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
- Claim Corrections/Adjustments
- Overpayments/Refund Requests
- Coordination of Benefits (COB)
- Third Party Liability (TPL)
- Billing the Member

Molina Healthcare generally follows HCA guidelines for claims processing and payment for the Apple Health programs. These guidelines are contained in the HCA Medicaid Provider Guides. The complete guide and information on ordering a printed copy can be found at http://www.hca.wa.gov/medicaid/provider/Pages/providerone_billing_and_resource_guide.aspx.

CLAIM SUBMISSION

Claims may be submitted to Molina Healthcare with appropriate documentation by mail or filed electronically for CMS-1500 claims 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 (See section 2, page 13). Providers billing Molina Healthcare directly should send claims to:

Molina Healthcare of Washington, Inc.
PO Box 22612
Long Beach, CA 90801

Providers billing Molina Healthcare electronically should use payor number: 38336

Providers must use good faith effort to bill Molina Healthcare for services with the most current coding (ICD-9, CPT, HCPCS etc.) available. The following information must be included on every claim:

- Member name, date of birth and ID number or PIC number
- Date(s) of service
- ICD-9 diagnosis and procedure codes
- Revenue, CPT or HCPCS for service or item provided
- Billed charges for service provided
- Place and type of service code
- Days or units, as applicable
- Provider tax identification and NPI number
- Provider name and address

National Provider Identifier (NPI); Effective May 23 2007, Providers must report any changes in their NPI or subparts to Molina Healthcare within 30 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. For Hospital claim submission instructions, please see section 9.

Electronic Claim Submissions: Molina Healthcare accepts electronic claim submissions for HCFA 1500 - Professional (837P), 14UB 92 - Institutional (837I), claims through Emdeon. Please use Molina Healthcare's Payor ID number - 38336. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure claims are received for processing in a timely manner.
The benefits of submitting your claim electronically are:

- Efficient information delivery
- Reduced operational costs associated with paper claims (printing, correlating, and postage)
- Increased accuracy in data
- Ensures HIPPA compliance

Electronic Remittance Advice and Electronic Funds Transfer: To register please go to https://providernet.adminisource.com. If you have any questions regarding the actual registration process, please contact FIS/ProviderNet at (877) 389-1160 or email Provider.Services@fisglobal.com.

Timely Claim Filing: Claims for covered services rendered to Molina Healthcare Members must be received by Molina Healthcare no later than the limitation stated in the provider contract or within 180 days from the date of service(s). Claims received with other insurance Explanation of Benefits (EOB) attached will not be subject to the timely filing restriction. However, the claim must be submitted to Molina Healthcare within 180 days of receiving the EOB from the other carrier. A Denied Claims Review may be requested on claims denied as untimely by submitting justification for the delay. See section 11, for information on Denied Claims Review Requests.

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 as soon as possible. Payment is subject to the following minimum standards as set forth by the Office of the Insurance Commissioner (OIC) and HCA:

- Ninety-five (95%) percent of the monthly volume of "clean" claims will be adjudicated within 30 calendar days of receipt by Molina Healthcare. A "clean" claim has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.

- Ninety-five (95%) percent of the monthly volume of claims shall be paid or denied within

60 calendar days of receipt by Molina Healthcare.

- Ninety-nine (99%) percent of all claims shall be paid or denied within 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. All hard copy claims received by Molina Healthcare will be clearly stamped with date of receipt. If Molina Healthcare fails to abide by the timely claims payment standards stated above, Molina Healthcare is required to pay interest on undenied and unpaid clean claims as described in WAC 284-43-321.

CLAIM EDITING PROCESS

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

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

Coding edits are based on Current Procedural Terminology (CPT), HCA guidelines, industry standard National Correct Code Initiative (NCCI) policy and guidelines and industry payment rules and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB). If you disagree with an edit please follow the Denied Claim Review Request guidelines located in Section 11.

CLAIM CORRECTIONS/ADJUSTMENTS

Providers seeking an adjustment, correction or reprocessing of a claim adjudicated after January 1, 2006 providers must submit the request within 24 months of receiving the original RA. Providers should submit the following documentation:

- The item(s) being resubmitted should be clearly marked as an 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

Failure to submit a corrected claim in the proper format will result in the claim being denied.

Claim corrections should be sent directly to Molina's claims processing department either electronically (payor number 38336) or via paper to:

Molina Healthcare of Washington
PO Box 22612
Long Beach, CA 90801

Requests for claim adjustments should be mailed or faxed to:

Provider Services Department
PO Box 4004
Bothell, WA 98041-4004

Fax: (425) 424-1172 or (877) 814-0342

Requests for correction of claims paid by a delegated medical group/IPA must be submitted to the group responsible for payment of the original claim. See Section 14 for additional information on delegated medical group/IPA's.

OVERPAYMENTS AND INCORRECT PAYMENTS REFUND REQUESTS

In the event Molina Healthcare finds an overpayment or incorrect payment for services provided to Molina Healthcare Members, a refund letter will be mailed to the provider. Molina Healthcare may request a refund for overpayments or incorrect payments on services provided within 24 months of paid dates January 1, 2006 forward and 30 months on COB claims. Recoupment of hospital provider claims with overpaid or incorrect payment will be processed according to their contract language.

If Molina Healthcare does not receive a refund or written notice that you wish to contest a refund request within 45 days, we may automatically retract monies overpaid from future payments. Any retraction activity will appear on your Remittance Advice.

If you prefer a retraction on a future Remittance Advice for overpaid or incorrectly paid claims, please fax a MHW Early Reversal Permission Form to the Claims Recovery Department at (888) 396-1520.

If you have any questions regarding a refund request letter, please call the Claims Recovery Department at (866) 642-8999.

In the event the provider receives a check that is not theirs or finds an overpayment, please send the refund with a copy of the RA and claim information to:

Molina Healthcare of Washington, Inc.
PO Box 30717
Los Angeles, CA 90030-0717

COORDINATION OF BENEFITS and THIRD PARTY LIABILITY

COB: Apple Health is secondary to all private insurance. Private insurance carriers must be billed prior to billing Molina Healthcare or medical groups/IPAs. The provider must include a copy of the other insurance's EOB with the claim.

When COB payment is as much as or more than Molina Healthcare's allowable rate and there is no patient responsibility from the primary insurance the claim has been paid in full. Molina Healthcare will make no additional payment.

When COB payment is as much as or less than Molina Healthcare's allowable rate with a patient responsibility from the primary insurance, Molina Healthcare reimburses the patient responsibility not to exceed Molina Healthcare's allowable rate.

When the COB payment is less than Molina Healthcare's allowable rate for services preformed, Molina Healthcare pays the difference between the primary payment and Molina Healthcare's allowable rate not to exceed Molina's allowable rate.

Molina Healthcare may request a refund for COB claims paid in error up to 30 months from the original paid date.

Molina Healthcare is required to notify HCA within 15 working days when a Member is verified to have Dual Coverage with Molina Healthcare and within 60 calendar days when a Member is verified to have health coverage with any other health carrier. In turn, HCA provides COB information to Molina Healthcare on a quarterly basis. If HCA determines the Member's other coverage is comparable to AH, the Member will be prospectively disenrolled from AH and enrolled in fee-for-service Medicaid.

TPL: Molina Healthcare will pay claims for covered services when probable TPL has not been established or third party benefits are not available to pay a claim. Molina Healthcare will attempt to recover any third-party resources available to Members and shall maintain records pertaining to TPL collections on behalf of Members for audit and review.

BILLING THE MEMBER

Molina Healthcare contracted providers may not bill the Member for any covered benefits except for co-payments, coinsurance and deductible, when applicable under Apple Health.

In accordance with WAC 182-502-0160, a contracted provider may only bill fee-for-service or managed care clients for covered health care services, if the Member and the provider both sign Health Care Authority form 13-879 "Agreement to Pay for Healthcare Services" no more than 90 days prior to services being rendered. The form must be completed in full. For Members with limited English proficiency, form 13-879 must be translated into the Member's primary language. If necessary, this form must also be interpreted for the Member. If the agreement is interpreted, the interpreter must also sign it. All other requirements for form 13-879 apply.

Providers must accept payment by Molina Healthcare as payment in full in accordance with 42 CFR 447.15. Balance billing is not permitted. For additional information, refer to WAC 182-502-0160 and HCA Memo #10-25.