

Section 9. Claims

As a contracted provider, it is important to understand how the claims process works to avoid delays in processing your claims. The following items are covered in this section for your reference:

- Claim Submission
- Corrected Claim
- Claims Disputes/Adjustments
- Overpayments/Refund Requests
- Coordination of Benefits (COB)/Third Party Liability (TPL)
- Billing the member

Claim Submission

Claims may be submitted to Molina Healthcare with appropriate documentation by mail or filed electronically (EDI) for CMS-1500 and UB-04 claims. For members assigned to a delegated medical group/IPA that processes its own claims, please verify the “Remit To” address on the member’s Molina Healthcare ID card (Refer to Section 2). Providers billing Molina Healthcare directly should send claims to:

Molina Healthcare of Ohio, Inc.
PO Box 22712
Long Beach, CA 90801

Providers billing Molina Healthcare electronically should use current HIPAA compliant ANSI X12N format (e.g., 837I for institutional claims, 837P for professional claims, and 837D for dental claims) and use electronic payor ID number: 20149.

Providers must use good faith effort to bill Molina Healthcare for services with the most current CMS approved diagnostic and procedural coding available as of the date the service was provided, or for inpatient facility claims, the date of discharge. The following information must be included on every claim:

- Institutional Providers:
 - The completed UB 04 data set or its successor format adopted by the National Uniform Billing Committee (NUBC), submitted on the designated paper or electronic format as adopted by the NUBC. Entries stated as mandatory by NUBC and required by federal statute and regulations and any state designated data requirements included in statutes or regulation.
- Physicians and Other Professional Providers:
 - The Centers for Medicare and Medicaid Services (CMS) Form 1500 or its successor adopted by the National Uniform Claim Committee (NUCC) submitted on the designated paper or electronic format. Current Procedural Terminology (CPT) codes and modifiers and International Classification of Diseases (ICD) codes. Entries states as mandatory by NUCC and required by federal statute and regulation and any state designated data requirements included in statutes or regulations.



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.

Electronic Claim Submissions

Molina Healthcare also accepts electronic claim submissions for both claims and encounters using the CMS-1500 and UB-04 claim types. Please use Molina Healthcare's Electronic Payor ID number – 20149. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure claims are received for processing in a timely manner.

When your claims are filed electronically:

- You should receive an acknowledgement from your current clearinghouse
- You should receive an acknowledgement from Emdeon within two (2) business days of your transmission
- You should contact your local clearinghouse representative if you experience any problems with your transmission
- For any direct submissions to Molina you should receive an acknowledgement of your transmission

Timely Claim Filing

Provider shall promptly submit to Molina Healthcare claims for Covered Services rendered to members. All claims shall be submitted in a form acceptable to and approved by Molina Healthcare, and shall include any and all medical records pertaining to the claim if requested by Molina Healthcare or otherwise required by Molina Healthcare's policies and procedures.

Claims must be submitted by provider to Molina Healthcare within 120 calendar days after the following have occurred: discharge for inpatient services or the date of service for outpatient services; and provider has been furnished with the correct name and address of the member's health maintenance organization. If Molina Healthcare is not the primary payer under coordination of benefits or third party liability, provider must submit claims to Molina Healthcare within 90 calendar days after final determination by the primary payer.

Except as otherwise provided by law or provided by government program requirements, any claims that are not submitted to Molina Healthcare within these timelines shall not be eligible for payment and provider hereby waives any right to payment therefore.

Fraud and Abuse

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

Timely Claim Processing

Claims payment will be made to contracted providers in accordance with the timeliness provisions set forth in the provider's contract. Unless the provider and Molina Healthcare or contracted medical group/IPA have agreed in writing to an alternate payment schedule, Molina Healthcare will pay the provider of service within 30 days after receipt of clean claims.

- Ninety (90%) percent of the monthly volume of clean claims will be adjudicated within 30 calendar days of receipt by Molina Healthcare.
- Ninety-five (95%) percent of the monthly volume of claims shall be paid or denied within sixty (60) calendar days of receipt by Molina Healthcare.
- Ninety-nine (99%) percent of all claims shall be paid or denied within ninety (90) calendar days of receipt by Molina Healthcare.

The receipt date of a claim is the date Molina Healthcare receives either written or electronic notice of the claim.

Claim Editing Process

Molina Healthcare has a claims pre-payment auditing process that identifies frequent billing errors such as:

- Bundling and unbundling coding errors
- Duplicate claims
- Services included in global care
- Incorrect coding of services rendered

Coding edits are generally based on state fee for service Medicaid edits, AMA, Current Procedural Terminology (CPT), HRSA and National Correct Code Initiative (NCCI) guidelines. If you disagree with an edit please refer to the Claim Disputes/Adjustments section below.

Coordination of Benefits and Third Party Liability

For members enrolled in a Molina Marketplace plan, Molina Healthcare and/or contracted Medical Groups/IPAs are financially responsible for the care provided to these members. Molina Marketplace will pay claims for covered services, however if TPL/COB is determined post payment, Molina Marketplace will attempt to recover any overpayments.

Coordination of benefits

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the "**Primary Plan**". The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the "**Secondary Plan**". The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions (applicable to this COB provision)

A "**Plan**" is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.



1. Plan includes: group and non-group insurance contracts, health insuring corporation contracts, Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Ohio Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

“This Plan” means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan’s benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

“Allowable Expense” is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an Allowable Expense.

“Closed Panel Plan” is a Plan that provides health care benefits to Members primarily in the form of services through a panel of providers which have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

“Custodial Parent” is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying Plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverage's that are superimposed over base plan hospital and surgical benefits, and insurance type coverage's that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

(2) Dependent child covered under more than one Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married: The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan. However, if one spouse's Plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that Plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Plan covering the Custodial Parent;
- The Plan covering the spouse of the Custodial Parent;
- The Plan covering the non-Custodial Parent; and then
- The Plan covering the spouse of the non-Custodial Parent.

(c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.(1) can determine the order of benefits.

(4) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

(5) If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect On The Benefits Of This Plan

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If a Member is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.



Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. Molina may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Molina any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, Molina may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Molina is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we paid or for whom we had paid, or any other person or organization that may be responsible for the benefits or services provided for the Member. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. Follow the steps described in the "Complaints" section, below. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department's website at <http://insurance.ohio.gov>.

Third-party liability

Molina shall be entitled to payment, reimbursement, and subrogation (recover benefits paid when other insurance provides coverage) in third party recoveries. Enrollee and/or provider shall cooperate to fully and completely assist in protecting the rights of Molina including providing prompt notification of a case involving possible recovery from a third party.

WORKERS' COMPENSATION

Molina shall not furnish benefits under this Agreement which duplicate the benefits to which You are entitled under any applicable workers' compensation law. You are responsible for taking whatever action is necessary to obtain payment under workers' compensation laws where payment under the workers compensation system can be reasonably expected. Failure to take proper and timely action will preclude Molina's responsibility to furnish benefits to the extent that payment could have been reasonably expected under workers' compensation laws. If a dispute arises between You and the Workers' Compensation carrier, as to Your ability to collect under



workers' compensation laws, Molina will provide the benefits described in this Agreement until resolution of the dispute.

Corrected Claims

Corrected claims are considered new claims. Corrected claims may be submitted electronically with the appropriate field on the 837 I or 837 P completed. Paper corrected claims need to be marked as corrected and should be submitted to the following address:

**Molina Healthcare of Ohio, Inc.
PO Box 22712
Long Beach, CA 90801**

Claims Disputes/Adjustments

Providers seeking a redetermination of a claim previously adjudicated must request such action within 120 days of Molina Healthcare's original remittance advice date. Additionally, the item(s) being resubmitted should be clearly marked as a redetermination and must include the following:

Providers should submit the following documentation:

- The item(s) being resubmitted should be clearly marked as a Claim Dispute/ Adjustment.
- Payment adjustment requests must be fully explained.
- The previous claim and remittance advice, any other documentation to support the adjustment and a copy of the Referral/Authorization form (if applicable) must accompany the adjustment request.
- The claim number clearly marked on all supporting documents

These requests shall be classified as a Claims Disputes/Adjustment and be sent to the following address:

**Molina Healthcare of Ohio, Inc.
Attention: Provider Services
P.O. Box 349020
Columbus, OH 43234-9020**

Requests for adjustments of claims paid by a delegated medical group/IPA must be submitted to the group responsible for payment of the original claim.

The Provider will be notified of Molina Healthcare's decision in writing within 30 days of receipt of the Claims Dispute/Adjustment request. Providers may request a claim dispute/adjustment when the claim was incorrectly denied as a duplicate or due to claims examiner or data-entry error.

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of coverage decisions or payment levels, Molina Healthcare determines that it has made an overpayment to a provider for services rendered to a member, it will make a claim for such overpayment. Molina Healthcare will not reduce payment to that provider for other services unless the provider agrees to the reduction or fails to respond to Molina Healthcare's claim as required in this subsection.



A provider shall pay a claim for an overpayment made by a Molina Healthcare which the provider does not contest or deny within the specified number of days on the refund request letter mailed to the provider.

Payment of a claim for overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to the organization, or the date that the provider receives a payment from the organization that reduces or deducts the overpayment.

Billing the Member

Molina Healthcare contracted providers may collect applicable Cost Sharing including co-payments, deductibles, and coinsurance from the member as required by the agreement. The contract between the provider and Molina Healthcare places the responsibility for verifying eligibility and obtaining approval for those services that require prior authorization on the provider.

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 HFS, 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, 837P – Professional, and 837D -- Dental. 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 create Molina's 837P, 837I, and 837D Companion Guides with the specific submission requirements available to providers.