Claim Submission

All claims (medical and behavioral health services) should be submitted to Molina Healthcare with appropriate supporting documentation.

- Molina Healthcare accepts the following claim forms:
  - CMS 1500 - AMA universal claim form also known as the National Standard Format (NSF)CMS Forms List - Centers for Medicare & Medicaid Services http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html
  - CMS 1450 - UB-04 (for hospitals) http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html
- Claims for services that require prior authorization, but were not prior approved by Molina Healthcare, will be denied for no authorization.
- Providers must bill Molina Healthcare for services with the most current coding available, using HIPAA-compliant transaction and code sets.

Claims Submission: Web-Portal

It is preferred that all LTSS claims submission be made through the Molina Web-Portal when available.

- Web-Portal (www.MolinaHealthcare.com) Provider Self-Services
  - Register today to access our on-line services. A video will guide you through the easy on-line registration process.
    - Submit claims
    - Status claims
    - Print claims reports
  - If you experience any problems with the Provider Self-Services website, please contact Molina Healthcare's Help Desk at 1-866-449-6848 for technical assistance or call your Provider Services Representative directly.

- Emdeon - Electronic Data Interchange (EDI) Gateway Partner
  - Emdeon accepts all electronic claims (837P/837I) on behalf of Molina Healthcare. As a provider, you may continue to submit claims to your existing EDI clearinghouse: they will forward your files to Emdeon.
  - Providers billing Molina Healthcare electronically should use **payer number 20149.**
  - If you experience any problems with your transmission, please contact your local clearinghouse representative.

For additional information, go to Molina Healthcare's EDI website - www.MolinaHealthcare.com.

Molina Healthcare encourages electronic claim submission as it provides your office with the following benefits:

- Reduces operational costs associated with paper claims
- Reduces time for Molina Healthcare to receive a claim by eliminating mailing time
- Increases accuracy of data
- Ensures HIPAA compliance

Track your electronic transmissions using acknowledgement reports to ensure that claims are received for processing in a timely manner. When your claims are filed electronically you will:

- Receive an acknowledgement from the clearinghouse.
- Receive an acknowledgement from Emdeon within 5-7 business days of your transmission.

Creating a Claim in Web-Portal

There are three (3) sections in creating professional claims**; Member, Provider** and **Summary.**

Member	
Member Information	Enter insured member's information and patient information will automatically populate based on input. If patient is not same as insured subscriber, enter patient information. (e.g. newborn covered under mother)
Patient Condition	Enter dates that apply to patient condition as well as referring information and EPSDT claims. Include ambulance claims information, if applicable.
Verify Required Information	Requires that you enter place of service, patient account number, other health benefit plan (if known) and authorization to release patient information.
Other Insurance	Enter information for other insurance, if applicable.
Other Information	Enter other information such as Auto Accident, Employment, Other Party Responsible, etc., if known.
Provider	
Submitter Contact Information	Enter all required fields for submitter's contact information.
Billing Provider Information	The required information will automatically populate based on your account or the Billing Provider you selected from the drop down menu.
Rendering Provider Information	The required information will automatically populate based on your account or the Renderings Provider you selected from the drop down menu. If the rendering provider information is not available, call the Provider Services department for your state.
Facility Information	The required information will automatically populate based on your account or the Facility you selected from the drop down menu.
Diagnosis Code	Enter or search for a diagnosis code(s). You must enter at least one (1) diagnosis code.
Claim Line Details	Service From Date, Service To Date, Place of Service, Procedure Code,

	Units of Measurement, Quantity and Charges are required to add Claim Line Details. At least one Diagnosis Code reference is required for each claim line entered to submit your claim.
Supporting Information	This section is available for comments and remarks or brief explanatory statements. Comments are limited to 256 characters.
Summary Section	Summary section shows all input from the member and provider forms. You may review your inputs in this section before submitting the claim.

Open Incomplete Claim
Providers have the option to save an incomplete claim. To retrieve a claim take note of the Tracking Number found on top of the claim and open unsaved claim through **Claims Inquiry** page.

Export Claims Report Excel
The export claims report module allows you to download a report of claims submitted. Enter Service Dates From and Service Dates To, then click **Submit**. Click **Search** and an Excel file will be generated and placed in the Download Exported Claims module.

Download Exported Claims File
After you have exported a claim file, click **Save** to download the file and open file in Excel.

TIMELY CLAIM PROCESSING

In accordance with 42 C.F.R. § 447.46, the ICDS Plan must pay ninety percent (90%) of all submitted Clean Claims within thirty (30) days of the date of receipt and ninety-nine percent (99%) of such claims within ninety (90) days of the date of receipt.
The clean pharmacy and non-pharmacy claims will be separately measured against the thirty (30) and ninety (90) day prompt pay standards. The prompt pay requirement applies to the processing of both electronic and paper claims for contracting and non-contracting providers by the ICDS Plan and delegated claims processing entities.

A clean claim is a claim that has no defect or impropriety, contains all required substantiating documentation and does not involve circumstances that require special treatment that could prevent timely payment. The receipt date of a claim is the date that Molina Healthcare receives either written or electronic notice of the claim. All hard copy claims received by Molina Healthcare will be stamped with the date of receipt.

ERA/EFT

Molina Healthcare offers Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT) with our contracted vendor Change Healthcare. There is no fee related to the accessibility of your payment data as well as the EFT payment processing. This is a FREE service for you to take advantage of. Registration for the EFT/ERA is available on the Change Healthcare website.

Registration for the EFT/ERA is available on the Change Healthcare website. Once your registration is complete the following will occur:

- It takes normally 10 calendar days for pre-note approval
- An initial payment to at least one Tax ID + NP association is necessary to become eligible for EFT through Change Healthcare
- Monies can be transferred into your bank account within 24 hours of Molina Healthcare's payment process.

Explanation of Payment (EOP)

- EOP's are available to view and download on the Change Healthcare website.
- The EOP PDF will remain online for up to 12 months after the original payment

If you have any questions regarding the process, please contact:
wco.provider.registration@changehealthcare.com

Registration can be made by logging onto
https://providernet.adminisource.com/Terms.aspx

Timely Filing

Original Claims: Claims for covered services rendered to Molina Healthcare members must be received by Molina Healthcare no later than the filing limitation stated in the provider contract or within 120 days from the date of service(s). Claims submitted after the filing limit will be denied.

Corrected Claims: Claims received with a correction of a previously adjudicated claim must be received by Molina Healthcare no later than the filing limitation stated in the provider contract or within 180 days of the original remittance advice. Claims submitted after the filing limit will be denied.

Claim Reconsiderations

Providers seeking an adjustment of a previously adjudicated claim must request such action within 180 days of the original remittance advice unless otherwise stated in the provider contract. Requests for claim adjustments submitted after the 180 day period or the timeframe specified in the provider contract cannot be considered.

In the event Molina Healthcare identifies the primary insurance information on file is incorrect, leaving Molina Healthcare as the primary carrier, the member's information will be updated and claims previously denied within 120 days of the COB update will be reprocessed. Claims denied prior to 120 days of the COB update will not be reprocessed.

The request for a claim adjustment must include the following documentation to allow for a thorough review of the request:

- A completed Molina Healthcare Claim Reconsideration Request Form marked as MyCare Ohio or a cover letter that includes the claim number and clearly explains the reason for the adjustment request.

- Additional documentation related to the claim, including the previous claim and remittance advice, a copy of the referral/authorization form (if applicable) and any other documentation to support the adjustment.
- The item(s) being resubmitted should be clearly marked as a request for an adjustment.

Forms are available at http://www.MolinaHealthcare.com. Select Providers, Ohio, Forms.

Requests for claim adjustments can be faxed to:
Fax: (800) 499-3406

90% of requests will be processed within 30 days of receipt. Molina Healthcare will return a response to the provider on the decision of the reconsideration request via fax, whenever this number is provided. All other responses will be sent via mail to the billing address on file.

Overpayment Requests

In the event Molina MyCare Ohio Dual Options determines that a claim has been overpaid; is a duplicate payment; or that funds were paid which were not provided for under the provider's contract, the overpayment amount will be automatically recovered by way of offset or recoupment unless the provider contract states otherwise. All recovery activity will appear on your Remittance Advice. The provider has sixty (60) days to refund Molina Healthcare by check or an accounts receivable will be established and the amount of the overpayment will be deducted from the provider's next check(s). All recovery activity will appear on your Remittance Advice. Use the Return of Overpayment Form to submit unsolicited refunds or check returns. Go to http://www.MolinaHealthcare.com. Select Providers, Ohio, Forms.

If you have any questions regarding a refund request letter, please call the Claims Recovery Unit at 1-866-642-8999 and follow the prompts to Ohio or Molina Healthcare Provider Services at 1-855-322-4079

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 Remittance Advice and claim information to:

Please direct payment and any correspondence to:

Molina Healthcare of Ohio
P.O. Box 715257
Columbus, Ohio 43271-5257

If returning a Molina Healthcare check, please send to:

Molina Healthcare of Ohio
P.O. Box 349020
Columbus, Ohio 43234-9020

Claims Coding

Billable codes are based on Current Procedural Terminology (CPT), Medicaid Purchasing Administration (MPA) 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).

The National Correct Coding Initiative (NCCI) developed by CMS helps promote national correct coding methodologies for ensuring that claims are coded appropriately according to State and Federal coding guidelines. The coding policies developed are based on:

- Coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual;
- National and local policies and edits;
- Coding guidelines developed by national societies;
- Analysis of standard medical and surgical practice; and
- Review of current coding practice.

Billing Molina Healthcare Members

In accordance with OAC 5160-26-05 Managed Health Care Programs: Provider Panel and Subcontracting Requirements, a provider may bill a Molina Healthcare member only for *non-covered* services OR those services determined not to be medically necessary by Molina Healthcare's Utilization Management Department if both the member and the provider sign a payment agreement prior to the services being rendered. The agreement must be specific to the services being rendered and clearly state:

- The service is not covered by ODM or Molina Healthcare OR services determined not to be medically necessary by Molina Healthcare's Utilization Management Department.
- The member is choosing to receive the service and agrees to pay for it, even though the service may have been determined by Molina Healthcare to be not medically necessary.
- The member is under no obligation to pay the provider if the service is later found to be a covered benefit, even if the provider is not paid because of non-compliance with Molina Healthcare's billing and/or prior authorization requirements.
- For members with limited English proficiency, the agreement must be translated or interpreted into the member's primary language to be valid and enforceable. This interpretation/translation service is the responsibility of the provider to supply.

Patient Liability

Patient Liability is the portion of health care costs that a patient is required to pay. Patient Liability is paid directly to a long-term care provider. Examples of services subject to Patient Liability are as follows:

- Medical Institution
- Long-Term Care Facility
- Intermediate Care Facility for Mentally Retarded (ICF-MR)
- Home and Community Based Waiver Service (HCBCS)

Patient Liability remains the same each month unless there is a change in the clients income or deductions. The amount that a patient pays is set by ODM standards and guidelines.

*******Please note billing members for missed appointments is prohibited.**

OAC References for LTSS Services and Covered Benefits

5101:3-46-04 Ohio home care waiver: definitions of the covered services and provider requirements and specifications.
5101:3-1-06.1 Home and community-based service waivers: PASSPORT.
173-39-02.6 Emergency Response Service
5101:3-46-04 Ohio Home Care Waiver: Definitions of Covered Services and Provider Requirements and Specifications, paragraph H

5101:3-1-06.1 HCBS Waivers: Passport, Appendix A
5101:3-31-02 , entitled Passport program definitions.
5101:3-1-06.4 Home and Community-Based Waivers: Choices
5101:3-1-06.4 HCBS Waivers: Choices, Appendix A
5101:3-46-06 Ohio Home Care Waiver Program: Reimbursement Rates and Billing Procedures

173-39-02.13- Non-emergency medical transportation service
173-39-02.18 Non-medical/supplemental transportation service
173-39-02.2 Alternative Meal Service
173-39-02.14 Home Delivered Meal Service
173-39-02.10 Nutritional Consultation Service
173-39-02.16: Assisted Living Service
5101:3-1-06.5: Home and Community Based Services (HCBS)
173-39-02.9 Minor home modification, maintenance, and repair services
5101:3-46-04 Ohio home care waiver: definitions of the covered services and provider requirements and specifications

173-39-02.3 Pest Control Services
5101:3-46-04 Ohio Home Care Waiver: Definitions of Covered Services and Provider Requirements and Specifications, paragraph G

5101:3-46-06 Ohio Home Care Waiver Program: Reimbursement Rates and Billing Procedures

5101:3-50-04 Transitions Carve-Out Waiver: Definitions of Covered Services and Provider Requirements and Specifications, paragraph G
5101:3-50-06 Transitions Carve-Out Waiver: Reimbursement Rates and Billing Procedures

Appendix

HCPC Code and Modifier Description Guide

HCPC Code	Modifier	Description	Unit Increment
S5101		Adult Day Health Center Svcs	half day
S5102		Adult Day Health Center Svcs	full day
T1019		Personal Care Aide Svcs	15 minutes
T2029		Supp Adaptive & Assistive Devices	per service
S5165		Home Modifications	per service
S5160		Emergency Response Services	installation
S5161		Emergency Response Services	monthly fee
S5170		Home Delivered Meals	per meal
S0215		Supplemental Transportation	per mile
T1002	RN	Waiver Nursing	15 minutes
T1003	LPN	Waiver Nursing	15 minutes
S5125		Home Care Attendant - Nursing	15 minutes
S5125	U8	Home Care Attendant - Personal Care	15 minutes
H0045		Out of Home Respite	per day
		Passport Waiver	
S5102	UA	Adult Day Service - Enhanced	1 day
S5101	UA	Adult Day Service - Enhanced	1/2 day
S5100	UA	Adult Day Service - Enhanced	15 minutes
S5102	UAU3	Adult Day Service - Intensive	1 day
S5101	UAU2	Adult Day Service - Intensive	1/2 day

S5100	UAU1	Adult Day Service - Intensive	15 minutes
A0080	UA	Adult Day Service - Transportation	1 mile
A0080	UAU2	Adult Day Service - Transportation (2nd)	1 mile
T2003	UA	Adult Day Service - Transporation	1 one-way trip
T2003	UAU2	Adult Day Service - Transportation (2nd)	1 one-way trip
T2025	UAU5	Adult Day Service - Transportation	1 round trip
T2025	UAU2	Adult Day Service - Transportation (2nd)	1 round trip
S5170	UA	Home Delivered Meals	1 meal
S5170	UAU6	Home Delivered Meals - Therapeutic	1 meal
S5170	UAU7	Home Delivered Meals - Kosher	1 meal
S5130	UA	Homemaker Service	1/4 hour
S5121	UA	Chore Service	1 job
G0155	UA	Social Work Counseling Service	1/4 hour
S9470	UA	Nutritional Consulation Service	1/4 hour
T1019	UA	PCS by Cert Long Term Care Agency Prov	1/4 hour
T1019	UAU2	PCS by Cert Long Term Care Agency Prov (2nd)	1/4 hour
T1019	UAU1	PCS by Consumer Directed Personal Care	1/4 hour
T1019	UAU3	PCS by Consumer Directed Personal Care (2nd)	1/4 hour
T1019	UAU4	PCS by Consumer Directed PC (OT)	1/4 hour
T1999	UAU1	Home Medical Equip/Supplies - Ambulatory	1 item
T1999	UAU2	Home Medical Equip/Supplies - Ambulatory (2nd)	1 item
T1999	UAU3	Home Medical Equip/Supplies - Ambulatory (3rd)	1 item
T1999	UAU4	Home Med Equip/Supplies - non-ambulatory	1 item
T1999	UAU5	Home Med Equip/Supplies - non-ambulatory (2nd)	1 item
T1999	UAU6	Home Med Equip/Supplies - non ambulatory (3rd)	1 item
T1999	UAU7	Home Med Equip/Supplies - Hygiene/disposables	1 item
T1999	UAU8	Home Med Equip/Supplies - Hygiene/disposables (2nd)	1 item
T1999	UAU9	Home Med Equip/Supplies - Hygeine/disposables (3rd)	1 item
T1999	UA	Home Med Equip/Supplies - Equipment and Repair	1 item
T1999	UAUC	Home Med Equip/Supplies - Nutrition Supplement	1 item
S5161	UAU1	Personal Emergency Response System	1 month rental
S5161	UAU2	Personal Emergency Response System	1 partial month
S5160	UA	Personal Emergency Response System	installation
S5161	UAU3	Personal Emergency Response System	2nd pendant rental
S5162	UA	Personal Emergency Response System	Alternative ERS Device
S5165	UA	Environmental Accessibility Adaptations	1 completed work order
S5135	UA	Independent Living Assist - In Person Activities	1/4 hour
S5135	UAU5	Independent Living Assist - Travel Attendant	1/4 hour
S2025	UA	Independent Living Assist - Telephone Assistance	1 completed call
T2025	UAU6	Transportation	1 round trip

T2025	UAU3	Transportation (2nd)	1 round trip
T2003	UAU5	Transportation	1 one-way trip
T2003	UAU4	Transportation (2nd)	1 one-way trip
T2038	UA	Community Transition Service	1 completed job order
A0200	UA	Non Medical Transportation	1 round trip
A0200	UAU2	Non Medical Transportation (2nd)	1 round trip
A0100	UA	Non Medical Transportation	1 one-way trip
A0100	UAU2	Non Medical Transportation (2nd)	1 one-way trip
T2025	UAU1	Enhanced Community Living Service	1/4 hour
		Choices Waiver	
S5102	UB	Adult Day Service - Enhanced	1 day
S5101	UB	Adult Day Service - Enhanced	1/2 day
S5100	UB	Adult Day Service - Enhanced	15 minutes
S5102	UBU3	Adult Day Service - Intensive	1 day
S5101	UBU2	Adult Day Service - Intensive	1/2 day
S5100	UBU1	Adult Day Service - Intensive	15 minutes
A0090	UB	Adult Day Service - Transportation	1 mile
A0090	UBU2	Adult Day Service - Transportation (2nd)	1 mile
T2003	UBU4	Adult Day Service - Transporation	1 one-way trip
T2003	UBU2	Adult Day Service - Transportation (2nd)	1 one-way trip
T2025	UBU5	Adult Day Service - Transportation	1 round trip
T2025	UBU4	Adult Day Service - Transportation (2nd)	1 round trip
T2029	UBU1	Home Medical Equip/Supplies - Ambulatory	1 item
T2029	UBU4	Home Med Equip/Supplies - non-ambulatory	1 item
T2029	UBU7	Home Med Equip/Supplies - Hygiene/disposables	1 item
T2029	UB	Home Med Equip/Supplies - Equipment and Repair	1 item
T2029	UBBC	Home Med Equip/Supplies - Nutrition Supplement	1 item
S5161	UBU1	Personal Emergency Response System	1 month rental
S5161	UBU2	Personal Emergency Response System	1 partial month
S5160	UB	Personal Emergency Response System	installation
S5161	UBU3	Personal Emergency Response System	2nd pendant rental
S5162	UB	Personal Emergency Response System	Alternative ERS Device
S5165	UB	Environmental Accessibility Adaptations	1 completed work order
S5170	UB	Home Delivered Meals	1 meal
S5170	UBU2	Home Delivered Meals - Therapeutic	1 meal
S5170	UBU7	Home Delivered Meals - Kosher	1 meal
S5170	UBU3	Alternative Meal Service	1 meal
S5121	UB	Pest Control	1 job
		Assisted Living Waiver	
T2031	U1	Tier 1	per day

T2013	U2	Tier 2	per day
T2031	U3	Tier 3	per day
T2038	U4	Community Transition Svc (for NH residents enrolling in the waiver)	1 completed job order
		ICDS Waiver	
T2031	U1	Assisted Living Service - Tier 1	per day
T2031	U2	Assisted Living Service - Tier 2	per day
T2031	U3	Assisted Living Service - Tier 3	per day
S5101		Adult Day Health	half day
S5102		Adult Day Health	full day
A0080		Adult Day Health - Transportation	per mile
T1019		Personal Care - Employer Authority	15 minutes
T1019	HQ	Personal Care - Employer Authority - group visit	15 minutes
S5130		Homemaker	15 minutes
S5121		Chore Service	per job
T2029		Home Med Equip and Supp Adaptive and Assist Devices - Budget	per service
S5165		Home Modifications maintenance and repair - Budget Authority	per service
S5160		Personal Emergency Response	installation
S5161		Personal Emergency Response	monthly rental
S5170		Home Delivered Meals	1 meal
S5170	UBU3	Alternative Meals - Budget Authority	1 meal
S0215		Waiver Transportation	per mile
T2001	RN	Waiver Nursing	15 minutes
T2003	LPN	Waiver Nursing	15 minutes
T2001	RNHQ	Waiver Nursing - group visit	15 minutes
T2003	LPNHQ	Waiver Nursing - group visit	15 minutes
S5125		Home Care Attendant - Nursing	15 minutes
S5125	U8	Home Care Attendant - Personal Care	15 minutes
H0045		Out of Home Respite	per day
T2025		Enhanced Community Living	15 minutes
G0155		Social Work Counseling	15 minutes
S9470		Nutritional Consultation	15 minutes
S5135		Independent Living Assistance	15 minutes
T2038		Community Transition	1 completed job
T2025	UB	Choices Home Care Attendant - Employer/Budget Authority	15 minutes
S5121	UB	Pest Control - Budget Authority	1 job