June 22, 2018

Provider Memorandum

Helpful Tips for Providers Regarding Timely Filing for Claims Submission

As a continued effort to provide resources to help reduce the number of claims denials for providers, Molina Healthcare of Illinois (Molina) has developed the following helpful tips for our partner providers.

Timely Filing Denials Can Apply to the Following Situations:

- Molina in-network providers exceeding the time allowed, as indicated in the mutual contract
- Non-participating providers exceeding the time frame of 180 days from date of service rendered, as allowed by the Illinois Department of Healthcare and Family Services (HFS)
- Corrected claims exceeding the allowed time frame of 180 days of the date of service rendered

To avoid claims denials and receive payment for medically necessary service rendered to Molina Members, providers should follow guidelines for submission of claims based on best practices by provider type. The receive date of a claim is the date Molina Healthcare receives either written or electronic notice of the claim. Providers should never hold claims. Claims submitted after timely filing limits will not be considered for payment.

Providers may reference HFS guidelines for claims submission and reimbursement at the following link: https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/default.aspx

Claims Rejection versus Denials

Please note that if a claim is rejected the claims has not been accepted in the Molina claims system. A rejection of a claim means that the submission was not received and usually comes back as an electronic claims error/rejection. Claims that have been rejected will not appear on a Molina Healthcare Explanation of Benefits (EOB) document or Electronic Remittance Advice (ERA). Timely filing rules apply until the claim is accepted by Molina.

A claim denial means that the claim has been accepted into the Molina system and details should be included in the EOB or the ERA.

Providers who receive a "**rejected"** claim must resubmit the claim as required. Separately, a claim that has been "**denied"** can be resubmitted following the corrected claims process to avoid a duplicate claim denial upon resubmission.

Corrected Claims

Corrected claims must be received within 180 days of the original date of service for providers and claims need to be marked as corrected; which should be submitted through one of the following options:

- **Provider Web Portal**: The Provider Web Portal can be accessed at Provider.MolinaHealthcare.com
- **Mail**: Corrected claims can be submitted via mail to the following address:

Molina Healthcare of Illinois
P.O. Box 540
Long Beach, CA 90801

Exceptions for Timely Filing:

Please note that documentation (such as medical records or submission proof) will be required via the claims dispute process to implement an exception to the Molina Healthcare timely filing guidelines. Exceptions to the claim submission time limit may be allowed when claims meet one or more of the following conditions:

- Medicaid delay in updating the eligibility file, such as newborn baby enrollment. Please refer to the Molina Healthcare provider memo issued July 10, 2017. Please use the following link to access that communication:
  http://www.molinahealthcare.com/providers/il/PDF/Medicaid/MHIL-Newborn-Enrollment-Memo.pdf
  - Within 180 days from the date the provider has been furnished with the correct name and address of the Member.
- Court or hearing decision, or statutory action
- System error or fiscal agent processing error on a claim that was originally submitted within the timely filing limit from the date of service
- If Molina is the secondary or tertiary payor, a provider has 60 days from the date of receipt of EOB from the other insurance provider to submit or resubmit the corrected claim with the appropriate documentation.
  - Claims for recipients who have third party insurance, other than Medicare, must be received by Medicaid or the Medicaid fiscal agent 180 days from the date of third party insurance payment or denial.

Appeals and Dispute Process
Please reference the Molina provider manual for further information regarding the claims appeals and claims dispute process. Providers have 90 days to provide a documented dispute to Molina from the claim payment date.

Proof of timely filing may be required, such as:

- A copy of a computer print screen with all of the following: the billed date within the timely filing limit which includes the patient's name, date of service, billed amount, submitted date and insurance where charges were submitted.
- EDI payor acceptance reports; must include patient name, date of service, billed amount, submitted date and insurance where charges were submitted.
- EOB received from another payer recouping the payment previously made due to retro-active disenrollment leaving Molina as primary as long as receipt date is within 90 days from the date on the EOB take back for date of service or within the standard timely filing timeframe.

Providers may access the Medicare-Medicaid Program (MMP) Provider Manual on the Molina website at: http://www.molinahealthcare.com/providers/il/duals/manual/Pages/manual.aspx. The Illinois Medicaid Provider Manual can be found at: http://www.molinahealthcare.com/providers/il/medicaid/manual/Pages/home.aspx.

The Importance of Checking Member Eligibility
Molina encourages providers to continue to utilize the state's Medical Electronic Data Interchange (MEDI) system for Member eligibility, in particular when the following applies:

- New patient appointment and at reoccurring appointments
- When the patient's care crosses into a new month
- As applicable when explanation of benefit denials indicate Member not eligible with the payor for the date of service billed

Providers may utilize the following link to access the MEDI system:
https://medi.hfs.illinois.gov/TruePassSample/AuthenticateUserRoamingEPF.html

Please note the following criteria that may impact the Member's payor and enrollment status:

- Medicaid redetermination efforts by HFS may affect eligibility dates for Members.
- Member effective dates and re-enrollment with a managed care organization may vary by Medicaid program and their enrollment dates.

If you have questions, please contact your Provider Network or the Provider Services Department via email at MHILProviderNetworkManagement@MolinaHealthcare.com. For help locating your respective Provider Network Manager, please visit Molina's Service Area page at http://www.molinahealthcare.com/providers/il/medicaid/contacts/Pages/servicearea.aspx.