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
- Claim Corrections/Adjustments
- Overpayments/Refund Requests
- Coordination of Benefits (COB)
- Third Party Liability (TPL)
- Billing the Member
- Fraud and Abuse
- Encounter Data

Molina Healthcare generally follows HCA guidelines for claims processing and payment for the Apple Health (AH), Fully Integrated Managed Care (FIMC) and Behavioral Health Services Only (BHSO) Medicaid programs. These guidelines are contained in the HCA Medicaid Provider Guides. The complete guide and information on ordering a printed copy can be found at [http://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides](http://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides).

NATIONAL PROVIDER IDENTIFIER (NPI) HCA BILLING AND NON-BILLING ENROLLMENT REQUIREMENTS

Per federal regulation (42.C.F.R. 455.410(b)) providers who have a contract with the state’s Medicaid agency or a contract with a Managed Care Organization (MCO) that serve Medicaid Clients must enroll with HCA under a Non billing or Billing agreement. The provider’s National Provider Identifier (NPI) submitted on all claims must be the NPI registered with HCA.

Effective January 1, 2018, Molina Healthcare will deny/reject all claims submitted to Molina for processing if billed with an NPI that is not enrolled with HCA or does not match what HCA identifies as the enrolled NPI number.

For additional information and to access the Non-Billing and Billing and servicing enrollment form, which must be used to register with HCA or to correct an NPI, visit the HCA website at [http://www.hca.wa.gov/billers-providers/apple-health-medicaid-providers/enroll-non-billing-individual-provider](http://www.hca.wa.gov/billers-providers/apple-health-medicaid-providers/enroll-non-billing-individual-provider).

CLAIM SUBMISSION

Participating Providers are required to submit Claims to Molina Healthcare with appropriate documentation. Providers must utilize electronic billing though a clearinghouse or Molina’s Provider WebPortal, and use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims) and use electronic Payer ID number: 38336. For Members assigned to a delegated medical group/IPA that processes its own Claims, please verify the Claim Submission instructions on the Member’s Molina ID card.
Claims that do not comply with Molina’s electronic Claim submission requirements will be denied. Providers must bill Molina 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.

**Required Elements:**
The following information must be included on every claim:

- Member name, date of birth and Molina Member ID number.
- Member’s gender.
- Member’s address.
- Date(s) of service.
- Valid International Classification of Diseases 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.

Inaccurate, incomplete, or untimely submissions and re-submissions may result in denial of the claim; and any paper claim submissions will be denied.

**National Provider Identifier (NPI):** A valid NPI which is enrolled with HCA as a billing or non billing NPI is required on all Claim submissions. Providers must report any changes in their NPI or subparts to Molina Healthcare as well as HCA or claims may be denied.

**Electronic Claim Submissions**
Molina requires Participating Providers to submit Claims electronically. Electronic Claims submission provides significant benefits to the Provider including:

- Helps to reduce operation costs associated with paper claims (printing, postage, etc.)
- Increases accuracy of data and efficient information delivery
- Reduces Claim delays since errors can be corrected and resubmitted electronically
- Eliminates mailing time and Claims reach Molina faster

Molina offers the following electronic Claims submission options:
- Submit Claims directly to Molina Healthcare via the secure Provider Portal
Submit Claims to Molina via your regular EDI clearinghouse using Payer ID 38336

**Provider Portal**

Molina’s secure Provider Portal offers a number of claims processing functionalities and benefits:

- Available to all Providers at no cost
- Available 24 hours per day, 7 days per week
- Ability to add attachments to claims
- Easily and quickly void claims
- Check claims status
- Receive timely notification of a change in status for a particular claim
- Submit Correct Claims
- Submit COB Claims

**Clearinghouse**

Molina uses Change Healthcare as its gateway clearinghouse. Change Healthcare has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit Claims to their usual clearinghouse.

Molina accepts EDI transactions through our gateway clearinghouse for Claims via the 837P for Professional and 837I for institutional. 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 via a Clearinghouse:**

- You should receive a 999 acknowledgement from your clearinghouse
- You should also receive 227CA response file with initial status of the claims from your clearinghouse
- You should contact your local clearinghouse representative if you experience any problems with your transmission

**EDI Claims Submission Issues**

Providers who are experiencing EDI Submission issues should work with their clearinghouse to resolve the issue. If the Provider’s clearinghouse is unable to resolve, the Provider may call the Molina EDI Customer Service line at (866) 409-2935 or email us at EDI.Claims@molinahealthcare.com for additional support.

**Paper Claim Submissions**

Paper claims are not accepted by Molina Healthcare. Claims submitted via paper will be denied and you will need to resubmit your claim electronically for processing.
**Electronic Remittance Advice and Electronic Funds Transfer**

Participating Providers are required 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.

To register please go to [https://providernet.adminisource.com](https://providernet.adminisource.com). If you have any questions regarding the actual registration process, please contact FIS/ProviderNet at (877) 389-1160 or email Provider.Services@fisglobal.com.

**Timely Claim Filing**

Provider shall promptly submit to Molina Claims for Covered Services rendered to Members. All Claims shall be submitted electronically. Claims must be submitted by Provider to Molina no later than the limitation stated in the provider contract or within 180 calendar days from the date of service. If Molina is not the primary payer under coordination of benefits or third party liability, Provider must submit Claims to Molina within 180 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 within these timelines shall not be eligible for payment and Provider hereby waives any right to payment therefore.

**Timely Claim Processing:** Claims processing will be completed for 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 will process the claim as soon as possible. Processing is subject to the following minimum standards as set forth by the Office of the Insurance Commissioner (OIC) and HCA:

- Ninety-five (95%) percent of the monthly volume of “clean” claims will be adjudicated within 30 calendar days of receipt by Molina Healthcare. A “clean” claim has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.
- Ninety-five (95%) percent of the monthly volume of claims shall be paid or denied within 60 calendar days of receipt by Molina Healthcare.
- Ninety-nine (99%) percent of all claims shall be paid or denied within 90 calendar days of receipt by Molina Healthcare.

The receipt date of a claim is the date Molina Healthcare receives electronic notice of the claim. If Molina Healthcare fails to abide by the timely claims payment standards stated above, Molina Healthcare is required to pay interest on undenied and unpaid clean claims as described in WAC 284-170-431.
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


CLAIM REVIEW

Claims will be reviewed and paid in accordance with industry standard billing and payment rules, including, but not limited to, current Uniform Billing (“UB”) manual and editor, Current Procedural Terminology (“CPT”) and Healthcare Common Procedure Coding System (“HCPCS”), Federal, and State billing and payment rules, National Correct Coding Initiative (“NCCI”) Edits, and Federal Drug Administration (“FDA”) definitions and determinations of designated implantable devices and/or implantable orthopedic devices. Furthermore, Provider acknowledges Molina’s right to conduct Medical Necessity reviews and apply clinical practices to determine appropriate payment. Payment may exclude certain items not billed in accordance with industry standard billing and payment rules or certain items which do not meet certain Medical Necessity criteria.

CLAIM AUDITING

Provider acknowledges Molina’s right to conduct post-payment billing audits. Provider shall cooperate with Molina’s audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting medical records, Provider’s charging policies, and other related data. Molina shall use established industry Claims adjudication and/or clinical practices, State, and Federal guidelines, and/or Molina’s policies and data to determine the appropriateness of the billing, coding, and payment.

CORRECTED CLAIMS/ADJUSTMENTS

Providers seeking an adjustment or reprocessing of a claim must submit the request within 24 months of receiving the original EOB/RA. Providers should submit the following documentation:

- The item(s) being resubmitted should be clearly marked as an adjustment request
- Explanation of why the adjustment is being requested
- The previous claim and remittance advice, any other documentation to support the adjustment
Corrected Claims are considered new Claims for processing purposes. Corrected Claims must be submitted electronically with the appropriate fields on the 837I or 837P completed. Molina’s Provider Portal includes functionality to submit corrected Institutional and Professional claims.

Corrected claims must include the correct coding to denote if the claim is Replacement of Prior Claim or Corrected Claim for an 837I or the correct Resubmission Code for an 837P.

**EDI (Clearinghouse) Submission:**

**837P**

- In the 2300 Loop, the CLM segment (claim information) CLM05-3 (claim frequency type code) must indicate one of the following qualifier codes:
  - “7”–REPLACEMENT (replacement of prior claim)
  - “8”–VOID (void/cancel of prior claim)
- In the 2300 Loop, the REF segment (claim information) must include the original claim number of the claim being corrected, found on the remittance advice.

**837I**

- Bill type for UB claims are billed in loop 2300/CLM05-1. In Bill Type for UB, the 7 or 8 goes in the third digit for “frequency”.
- In the 2300 Loop, the REF segment (claim information) must include the original claim number of the claim being corrected, found on the remittance advice.

Requests for claim adjustments/reprocessing not related to a corrected claim should be mailed, faxed or e-mailed to the below:

Fax: (877) 814-0342  
Email: MHWProviderServicesInternalRep@Molinahealthcare.com

Requests for correction of claims paid by a delegated medical group/IPA must be submitted to the group responsible for payment of the original claim. See Section 14 for additional information on delegated medical group/IPA’s.

**OVERPAYMENTS AND INCORRECT PAYMENTS REFUND REQUESTS**

If, as a result of retroactive review of coverage decisions or payment levels, Molina determines that it has made an Overpayment to a Provider for services rendered to a Member, it will make a claim for such Overpayment. A refund letter will be mailed to the provider. Molina Healthcare may request a refund for overpayments or incorrect payments on services provided within 24 months and 30 months for COB claims.

If Molina Healthcare does not receive a refund or written notice that you wish to contest a refund request within 45 days, we may automatically retract monies overpaid from future payments. Any retraction activity will appear on your Remittance Advice.
If you prefer a retraction on a future Remittance Advice for overpaid or incorrectly paid claims, please fax a MHW Early Reversal Permission Form to the Claims Recovery Department at (888) 396-1520.

If you have any questions regarding a refund request letter, please call the Claims Recovery Department at (866) 642-8999.

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 RA and claim information to:

Molina Healthcare of Washington, Inc.
PO Box 30717
Los Angeles, CA 90030-0717

**COORDINATION OF BENEFIT**

Medicaid is secondary to all private insurance and Medicare. Private and government carriers must be billed prior to billing Molina Healthcare or Medical groups/IPAs. Provider shall make reasonable inquiry of Members to learn if the Member has health insurance, benefits or Covered Services other than from Molina Healthcare or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Molina Healthcare of said entitlement. In the event that coordination of benefits occurs, Provider shall be compensated based on the state regulatory COB methodology. Primary carrier payment information is required with the claim submission. Provider can submit a claim with attachments, including EOBs and other required documents by utilizing Molina’s secure Provider Portal. You may also submit COB claims via the clearing house by populating the appropriate segments with the primary payment information.

There are three exceptions for which Molina Healthcare does not require an EOB from the primary insurance:

- Medicare is primary and the service being billed is a non-covered service by Medicare
- The primary carrier has no available provider within a 25 mile radius of the members address. If claims are denied for this reason the provider may contact Provider Services to request the claim be processed for payment
- The primary insurance only covers emergency services or offers limited benefits. Molina will contact the primary carrier to validate and update our systems to reflect Molina as the primary carrier
- The member is American Indian / Alaskan Native (AI/AN)

When COB payment is as much as or more than Molina Healthcare’s allowable rate and there is no patient responsibility from the primary insurance the claim has been paid in full. Molina Healthcare will make no additional payment.

When COB payment is as much as or less than Molina Healthcare’s allowable rate with patient responsibility from the primary insurance, Molina Healthcare reimburses the patient responsibility not to exceed Molina Healthcare’s allowable rate.
Molina Healthcare may request a refund for COB claims paid in error up to 30 months from the original paid date.

Molina Healthcare is required to notify HCA monthly when a Member is verified to have health coverage with any other health carrier, including Dual Coverage. HCA provides COB information to Molina Healthcare on a regular basis through daily enrollment files. If HCA determines the Member has Dual Coverage with Medicare, the Member will be prospectively dis-enrolled from AH and enrolled in fee-for-service Medicaid.

**THIRD PARTY LIABILITY**

Molina Healthcare is the payer of last resort and will make every effort to determine the appropriate Third Party payer for services rendered. Molina Healthcare may deny Claims when Third Party has been established and will process Claims for Covered Services when probable Third Party Liability (TPL) has not been established or third party benefits are not available to pay a Claim. Molina Healthcare will attempt to recover any third-party resources available to Members and shall maintain records pertaining to TPL collections on behalf of Members for audit and review.

**BILLING THE MEMBER**

Molina Healthcare contracted providers may not bill the Member for any covered benefits. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization. Provider agrees that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina to the Provider. Provider agrees to accept payment from Molina as payment in full, or bill the appropriate responsible party.

In accordance with WAC 182-502-0160, a contracted provider may only bill fee-for-service or managed care clients for covered health care services, if the Member and the provider both sign Health Care Authority form 13-879 “Agreement to Pay for Healthcare Services” no more than 90 days prior to services being rendered. The form must be completed in full. For Members with limited English proficiency, form 13-879 must be translated into the Member’s primary language. If necessary, this form must also be interpreted for the Member. If the agreement is interpreted, the interpreter must also sign it. All other requirements for form 13-879 apply.

Providers must accept payment by Molina Healthcare as payment in full in accordance with 42 CFR 447.15. Balance billing is not permitted. For additional information, refer to WAC 182-502-0160 and HCA Memo #10-25.

**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 Compliance section of this Provider Manual for more information.
ENCOUNTER DATA

Each capitated Provider/organization delegated for Claims processing is required to submit Encounter data to Molina 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 should be reported.

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

Please see Molina’s 837P, 837I, and 837D Companion Guides with the specific submission requirements available to Providers on our website at http://www.molinahealthcare.com/providers/common/duals/ediera/PDF/edi_comm_molina_companion_guide_5010.pdf.

When your Encounters are filed electronically you should receive:

- For any direct submission to Molina you should receive a 999 acknowledgement of your transmission
- For Encounter submission you will also receive a 277CA response file for each transaction