CLAIMS and COMPENSATION

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:

- National Provider Identifier (NPI) HCA Enrollment Requirements
- Hospital Acquired Conditions and Present on Admission Program
- Claim Submission
- Coordination of Benefits (COB)
- Third Party Liability (TPL)
- Timely Claim Filing
- Claim Edit Process
- Clam Review
- Claim Auditing
- Corrected Claims
- Timely Claim Processing
- Electronic Remittance Advice and Electronic Funds Transfer
- Claim Corrections
- Overpayment and Incorrect Payment
- Claim Adjustment Disputes/Reprocessing
- Billing the Member
- Fraud and Abuse
- Encounter Data

Molina Healthcare generally follows HCA guidelines for claims processing and payment for the Apple Health (AH), Integrated Managed Care (IMC) and Behavioral Health Services Only (BHSO) Medicaid 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/billers-providers/claims-and-billing/professional-rates-and-billing-guides.

NATIONAL PROVIDER IDENTIFIER (NPI) HCA BILLING AND NON-BILLING ENROLLMENT REQUIREMETNS

Per federal regulation (42.C.F.R. 455.410(b)) providers who have a contract with the state's Medicaid agency or a contract with a Managed Care Organization (MCO) that serve Medicaid Clients must enroll with HCA under a Non billing or Billing agreement. The provider's National Provider Identifier (NPI) submitted on all claims must be the NPI registered with HCA.

Effective January 1, 2018, Molina Healthcare will deny/reject all claims submitted to Molina for processing if billed with an NPI that is not enrolled with HCA or does not match what HCA identifies as the enrolled NPI number.

For additional information and to access the Non-Billing and Billing and servicing enrollment form, which must be used to register with HCA or to correct an NPI, visit the HCA website at

http://www.hca.wa.gov/billers-providers/apple-health-medicaid-providers/enroll-non-billing-individual-provider.

HOSPITAL-ACQUIRED CONDITIONS and PRESENT on ADMISSION PROGRAM

The Deficit Reduction Act of 2005 (DRA) mandated that Medicare establish a program that would modify reimbursement for fee for service beneficiaries when certain conditions occurred as a direct result of a hospital stay that could have been reasonably been prevented by the use of evidenced-based guidelines. CMS titled the program "Hospital-Acquired Conditions and Present on Admission Indicator Reporting" (HAC and POA).
The following is a list of CMS Hospital Acquired Conditions. Effective October 1, 2008, CMS reduces payment for hospitalizations complicated by these categories of conditions that were not present on admission (POA):

1) Foreign Object Retained After Surgery
2) Air Embolism
3) Blood Incompatibility
4) Stage III and IV Pressure Ulcers
5) Falls and Trauma
    a) Fractures
    b) Dislocations
    c) Intracranial Injuries
    d) Crushing Injuries
    e) Burn
    f) Other Injuries
6) Manifestations of Poor Glycemic Control
    a) Hypoglycemic Coma
    b) Diabetic Ketoacidosis
    c) Non-Ketotic Hyperosmolar Coma
    d) Secondary Diabetes with Ketoacidosis
    e) Secondary Diabetes with Hyperosmolarity
7) Catheter-Associated Urinary Tract Infection (UTI)
8) Vascular Catheter-Associated Infection
9) Surgical Site Infection Following Coronary Artery Bypass Graft – Mediastinitis
10) Surgical Site Infection Following Certain Orthopedic Procedures:
    a) Spine
    b) Neck
    c) Shoulder
    d) Elbow
11) Surgical Site Infection Following Bariatric Surgery Procedures for Obesity
    a) Laparoscopic Gastric Restrictive Surgery
    b) Laparoscopic Gastric Bypass
    c) Gastroenterostomy
12) Surgical Site Infection Following Placement of Cardiac Implantable Electronic Device (CIED)
13) Iatrogenic Pneumothorax with Venous Catheterization

14) Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
    a) Total Knee Replacement
    b) Hip Replacement

What this means to Providers:

- Acute IPPS Hospital claims will be returned with no payment if the POA indicator is coded incorrectly or missing; and
- No additional payment will be made on IPPS hospital claims for conditions that are acquired during the patient's hospitalization.

If you would like to find out more information regarding the Medicare HAC/POA program, including billing requirements, the following CMS site provides further information: http://www.cms.hhs.gov/HospitalAcqCond/

CLAIM SUBMISSION

Providers are required to submit Claims to Molina Healthcare with appropriate documentation. Providers must follow the appropriate State and CMS Provider billing guidelines. Providers must utilize electronic billing though a clearinghouse or Molina's Provider WebPortal, and use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims) and use electronic Payer ID number: 38336**.** For Members assigned to a delegated medical group/IPA that processes its own Claims, please verify the Claim Submission instructions on the Member's Molina ID card or refer to Section 14 of this Provider Manual, Delegation -Medical Group-IPA Operations.

Claims that do not comply with Molina's electronic Claim submission requirements will be denied.

Providers must bill Molina 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.

Required Elements:
The following information must be included on every claim:

- Member name, date of birth and Molina Member ID number
- Member's gender
- Member's address
- Date(s) of service
- Valid International Classification of Diseases diagnosis and procedure codes
- Valid revenue, CPT or HCPCS for services or items provided
- Valid Diagnosis Pointers
- Total billed charges for service provided
- Place and type of service code
- Days or units as applicable
- Provider tax identification
- National Provider Identifier (NPI)

- Rendering Provider as applicable
- Provider name and billing address
- Place of service and type (for facilities)
- Disclosure of any other health benefit plans
- E-signature
- Service Facility Location

Inaccurate, incomplete, or untimely submissions and re-submissions may result in denial of the claim; and any paper claim submissions will be denied.

National Provider Identifier (NPI)

A valid NPI which is enrolled with HCA as a billing or non-billing NPI is required on all Claim submissions. Providers must report any changes in their NPI or subparts to Molina Healthcare as well as HCA or claims may be denied.

Electronic Claim Submissions

Molina requires Participating Providers to submit Claims electronically. Electronic Claims submission provides significant benefits to the Provider including:

- Helps to reduce operation costs associated with paper claims (printing, postage, etc.)
- Increases accuracy of data and efficient information delivery
- Reduces Claim delays since errors can be corrected and resubmitted electronically
- Eliminates mailing time and Claims reach Molina faster

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina Healthcare via the secure Provider Portal
- Submit Claims to Molina via your regular EDI clearinghouse using Payer ID 38336

Provider Portal

Molina's secure Provider Portal offers a number of claims processing functionalities and benefits:

- Available to all Providers at no cost
- Available 24 hours per day, 7 days per week
- Ability to add attachments to claims through the Portal
- Submit corrected claims
- Easily and quickly void claims
- Check claim status
- Receive timely notification of a change in status for a particular claim
- Submit COB Claims

Clearinghouse

Molina uses Change Healthcare as its gateway clearinghouse. Change Healthcare has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit Claims to their usual clearinghouse.

Molina accepts EDI transactions through our gateway clearinghouse for Claims via the 837P for Professional and 837I for institutional. 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 via a Clearinghouse:

- You should receive a 999 acknowledgement from your clearinghouse
- You should also receive 227CA response file with initial status of the claims from your clearinghouse
- You should contact your local clearinghouse representative if you experience any problems with your transmission

EDI Claims Submission Issues

Providers who are experiencing EDI Submission issues should work with their clearinghouse to resolve the issue. If the Provider's clearinghouse is unable to resolve, the Provider may call the Molina EDI Customer Service line at (866) 409-2935 or email us at EDI.Claims@molinahealthcare.com for additional support.

Paper Claim Submissions

Paper claims are not accepted by Molina. Claims submitted via paper may be denied and you will need to resubmit your claim electronically for processing.

COORDINATION OF BENEFITS (COB) and THIRD PARTY LIABILITY

Medicaid is the payer of last resort. Private and government carriers must be billed prior to billing Molina Healthcare or Medical groups/IPAs. Provider shall make reasonable inquiry of Members to learn if the Member has health insurance, benefits or Covered Services other than from Molina Healthcare or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Molina Healthcare of said entitlement. In the event that coordination of benefits occurs, Provider shall be compensated based on the state regulatory COB methodology. Primary carrier payment information is required with the claim submission. Providers can submit claims with attachments, including EOBs and other required documents by utilizing Molina's secure Provider Portal. You may also submit COB claims via the clearing house by populating the appropriate segments with the primary payment information.

There are three exceptions for which Molina Healthcare does not require an EOB from the primary insurance:

- Medicare is primary and the service being billed is a non-covered service by Medicare
- The primary carrier has no available provider within a 25 mile radius of the members address. If claims are denied for this reason the provider may contact Provider Services to request the claim be processed for payment
- The primary insurance only covers emergency services or offers limited benefits. Molina will contact the primary carrier to validate and update our systems to reflect Molina as the primary carrier
- The member is American Indian / Alaskan Native (AI/AN)

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 patient responsibility from the primary insurance, Molina Healthcare reimburses the patient responsibility not to exceed Molina Healthcare'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 monthly when a Member is verified to have health coverage with any other health carrier, including Dual Coverage. HCA provides COB information to Molina Healthcare on a regular basis through daily enrollment files. If HCA determines the Member has Dual Coverage with Medicare, the Member will be prospectively dis-enrolled from AH and enrolled in fee-for-service Medicaid.

THIRD PARTY LIABILITY

Molina Healthcare is the payer of last resort and will make every effort to determine the appropriate Third Party payer for services rendered. Molina Healthcare may deny Claims when Third Party has been established and will process Claims for Covered Services when probable Third Party Liability (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.

Timely Claim Filing

Provider shall promptly submit to Molina Claims for Covered Services rendered to Members. All Claims shall be submitted in a format acceptable to and approved by Molina, and shall include any and all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina's policies or procedures. Claims must be submitted by the Provider to Molina no later than the limitation stated in the provider contract or within 180 calendar days after discharge for inpatient services or the Date of Service for outpatient services. If Molina is not the primary payer under coordination of benefits or third party liability, Provider must submit Claims to

Molina within 180 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 within these timelines shall not be eligible for payment and Provider hereby waives any right to payment.

Reimbursement Guidance and Payment Guidelines

Providers are responsible for submission of accurate claims. Molina requires coding of both diagnoses and procedures for all claims. The required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification ICD-10-CM for diagnoses. For procedures, the Healthcare Common Procedure Coding System Level 1 (CPT codes), Level 2 and 3 (HCPCS codes) are required for professional and outpatient claims. Inpatient hospital claims require ICD-10-PCS (International Classification of Diseases, 10th Revision, Procedure Coding System). Furthermore, Molina requires that all claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

Molina utilizes a claims adjudication system that encompasses edits and audits that follow Washington Federal requirements and also administers payment rules based on generally accepted principles of correct coding. Payment rules based on generally accepted principles of correct coding include, but are not limited to, the following:

- Manuals and RVU files published by the Centers for Medicare and Medicaid Services (CMS), including:
  - National Correct Coding Initiative (NCCI) edits, including procedure-to-procedure (PTP) bundling edits and Medically Unlikely Edits (MUEs). In the event a State benefit limit is more stringent/restrictive than a Federal MUE, Molina will apply the State benefit limit. Furthermore, if a professional organization has a more stringent/restrictive standard than a Federal MUE or State benefit limit, the professional organization standard may be used.
  - In the absence of State guidance, Medicare National Coverage Determinations (NCDs).
  - In the absence of State guidance, Medicare Local Coverage Determinations (LCDs).
  - Medicare Physician Fee Schedule Relative Value File (RVU) indicators.
- Current Procedural Technology (CPT) guidance published by the American Medical Association (AMA).
- ICD-10 guidance published by the National Center for Health Statistics.
- State-specific claims reimbursement guidance.
- Other coding guidelines published by industry-recognized resources.
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than State and Federal guidelines.
- Molina policies based on the appropriateness of health care and medical necessity.
- Payment policies published by Molina.
- In the absence of inpatient guidelines, outpatient guidance is followed.
- In the absence of facility guidance, professional guidance is followed.

General Coding Requirements

Correct coding is required to properly process electronic and paper claims. The Plan requires that all claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

CPT and HCPCS Codes

Codes must be submitted in accordance with the chapter and code-specific guidelines set forth in the current/applicable version of the AMA CPT and HCPCS codebooks. In order to ensure proper and timely reimbursement, codes must be effective on the date of service (DOS) for which the procedure or service was rendered and not the date of submission.

Modifiers

Modifiers consist of two alphanumeric characters and are appended to HCPCS/CPT codes to provide additional information about the services rendered. **Modifiers may be appended only if the clinical circumstances justify the use of the modifier(s).** For example, modifiers may be used to indicate whether a:

- Service or procedure has a professional component
- Service or procedure has a technical component
- Service or procedure was performed by more than one physician
- Unilateral procedure was performed
- Bilateral procedure was performed
- Service or procedure was provided more than once
- Only part of a service was performed

For a complete listing of modifiers and their appropriate use, consult the AMA CPT and the HCPCS code books.

ICD-10-CM/PCS Codes

Effective 10/01/2015, Molina will utilize ICD-10-CM and PCS billing rules, and will deny claims that do not meet the Plan's ICD-10 Claim Submission Guidelines. In order to ensure proper and timely reimbursement, codes must be effective on the dates of service (DOS) for which the procedure or service was rendered and not the date of submission. Refer to the ICD-10 CM/PCS Official Guidelines for Coding and Reporting on the proper assignment of principal and additional diagnosis codes.

- Providers must submit ICD-10 codes for DOS or discharge on or after 10/01/2015. Claims containing ICD-9 codes for DOS on or after October 1, 2015, will be denied. Providers will be required to re-submit these claims with the appropriate ICD-10 code.
- If an inpatient hospital claim spans 9/30 & 10/1 and has an admission and/or from date prior to 10/1/15, then the entire claim should be billed using ICD-10 codes.
- The Plan will deny all claims that are billed with both ICD-9 and ICD-10 diagnosis codes on the same claim.

- The Plan will only accept ICD-10 codes comprised of upper case characters. Any claim submitted with ICD-10 codes comprised of lower case characters will be denied.

Place of Service (POS) Codes

Place of Service Codes (POS) are two-digit codes placed on health care professional claims (CMS 1500) to indicate the setting in which a service was provided. The Centers for Medicare & Medicaid Services (CMS) maintain POS codes used throughout the health care industry. The POS should be indicative of where that specific procedure/service was rendered. If billing multiple lines, each line should indicate the POS for the procedure/service on that line.

Type of Bill

Type of bill is a four-digit alphanumeric code that gives three specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care, also referred to as a "frequency" code. For a complete list of codes, reference the National Uniform Billing Committee's (NUBC's) Official UB-04 Data Specifications Manual.

Revenue Codes

Revenue codes are four-digit codes used to identify specific accommodation and/or ancillary charges. There are certain revenue codes that require CPT/HCPCS codes to be billed. For a complete list of codes, reference the National Uniform Billing Committee's (NUBC's) Official UB-04 Data Specifications Manual.

Diagnosis Related Group (DRG)

Facilities contracted to use DRG payment methodology submit claims with DRG coding. Claims submitted for payment by DRG must contain the minimum requirements to ensure accurate claim payment.

The Plan processes DRG claims through DRG software. If the submitted DRG and system-assigned DRG differ, the Plan-assigned DRG will take precedence. Providers may appeal with medical record documentation to support the ICD-10-CM principal and secondary diagnoses (if applicable) and/or the ICD-10-PCS procedure codes (if applicable). If the claim cannot be grouped due to insufficient information, it will be denied and returned for lack of sufficient information.

National Drug Code Number (NDC)

Effective May 1, 2014 the eleven (11) digit National Drug Code Number (NDC) must be reported on all professional and outpatient claims when submitted on the CMS-1500 claim form, UB-04 or its electronic equivalent.

Providers will need to submit claims with both HCPCS and NDC codes with the exact NDC that appears on the medication packaging in the 5-4-2 digit format (i.e. xxxxx-xxxx-xx) as well as the NDC units and descriptors. Claims submitted without the NDC or an invalid NDC number will be denied.

CODING SOURCES

Definitions

CPT – Current Procedural Terminology 4th Edition; an American Medical Association (AMA) maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. There are three types of CPT codes:

- Category I Code – Procedures/Services
- Category II Code – Performance Measurement
- Category III Code – Emerging Technology

HCPCS – HealthCare Common Procedural Coding System; a Centers for Medicare and Medicaid Services (CMS) maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify procedure, supply and durable medical equipment codes furnished by physicians and other health care professionals.

ICD-10-CM – International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM diagnosis codes are maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).

ICD-10-PCS - International Classification of Diseases, 10th revision, Procedure Coding System used to report procedures for inpatient hospital services.

CLAIM AUDITING

Provider acknowledges Molina's right to conduct post-payment billing audits. Provider shall cooperate with Molina's audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting medical records, Provider's charging policies, and other related data. Molina shall use established industry Claims adjudication and/or clinical practices, State, and Federal guidelines, and/or Molina's policies and data to determine the appropriateness of the billing, coding, and payment.

CORRECTED CLAIMS

Corrected Claims are considered new Claims for processing purposes. Corrected Claims must be submitted electronically with the appropriate fields on the 837I or 837P completed. Molina's Provider Portal includes functionality to submit corrected Institutional and Professional claims. Corrected claims must include the correct coding to denote if the claim is Replacement of Prior Claim or Corrected Claim for an 837I or the correct Resubmission Code for an 837P. **Claims submitted without the correct coding will be returned to the Provider for resubmission.**

EDI (Clearinghouse) Submission:

837P

- In the 2300 Loop, the CLM segment (claim information) CLM05-3 (claim frequency type code) must indicate one of the following qualifier codes:
  - "1"-ORIGINAL (initial claim)
  - "7"–REPLACEMENT (replacement of prior claim)
  - "8"-VOID (void/cancel of prior claim)
- In the 2300 Loop, the REF segment (claim information) must include the original claim number of the claim being corrected, found on the remittance advice.

837I

- Bill type for UB claims are billed in loop 2300/CLM05-1. In Bill Type for UB, the "1", "7" or "8" goes in the third digit for "frequency".
- In the 2300 Loop, the REF *F8 segment (claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN).

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.

Timely Claim Processing

Claims processing will be completed for contracted providers in accordance with the timeliness provisions set forth in the provider's contract. Unless the provider and Molina or contracted medical group/IPA have agreed in writing to an alternate payment schedule, Molina will process the claim for services within the 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 notice of the claim.

Electronic Remittance Advice and Electronic Funds Transfer

Participating Providers are required to enroll for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers who enroll in EFT payments will automatically receive ERAs as well. EFT/ERA services allow providers to reduce paperwork, provides searchable

ERAs, and providers receive payment and ERA access faster than the paper check and RA processes. There is no cost to the provider for EFT enrollment, and providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery.

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

OVERPAYMENTS AND INCORRECT PAYMENTS REFUND REQUESTS

If, as a result of retroactive review of coverage decisions or payment levels, Molina 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 may request a refund for overpayments or incorrect payments on services provided within 24 months and 30 months for COB claims from the date of the original remittance advice. If a provider does not repay or dispute the overpaid amount within 45 days of the request, Molina may offset the payment amount(s) against future payments made to the provider.

If you prefer Molina offset payment on a future Remittance Advice for overpaid or incorrectly paid claims, please fax a Molina 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 remittance advice and claim information to:

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

BILLING THE MEMBER

Molina Healthcare contracted providers cannot bill the Member for any covered benefits. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization. Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina to the Provider. Provider agrees to accept payment from Molina as payment in full, or bill the appropriate responsible party.

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.

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 Compliance section of this Provider Manual for more information.

ENCOUNTER DATA

Each capitated Provider/organization delegated for Claims processing is required to submit Encounter data to Molina for all adjudicated Claims. The data is used for many purposes, such as regulatory reporting, rate setting and risk adjustment, hospital rate setting, the Quality Improvement program and HEDIS® reporting.

Encounter data must be submitted at least once per month, and within your contracts timely claims filing requirements in order to meet State and CMS encounter submission threshold and quality measures. Encounter data 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 should be reported.

Molina shall have a comprehensive automated and integrated Encounter data system capable of meeting these requirements.

Providers must correct and resubmit any encounters which are rejected (non-HIPAA compliant) or denied by Molina. Encounters must be corrected and resubmitted within fifteen (15) days from the rejection/denial.

Please see Molina's 837P, 837I, and 837D Companion Guides with the specific submission requirements available to Providers on our website at http://www.molinahealthcare.com/providers/common/duals/ediera/PDF/edi_comm_molina_companion_guide_5010.pdf .

When your Encounters are filed electronically you should receive:

- For any direct submission to Molina you should receive a 999 acknowledgement of your transmission
- For Encounter submission you will also receive a 277CA response file for each transaction