requirements included in statutes or regulations.

When billing for services rendered to Molina Medicare Members, providers must bill with the most current Medicare approved coding available as of the date the service was provided, or for inpatient facility claims, the date of discharge Claims must be submitted using the proper claim form/format, e.g., for paper claims a CMS1500 or UB04, and for an electronically submitted claim – in approved ANSI/HIPAA format.

The following information must be included on every claim:

- Member name, date of birth and Molina Medicare member ID number.
- Member's gender.
- Member's address.
- Date(s) of service.
- Valid International Classification of Diseases (ICD) diagnosis and procedure codes.
- Valid revenue, CPT or HCPCS for services or items provided.
- Valid Diagnosis Pointers
- Total billed charges for service provided.
- Place and type of service code.
- Days or units as applicable.
- Provider tax identification.
- National Provider Identifier (NPI).
- Rendering Provider as applicable.
- Provider name and billing address.
- Place of service and type (for facilities).
- Disclosure of any other health benefit plans.
- E-signature.
- Service Facility Location (Box 32 of CMS 1500 form)

National Provider Identifier (NPI)

Providers must report any changes in their NPI or subparts to Molina Healthcare within thirty (30) calendar days of the change.

Documents that do not meet the criteria described above may result in the claim being denied or returned to the provider. Claims must be submitted on the proper claim form, either a CMS-1500 or UB-04. Molina Healthcare will only process legible claims received on the proper claim form containing the essential data requirements. Incomplete, inaccurate, or untimely re-submissions may result in denial of the claim.

Electronic Claim Submissions

Providers are encouraged to enroll for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers who enroll in EFT payments will automatically receive ERAs as well. EFT/ERA services allow providers to reduce paperwork, provides searchable ERAs, and providers receive payment and ERA access faster than the paper check and RA processes. There is no cost to the provider for EFT enrollment, and providers are not required to be in-network to enroll. Molina Healthcare uses a vendor to facilitate the HIPPA compliant EFT payment and ERA delivery. Additional information about EFT/ERA is available at molinahealthcare.com or by contacting our Provider Services Department.

Molina Healthcare also accepts electronic claim submissions for both claims and encounters using the CMS-1500 and UB-04 claim types. Please use Molina Healthcare's Electronic Payor ID number – SX109 for HCFA and 12X09 for UB. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure claims are received for processing in a timely manner.

When your claims are filed electronically:

- You should receive an acknowledgement from your current clearinghouse
- You should receive an acknowledgement from Emdeon within two (2) business days of your transmission
- You should contact your local clearinghouse representative if you experience any problems with your transmission
- For any direct submissions to Molina you should receive an acknowledgement of your transmission

Timely Claim Filing

Provider shall promptly submit to Molina Healthcare claims for Covered Services rendered to members. All claims shall be submitted in a form acceptable to and approved by Molina Healthcare, and shall include any and all medical records pertaining to the claim if requested by Molina Healthcare or otherwise required by Molina Healthcare's policies and procedures. Claims must be submitted by provider to Molina Healthcare within three-hundred sixty-five (365) calendar days after the following have occurred: discharge for inpatient services or the date of service for outpatient services; and provider has been furnished with the correct name and address of the member's health maintenance organization. If Molina Healthcare is not the primary payer under coordination of benefits or third party liability, provider must submit claims to Molina Healthcare within three hundred sixty (365) calendar days after final determination by the primary payer. Except as otherwise provided by law or provided by government program requirements, any claims that are not submitted to Molina Healthcare within these timelines shall not be eligible for payment and provider hereby waives any right to payment therefore.

Fraud and Abuse

Failure to report instances of suspected Fraud and Abuse is a violation of the law and subject to the penalties provided by law. Please refer to the Fraud and Abuse section of this manual for more information.

Timely Claim Processing

Claims payment will be made to contracted providers in accordance with the timeliness provisions set forth in the provider's contract. Unless the provider and Molina Healthcare or contracted medical group/IPA have agreed in writing to an alternate payment schedule, Molina Healthcare will pay the provider of service within thirty (30) days after receipt of clean claims.

The receipt date of a claim is the date Molina Healthcare receives either written or electronic notice of the claim.

Claim Editing Process

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

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

Coding edits are generally based on state fee for service Medicaid edits, AMA, Current Procedural Terminology (CPT), HRSA and National Correct Code Initiative (NCCI) guidelines. If you disagree with an edit please refer to the Claim Disputes/Adjustments section below.

Coordination of Benefits and Third Party Liability

For members enrolled in a Molina Marketplace plan, Molina Healthcare and/or contracted Medical Groups/IPAs are financially responsible for the care provided to these members. Molina Marketplace will pay claims for covered services, however if TPL/COB is determined post payment, Molina Marketplace will attempt to recover any overpayments.

Corrected Claims

Corrected claims are considered new claims. Corrected claims may be submitted electronically with the appropriate field on the 837 I or 837 P completed. Paper corrected claims need to be

marked as corrected and should be submitted to the following address: (subject to timely filing requirements)

Molina Healthcare of Utah, Inc.
PO Box 22630
Long Beach, CA 90806

Claims Disputes/Adjustments

Providers seeking a redetermination of a claim previously adjudicated must request such action within ninety (90) days of Molina Healthcare's original remittance advice date. Additionally, the item(s) being resubmitted should be clearly marked as a redetermination and must include the following:

Providers should submit the following documentation:

- The item(s) being resubmitted should be clearly marked as a Claim Dispute/ Adjustment.
- Payment adjustment requests must be fully explained.
- The previous claim and remittance advice, any other documentation to support the adjustment and a copy of the Referral/Authorization form (if applicable) must accompany the adjustment request.
- The claim number clearly marked on all supporting documents

These requests shall be classified as a Claims Disputes/Adjustment and be sent to the following address:

Molina Healthcare of Utah, Inc. Attention:
Claims Disputes / Adjustments
7050 Union Park Center, Suite 200
Midvale, UT 84047

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

The Provider will be notified of Molina Healthcare of Utah's decision in writing within forty-five (45) days of receipt of the Claims Dispute/Adjustment request. Providers may appeal and request a claim dispute/adjustment when the claim was incorrectly denied as a duplicate or due to claims examiner or data-entry error. The request for claim dispute/adjustment must be submitted within 90 days of the original RA from Molina Healthcare of Utah.

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of coverage decisions or payment levels, Molina Healthcare determines that it has made an overpayment to a provider for services rendered to a member, it will make a claim for such overpayment. Molina Healthcare will not reduce payment to that provider for other services unless the provider agrees to the reduction or fails to respond to Molina Healthcare's claim as required in this subsection.

A provider shall pay a claim for an overpayment made by a Molina Healthcare which the provider does not contest or deny within the specified number of days on the refund request letter mailed to the provider.

Payment of a claim for overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to the organization, or the date that the provider receives a payment from the organization that reduces or deducts the overpayment.

Billing the Member

Molina Healthcare contracted providers may collect applicable Cost Sharing including co-payments, deductibles, and coinsurance from the member as required by the agreement. The contract between the provider and Molina Healthcare places the responsibility for verifying eligibility and obtaining approval for those services that require prior authorization on the provider.

Encounter Data

Each capitated provider/organization delegated for Claims payment is required to submit encounter data to Molina Healthcare for all adjudicated Claims. The data is used for many purposes, such as reporting to HFS, rate setting and risk adjustment, hospital rate setting, the Quality Improvement program and HEDIS reporting.

Encounter data must be submitted once per month, and must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I – Institutional, 837P – Professional, and 837D -- Dental. Data must be submitted with claims level detail for all non-institutional services provided. For institutional services, only those services covered by Molina Healthcare should be reported.

Molina Healthcare shall have a comprehensive automated and integrated encounter data system capable of meeting these requirements.

Molina Healthcare will create Molina's 837P, 837I, and 837D Companion Guides with the specific submission requirements available to providers.