Lactation Consultant Billing

2025 | Presented by Provider Relations Team

Thank you for joining us! We will begin shortly. ☺
Please make sure your microphone is muted until Q&A at the end.

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Housekeeping

- Welcome! Thanks for joining!
- Please make sure your mic is muted until Q&A at the end.
- Questions can also be typed in the chat.
- A PDF version of these slides will be emailed to you afterward.

Introduction

Medicaid and Lactation Consultants

Lactation consultants can become Medicaid providers in the Department of Healthcare and Family Services (HFS) medical programs.

Services are covered under the Medicaid fee-for-service (FFS) program and the HealthChoice Illinois MCOs (such as Molina).

In accordance with Public Act 102-0665, HFS pursued coverage of such services with a State Plan Amendment (SPA) submitted to the Federal Centers for Medicare & Medicaid Services (CMS). This SPA was approved with a coverage effective date of January 1, 2024.

Covered Services

- The term “lactation consultants” encompasses all certified lactation consultants, certified lactation counselors, and certified lactation specialists.
- Medicaid coverage for lactation consultant services includes the entire perinatal period through infant weaning, including:
  - Perinatal education about breastfeeding and human lactation.
  - Comprehensive maternal, infant, and feeding assessments related to breastfeeding and lactation.
  - Evidence-based lactation counseling and the provision of support and encouragement to promote the successful attainment of breastfeeding goals.
  - Services may be delivered individually or in a group setting, either in person or via telehealth.

Certification

Certifying Boards

- Lactation consultants **must** obtain a certificate from their certifying board prior to completing the Medicaid enrollment process with HFS.
  - International Board-Certified Lactation Consultants (IBCLCs) must be certified by the International Board of Lactation Consultant Examiners.
  - Certified Lactation Counselors (CLCs) must be certified by the Academy of Lactation Policy and Practice, Inc. and the Lactation Education Consultants.

IBLCE
International Board of Lactation Consultant Examiners

Lactation Education Consultants

ALPP

Certificate

- Once a lactation consultant becomes certified, they will be issued a certificate confirming that all applicable requirements have been met.
  - The certificate must contain a unique certification number tied to the lactation consultant, with a certificate effective date and expiration date.
  - It must also be uploaded during the provider enrollment process with HFS. When lactation consultants recertify their credentials, they must submit proof of recertification to HFS.

- Questions regarding certification may be directed to the applicable certifying board.

Medicaid Enrollment

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Enrollment Through HFS

- Lactation consultant services are reimbursable to certified lactation consultants enrolled in the **Illinois Medicaid Program Advanced Cloud Technology** (IMPACT) provider enrollment system.
- Lactation consultants should review the IMPACT **Account Activation Instructions for New External IMPACT Users**.
- IMPACT will also provide a Medicaid ID number.

IMPACT

- If you are already enrolled in IMPACT as a different individual provider type **or** have a National Provider Identifier (NPI) with another taxonomy code, please contact mtac.maternalhealth@uillinois.edu for guidance **before** making any changes to your NPI or IMPACT enrollment.

IMPACT
Illinois Medicaid Program
Advanced Cloud Technology

Provider Types

In IMPACT, a lactation consultant may select an enrollment type of either:

- **Rendering/servicing provider**—An individual provider who will be rendering services to Medicaid members but will not be submitting claims directly to the state for reimbursement. Enrolling as a rendering provider requires that the provider associate with a group practice, or Facility Agency Organization (FAO) as a billing provider in the IMPACT system and would not allow the provider to bill for themselves.
- **Regular individual/sole proprietor**—A provider that owns their own practice. A sole proprietor may receive payments directly or associate themselves with billing providers and/or billing agents. Providers enrolled as a sole proprietor can still also associate with a group practice or FAO as the billing provider(s) and they may bill on your behalf, but this is optional. The provider can use this enrollment option to work as part of an organization and/or bill for yourself.

- You will work with IMPACT on this during enrollment.

National Provider Identifier (NPI)

- Lactation consultants **must** have a National Provider Identifier (NPI) to enroll.
- Information about obtaining an NPI is located on the CMS website.

Enrollment Assistance

The Medicaid Technical Assistance Center (MTAC), in partnership with HFS, has prepared enhanced onboarding educational materials and support to aid in the enrollment process. This includes:

- Medicaid provider overview specifically for lactation consultants.
- Obtaining a National Provider Identifier (NPI).
- Enrollment in IMPACT, the Illinois Medicaid provider enrollment system.

MTAC
Medicaid Technical Assistance Center

Enrollment Assistance

- You may also contact MTAC for technical assistance support at **mtac.maternalhealth@uillinois.edu**.
- To schedule a MEDI billing training, contact the Bureau of Professional and Ancillary Services at (877) 782-5565 for FFS claims.

Medicaid Technical Assistance Center

AN HFS - UNIVERSITY OF ILLINOIS SYSTEM PARTNERSHIP

APRNs and Clinics

- **Note regarding advanced practice registered nurses**: If you are an advanced practice registered nurse who is also an IBCLC, CLC, or CLS, you can bill using Evaluation & Management (E/M) codes and do **not** need to enroll under the new provider type.
- **Note regarding clinics**: Federally Qualified Health Centers, Rural Health Clinics, and Encounter Rate Clinics will be allowed to bill practitioner claims (instead of medical encounters). Lactation consultation services **must** be billed under the enrolled rendering consultant's NPI, with payment directed to the clinic/center's corporate NPI.

Joining the Molina Network

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Contracting With Us

- Contact the Molina Provider Relations Manager for your location:
  - For Cook County, Detra Alexander Detra.Alexander@MolinaHealthcare.com
  - For all other counties, Tammy Gosslin Tammy.Gosslin@MolinaHealthcare.com
- Have your W-9 and NPI ready.
- Your dedicated PRM will guide you through the details.

Medicaid Access to Timely Appointments

Medical Appointment Types	Standard
Routine preventive care	Within five (5) weeks from the date of request
Routine preventive care for infant under 6 months of age	Within two (2) weeks from the date of request
Routine, symptomatic, but not deemed serious	Within three (3) weeks from the date of request
Routine, symptomatic, not deemed serious, but requires medical attention	Within seven (7) days from the date of request
Urgent care	Within 24 hours
After-hours care	24 hours/day 7 days/week availability
Specialty care (high volume)	Within three (3) weeks from the date of request (for complaints not deemed serious)
Specialty care (high impact)	Within three (3) weeks from the date of request (for complaints not deemed serious)
Urgent specialty care	Within 24 hours
Initial prenatal visit—first trimester	Within two (2) weeks from the date of request
Initial prenatal visit—second trimester	Within one (1) week from the date of request
Initial prenatal visit—third trimester	Within three (3) days from the date of request
Behavioral Health Appointment Types	**Standard**
Life-threatening emergency	Immediately
Non-life threatening emergency	Within six (6) hours
Urgent care	Within 24 hours
Initial routine care visit	Within 14 business days
Follow-up routine care visit	Within 30 calendar days

Marketplace Access to Timely Appointments

Medical Appointment Types	Standard
Routine preventive care	Within 30 calendar days
Routine preventive care for infants under 6 months of age	Within 2 weeks
Routine, symptomatic, but not deemed serious	Within 7 calendar days
Urgent care	Within 24 hours
After-hours/emergency care	24/7 year-round
Specialty care (high-volume)	Within 20 to 30 calendar days
Specialty care (high-impact)	Within 20 to 30 calendar days
Urgent specialty care	Within 24 hours
Initial prenatal visit—first trimester	Within 2 weeks
Initial prenatal visit—second trimester	Within 1 week
Initial prenatal visit—third trimester	Within 3 days
Behavioral Health Appointment Types	**Standard**
Life-threatening emergency	Immediately
Non-life-threatening emergency	Within 6 hours
Urgent care	Within 48 hours
Initial routine care visit	Within 10 business days
Follow-up routine care visit	Within 20 calendar days

Claim Requirements

Prior Authorization

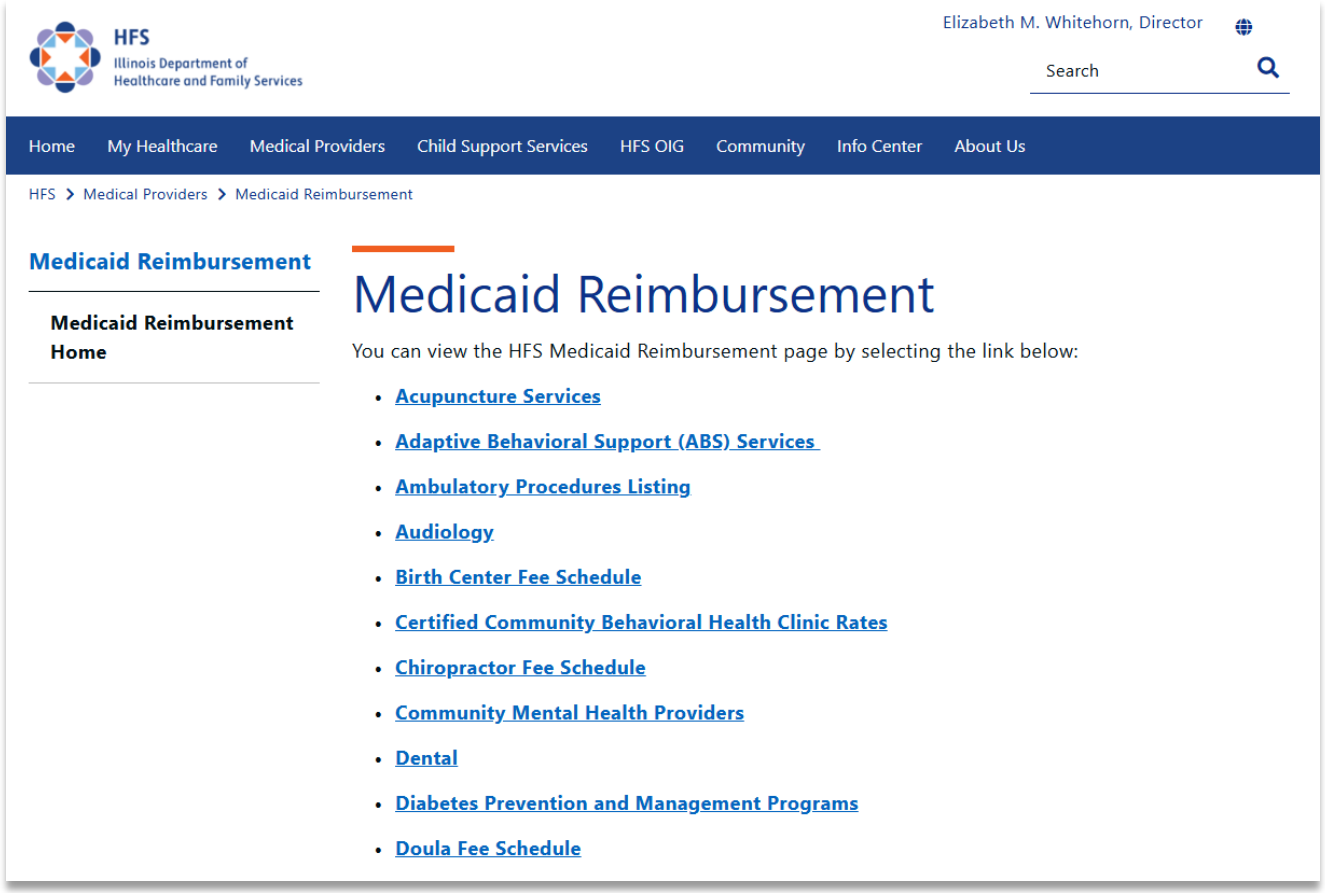
- Preservice/Prior Authorization is not required for the Medicaid-approved lactation consultation services.
- Refer to the next slide for descriptions and codes.

Procedure Codes & Units

Procedure Code	Modifier	Description
S9443	HD (Pregnant/Parenting Women's Program)	Lactation Consultation Service by International Board-Certified Lactation Consultant (IBCLC)
S9443	(No Modifier)	Lactation Consultation Service by Certified Lactation Counselor (CLC) or Certified Lactation Specialist (CLS)
S9443	HD HQ (Group Services)	Group Lactation Consultation Service by International Board-Certified Lactation Consultant (IBCLC) (2+ customers)
S9443	HQ (Group Services)	Group Lactation Consultation Service by Certified Lactation Counselor (CLC) or Certified Lactation Specialist (CLS) (2+ customers)

Lactation Consultant Fee Schedule

- More detail regarding billable procedures is located in the **Lactation Consultant Fee Schedule** on the Reimbursements page of the HFS website.



Provider Type/Category of Service/Taxonomy Code

- To be processed, all claims **must** include the specific 10-digit provider taxonomy code.
- The taxonomy code for lactation consultant services is 174N00000X

Information on provider taxonomy codes is available at Illinois.gov/hfs.

Provider Type/Category of Service/Taxonomy Code

The taxonomy code used **must** match a corresponding Category of Service (COS), Procedure Code (PC), and/or Place of Service (POS). A crosswalk of taxonomies with COS, PC, and POS is available here:

illinois.gov/hfs/MedicalProviders/Handbooks/Pages/default.aspx

illinois.gov/hfs/SiteCollectionDocuments/MCOManual.pdf

The matching COS must also match the COS in IMPACT enrollment.

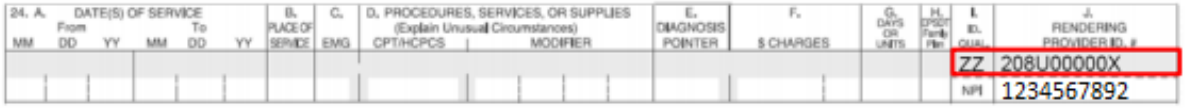
Taxonomy Code Placement

Examples of where to place the taxonomy code on the CMS 1500:

CMS 1500

PAPER SUBMISSION:

Rendering – Box 24i should contain the qualifier "ZZ." Box 24j (shaded area) should contain the taxonomy code.



Billing – Box 33b should contain the qualifier "ZZ" along with the taxonomy code.

Referring – If a referring provider is indicated in Box 17 on the claim, Box 17a should contain the qualifier of "ZZ" along with the taxonomy code in the next column.

Important Note: If you have multiple NPIs and IMPACT Medicaid IDs, they **must** match on the claim. Molina will **not** process the claim if the specific NPI used does not match the corresponding Medicaid ID and IMPACT-registered COS, etc.

Telehealth

- The telehealth delivery method is allowable for all services utilizing modifier GT (Via Audio and Video Telecommunications Systems) or 93 (Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system) and place of service 02 (Telehealth Provided Other than in Patient's Home) or 10 (Telehealth Provided in Patient's Home), as applicable.

Illinois Standing Recommendation

- The State of Illinois has issued a standing recommendation for lactation consultant services. When lactation consultants document the services they deliver, they must note in their documentation that they either:
  - Used the standing recommendation, or
  - Used a recommendation from a specific licensed physician, physician assistant, or advanced practice registered nurse. This documentation is for audit purposes and to meet the federal requirement that preventive services provided by the lactation consultant provider type be recommended by a licensed provider. It will not go on the claim submitted for reimbursement.
- The standing recommendation cannot be used by IBCLCs, CLCs, or CLSs if breastfeeding is contraindicated by any drug use or health condition, as specified in the standing recommendation.

Claims Submissions

Avenues for Submitting Claims

- **Availity Essentials provider portal**: This is the preferred method. Availity can help streamline your admin functions and expedite many processes.
- **EDI Clearinghouse**: Molina uses the SSI Group, which works with virtually all clearinghouses. Molina's payer ID is 20934.
- **Mail (paper claim)**: This is the method of last resort.
- Please refer to the Medicaid Provider Manual for detailed claims requirements.

Claim Format

- Lactation consultant services are billed electronically on the 837 Professional transaction. Information regarding electronic 837P transactions is available in the HFS **Chapter 300 Companion Guide**.
- Claims may also be submitted via direct data entry within the **MEDI** system.
- **Please note:** Lactation consultant services must be billed under the birthing person's Recipient Identification Number (RIN), or the child's RIN if the birthing person is not Medicaid-eligible.

General Claim Submission Guidelines

Claims will be rejected or denied if billed with:

- Missing, invalid, or deleted codes.
- Codes inappropriate for the age of the member or services provided.
- An ICD-10 CM code missing any 4th, 5th, and 6th character requirements and 7th character extension requirements.

Requirements for All Submitted Claims

All claims submitted must:

- Identify the name and appropriate TIN number (Medicaid ID number) of the health professional or facility that provided treatment or service, plus a matching NPI number based on the billing guidance for the IMPACT provider type.
- Identify the patient:
  - Recipient ID Number (RIN) and/or Molina-specific Plan ID
  - Address
  - Date of birth (mm/dd/yyyy)
  - Place of service
- Have valid diagnosis, procedure, and location codes.

Requirements for All Submitted Claims

The submitting provider must:

- Ensure that all other insurance resources (i.e., third-party coverage) have been exhausted before submission. Include any Coordination of Benefit (COB) documentation (e.g., a copy of the primary insurance EOB, including pages with run dates, coding explanations, and messages) with the claim submission. Medicaid is always the payer of last resort.

Requirements for All Submitted Claims

All claims submitted must:

- Be certified by the provider that the claim:
  - Is true, accurate, and prepared with the knowledge and consent of the provider.
  - Does not contain untrue, misleading, or deceptive information.
  - Identifies each attending, referring, or prescribing physician or other practitioner.

Important Note: Before providing services, providers **must** verify that the member was eligible and enrolled with Molina on the date(s) of service through either the MEDI system or Availity Essentials portal: provider.molinahealthcare.com/Provider/Login.

A Molina ID card is not sufficient verification by itself.

Timely Filing Requirements

It is important that claims are submitted according to Molina's timely filing deadlines.

Timely filing requirements for original or corrected claims:

- Providers must submit claims within 180 calendar days after the following have occurred: discharge for inpatient services or the date of service for outpatient services.

Electronic Claim Submission

Electronic Data Interchange (EDI) allows faster, more efficient and cost-effective claim submission for providers. EDI, performed in accordance with nationally recognized standards, supports the health care industry's efforts to reduce administrative costs.

- Molina requires the ANSI X12N 837 format, version 5010A (or its successor) for EDI claim submission.
- Providers must use the HIPAA-compliant 837 electronic formats.

Claims transmitted electronically **must** contain all the same data elements identified within the General Claims Submission section of the Provider Manual.

Molina Payer ID: **20934**

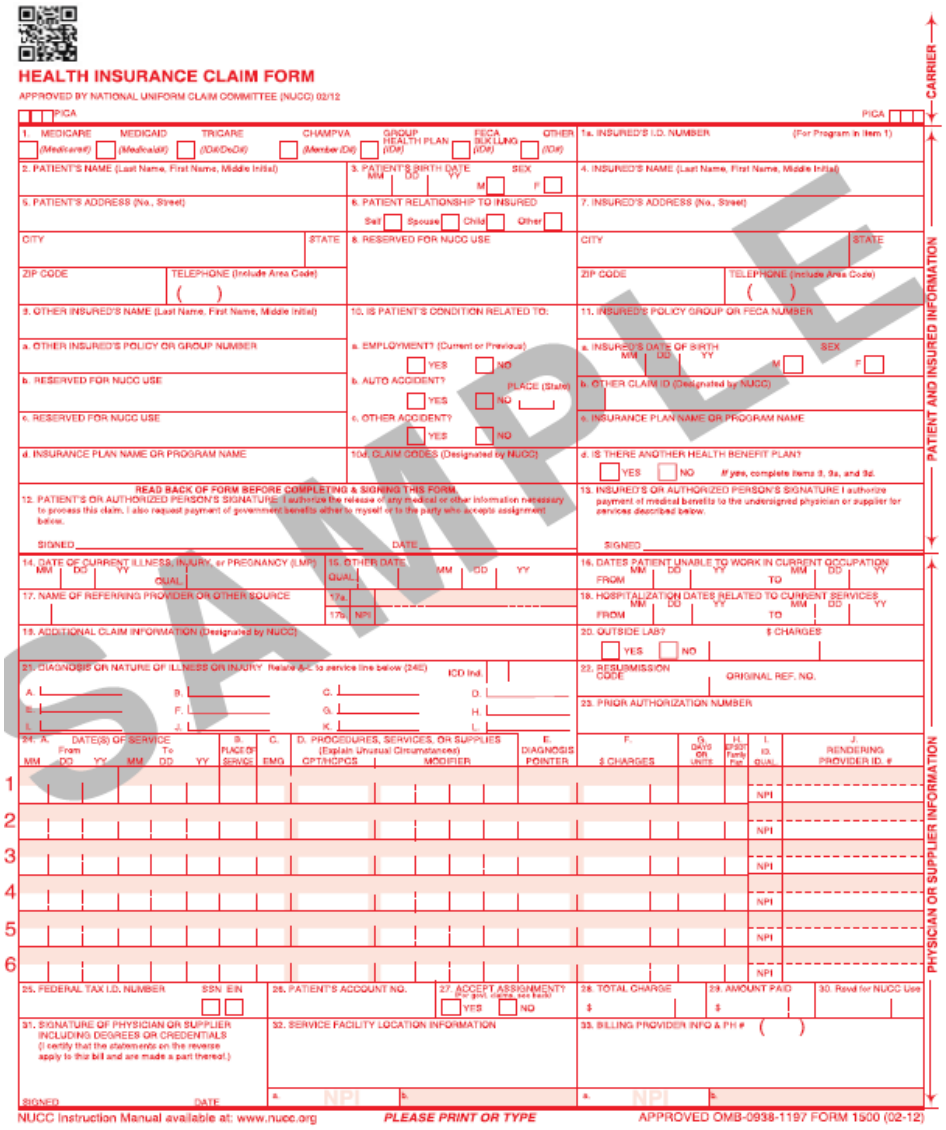
Type of Claim Submission

All claims must be filed using:

- Original CMS 1500 (red form).
- 837P if filing electronically (preferred method).

Filing claims via Molina's Provider Portal (available to all providers at no cost) offers many claims-processing benefits.

Remember to verify that the member was eligible and enrolled with Molina on the date of service.


HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO (PLACE (State))

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE MM DD YY QUAL

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Modifiers

The Two Types of Modifiers

- **Level 1 Modifiers**: Those included with CPT codes and updated annually by the American Medical Association (AMA). Definitions and use of Level 1 modifiers can be found in the annual edition of the CPT manual: ama-assn.org/amaone/cpt-current-procedural-terminology
- **Level 2 Modifiers**: Used with HCPCS codes and recognized nationally. They are updated annually by CMS. Level 2 modifiers are found in the annual edition of the HCPCS procedure manual.

The Two Types of Modifiers

Pricing modifiers are added to procedures listed in the Medicaid fee schedule to affect a procedure code's pricing, indicating that a service has been altered in some way by a specific circumstance, or to identify or distinguish a service.

Molina generally follows National Correct Coding Initiative (NCCI) guidelines, unless otherwise specified by HFS.

Ensure that all appropriate modifiers are included on submitted claims: illinois.gov/hfs/SiteCollectionDocuments/10.1.16%20Modifier%20Listing.pdf.

Code Editing and Auditing

Molina uses code-auditing software to help improve accuracy and efficiency in claims processing, payments, and reporting, as well as meeting HIPAA compliance regulations.

The software detects and documents coding errors on provider claims prior to payment by analyzing CPT, HCPCS, modifiers, and POS codes against rules that have been established by the AMA, CMS, public-domain specialty society guidance, clinical consultants, and the State of Illinois.

Claims billed in a manner that does not adhere to these coding conventions will be denied.

Successful EDI Submission

Providers should take these steps to ensure success:

- Select a clearinghouse to use.
- Contact the clearinghouse to inform them you wish to submit electronic claims to Molina Healthcare, **Payer ID 20934**.
- Ask the clearinghouse what data records are required.
- You will receive two reports—always review them daily.
  - The first shows the claims that were accepted and being transferred to Molina, along with claims not meeting the clearinghouse's requirements.
  - The second shows claims submitted to but rejected by Molina. These claims must be corrected and resubmitted.
- All claims must be submitted with the provider's identifying numbers (NPI and HFS Medicaid number, as appropriate).

Successful EDI Submission

Because the clearinghouse returns the acceptance reports directly to the sender (i.e., the provider), submitted claims not accepted by the clearinghouse are **not** transmitted to Molina.

If you need assistance in resolving submission issues reflected on either the acceptance or claim status reports, contact your clearinghouse or vendor customer service department.

Rejected electronic claims may be resubmitted electronically within timely filing deadlines (see Timely Filing Deadlines section of the Provider Manual) once the error has been corrected.

It is important that providers review the acceptance and claims status reports received from the clearinghouse to identify and resubmit these claims accurately.

Claim Rejection

COMMON REJECTIONS	
Member DOB missing from the claim.	**DOS Prior to Effective Date** of Health Plan or member eligibility date.
Member Name or ID Number missing or invalid for the claim.	**Incorrect Form Type** used.
Provider Name, TIN or NPI missing from the claim.	**Invalid TOB** or invalid type of bill.
Claim data is unreadable due to either too light, dot matrix, or too small font.	**No Detail Service** line submitted.
Diagnosis Code missing or invalid.	**Admission Type** is missing.
Rev Code missing or invalid.	**Patient Status** is missing.
CPT/Procedure Code/Modifier missing or invalid.	**CLIA certification missing/invalid or incomplete.**
Dates Missing from required fields. Example "statement from" UB-04 or "Service From" CMS 1500.	**DOS on Claim** is not prior to receipt of claim. Cannot be a future DOS.

Note: These are examples and are **not** a complete list of rejections.

Do’s and Don’ts

Paper Claim Submission Do's

Electronic claim submission is **highly encouraged**. Providers may submit paper claims only when electronic billing is not attainable.

DO

- Use the original billing forms (e.g., CMS 1500 red and white form). Photocopies **will not** be accepted.
- Ensure the claim is computer generated or typed using 12-point Times New Roman. The font must never be smaller than 10-point.
- Ensure that claims information is within the outlines of the data fields. Information that extends beyond the box may cause the claim to be rejected.
- Submit all claims in a 9"x12" or larger envelope.
- Include all other insurance information (policy holder, carrier name, ID number, and address) when applicable.
- Any claim that is not properly signed or has an altered certification statement will be rejected. A rubber signature stamp or other substitute is **not** acceptable.

Paper Claim Submission Don’ts

DON’T

- Submit black-and-white, photocopied, or other facsimiles of the original red and white form.
- Submit a claim with multiple members on a single claim. Each member requires a separate claim.
- **Handwrite the billing form.**
- Use colored ink, highlights, italics, bold, or script text.
- Use rubber signature stamp.
- Use staples.
- Circle any data or add any extraneous information to any claim form field.
- **Submit forms by fax.**

Claim Disposition

Claim Processing

A **clean claim** is a claim submitted on the proper form to a health plan for an eligible member by a provider authorized to perform a covered benefit that is Medically Necessary and appropriate, where no additional information is required to process the claim.

HFS has established **processing** requirements for Molina related to clean claims:

- 90% of clean claims must be processed within 30 days.
- 99% of clean claims must be processed within 90 days.

Claim Disposition

Note: The requirements are for claims processing, also known as claims adjudication. Claims processing/adjudication does **not** mean payment is necessarily made. It **does** mean that a determination has been made as to the outcome of the claim process. Those determinations can include **pending**, **denying**, or **paying** the claim.

Correcting a Rejected Claim

If a claim is rejected, review the clearinghouse reports you received and determine what needs to be corrected. Make the applicable correction(s) as noted and resubmit the claim.

In this instance, you do not need to follow the corrected/replacement claim guidelines. This is a new claim being submitted.

When a rejection is received, proceed as follows:

- Verify that the claim data submitted is correct.
- Verify with your clearinghouse that accurate data was sent to Molina.
- If you believe the rejection from the clearinghouse was in error, please contact Molina directly using the provider escalation process.

Explanation of Payment

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Explanation of Payment (EOP)

Molina will send an Explanation of Payment (EOP) that provides details about claims that have been paid, denied, or adjusted. An EOP contains information such as member ID, member name, date of service, provider name/number, billed amount, allowed amount, paid amount, and adjustment codes/reasons.

This provider memo offers EOP guidance: Enhancements to EOP/835 Refund and Forwarding Balance Reporting

Note: An EOP can also be referred to as a Remittance Advice or Report (ANSI X12N 835).

If a denial is noted, pay special attention to the **adjustment codes/reason codes/remark codes**.

The report uses HIPAA-compliant remark/adjustment code/reason codes.

Obtaining an EOP

Instructions for obtaining/retrieving an EOP from Molina:

- Providers can retrieve the EOP/remit via the Provider Portal. EOPs on the portal can be viewed up to 24 months from the remit date.
- Providers registered for Electronic Funds Transfer (EFT) are automatically registered for Electronic Remittance Advice (ERA) reports. ERAs are managed by the SSI Group.

Provider services will fax or email the remits to the provider if electronic billing is not attainable. **Important Note:** This is **not** the preferred method.

Interpreting and Understanding an EOP

The top five reasons for denial encountered by Molina and the actions the provider can take to correct them:

Denial Reason	Action
Not Enrolled on DOS	Verify if member was active on DOS. If member was active, submit a claim dispute. Use MEDI system to validate enrollment.
The Time Limit for Filing Has Expired	Determine if the claim was an initial claim or a corrected/replacement claim. If the claim was a corrected/replacement claim, validate that you have the appropriate type of bill.
Missing or Invalid Taxonomy	Resubmit corrected/replacement clean claim with the valid taxonomy.
Service Not Included on Fee Schedule	No action needed. Non-covered service per HFS fee schedule.
Recipient Not Eligible on Date of Service	Correct claim or validate with MEDI. Potential update may need to be done at State level.

Corrected Claims

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Submitting a Corrected (Replacement) Claim

A corrected/replacement claim **must** be submitted when all or a portion of the claim was paid incorrectly, or a third-party payment was received after Molina made the payment.

When a replacement claim is received, Molina deletes the entire original claim and replaces it with the information contained in the replacement claim.

To ensure accurate processing, appropriate resubmission code and original claim number must be reported in field 22 of a 1500 claim form.

Submitting a Corrected (Replacement) Claim

All money paid on the original claim is debited, and a new payment is issued based solely on information reported on the replacement claim.

File a corrected/replacement claim when:

- The EOP shows that corrections to the original claim are required. For example, invalid DOS, modifiers or CPT code edits/changes, POS changes, etc.
- The EOP shows that the claim was denied at Molina for a billing error.

Provider Resources

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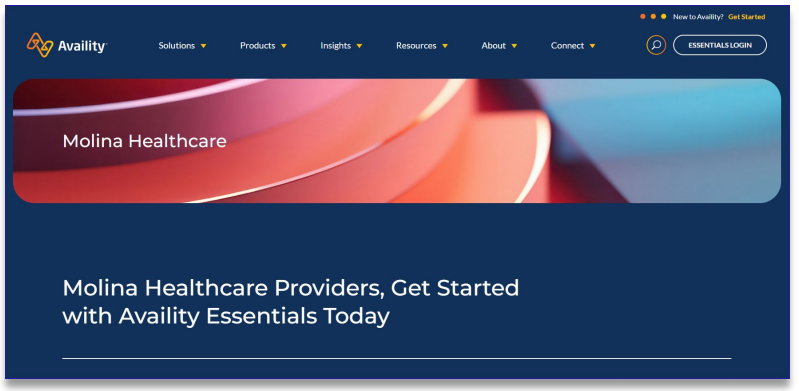
Availity Essentials Portal

- Availity Essentials is Molina's exclusive provider portal. Providers are **strongly encouraged** to register and use the Portal.
- Availity Portal landing page: availity.com/molinahealthcare
- Access via our website: provider.molinahealthcare.com/Provider/Login
- With technical issues, contact Availity Help Desk at **(800) 282-4548**.
- Availity can help streamline your admin functions:
  - Check member eligibility
  - Submit and check the status of your claims
  - Submit and check the status of your service or request authorizations
  - View your HEDIS scores
  - Access rosters
  - **So much more**



Online Provider Resources

- Provider manual
- Provider online directories
- Provider portal (Availity)
- Frequently used forms
- Preventive & clinical care guidelines
- Prior authorization information
- Advance directives
- Model of Care training
- Pharmacy information
- HIPAA
- Fraud, Waste & Abuse information
- Communications & newsletters
- Member rights & responsibilities
- Contact information
- News & updates

Helpful Links

- HFS Website: illinois.gov/hfs/Pages/default.aspx
- IMPACT Website: illinois.gov/hfs/impact/Pages/default.aspx
- IAMHP Website: iamhp.net/providers
- MTAC Website: hfs.illinois.gov/medicalproviders/mtac/mtaclearningcenter.html
- IBLCE Website: IBLCE – International Board of Lactation Consultant Examiners
- ALPP Website: Home – ALPP
- LEC Website: Lactation Education Consultants - Home
- Molina Website >> News & Updates: molinahealthcare.com/providers/il/medicaid/comm/Pages/newsupdates.aspx
- Molina Website >> Medicaid Provider Manual: molinahealthcare.com/providers/il/medicaid/manual/home.aspx
- Provider Portal: availity.com/molinahealthcare
- Molina Provider Relations team email: MHILProviderNetworkManagement@molinahealthcare.com
- Molina Website >> Provider Education Series (live webinars): molinahealthcare.com/providers/il/medicaid/comm/updatesevents.aspx

Your Molina Contacts

Your dedicated **Provider Relations Manager (PRM)** is your liaison to all of Molina's programs and provider services.

Cook County
Detra Alexander
detra.alexander@molinahealthcare.com
(630) 381-0470

All Other Counties
Tammy Gosslin
tammy.gosslin@molinahealthcare.com
(630) 381-1076

You can always email the team:
MHILProviderNetworkManagement@Molinahealthcare.com

Questions? Answers!

Thanks for participating!

Please register for email updates:
molinahealthcare.activehosted.com/f/1