SPECIAL PROVIDER BULLETIN
A bulletin for the Molina Healthcare of Ohio provider networks

MOLINA HEALTHCARE

August 2026

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New In This Issue

Reminder: Nursing Facility Ventilator Pre-Payment Policy

Information for Medicaid and MyCare Ohio providers

As a reminder, Molina Healthcare posted the new Molina Nursing Facility (NF) Ventilator Pre-Payment Policy for an effective date of Sept. 2, 2026.

Per the new policy, Molina will conduct a review of supporting documentation for services billed for Molina Medicaid and MyCare Ohio members. This policy is being implemented to align with Ohio Administrative Code (OAC) 5160-3-18 Nursing Facility: Ventilator Program and recent ODM policy updates.

For claims submitted with a date of service on or after Sept. 2, 2026, providers must include supporting documentation at the time of claim submissions containing revenue codes 0419 and 0410.

Documentation should include at minimum the following:

- The type of mechanical ventilation used.
- The number of hours per day mechanical ventilation was utilized for each date of service billed under revenue code 0419 and 0410.
- NFs are responsible for billing Diagnosis Code Z99.11 to indicate if the individual is vent dependent along with the underlying diagnosis codes which relate to the individual's vent dependency.
- Ventilator dependency should be documented with a respiratory assessment and physician order.
- Respiratory or nursing care flow sheets or other documentation indicating delivery of ventilator-related services.

Based on Molina's review of the claim and supporting documentation, as applicable, reimbursement may be adjusted when the billed revenue code or enhanced ventilator rate is not supported. Providers will receive notice regarding the claim review outcome. Actions may include:

- Revenue codes 0419 or 0410 may be adjusted to the revenue code supported by the documentation.
- If required documentation is not submitted with the claim, the claim may be paid at the applicable non-enhanced rate.

Providers can access the Ohio Ventilator Reimbursement Policy on the Payment Integrity Policies page, under the Policies tab on our Provider Website.

To submit medical records for review with your claim:

- **Initial claim via Availity:** When submitting a claim in Availity, you will be able to attach a supporting document. Once you select Attachments you will be able to choose the type of attachment and then you will want to select the file type as "**File Transfer**." The last page of the claim submission is an overview confirmation page before you officially submit the claim, this section will confirm the attachment is included.
- **Initial claim via Electronic Data Interchange (EDI):** If you submit via EDI, EDI does not accept attachments. Within 1-2 days following the EDI submission, you must log into Availity to add the attachments. To add the attachments to a previously submitted EDI claim, you will perform a claim status inquiry. During the claim status inquiry, there is an option to "Send Attachments." Please note, failure to add the attachment timely after the EDI submission will result in the attachment not being processed by Molina.

- Important: Molina does not utilize the attachment dashboard on Availity for claim attachment requests/submissions. The attachment must be present at the time of claim submission.

If the claim to Molina receives a reduction or denial, you must follow the claim dispute process. Providers must include supporting documentation at the time of claim dispute submission. To learn more about the claim dispute process review the Provider Manual.

If you need additional education, please contact Provider Relations at OHProviderRelationsNF@MolinaHealthcare.com.

Nursing Facility Ventilator Pre-Payment Policy Frequently Asked Questions (FAQ)

Information for Medicaid and MyCare Ohio providers

Disclaimer: The Nursing Facility Ventilator Pre-Payment Policy and this FAQ do not apply to the post pay review process. Post pay reviews are still applicable for claims with dates of service Sept. 1, 2026, and prior.

Nursing Facility Ventilator Pre-Payment Policy

Q. What is changing?

A. Effective for dates of service on or after Sept. 2, 2026, Molina Healthcare of Ohio, Inc. will conduct a pre-payment review of supporting documentation submitted with Nursing Facility (NF) ventilator claims billed under specific ventilator-related revenue codes.

Q. Why is Molina implementing this policy?

A. The policy is being implemented to align with Ohio Administrative Code (OAC) 5160-3-18 Nursing Facility Ventilator Program requirements and recent Ohio Department of Medicaid (ODM) policy updates.

Q. Which claims are impacted?

A. The policy applies to claims submitted for Molina Medicaid and MyCare Ohio members that include:

- Revenue Code 0419 (Ventilator Dependent)
- Revenue Code 0410 (Ventilator Weaning)

Q. What documentation must be submitted with the claim?

A. Providers must submit supporting documentation that includes, at a minimum, but not limited to:

- The type of mechanical ventilation used
    - Include details such as name of device and mode
- The number of hours per day ventilation was utilized for each billed date of service
- All documentation supporting ventilator dependency, including respiratory assessments and physician orders
- Respiratory or nursing care flow sheets or other documentation indicating delivery of ventilator-related services

Q. What diagnosis codes should be billed?

A. If appropriate, providers are responsible for billing Diagnosis Code Z99.11 to indicate if the individual is vent dependent along with the underlying diagnosis codes which relate to the individual's vent dependency.

Q. What happens if the documentation is not submitted with the claim or is insufficient?

A. If required documentation is not submitted or is insufficient, the claim will be paid at the applicable non-enhanced reimbursement rate rather than the ventilator-enhanced rate.

Q. What happens during Molina's review?

A. Molina will review the submitted claim and supporting documentation to determine whether the billed ventilator revenue code and enhanced reimbursement are supported by the medical record.

Q. How will providers know the outcome of the review?

A. If the review results in findings, providers will receive a letter via mail to the "pay to" provider regarding the outcome of Molina's claim review. In addition, payment adjustments will display on the remittance. If no findings are found during the review, no letter will be received.

Q. How do providers submit attachments through Availity?

A. When submitting a claim in Availity, providers will be able to attach a supporting document. Once the user selects "Attachments" they will be able to choose the type of attachment and then select the file type as "File Transfer." The last page of the claim submission is an overview confirmation page before the user officially submits the claim. This section will confirm the attachment is included.

Q. How do providers submit documentation if claims are billed through EDI?

A. If the provider submits claims via EDI, EDI does not accept attachments. Within 1-2 days following the EDI submission, providers must log into Availity to add the attachments. To add the attachments to a previously submitted EDI claim, the user will perform a claim status inquiry. During the claim status inquiry, there is an option to "Send Attachments." Please note, failure to add the attachment timely after the EDI submission will result in the attachment not being processed by Molina.

Q. Is the PWK indicator required for EDI submissions?

A. Yes, to ensure the attachment is reviewed, the EDI submission needs to include an attachment indicator using the PWK segment. PWK is a segment within the 2300/2400 Loop of the 837 Professional and Institutional electronic transactions that provides the link between electronic claims and additional documentation. This allows providers to submit claims via EDI that require additional documentation, and then providers can log into the Availity Essentials Portal to upload the documentation to the claim for adjudication. Providers should review the Reference Guide for Supporting Documentation for Claims located on the Molina provider website under Quick Reference Guides & FAQs for PWK specific information.

Q. Does submission of documentation guarantee payment at the enhanced ventilator rate?

A. No. Submission of documentation allows Molina to review the claim. Payment of the enhanced ventilator rate depends on whether the documentation supports the billed ventilator services and applicable revenue code.

Q. Where can providers find the full policy?

A. The Ohio Ventilator Reimbursement Policy is available on Molina's Payment Integrity Policies webpage under the Policies section of the Provider Website.

Q. What action will take place for claims submitted with dates of service prior to Sept. 2, 2026?

A. For pre-payment review, Molina will not review for supporting documentation for dates of service prior to Sept. 2, 2026. If claims submitted include dates prior, no review of that specific claim line will take place for this process. However, dates of service Sept. 1, 2026, and prior will be subject to post-payment review.

Q. What is the expected turnaround time for claims subject to pre-payment review?

A. Molina will review and process the claims within required timelines. Visit the Provider Manual under the Timely Claim Processing section to learn more.

Q. Will Molina conduct reviews on every claim or use a sampling methodology?

A. Molina will be conducting reviews on all applicable claims where revenue codes 0419 and 0410 are billed for enhanced ventilator payment.

Q. If documentation is partially sufficient, will Molina request additional records before reducing payment?

A. No, Molina will not solicit for additional documentation. Providers are required to submit all documentation at the time of the claim submission.

Q. If a provider submits a claim without supporting documents and receives a reduction which removed the enhanced payment, what action should the provider take?

A. If the claim to Molina receives a reduction or denial, a provider must follow the claim dispute process. To learn more about the claim dispute process review the Provider Manual.

Q. What is the timeframe to submit a claim dispute following the claim determination?

A. Timelines are outlined the Provider Manual and can also be located within the Processes by Line of Business document on the Molina Provider website. In general, providers have no later than 12 months from the date of service or 60 calendar days after the payment, denial or partial denial of a timely claim submission, whichever is later.

Q. Does this policy impact Hospice providers?

A. Yes, if a Hospice provider is billing for the Room and Board charges that include the applicable revenue codes then this policy is in scope.

Q. Are Hospice providers required to bill in any special manner?

A. Yes, when billing Ventilator Dependent and Weaning claims, the hospice provider is required to include the Name and NPI of the nursing facility in which the services were delivered in Box 80 (Remark code). In addition, when billing for Ventilator and/or Ventilator Weaning services, the diagnosis code Z99.11 must be included. To learn more visit MolinaHealthcare.com, Provider Manual, then Hospice Nursing Facility Room & Board Billing Guidance Add-On Rate.

Questions and Quick Links		
Provider Services: (855) 322-4079 Mon. – Fri. Medicaid 7 a.m. to 8 p.m., MyCare Ohio 8 a.m. to 8 p.m., Medicare and Marketplace 8 a.m. to 5 p.m.	Email: OHProviderRelations@MolinaHealthcare.com	Provider Website: Molina Healthcare.com/OhioProviders