Claims

Molina Healthcare of Wisconsin, Inc. follows Medicaid rules except where there are rules specific to a physician network or Participating Provider.

Service-Specific Policies and Procedures

Emergency Care Services

ER physicians cannot bill for after hours codes. These are 99050 through 99054 in the ER setting. This is not a Covered Service for Medicaid.

Non-anatomical Pathology Charges

Reimbursement for the professional component of non-anatomical pathology is included in the reimbursement paid for the visit by the attending physician. Claims submitted for the professional component for non-anatomical pathology will be denied. This includes Claims submitted by a pathologist.

Implanon

A pregnancy test must be performed on the same day the Implanon is inserted to determine that, to the best of the physician's knowledge, the patient is not pregnant at the time of insertion. In addition, the manufacturer's recommendations should be used as a guideline.

For eligible Members a physician's Claims for Implanon implants should include both a charge for Implanon insertion and a pregnancy test on the same date of service. Payment will be made for each service. Claims without pregnancy tests should be referred to the Molina Healthcare of Wisconsin, Inc. Medical Director for quality review.

Obstetrical Billing

The purpose of this section is to ensure that providers are billing obstetrical charges appropriately for the services they have performed. This section may be adapted to a review format if poor compliance is identified.

Antepartum Care

Antepartum care includes the initial and subsequent history, physical examinations, recording of weight, blood pressure, fetal heart tones, routine chemical urinalysis, hemoglobin, assessment of uterine size and fundal height. Global antepartum care is defined as four (4) or more OB-related visits to the same physician, coverage group or clinic.

Delivery Services

Delivery services include admission to the hospital, the admission history and physical examination, management of labor, vaginal delivery (with or without episiotomy), operative vaginal delivery (with or without forceps) or cesarean delivery.

Delivery Only

Delivery only codes are to be used when the physician, coverage group or clinic performing the delivery is not the physician providing the antepartum care.

Postpartum Care

Postpartum care includes hospital and normal postpartum office visits usually occurring within six (6) weeks following vaginal or cesarean delivery, pelvic exam, routine chemical urinalysis, suture removal, and contraceptive management.

Postpartum Care Only

The postpartum care only code is to be used when the physician or clinic providing the postpartum care is not the physician or clinic that performs the delivery.

Global Antepartum Codes

More than three (3) office visits provided for antepartum care should be submitted as follows:

- Antepartum care only; four (4) to six (6) visits
- Antepartum care only; seven (7) or more visits

Lab Work

Any associated lab work allowed on Molina Healthcare of Wisconsin, Inc.'s in-office lab list may also be coded separately.

Non-Obstetrical Diagnosis

If a patient sees her physician for a non-obstetrical related diagnosis on a separate date of service than her normally scheduled OB visit, the physician may bill separately for these visits using the appropriate office visit code.

Obstetrical Assistant Surgeon

Assistant surgeon's fees are not covered for a single or multiple birth vaginal delivery. Therefore, a Claim submitted with modifier 80 will be denied. Assistant surgeons are allowed with cesarean deliveries, except in teaching facilities where obstetrical residents are available. The assistant should attach the appropriate modifier to the cesarean delivery only code.

Complications of Maternity Services

Any complications or unusual circumstances related to maternity services should be identified by submitting a 22 modifier on the corresponding obstetrical code. **In order to be considered for additional reimbursement, supporting documentation must be submitted with the original Claim for all complications and unusual circumstances.**

Twin Vaginal Delivery

Will be reimbursed for the first delivery performed, plus fifteen percent (15%) for the second delivery.

Cesarean Delivery

Will be reimbursed in accordance with the global cesarean delivery, plus vaginal delivery only.

Additional OB/GYN Information

Physicians will be reimbursed for tubal ligation done at the time of cesarean delivery. As required by the State, payment will not be allowed if the sterilization consent form has not been appropriately completed by Medicaid recipient.

Delivery may be paid separately if the physician is not the one who performed the prenatal care. Office visits related to the pregnancy are denied because they are included in the global OB fee billed at time of delivery.

Pitocin drip and tocolytic infusions to induce labor may not be billed separately.

Antepartum care may be paid separately if the physician will not be the one delivering the child. Otherwise antepartum (prenatal) care is included in the delivery charge. [Global should be used if a provider provides all six (6) antepartum visits, delivery, and postpartum care.]

Nurse midwives under participating networks are payable. If a physician delivers the child the nurse midwife can submit charges under 99499 (unlisted). Documentation must be included with the Claim.

Surgical Services

Cosmetic surgery is not covered for Medicaid recipients.

Molina Healthcare of Wisconsin, Inc. does not require second opinions for any surgical procedure.

Hysterectomies are not covered for the following conditions:

- Uncomplicated
- Fibroids
- Fallen uterus
- Retroverted uterus

Assistant Surgeons

If medical circumstances warrant the use of an assistant surgeon, providers should submit the Claim with the appropriate modifier.

Multiple Procedures

Modifier 51 is required for Claim processing when multiple procedures are performed on the same date. If modifier 51 is not appended to the CPT's after the primary procedure then those CPT's will be denied.

Global Charges

Molina Healthcare of Wisconsin, Inc. follows CPT guidelines for the application of global billing requirements. For maternity/delivery charges billed as global, Molina Healthcare of Wisconsin, Inc. only requires a flow sheet for Members who have been effective less than three (3) months.

Podiatry Services

BadgerCare Plus - Podiatry services are covered.

Routine foot care including cleaning/trimming nails is covered with the following diagnoses diabetes; arteriosclerosis with claudication; peripheral neuropathies associated with:

- Malnutrition
- Diabetes
- Drugs and toxins
- Multiple sclerosis or uremia
- Cerebral palsy
- Spinal cord injuries
- Blindness
- Parkinson's Disease
- Cerebrovascular accident
- Polio
- Guillian-Barre syndrome
- Scleroderma

An evaluation and management (E/M) code is not reimbursable on the same day as routine foot care, mycotic procedures, surgery, or casting/strapping/tapping.

Services are not covered for flat feet, 99401-99404, treatment of subluxation of foot, dispensing corrective shoes, orthopedic services, and orthotics (except casting).

Vaccines For Children Program (VFC)

Under the Vaccines for Children Program (VFC) certain vaccines are available to providers free of charge for children less than nineteen (19) years of age when those providers are enrolled in the Vaccines for Children Program. Molina Healthcare of Wisconsin, Inc. assumes all providers are enrolled in this program until it is told otherwise. **Providers must bill with the actual vaccine code and not the administration code per Medicaid requirements**. Therefore, Molina Healthcare allows the vaccine code but denies the administration code if billed in addition to the vaccine.

The current vaccines available are:

- DT
- DTaP
- DTaP, Hep B, IPV (Pediarix)
- Gardicil
- Haemophilus Influenza (Hib)
- Hepatitis A
- Hepatitis B
- Hepatitis B - Hib (Comvax)
- Human Papillomavirus (HPV)
- Influenza Vaccine (includes FluMist)
- IPV
- Measles, Mumps, Rubella (MMR)
- Meningococcal Conjugate (MCV4)
- Prevnar
- Rotavirus
- Td
- Tdap
- Varicella

Special Regulations for Medicaid Claims

The following situations have special regulatory requirements for all Medicaid physicians and providers, whether or not contracted with Molina Healthcare of Wisconsin, Inc.

Sterilization

Molina Healthcare of Wisconsin, Inc. must receive an informed consent form before processing anything related to sterilization. Medicaid regulations dictate the following:

- Individual must be twenty-one (21) years old at the time consent is given.
- Individual must not have been declared mentally incompetent by Federal, State or local court.
- Individual has voluntarily given informed consent as follows:
    - At least thirty (30) days, but not more than one hundred eighty (180) days have passed between the date of informed consent and surgery (except in the case of premature delivery or emergency abdominal surgery).

- An individual may be sterilized at the time of premature delivery or emergency abdominal surgery if at least seventy-two (72) hours have passed since he/she gave informed consent for sterilization.
- In the case of premature delivery, the informed consent must have been given at least thirty (30) days before the expected date of delivery.

Sterilization by Hysterectomy

Hysterectomy performed ONLY to produce sterility is covered if:

- The individual who secured the Authorization for the hysterectomy has informed the individual orally and in writing that the procedure will render her permanently incapable of reproducing; and
- The individual has signed and dated a written acknowledgement of receipt of that information prior to the hysterectomy being performed.

Hysterectomy may be performed on an individual who was already sterile and whose physician has provided written documentation, including a statement of the reason for sterility, with the Claim form or requiring a hysterectomy due to a life-threatening situation in which the physician determines that prior acknowledgement is not possible (the physician performing the operation shall provide written documentation including a description of the nature of the emergency with the Claim form).

Before reimbursement for either sterilization or hysterectomy is made Molina Healthcare must have:

- Consent form.
- Acknowledgement of receipt of hysterectomy information or a physician's certification form for hysterectomy performed without prior acknowledgement of receipt of hysterectomy information.

Abortion

The abortion must be directly and Medically Necessary to save the life of the mother. The physician must attest that based on his/her best clinical judgment that the abortion meets this condition. There should be a statement to that with the Claim.

In a case of sexual assault or incest, provided that prior to the abortion the physician attests to his/her belief that sexual assault or incest has occurred by signing a certification, and provided that the crime has been reported to the law enforcement authorities.

Due to a medical condition existing prior to the abortion, the physician determines that the abortion is directly and Medically Necessary to prevent grave, long-lasting physical health damage to the mother, provided that prior to the abortion, the physician attests, based on his/her best clinical judgment that the abortion meets this condition by signing a certificate.

Mifeprex

Administration of Mifeprex (morning after pill) follows the same rules as for abortions. Wisconsin Medicaid reimburses for Mifeprex (known as RU-486 in Europe) under the same coverage policy that it reimburses other surgical or medical abortion. Only physicians may obtain and dispense Mifeprex.

The provider must attach to each Claim a completed Abortion Certification Statement that includes information showing the situation is one in which Wisconsin Medicaid covers abortion. A woman's consent to an abortion is not considered informed consent unless at least twenty-four (24) hours prior to an abortion a physician has, in person, orally provided the woman with certain information specified in the statute. That information includes, among other things, all of the following:

- Whether the woman is pregnant.
- Medical risks associated with the woman's pregnancy.
- Details of the abortion method that would be used.
- Medical risks associated with the particular abortion procedure.
- Any other information that a reasonable patient would consider material and relevant to a decision of whether or not to carry a child to birth or to undergo an abortion.

Claims submitted with no consent form on file are denied.

Billing a BadgerCare Plus and Medicaid SSI Member

Balance billing a BadgerCare Plus and Medicaid SSI members by Wisconsin Medicaid providers is not allowed by regulation. Under State and Federal laws, if a provider inappropriately collects payment from an enrolled Member or Authorized Representative acting on behalf of the Member, that provider may be subject to program sanctions including termination of Medicaid enrollment. In addition, the provider may also be fined, imprisoned, or both pursuant to Section 42 USC s. 1320a-7b and Wis. Stats. 49.49 (3m).

The standard release form signed by the Member at the time of services does not relieve the HMO and its providers and subcontractors from the prohibition against billing a Member in the absence of a knowing assumption of liability for a non-BadgerCare Plus and/or Medicaid SSI covered service. If a Member agrees in advance in writing to pay for a service not covered by BadgerCare Plus and/or Medicaid SSI, then the HMO, HMO provider, or HMO subcontractor may bill the Member. However, the form or other type of acknowledgment relevant to a Member's liability must specifically state the admissions, services, or procedures that are not covered by BadgerCare Plus and/or Medicaid SSI.

Billing Copayments

Effective for dates of service January 1, 2014 and after, Molina Healthcare of Wisconsin, Inc. is no longer applying Member copayments. Copayments still apply for dates of services prior to January 1, 2014.

Medical Copayments

For dates of service prior to January 1, 2014 providers should review the see copayment summary for each health plan on Molina Healthcare of Wisconsin Inc.'s website. See link below.

www.molinahealthcare.com/medicaid/providers/wi/forms/Pages/fuf.aspx

For more information on BadgerCare Plus, please see the DHS website or call DHS provider services at 1-800-947-9627.

Coordination of Benefits (COB)

Molina Healthcare of Wisconsin, Inc. will deny Claims if it is determined that the Member has other insurance as his/her primary carrier. Molina Healthcare of Wisconsin, Inc. requires a copy of the Explanation of Benefits (EOB) showing a denial or payment from that primary insurance before payment will be considered or coordinated.

Claims submitted with an EOB will be processed for any secondary benefits due. If the primary insurance paid more than Molina Healthcare of Wisconsin Inc.'s maximum contracted allowable rate, the Claim will pay zero dollars.

Only services covered by Medicaid are payable regardless of other insurance coverage. Even if the primary insurance covers a non-Covered Service, Molina Healthcare of Wisconsin, Inc. does not pay as secondary in this situation.

No Referral or prior Authorization from Molina Healthcare of Wisconsin, Inc. is needed when other insurance is primary. Exception: If the provider performs a service that is considered non-covered by the primary payor but is covered by Molina Healthcare of Wisconsin, Inc. then an Authorization is required.

Timely Filing

Timely filing for Participating Providers is sixty (60) days unless otherwise defined in the provider's contract. Providers should refer to their contract for specific details, or contact Molina Healthcare of Wisconsin, Inc. Member Services at 855-326-5059. Interim billing is not permitted for inpatient hospital stays unless the provider's contract specifically allows it.

Timely Filing with Other Insurance

Timely filing for Participating Providers is sixty (60) days from the date on the remit from the primary payor unless otherwise stated in the provider's contract. The EOB from the primary payor is required with Claim submission.

E-Portal

In March 2012, Molina Healthcare of Wisconsin, Inc. implemented a Web Portal specifically for its providers to be able to access some of Molina Healthcare's helpful tools for their office.

The Web Portal provides access to the following information:

- **PCP Roster –** Rosters for Molina Healthcare's Primary Care Providers
- **Service Request/Authorization –** Helps provider to create, save, submit and check the status of a Service Request/Authorization form in real time.
- **Member Eligibility –** Quickly and easily search for Members and see if they are currently eligible with a few simple steps.
- **Claims –** Perform Claim status inquiries, create, save and submit professional Claims.

Providers can register by visiting: http://www.molinahealthcare.com/common/Pages/login.aspx

Claim Submission

In order to expedite payment, please follow the Claim submission procedures outlined below: Please note that Claims must be submitted within sixty (60) days of the date of service unless another time frame is specified in the provider's contract.

Paper: Submit to:
Molina Healthcare of Wisconsin, Inc.
P.O. Box 22815
Long Beach, CA 90801

Electronic: Submit through Emdeon
Payer ID: Abri1

Revised Timeline for New CMS-1500 (02/12) Claim Form

In response to guidelines recommended by the National Uniform Claim Committee (NUCC) and set forth by the Centers for Medicare and Medicaid Services (CMS), Molina Healthcare is implementing the revised CMS-1500 Health Insurance Claim Form (02/12) version effective January 6, 2014.

Effective April 1, 2014 the revised CMS-1500 form (version 02/12) will replace version 08/05. The recently revised CMS-1500 Claim form introduces new fields which include identification of the International Classification of Diseases Ninth Revision, Clinical Modification (ICD-9-CM) or Tenth Revision (ICD-10-CM), and expands to allow twelve (12) possible ICD-9-CM or ICD-10-CM diagnosis codes instead of the current four (4) diagnosis codes. ICD-10-CM codes must be used for dates of service on or after October 1, 2014.

As a result, Molina Healthcare is in the process of updating its systems and clean Claim (as defined in CFR § 447.45) editing to integrate new and revised data elements. By doing so, Molina Healthcare will ensure its clean Claims processing methodologies will continue to meet Claims processing and provider reimbursement timelines mandated by State and Federal laws.

CMS 1500 02/12 Implementation Timeline

Form	Action	Effective
CMS 1500 v 08/05 and v02/12	Both accepted during transition period	1/6/2014 through 3/31/2014
CMS 1500 v 08/05	Will be rejected if submitted after transition period	4/1/2014
CMS 1500 v 02/12	Will be the only accepted version of the CMS 1500	04/1/2014

*The table above captures the CMS approved time frame and can change if communicated by CMS.

Note: The effective dates for transition to the new form are based on date of Claim submission rather than the date of service.

Claims may be submitted utilizing E-Portal.

IMPORTANT NOTE: Reference Labs: Please note that billing for reference labs must be submitted on a CMS-1500 Claim form using CPT codes.

5010

As of July 1, 2012, the PO Box edit will be turned on (required for 5010 compliance) and all Claims received with a non-physical street address (PO Box and its permutations, Lock Box, File, etc.) in the billing address field will be denied. Molina Healthcare recommends that all providers comply with this 5010 requirement as soon as possible to avoid any unnecessary Claim rejections after July 1, 2012.

HIPAA TCS Questions

For HIPAA TCS questions or concerns, please call Molina Healthcare's toll-free HIPAA Provider Hotline at 1-866-MOLINA2 (1-866-665-4622).

Professional (1500) Claim forms

Professional (1500) Claim forms should contain all pertinent information for the patient, the provider of service and the service being performed.

Block #	Required?	Description
1	No	Check Applicable Program
1a	Yes	Member's Health Plan ID Number
2	Yes	Member's Name
3	Yes	Member's Birth date and Sex
4	Yes	Insured's Name
5	Yes	Member's Address
6	No	Member's Relationship to Insured
7	No	Insured's Address
8	No	Member's Status

Block #	Required?	Description
9	Yes	Other Insured's Name (If Applicable)
9a	Yes	Other Insured's Policy or Group Number
9b	Yes	Other Insured's Date of Birth and Sex
9c	Yes	Employer's Name or School Name
9d	Yes	Insurance Plan Name or Program Name
10a-c	No	Member's Condition Related to Employment, Auto Accident, Other Accident
11	No	Member's Policy, Group or FICA Number (If Applicable)
11a	No	Member's Date of Birth (MM, DD, YY) and Sex (check box)
11b	No	Employer's Name or School Name (If Applicable)
11c	No	Insurance Plan Name or Program Name (If Applicable)
11d	No	Is there another health benefit plan?
12	No	Member's or Authorized Person's Signature and Date On File
13	No	Member's or Authorized Person's Signature
14	No	Date of Current Illness
15	No	Date of Same or Similar Illness
16	No	Date Client Unable to Work in Current Occupation
17	Yes	Name of Referring Physician or Other Source (required for E/M consults, laboratory, and radiological services only)
17 b	Yes	NPI of referring Physician (required for E/M consults, laboratory, and radiological services only)
18	Yes	Hospitalization Dates Related to Current Services (If Applicable)
19	No	Reserved for local use
20	No	Outside Lab? (Yes, if labs are drawn and sent to a referance lab)
21	Yes	Diagnosis or Nature of Illness or Injury
22	No	Medicaid Resubmission Code
23	No	Prior Authorization Number
24a	Yes	Date of Service
24b	Yes	Place of Service code (HIPAA Compliant)
24c	No	If procedure performed as an emergency enter "Y" otherwise leave blank
24d	Yes	Procedure Code and Modifier when applicable
24e	Yes	Diagnosis Code
24f	Yes	Charges
24g	Yes	Days or Units
24h	No	If applicable enter "Y" for EPSDT or Family planning otherwise leave blank
24i	No	ID Qualifier
24 j	Yes	Rendering Provider Name and Rendering Provider NPI
25	Yes	Federal Tax ID Number
26	No	Provider's Member Account Number
27	No	Accept Assignment (check box)

Block #	Required?	Description
28	Yes	Total Charges
29	Yes	Amount Paid by Other Insurance (If Applicable)
30	Yes	Balance Due
31	Yes	Signature of Physician/Practitioner including Degrees and Credentials along with the date - **SIGNATURE ON FILE IS NOT ACCEPTABLE**
32	Yes	Name and Address of Facility where services were rendered
32 a	No	NPI of Servicing Facility
33	Yes	Billing address and Phone # **(as of 7/1/2012 the physical address is required – no P.O. Boxes will be accepted – the Claim will deny if submitted with a P.O. Box)**
33 a	Yes	Billing Provider NPI
33 b	No	

Additional information needed:

- Operative notes for Claims billed with modifiers 22, 62, or 66;
- Detailed description for Claims submitted with unlisted procedure codes;
- Purchase price for DME rental items expected to exceed $500 cumulative total during the rental period; and
- Therapy progress notes with therapy Claims flow sheet for office visits for pregnant women when billing delivery if Member has been with Molina Healthcare of Wisconsin, Inc. less than three (3) months.

Institutional (UB-04) Claim forms

Institutional (UB-04) Claim forms should contain all the same pertinent information for the patient, the provider of service and the service being performed.

Block #	Required?	Description
1	Yes	Provider Name, Address, Telephone #
2	No	Pay to Name, Address, and ID
3a	No	Patient Control #
3b	No	Medical Record #
4	Yes	Type of Bill
5	Yes	Federal Tax ID Number
6	Yes	Statement Covers Period (Include date of Discharge)
7	No	Unlabeled field
8a-b	Yes	Member Name
9a-e	Yes	Member Address
10	Yes	Member Birth Date
11	Yes	Member Sex
12	Yes	Admission Date
13	Yes	Admission Hour

Block #	Required?	Description
14	Yes	Admission Type
15	Yes	Admission Source
16	Yes	Discharge Hour
17	Yes	Discharge Status
18 -28	No	Condition Codes (if applicable)
29	No	ACDT States
30	No	Unlabeled field
31-34	No	Occurrence Code And Date (if applicable)
35-36	No	Occurrence Span
37	No	REC.ID For Resubmission
38	No	Untitled
39-41a-d	Yes/No	Value Code and Amount – INPATIENT required - Enter the applicable value code and associated amount. Enter covered days using value code "80" and enter the number of covered days in the corresponding amount field using two decimal places. (For example, to indicate one day, providers would enter "1.00;" to indicate 12 days, providers would enter "12.00.") Enter non-covered days using value code "81" and enter the number of non-covered days in the amount field using two decimal places. Do not count the day of discharge for covered days. For non-covered days, enter the total non-covered days by the primary payer. The sum of covered days and non-covered days must equal the number of days in the "From-Through" period in Form Locator 6. OUTPATIENT – not required – leave field blank.
42	Yes	Revenue Code
43	Yes	Revenue Description
44	Yes	Procedure Code (CPT) (if applicable the modifier is listed next to the CPT code)
45	Yes	Service Date
46	Yes	Units Of Service
47	Yes	Total Charges
48	No	Non-Covered Charges
49	No	Unlabeled field
Detail line 23	Yes	Enter the current page number in the first blank and the total number of pages in the second blank. This information must be included for both single and multiple page Claims. Creation date not required.
Totals	Yes	Enter the sum of all the charges for the Claim in this field. If submitting a multiple page Claim, enter the total charge for the Claim (i.e., the sum of all details from all pages of the Claim) only on the last page of the Claim.
50 a-c	Yes	Payer Name
51 a-c	No	Health Plan ID
52 a-c	No	Release Of Information Authorization Indicator
53 a-c	No	Assignment Of Benefits Authorization Indicator
54 a-c	Yes	Prior Payments (If Applicable)
55	No	Estimated. Amount Due

Block #	Required?	Description
56	Yes	Facility NPI - should correspond with the name I form locator 1
57	No	Other ID
58 a-c	Yes	Insured's Name
59 a-c	No	Member's Relationship To Insured
60 a-c	Yes	Member's Identification Number
61 a-c	No	Group Name
62 a-c	No	Insurance Group Number
63 a-c	No	Prior Authorization Number (If Applicable)
64 a-c	No	Document Control Number
65 a-c	No	Employer Name
66	No	DX (if applicable)
67	Yes	Principal Diagnosis Code – POA Indicator required
67 a-q	Yes	Other Diagnosis (if applicable) – POA Indicator required
68	No	Unlabeled field
69	Yes	Admit Diagnosis
70	No	Patient Reason Diagnosis
71	No	PPS Code
72	No	ECI
73	No	Unlabeled field
74	Yes	Principle Procedure (if applicable)
74 a-e	Yes	Other Procedure Code and Date (if applicable)
75	No	Unlabeled field
76	Yes	Attending Physician NPI First And Last Name (Required)
77	No	Operating Physician NPI
78 -79	No	Other NPI (if applicable)
80	No	Remarks (when applicable)
81 a-d	No	Code-Code

Attach an Itemized Statement for all Claims of $70,000 or more.

For inpatient stays the Claim may not be billed until the patient is discharged. No cycle (or interim) bills will be accepted.

Checking Claim Status

The status of submitted Claims may be obtained either by calling 855-326-5059 and speaking with the Member Services staff, through the IVR system. Please refer to the IVR (Interactive Voice Response) Reference Guide which is on Molina Healthcare's website at www.MolinaHealthcare.com/Medicaid/providers/wi/manual for complete instructions. When speaking with a Member Services Representative, Molina Healthcare asks that providers limit the number of Claims they are calling on to three (3) per call. Molina Healthcare needs to do this in

order to ensure that other callers receive prompt attention. Claims will be paid or denied within thirty (30) days of receipt.

Payment and Remittance

Molina Healthcare of Wisconsin, Inc. will send payment along with a remittance that shows each Member, date of service, Claim number, patient account number, procedure with modifiers, units, billed, allowed, discounted, copayment, COB, services not covered, deductible, coinsurance and paid amounts along with an explanation of payment or denial code for each service line. The total amount for the check can be found in the top section of the first page.

Electronic Remittance Advice (ERA)/Electronic Fund Transfer (EFT)

Providers can register at: https://ProviderNet.Alegeus.com

Benefits:

- Providers have administrative rights to sign up and manage their own EFT account and routing information.
- Providers can associate new providers within their organization to receive EFT/835s (combination of Tax ID and multiple NPIs as well as Tax ID and single NPI).
- Providers can view/print/download/save PDF version of their Explanation of Payment - EOP (also known as Remittance Advice).
- Providers can search for a historical EOP by various methods, such as Claim number and Member name.
- Providers can have their files routed to their file transfer protocol (ftp) and/or their associated clearing house.

Once the provider's account is activated:

- Providers will begin receiving all payments through EFT [Providers must have received one (1) payment by check before EFT begins], and will no longer receive a paper EOP (i.e. remittance) through the mail.
- Providers WILL receive 835's (by their selection of routing or via manual download)
- Providers WILL also have the ability to view/print/download/save historical and new EOPs.

Claim Editing Process

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 services rendered

Coding edits are generally based on State Fee-For-Service Medicaid edits, American Medical Association (AMA), Current Procedural Terminology (CPT), HRSA and National Correct Code Initiative (NCCI) guidelines. Providers who disagree with an edit can refer to the Claim Disputes/Adjustments and Appeals section below.

NOTE: Appending modifiers (e.g. -25 or -59) to the bundled procedure or service may not bypass the Claim editing process. If the Claim is denied due to Molina Healthcare's Claim editing process, providers have the right to appeal with supporting documentation within sixty (60) days from the remit as outlined in the Claims Dispute / Adjustments and Appeals section below.

Claims Disputes/Adjustments and Appeals

Providers who have a question about a Claim or service denial should call Molina Healthcare.

Informal requests to have a Claim or prior Authorization decision reviewed or to ask for clarification do not need to go through a formal Appeals process. Providers can simply call the Member Services line or send an email request.

Business Hours:	8:00 AM to 5:00 PM CST, Monday through Friday
Phone:	855-326-5059
Email:	MWI_ContactUs@MolinaHealthcare.com

Corrected Claims

Paper

Corrected billing may be submitted on paper and clearly marked as "corrected claim". This does not have to go through the Appeals process. Marking the Claim "corrected billing" will ensure that the Claim is not automatically denied as a duplicate. Submit your corrected Claim to:

Molina Healthcare of Wisconsin, Inc.
PO Box 22815
Long Beach, CA 90801

Electronic

Corrected Claims may be submitted electronically with the appropriate field on the 837I or 837P completed.

Corrected Claim Examples

CMS-1500

Submitting a corrected Claim on a 837 P/CMS-1500 box 22 must be completed. Enter the appropriate bill frequency code along with the original Molina Healthcare Claim number as shown in the example below.

Bill Frequency code:

•7 – Replacement of prior claim

•8 – Void / cancel of prior claim

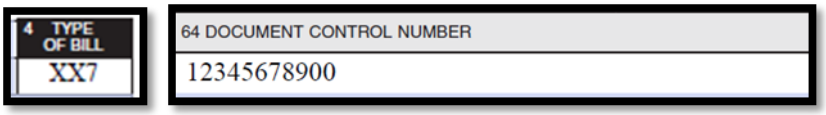
UB-04

Submitting a corrected Claim on a 837 I/UB-04 boxes 4 and 64 must be completed. Enter the appropriate Type of Bill Frequency Code in box 4 (the 3rd digit of the type of bill) and the original Molina Healthcare Claim number in box 64 as shown in the example below.

Type of Bill Frequency Code:

•7 – Replacement of prior claim

•8 – Void / cancel of prior claim



Denied Claims

Denied Claims must be appealed within sixty (60) days of receipt of the denial. Formal Appeals must be submitted in writing clearly marked "appeal". The Appeal must include the provider's name, date of service, date of billing, date of payment and/or nonpayment, Member's name and BadgerCare Plus ID number. It must also include the reason(s) the Claim merits reconsideration. If the Appeal relates to Medical Emergency, Medical Necessity and/or prior Authorization, Medical Records or substantiating documentation must accompany the request for reconsideration.

NOTE: Claims that are denied for specific information, invalid coding, request for office notes etc. may simply be resubmitted for Claims processing with the corrected or requested information and do not need to go through any formal Appeals process.

Mail, Fax or Email the Appeal to:

Address: Molina Healthcare of Wisconsin, Inc.
ATTN: Provider Appeals Department
P.O. Box 270208
West Allis, WI 53227

Fax: 414-847-1778

Email: MWIAppeals@MolinaHealthcare.com

Upon receipt of the Appeal, Molina Healthcare of Wisconsin, Inc. will review the Appeal, send an acknowledgement letter within ten (10) business days and respond to that Appeal within forty-five (45) days. If the decision is in the provider's favor, the Claim will be adjusted within thirty (30) days of the resolution letter. If Molina Healthcare does not respond to the Appeal in that time or if the provider is dissatisfied with the outcome, the provider has the right to appeal to the Department of Health Services. **All BadgerCare Plus providers must appeal first to the HMO and then to the Department of Health Services if they disagree with the HMO's payment or nonpayment of a Claim.**

Appeals to the Department of Health Services (DHS) must be submitted using DHS form F12022 and all elements of the form must be completed at the time the form is submitted (i.e. Medical Records for Appeals regarding Medical Necessity). The form is available on the Molina Healthcare of Wisconsin, Inc. website and also on the ForwardHealth Portal. Appeals to DHS must be made within sixty (60) days of Molina Healthcare of Wisconsin Inc.'s final decision or in the case of no response, within sixty (60) days from the forty-five (45) day time allotted to Molina Healthcare of Wisconsin, Inc. to respond. DHS Appeals should be mailed to: Forward Health Managed Care Appeals, P.O. Box 6470, Madison, WI 53716-0470. DHS has thirty (30) days from the date of receipt of all written comments to inform the provider and Molina Healthcare of Wisconsin, Inc. of the final decision. If the decision of DHS is in the provider's favor, Molina Healthcare of Wisconsin, Inc. will pay the Claim within thirty (30) days of receipt of the final determination.

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 DHS, 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 and the 837P - Professional. 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 make its 837P and 837I Companion Guides with the specific submission requirements available to providers.

Fraud, Waste and Abuse

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

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.

Billing Tips for Members with Chronic Conditions

Members with chronic conditions are eligible for Molina Healthcare of Wisconsin, Inc. Disease Management and Case Management services. These programs will aid Members in:

- Finding the right doctor;
- Understanding their condition and the prescribed treatment plan; and
- Coordinating overall care.

Disease Management is designed to provide Members with information about their disease and to provide reminders to ensure they obtain essential medical services. Molina Healthcare of Wisconsin, Inc. currently offers the following programs:

- ***Asthma*** – Breathe with Ease
- ***Cardiovascular Disease*** – Heart Healthy Living
- ***Pregnancy*** – Motherhood Matters
- ***COPD*** – Healthy Living with COPD
- ***Diabetes*** – Healthy Living with Diabetes

Case Management targets Members with various conditions. The program will help Members manage their medical condition to suit their lifestyle.

What Can Providers Do to Help?

Molina Healthcare needs help from providers to accurately identify Members with chronic conditions that may be eligible for one (1) of the Disease Management or Case Management programs. Suggested billing tips and examples are listed below:

- Submit accurate and timely Claims for each office visit.
- For Members with chronic illness, ***always*** include appropriate **chronic and disability** diagnoses on all Claims when appropriate.
- Document chronic disease on each date of service (DOS) visit note (Molina Healthcare of Wisconsin, Inc. 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**.

Example One:

A patient with a chronic disease comes in for a visit regarding his/her chronic condition. The diagnosis code must be noted to the highest level of specificity.

- Diabetes Type 2 should be reported as 250.00.
- Diabetes Type 2 Uncontrolled is reported as 250.02.
- Diabetes Type 2 with Retinopathy is reported as 250.50 ***and*** 362.01-362.07.

Example Two:

A patient with a chronic disease comes in for a visit regarding an illness other than his/her chronic condition. **It is suggested to note the chronic disease as a secondary diagnosis if the condition was taken into consideration to treat the patient. This includes prescriptions.**

Diabetic uncontrolled, but comes in with an upper respiratory infection. Suggested diagnosis codes are:

- DX [1] – 465.9 (upper respiratory)
- DX [2] – 250.02 (diabetes – chronic condition)

If a provider's Superbills/Routes/Encounters are populated with non-specific diagnosis codes, he/she should share this information with the physician(s) to ensure appropriate diagnosis codes are reported.

If providers have any questions, they can call the Provider Services Department. A representative will be available to assist them Monday through Friday from 8:00 a.m. – 5:00 p.m., CST. Please call toll free at 855-326-5059, or TTY: 1-800-688-4889.