August 31, 2022

Provider Memorandum

Notification of Inpatient Clinical Validation Review

Beginning November 1, 2022, Molina Healthcare of Illinois (Molina) shall review services provided to our members to ensure program integrity, which includes both prepayment and post-payment review of claims and clinical documentation. This will impact all lines of business.

Molina conducts Medical Claim Reviews as noted in the provider agreement. This ensures that claims are reimbursed in accordance with generally accepted federal and state regulatory requirements, billing and coding guidelines, contract provisions, and established Molina policies and procedures.

Process

Molina will be conducting an APR DRG and/or MS DRG Clinical Validation Review that will evaluate whether diagnoses and procedure codes on the claim align with industry coding standards:

- Official ICD-10-CM Coding Guidelines
- Applicable ICD Coding Manual
- Uniform Hospital Discharge Data Set (UHDDS)
- Coding Clinics

The APR DRG and/or MS DRG principal diagnosis assigned represents the condition established after study to be chiefly responsible for the admission of the patient to the hospital for care and not based on clinical suspicions at the time of admission. The Clinical Validation determination will be made using the medical record documentation available at the time of review and must support all diagnoses and procedures billed, including Major Complication or Comorbidity (MCC) and Complication or Comorbidity (CC) and Severity of Illness.

APR DRG and/or MS DRG Clinical Validation includes, but is not limited to, verification of:

- Diagnostic code assignments
- Procedural code assignments
- Sequencing of codes
- Grouping assignment and associated payment
- MCC and CC and severity of illness (if applicable)

In the event that the APR DRG and/or MS DRG Clinical Validation does **not** substantiate what was billed or is inconsistent with industry coding standards and requirements, Molina Healthcare may:

- Adjust to an APR DRG and/or MS DRG as supported by the documentation
- Adjust payment
- Request refunds
- Issue a base payment

Molina will be conducting an Appropriate Level of Care (short stay) Review that will evaluate whether the level of care billed is supported in the clinical documentation reviewed. When performing inpatient and observation status reviews, Molina applies an evidenced-based clinical criteria guideline, as long as the methodology complies with federal or state regulations and the hospital or provider services agreement.

If Molina determines that the provider has submitted a claim beyond the authorization provided, Molina will conduct the appropriate Level-of-Care Review. If the review findings indicate an inappropriate level of care was billed, Molina may deny the claim and request the provider to resubmit the claim as observation.

Note: A detailed findings letter will be mailed to the provider to accompany the above reviews if a change or denial in payment is made.

To review current Molina Payment Integrity Payment and Coding Polices, including Itemized Bill Review, visit this page on the Molina website: molinahealthcare.com/providers/il/medicaid/policies/payment.aspx.

Formal Disputes

Provider disputes/appeals **must** be submitted within 90 days from the remittance date. A request to review the processing, payment, or non-payment of a claim by Molina shall be classified as a Provider Claim Dispute and can be submitted via:

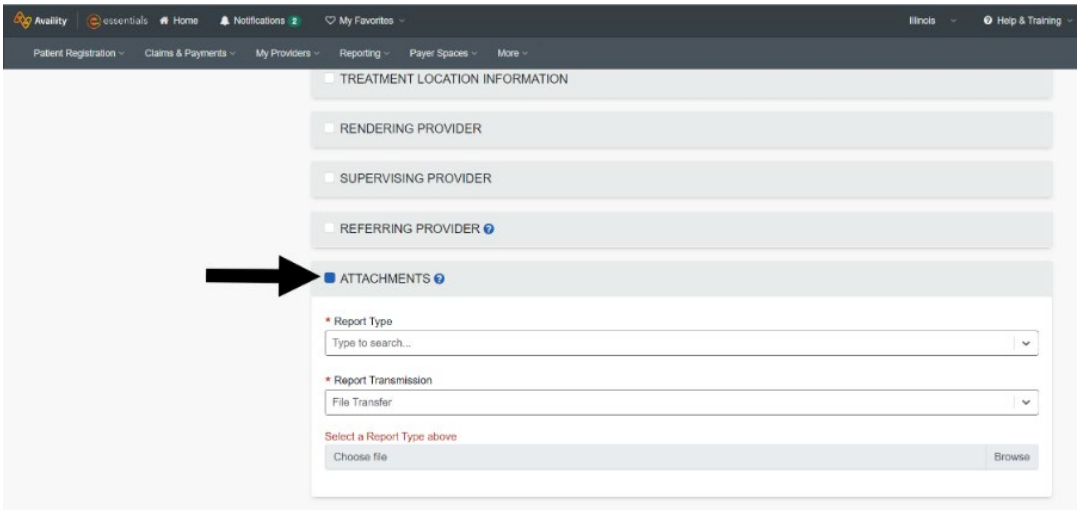
- Provider Portal (**preferred**): availity.com/molinahealthcare (Molina Payer ID **20934**)
- Fax: (855) 502-4962. **Must** include a completed Claims Dispute Form.

Note: CDs containing medical records may be sent to:
Molina Healthcare of Illinois, Inc.
Attention: Provider Disputes
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523

Submissions **must** include a completed Claims Dispute Request Form (one claim per form). The Claims Dispute Request Form can be found on the Frequently Used Forms page at MolinaHealthcare.com under the header Contracting & Provider Forms.

How To Attach

1. Log into the Availity Portal: availity.com/molinahealthcare
2. You will be prompted to select your organization, transaction, and payer.
3. As you complete the form, you will come to the **Attachments** section. On the **Report Type** dropdown select "**Medical Record Attachment.**"



Attachment Rules

- You can attach multiple files.
- The size of all files combined cannot exceed 120 megabytes (MB).
- Only these file types are allowed: PDF, TIF, JPG, BMP, and GIF.
- File names must be alphanumeric with no special characters.
- Duplicated file names are not allowed.

For Provider Portal support, contact Availity at **(800) 282-4548**, 7 a.m. to 7 p.m. Central Time.

Questions?

We're here to help. Contact your Provider Network Manager or email the Provider Network Management team at MHILProviderNetworkManagement@MolinaHealthcare.com. For help identifying your Provider Network Manager, visit Molina's Service Area page at MolinaHealthcare.com.

Availity Provider Portal

We continue our transition to the Molina Availity Provider Portal, a tool that streamlines your claims management, authorizations, and eligibility/benefit verification. Are you registered? Click here.

Get Critical Updates

Receive news and updates about Molina services and plan requirements delivered straight to your inbox! Click here to join Molina's provider email list.

Note: Molina's website and documents are best viewed in Google Chrome or Microsoft Edge.