Claims and Billing Orientation

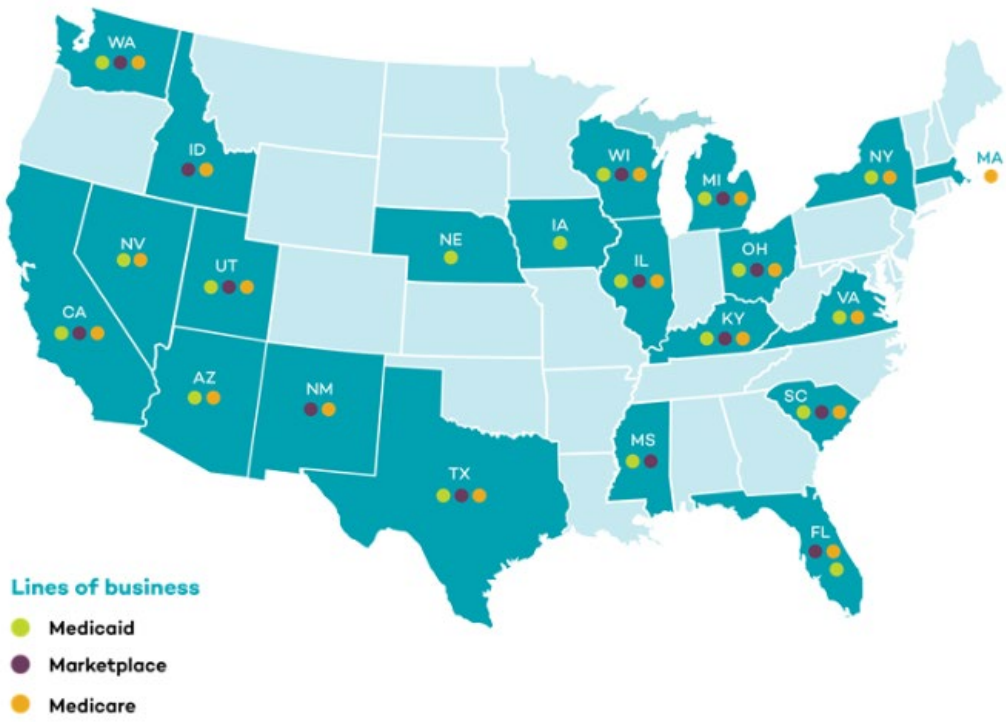
2024 | Molina Healthcare of Ohio, Inc.

MOLINA HEALTHCARE

MHO-PROV-0021
0724

Agenda

- Provider Resources
- Types of Claim Forms
- Claim Submission
- Coordination of Benefits
- Code Editing
- Corrected Claim
- Claim Attachments
- Non-Clinical Claim Dispute (Claim Reconsideration)
- Potentially Preventable Readmissions
- Sepsis
- Contact Molina



Provider Resources

MOLINA HEALTHCARE

Provider Relations

Satisfaction

- Provider Relations Representatives and Engagement Teams
- Annual Assessment of Provider Satisfaction
- The You Matter to Molina Program that includes Monthly Forums, surveys and an Information Page on the Provider Website

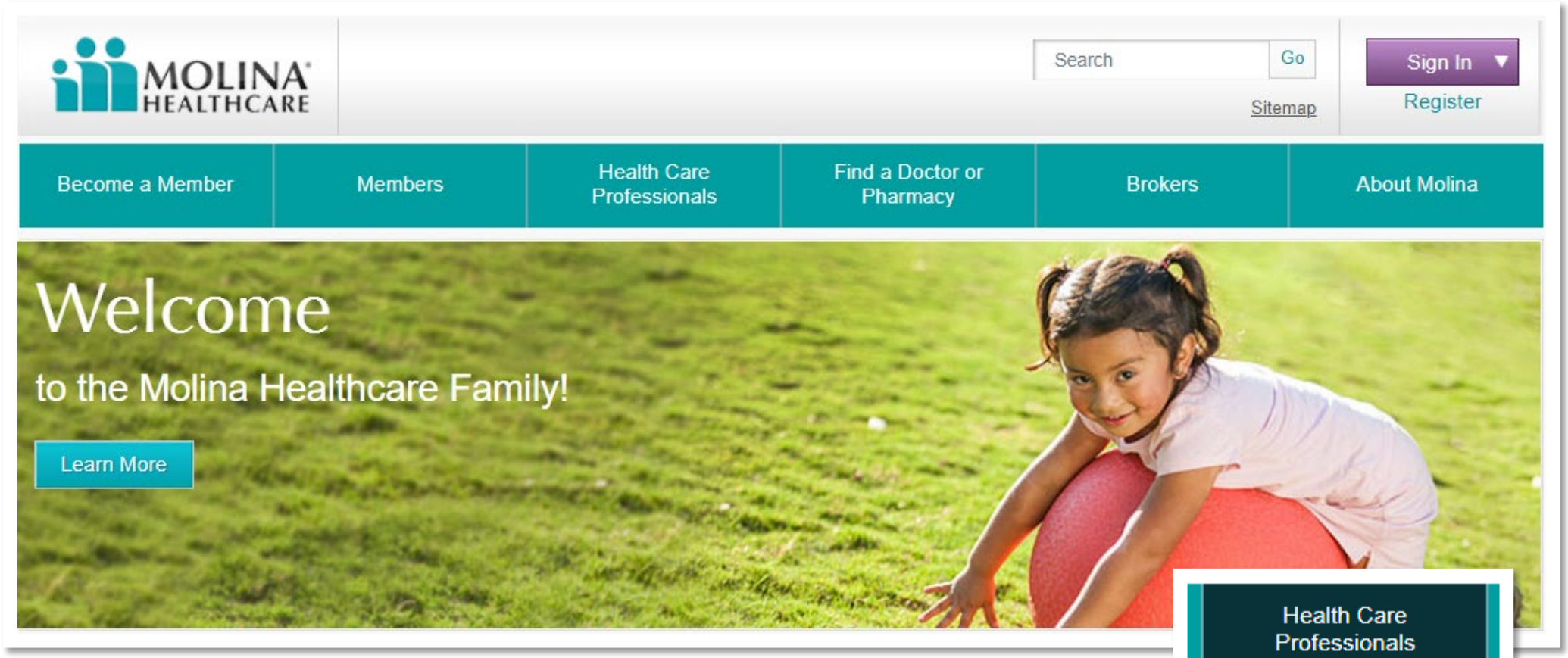
Communication

- Provider Bulletin and Provider Newsletters
- Online Provider Manuals
- Online Trainings, Health Resources and Provider Resource Guides
- Secure Messaging on the Availity Essentials Portal

Technology

- 24-hour Provider Portal
- Online Prior Authorization (PA) and Claim Dispute Submission
- Supplemental PA Lookup Tool on Provider Portal and Provider Website
- MCG Auto-Authorization for Advanced Imaging PA Submission
- Availity Essentials Overpayments

Provider Website



Molina has a Provider Website for each line of business, available under the Health Care Professionals drop-down menu.

Find the Provider Website at MolinaHealthcare.com.

Provider Online Resources

Molina's Provider Website has a variety of online resources:

- Provider Manual
- Dental Manual
- Claims Information
- You Matter to Molina Page and a Claims Payment Systemic Errors (CPSE) Page
- Contact Information
- Provider Online Directory

- Availity Essentials Portal
- Member Rights and Responsibilities
- Preventive and Clinical Care Guidelines
- Prior Authorization Information
- Claim Dispute
- Provider Communications: Provider Bulletins and Provider Newsletters
- Fraud, Waste and Abuse Information
- Advanced Directives
- Molina Payment Policies
  Molina Clinical Policies
- Pharmacy Information
- Health Insurance Portability and Accountability Act (HIPAA)
- Frequently Used Forms

Provider Manual Highlights

Provider Manuals are specific to each line of business. Each Provider Manual is customarily updated annually but may be updated more frequently. Information in the Provider Manual includes:

- Benefits and Covered Services
- Claims and Compensation
- Member Appeals and Grievances
- Credentialing and Recredentialing
- Delegation Oversight
- Enrollment and Disenrollment
- Eligibility
- Health Care Services
- Interpreter Services
- HIPAA
- Member Rights and Responsibilities
- Preventive Health Guidelines
- Quality Improvement
- Transportation Services
- Referral and Authorizations
- Provider Responsibilities
- Pharmacy
- Address and Phone Numbers
- Provider Data Accuracy
- Long-Term Services and Supports

Provider Bulletin

A monthly Provider Bulletin is sent to Molina's provider network to share news and updates.

The Provider Bulletin includes:

- Prior authorization changes
- Training opportunities
- Updates to the Availity Essentials Portal
- You Matter to Molina Corner
- Changes in policies that could affect:
  - Claim submissions
  - Billing procedures
  - Payment
  - Disputes & Appeals (Reconsiderations)

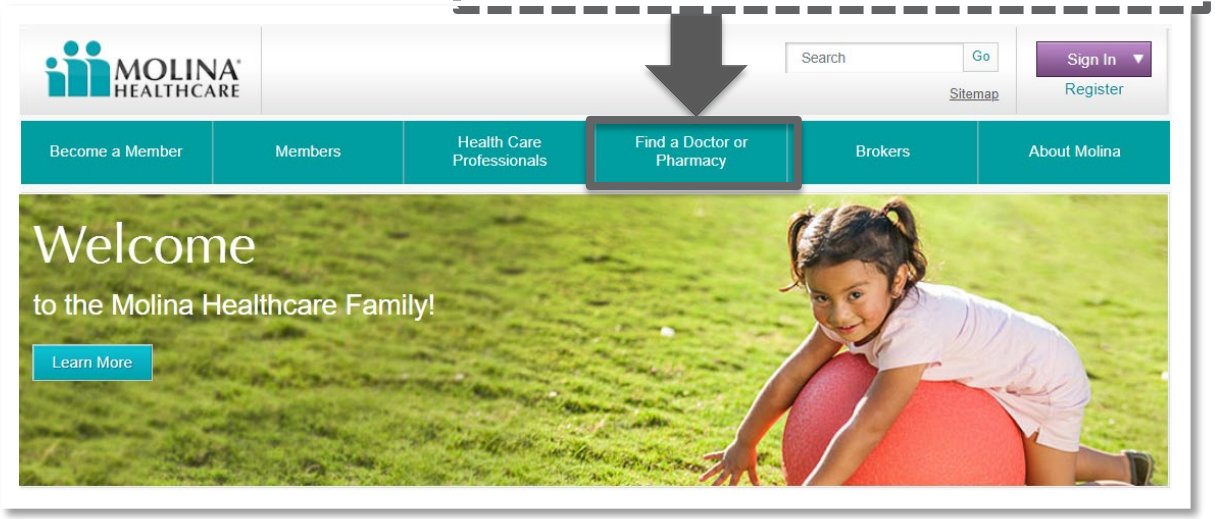
To join our distribution list, visit our Provider Website at MolinaHealthcare.com and under the "Communications" tab, on the "Provider Bulletin" page select "click here."

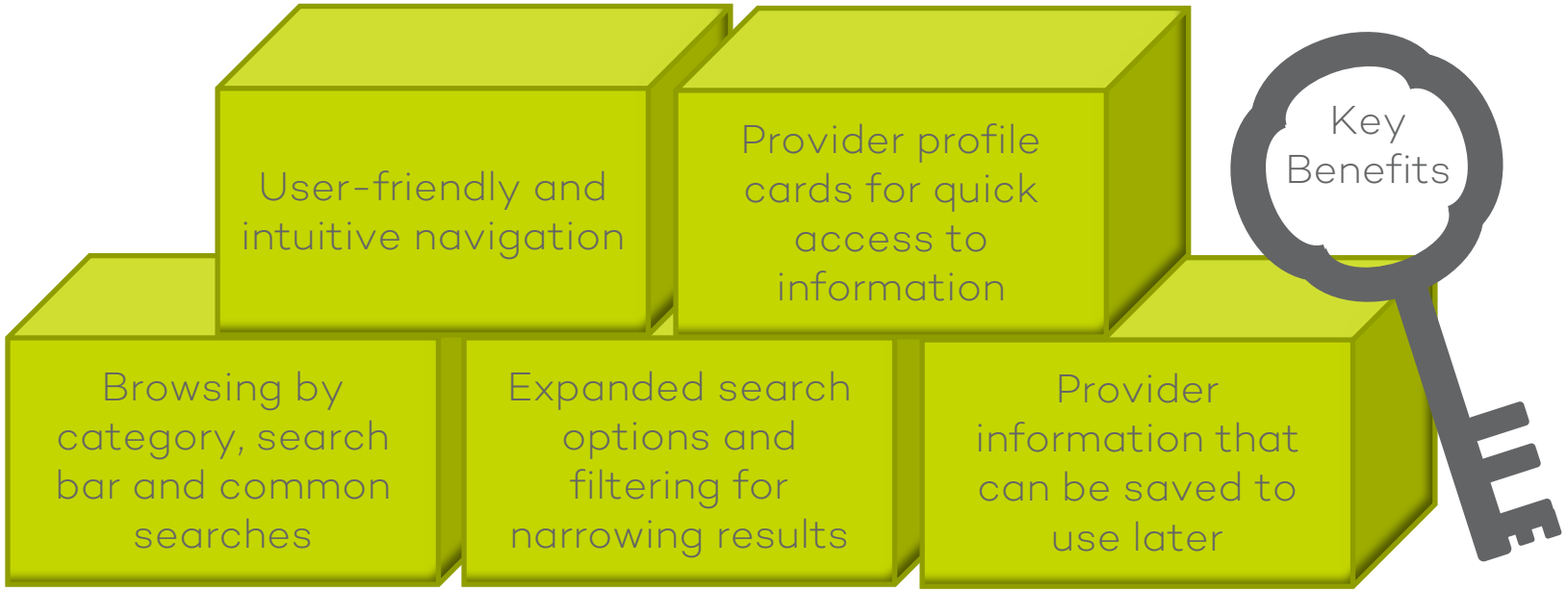
Molina Provider Online Directory

To find a Molina provider, click "Find a Doctor or Pharmacy"

The Molina Provider Online Directory offers enhanced search functionality so information is available quickly and easily.

Providers are encouraged to use the Provider Online Directory linked on our Provider Website to find a network provider or specialist.



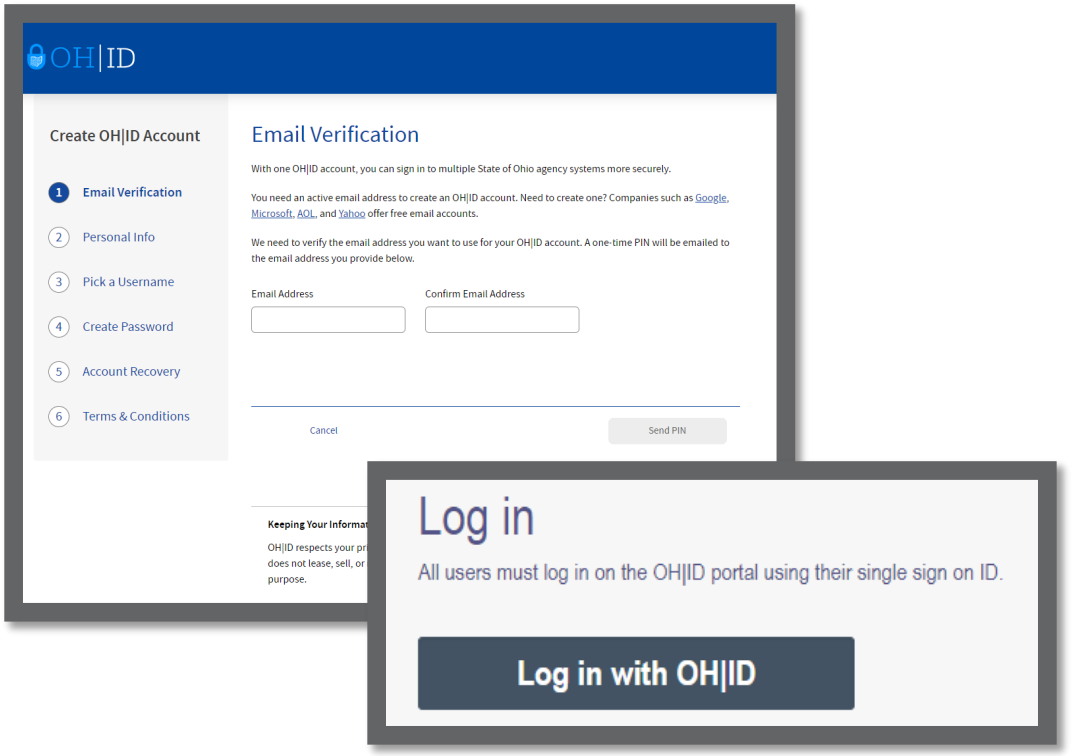


Reminder: Members should be referred to participating providers.

ODM Provider Online Directory and OH|ID

As of Oct. 1, 2022, the Ohio Department of Medicaid (ODM) launched the Provider Network Management (PNM) module to develop a comprehensive provider directory at the state level. View the ODM Quick Reference Guides to learn more.

Important! Medicaid providers are required to obtain a State of Ohio ID (OH|ID) to do business with Ohio Medicaid. Register at Create Account | OH|ID | Ohio's State Digital Identity Standard.



An OH|ID is a personal online user account that provides a secure, personalized experience for providers to interact with multiple state agencies, programs and services—all with a single username and password.

Find out more in the ODM Provider Network Management Frequently Asked Questions.

Provider Data Accuracy

Maintaining an accurate and current Provider Directory is a state and federal regulatory requirement, as well as a National Committee for Quality Assurance (NCQA)-required element.

Medicaid and MyCare Ohio: On Oct. 1, 2022, ODM migrated to the new PNM system for provider information and updates. View the ODM Quick Reference Guides for more information. Note: The Provider Information Update Form may still be required for some Medicaid and MyCare Ohio updates.

Medicare and Marketplace: Providers can update their information via the Council for Affordable Quality Healthcare (CAQH) DirectAssure application or by submitting a Provider Information Update Form to Molina.

Important Reminders:

- Providers must validate their information at least quarterly for correctness and completeness.
- Notice of changes must be made at least 30 days in advance of any of the following:
  - Change in office location, office hours, phone, fax or email
  - Addition or closure of an office location
  - Addition or termination of a provider
  - Change in Practice Name, Tax ID and/or National Provider Identifier (NPI)
  - Open or close your practice to new patients (PCP only)

Molina ID Cards

Providers are encouraged to review the most up-to-date version of the Molina Member ID Cards available in our Provider Manuals at MolinaHealthcare.com on the "Manual" page.

- Medicaid Member Cards
- MyCare Ohio Member Cards
- Medicare Member Card
- Marketplace Member Card

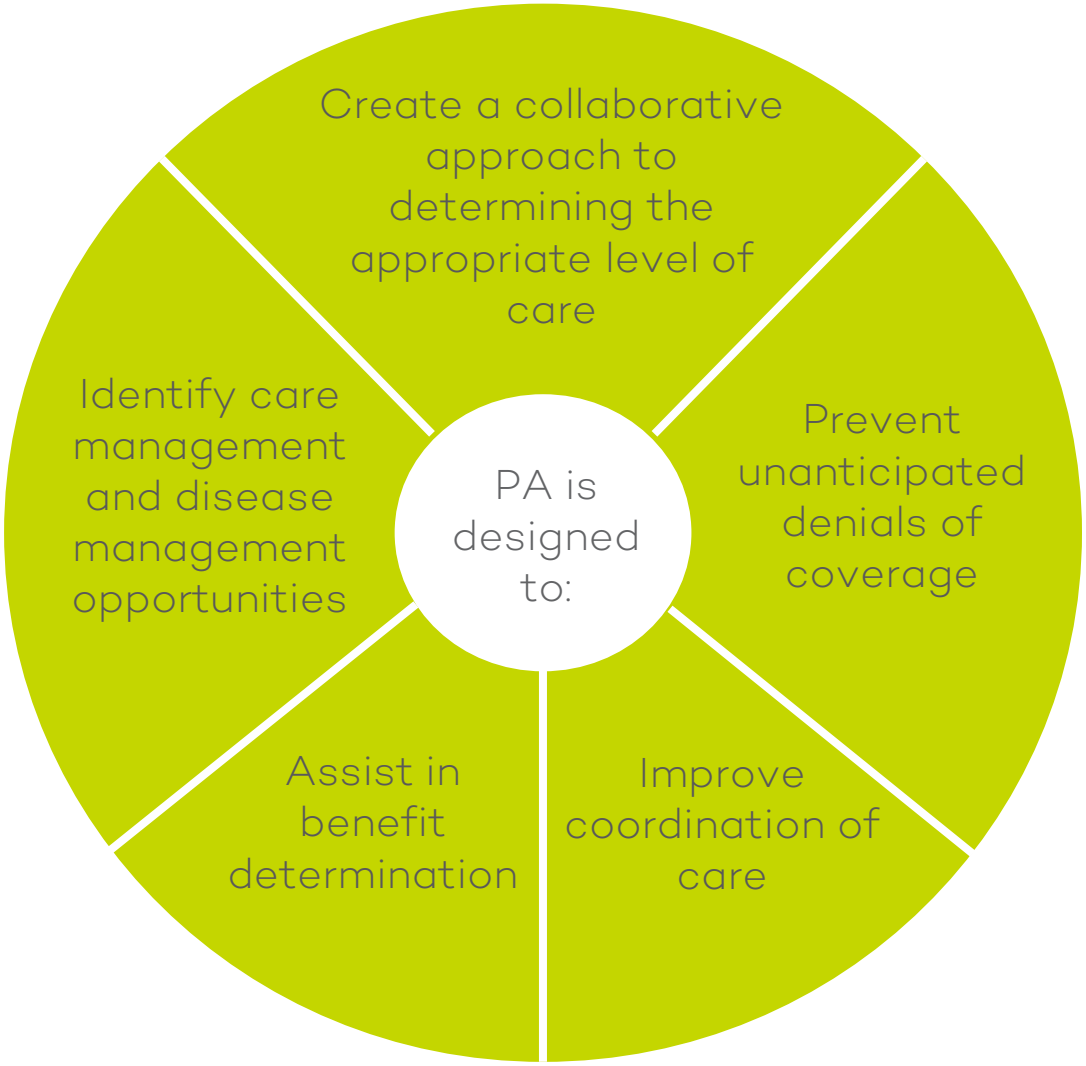
Prior Authorization (PA)

Prior Authorization (PA) is a request for prospective review. Requests for services on the PA Lookup Tool on our Provider Website and Provider Portal are evaluated by licensed nurses and trained staff.

Health Care Professionals

- Medicaid
- Medicare
- MyCare Ohio
- Marketplace
- Provider Portal
- Prior Auth LookUp Tool

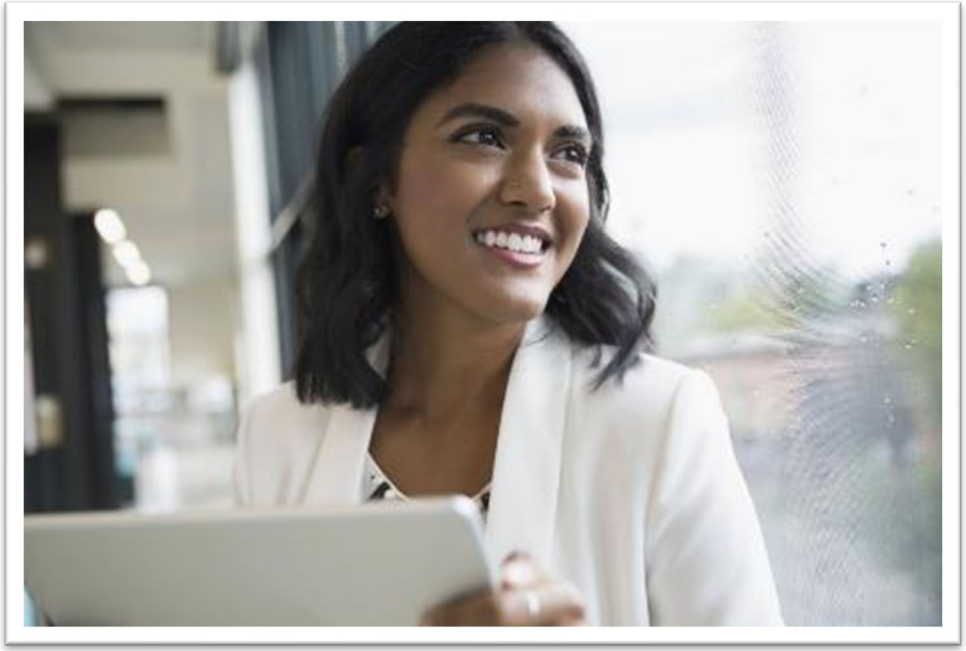
Utilize the PA Lookup Tool on our Provider Website and Provider Portal to determine if a PA is required



Provider Responsibilities

Molina expects our contracted providers will respect the privacy of Molina members (including Molina members who are not patients of the provider) and comply with all applicable laws and regulations regarding the privacy of patient and member Protected Health Information (PHI).

For additional information view the "Provider Responsibilities" section of the Provider Manual, located at MolinaHealthcare.com under the "Manual" tab. Topics include:



- Non-Discrimination of Health Care Service Delivery
- Provider Data Accuracy and Validation
- National Plan and Provider Enumeration System (NPPES) Data Verification
- Electronic Solutions/Tools Available to Providers
- Primary Care Provider (PCP) Responsibilities

You Matter to Molina

At Molina of Ohio, our providers matter! Our "You Matter to Molina" program connects us directly to our entire network of providers as we support their efforts to delivery high-quality and efficient health care for Molina members.

- The program gives providers access to monthly Provider Bulletins, newsletters, trainings, surveys, presentations, videos, resource documents, reference guides and more.
- Free access to the PsychHub platform offering free mental health educational courses and CEU opportunities for providers, as well as patient-facing resources.
- Availity Essentials Portal access and training resources.
- Learn more now at MolinaHealthcare.com/OH/YouMatterToMolina.

Thank you for being part of the Molina family.

Medicaid Definitions of Terms: Authorization Appeal and Claim Disputes

Authorization Appeal

Formerly known as an "authorization reconsideration." A provider dispute for the denial of a PA. Should be submitted on the Authorization Reconsideration Form (Authorization Appeal and Clinical Claim Dispute Request Form) and submitted via fax.

Clinical Claim Dispute

Formerly known as an "authorization reconsideration." A post-claim provider dispute for the denial of a PA or a retro-authorization request for Extenuating Circumstances. Must be submitted on the Authorization Reconsideration Form (Authorization Appeal and Clinical Claim Dispute Request Form). May be submitted via Availity Essentials, fax or verbally.

Non-Clinical Claim Dispute

Formerly known as a "claim reconsideration." This process is used only for disputing a payment denial, payment amount or a code edit. The Non-Clinical Claim Dispute must be submitted on the Claim Reconsideration Form (Non-Clinical Claim Dispute Form). May be submitted via Availity Essentials, fax or verbally.

MyCare Ohio, Medicare and Marketplace Definitions of Terms: Authorization Reconsideration and Claim Reconsideration

Authorization Reconsideration is either:

- A provider dispute for the denial of a PA. Should be submitted on the Authorization Reconsideration Form and submitted via fax.
- A post-claim provider dispute for the denial of a PA or a retro-authorization request for Extenuating Circumstances. Must be submitted on the Authorization Reconsideration Form. May be submitted via the Availity Essentials Portal or via fax.

Claim Reconsideration is used only for disputing a payment denial, payment amount or a code edit. The Claim Reconsideration must be submitted on the Claim Reconsideration Form. May be submitted via the Availity Essentials Portal or via fax.

Types of Claim Forms

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Professional and Institutional Claim Forms

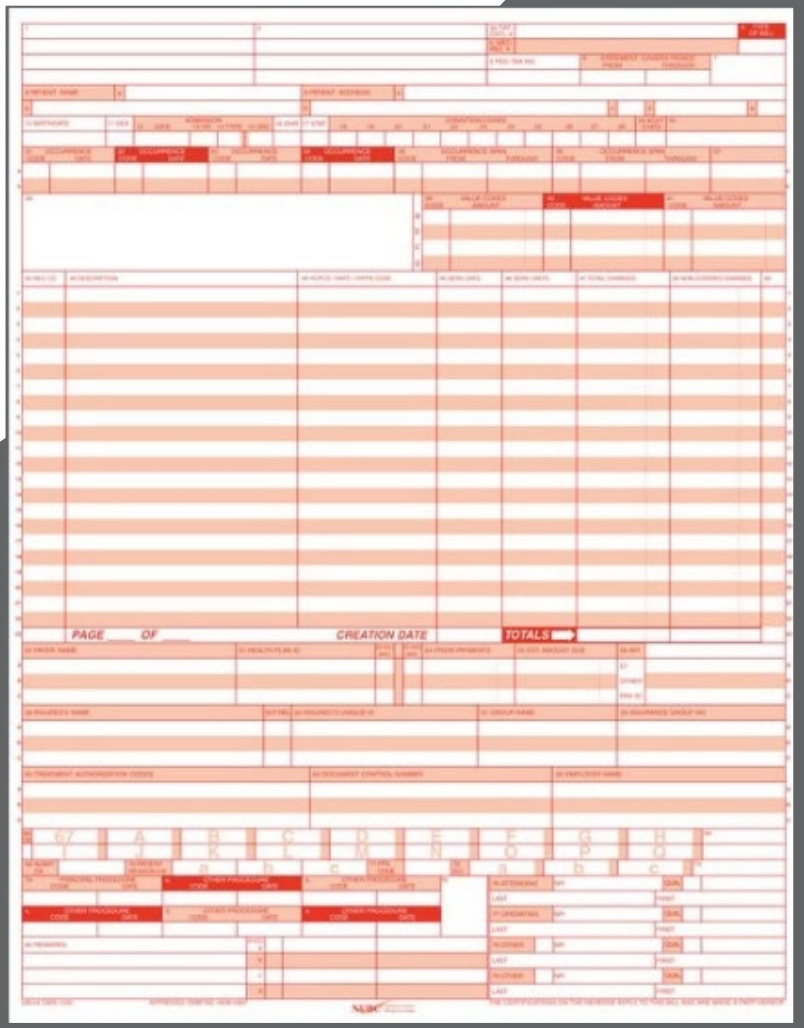
The two claim forms used for billing Molina include:

Providers should follow standard guidance for accurate completion of UB-04 and CMS-1500 claims prior to submission

The two form types do not always stand alone. For example, if a surgeon performs a procedure in a facility such as a hospital or Ambulatory Surgery Center (ASC), a CMS-1500 will be submitted for the surgeon's services only, while a separate UB-04 form will be submitted for the use of the facility. Both forms will be needed to fully bill out for a procedure.

UB-04 Claim Form

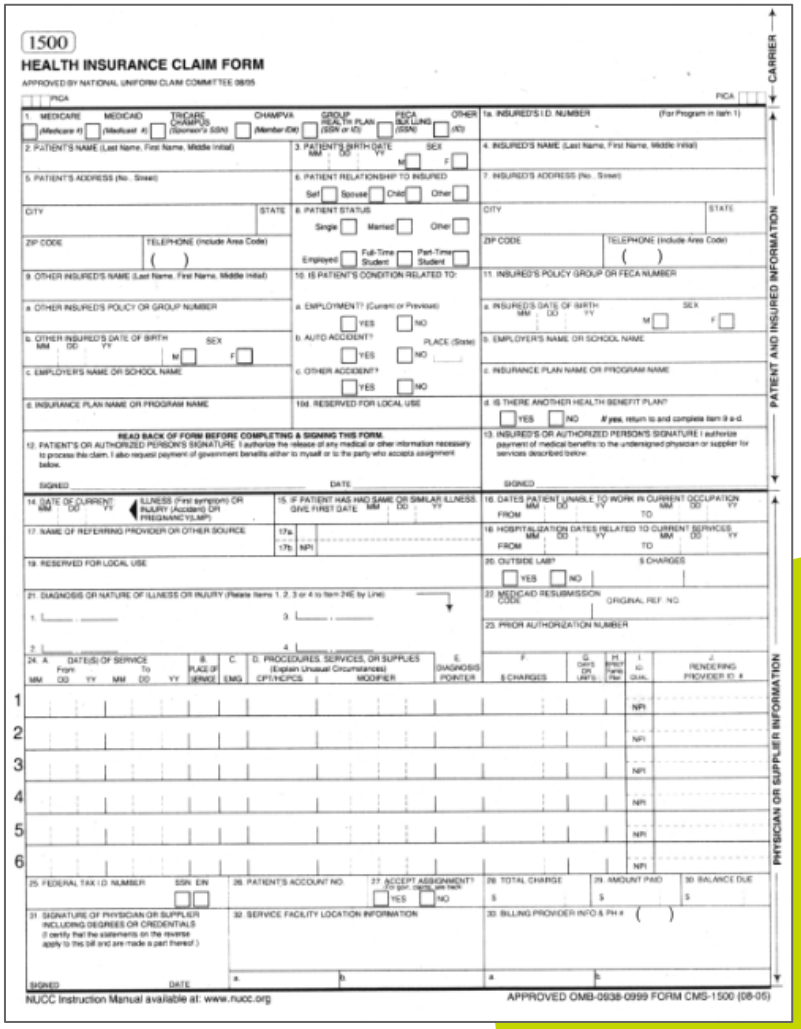
The National Uniform Billing Committee (NUBC) UB-04 claim form includes 81 fields and is used by facility providers, including:



Molina strongly encourages providers to submit claims electronically, including secondary claims.

CMS-1500 Claim Form

The National Uniform Billing Committee (NUBC) CMS-1500 claim form includes 33 fields and is used by non-institutional providers, up to and including:



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

18. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

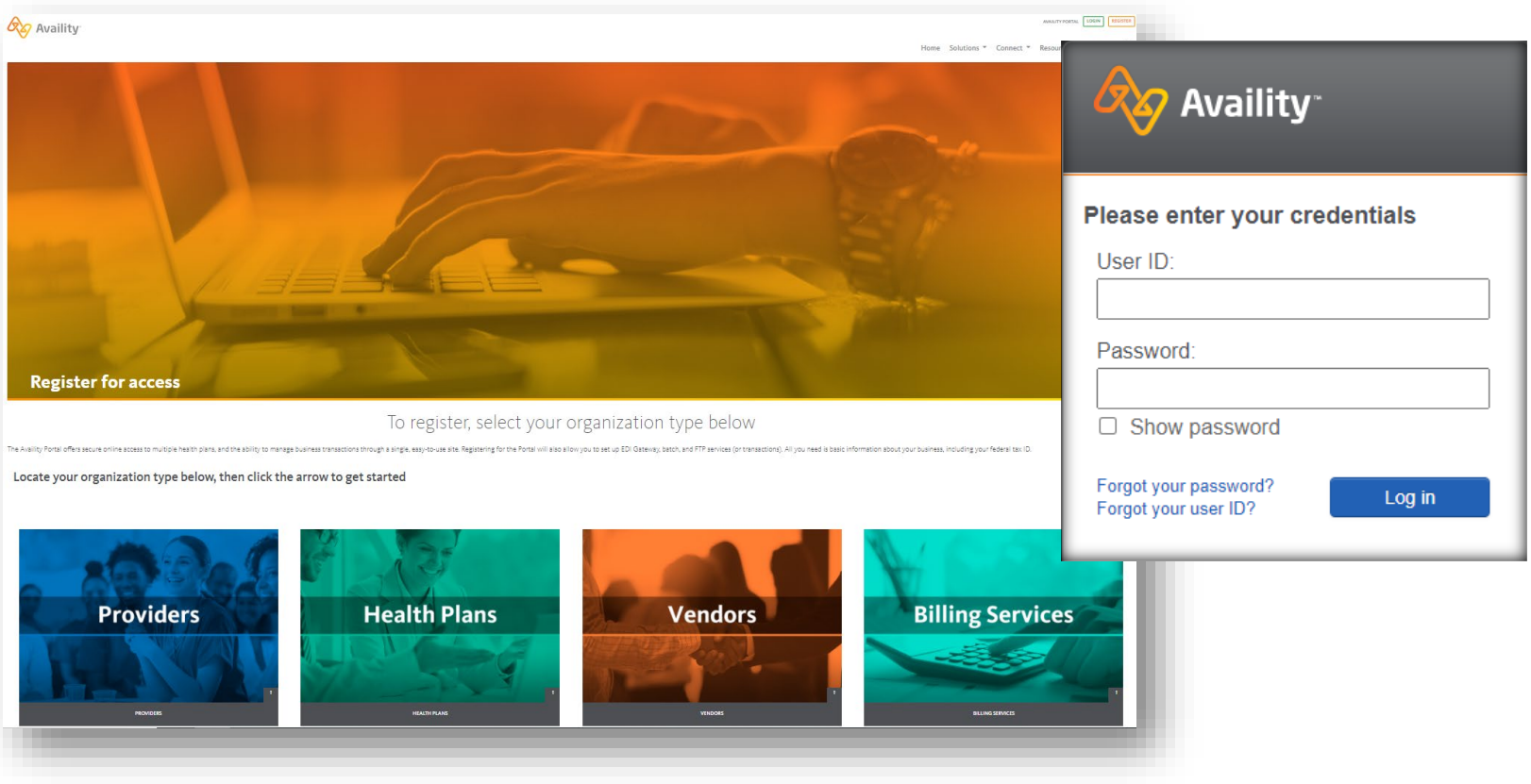
Molina strongly encourages providers to submit claims electronically, including secondary claims.

Availity Essentials Portal

MOLINA HEALTHCARE

Availity Essentials (Availity) Provider Portal

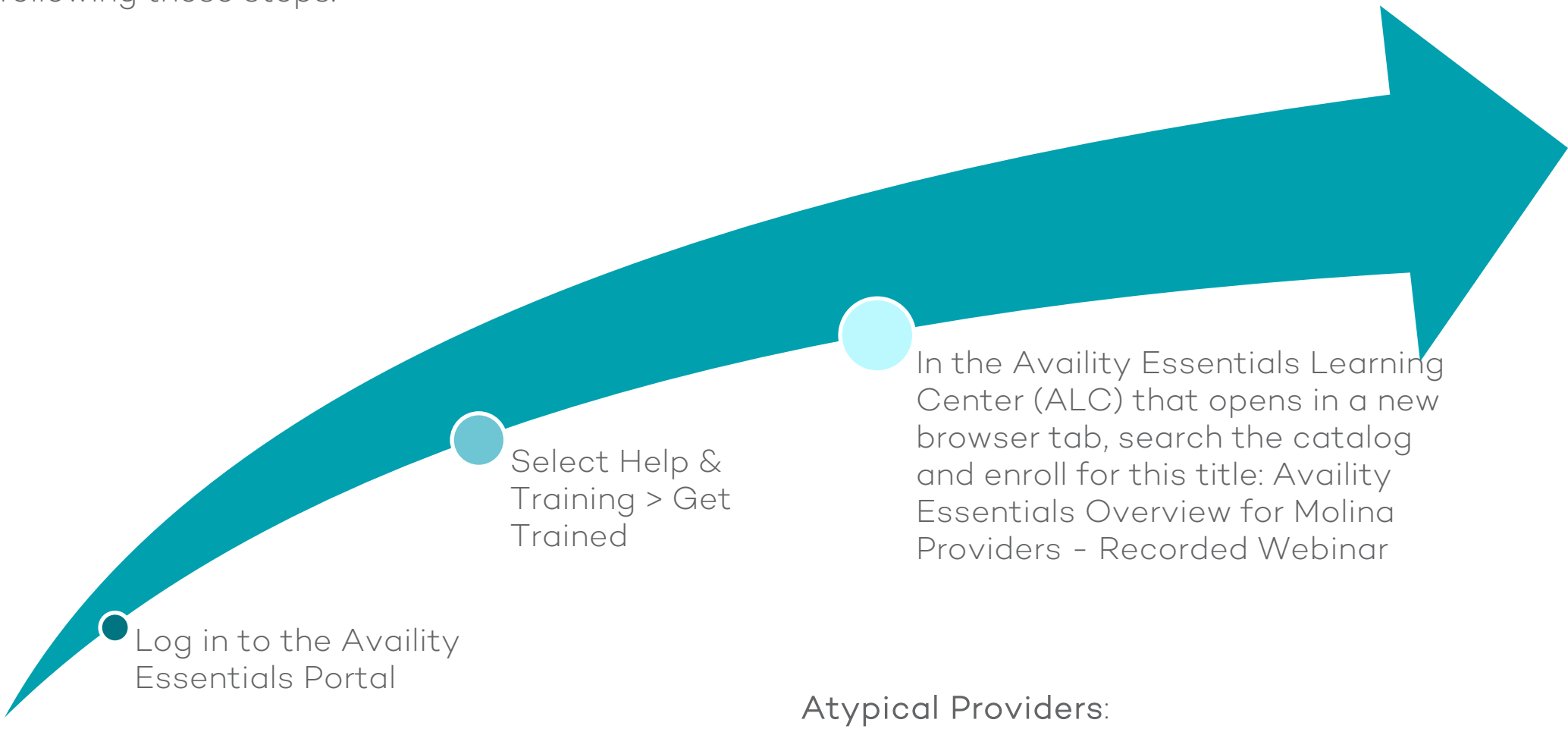
Register for the Availity Essentials Portal at availity.com/provider-portal-registration and select your organization type.



Log into the Availity Essentials Portal at:
apps.availity.com/availity/web/public.elegant.login.

Availity Essentials Portal

Once registered providers will have access to the Availity Essentials Portal training by following these steps:



Atypical Providers:
Under "News and Announcements" select "Atypical Providers: Here's your Ticket to Working with the Availity Essentials Portal" to view training sessions.

Availity Essentials Portal

The Availity Essentials Provider Portal is secure and available 24 hours a day, seven days a week. Self-service Provider Portal options include:

- Online Claim Submission
- Claims Status Inquiry
- Corrected Claims
- Member Eligibility Verification and Benefits
- Secure Messaging
- Check Status of Claim Dispute

- Manage Overpayment Request
- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Online Non-Clinical Claim Dispute (Claim Reconsideration) Requests
- Care Coordination Portal
- Remittance Viewer
- View PCP Member Roster
- Submit and Check Status of PA Requests

Coordination of Benefits

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Primary Insurance

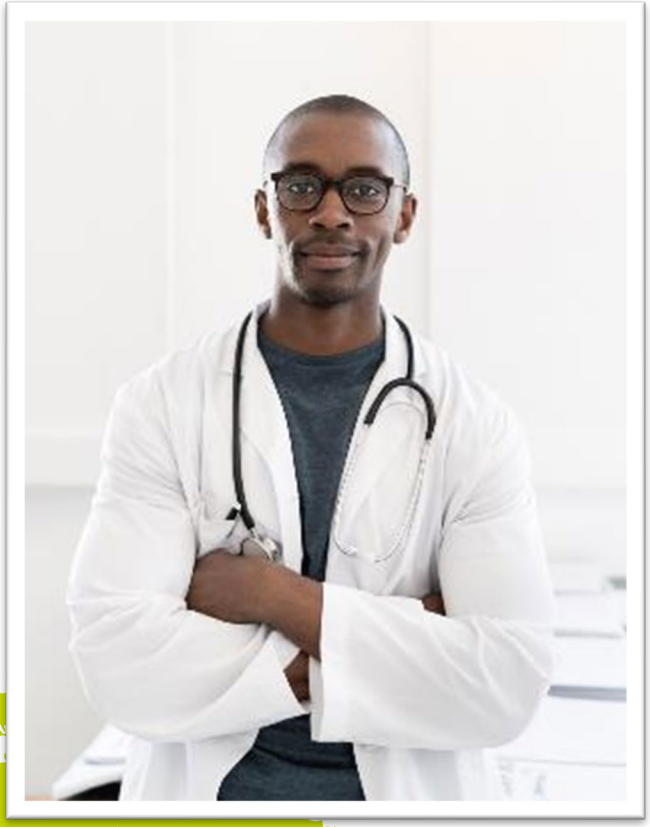
A Medicaid beneficiary may have a third-party resource (health insurance, another person or entity) that is liable to pay for the beneficiary's health care.

Third Parties could include:

- Health Insurers (include private or employer-based coverage, Medicare and TRICARE)
- Other government programs
- Other liable people or entities

Coordination of Benefits (COB) ensures that payment is not more than required and helps recover payments when a third party is responsible to pay for all or some of the health care received by a member.

Primary and Payer of Last Resort



When a person has Medicaid and there is another liable third party:

Health insurance, including Medicare and TRICARE generally pays first, to the limit of coverage liability.

Other third parties generally pay after settlement of claims.

Medicaid is payer of last resort for services covered under Medicaid, except in those limited circumstances where there is a federal statute making Medicaid primary to a specific federal program.

For members with an active waiver enrollment, the waiver is the payer of last resort.

Deficit Reduction Act of 2005: Impact on Claims

Consistent with the Deficit Reduction Act of 2005 and the Ohio Administrative Code, Molina has an established process to identify third party liability through review and coordination of benefits (COB).

This process may identify and coordinate benefits pre-claim or post-claim payment.

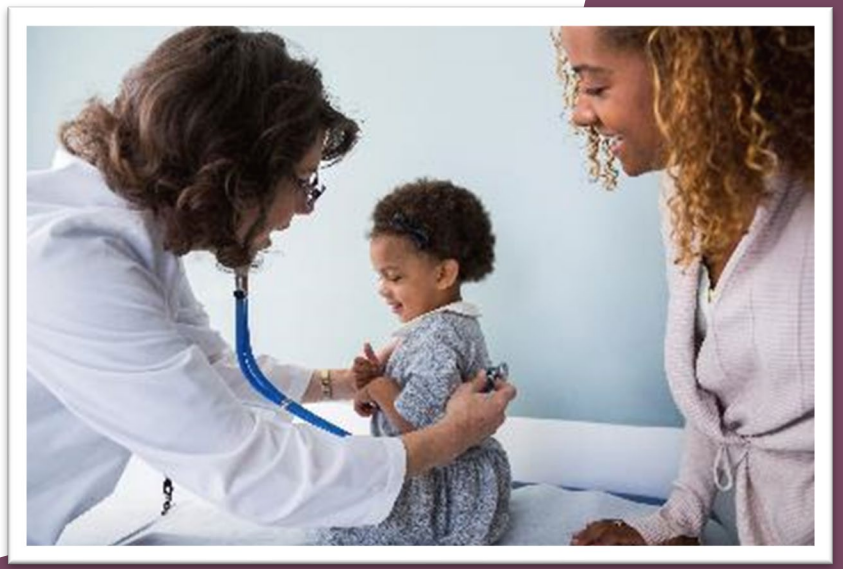
Pre-Claim: Provider receives Molina remittance advice denying the claim for other coverage/ primary Explanation of Benefits (EOB) as noted in the following grid.

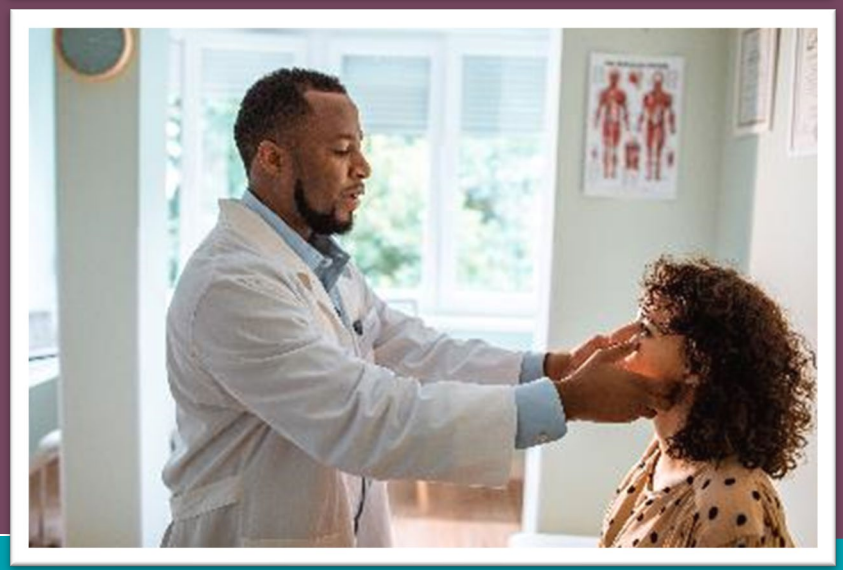
Claim remit number	Claim remit message
377	EOB not received on Claim
216	No COB entered with a Secondary Enrollment

Deficit Reduction Act of 2005: Impact on Claims, Continued

If Molina identifies commercial third party liability within 270 days from the provider's payment date from Molina:

- Molina will issue a letter to the provider stating the details of the third party payer identified by Molina as well as a request for refund of the impacted claims within 60 days.
- Provider to perform COB and bill the third party payer identified.
- Provider should refund Molina for the amount paid on the impacted claim(s) within 60 days.





- If no refund is received from the provider within 60 days, Molina will recover the amount paid from future claim payments.
- Upon receipt of third party payment, provider should submit the claim and third party remittance to Molina for COB, subject to timely filing requirements.

Deficit Reduction Act of 2005: Impact on Claims, Continued

If Molina identifies commercial third party liability more than 270 days from the provider's payment date from Molina for MyCare Ohio and Medicare lines of business:

- Molina will issue a letter to the provider stating the details of the third party payer identified by Molina as well as a request for refund of the impacted claims within 60 days.
- Provider to perform COB and bill the third party payer identified.
- Provider should refund Molina for the amount paid on the impacted claim(s) within 60 days.
- If no refund is received from the provider within 60 days, Molina will recover the amount paid from future claim payments.
- Upon receipt of third party payment, provider should submit the claim and third party remittance to Molina for COB, subject to timely filing requirements.

Deficit Reduction Act of 2005: Impact on Claims, Continued

Post-claim more than 270 days for Medicaid: If Molina identifies commercial third party liability more than 270 days from the provider's payment date from Molina for Medicaid line of business:

- Molina will submit the provider's claim to the third party payer following the Claim Reclamation process.

- OPT-OUT PROCESS: Providers may choose to opt-out of the Molina Claim Reclamation process. To do so, providers must submit a request to opt-out. The request will include the following elements:
  - Submitted on the provider's letterhead
  - List the specific tax identification number(s) to opt-out
  - Email to: OHProviderRelations@MolinaHealthcare.com

Risks of opt-out: For providers who opt-out of Claim Reclamation, Molina will recover claim payment via provider refund or recovery from future claim payments. In the event the third party payer denies the provider's claim due to timely filing or lack of medical necessity, Molina will also deny the claim as the secondary payer. Molina will also confirm the provider's claim meets Molina timely filing requirements for any additional payment as the secondary payer.

Code Editing

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Claim Editing Process

Coding edits are based on Current Procedural Terminology (CPT), Medicaid Purchasing Administration (MPA) guidelines, industry standard 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).

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

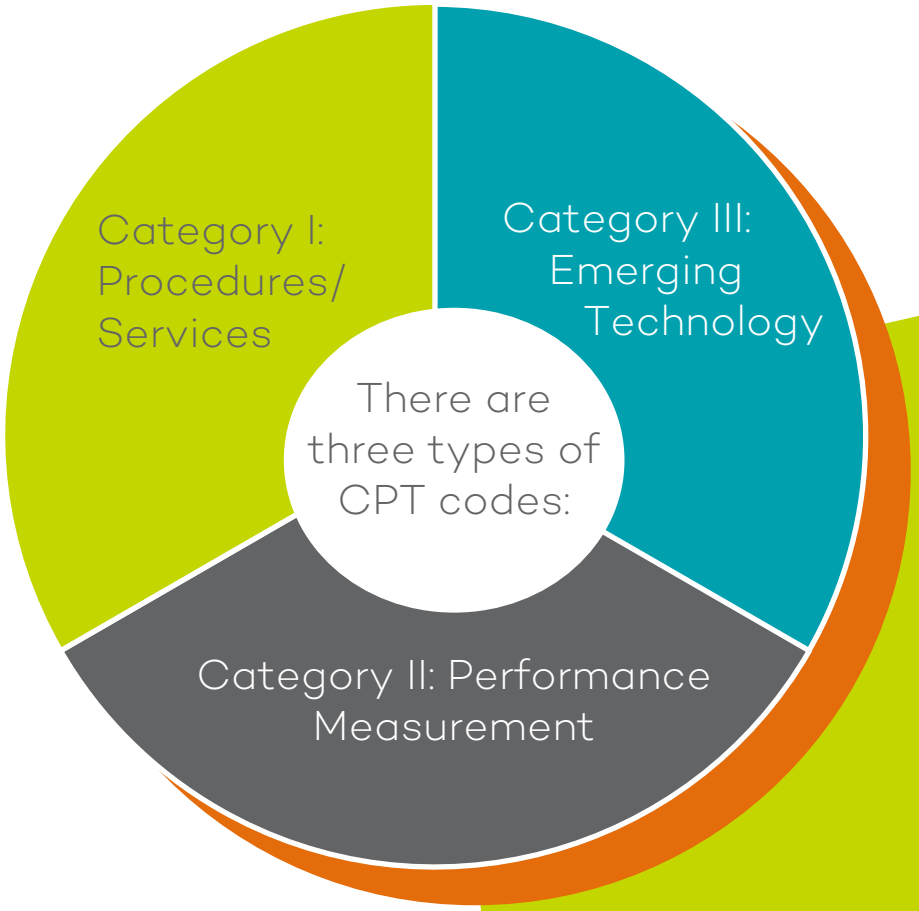
- Bundling and unbundling coding errors
- Duplicate claims
- Services included in global care
- Incorrect coding of services rendered

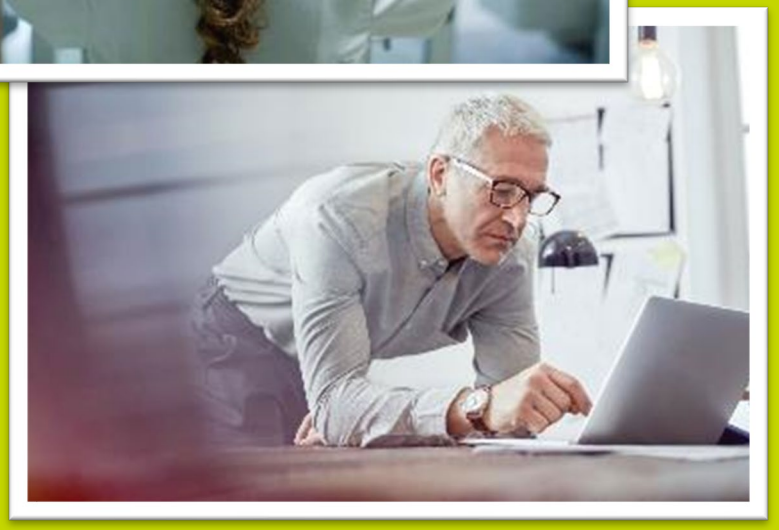
If you disagree with an edit, please follow the Non-Clinical Claim Dispute (Claim Reconsideration) process guidelines located in the Provider Manual.

Coding Sources: CPT

CPT is an American Medical Association (AMA) maintained uniform coding system.

CPT codes are five-digit numeric codes used to identify medical services and procedures furnished by physicians and other health care professionals.





Coding Sources: HCPCS

Health Care Common Procedure Coding System (HCPCS) is a CMS-maintained uniform coding system.

HCPCS codes are five-digit numeric codes used to identify procedure, supply and Durable Medical Equipment (DME) codes furnished by physicians and other health care professionals.

There are two types of HCPCS codes:

Level I:
Comprised of CPT codes

Level II:
Used to identify products, supplies and services not included in CPT codes (ex. ambulance services and DME)

Coding Sources: ICD-10 Diagnosis

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 (NCHS), 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 (ICD-10-PCS) are used to report procedures for inpatient hospital services.

11-Digit National Drug Code (NDC)

The 11-digit National Drug Code (NDC) number must be reported on all professional and outpatient claims when submitted on the CMS-1500 and UB-04 claim forms, or 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.

If the NDC information is missing or invalid, the claim line(s) will be denied.

10-Digit National Drug Code (NDC)

When the package of a drug only includes a 10-digit NDC number, the 10 digits must be converted to 11 digits by adding a leading zero to only one segment as indicated below:

Ex. 09999-9999-99

If the first segment contains only four digits, add a leading zero to the segment

Ex. 99999-0999-99

If the second segment contains only three digits, add a leading zero to the segment

Ex. 99999-9999-09

If the third segment contains only one digit, add a leading zero to the segment

Enteral Nutrition Payment

Effective June 1, 2023, HCPCS B4157-B4162 for Enteral Nutrition will require an invoice for pricing. Claims will be priced at 185% of the provider's cost multiplied by the contractual agreement.

An NDC is required for HCPCS codes B4150-4162 even with the invoice requirement.

For information on submitting the invoice attachment with the claim, refer to the Reference Guide for Supporting Documentation for Claims.

Covered Days: Value Code 80

Value code 80 (Medicaid Covered Days) must be present on inpatient and long-term care claims, or the claims will be denied.

Note: Institutional (UB) outpatient services are excluded from this requirement.

Units billed with value code 80 are the number of covered full days and must correspond with units billed on the room and board Claim line

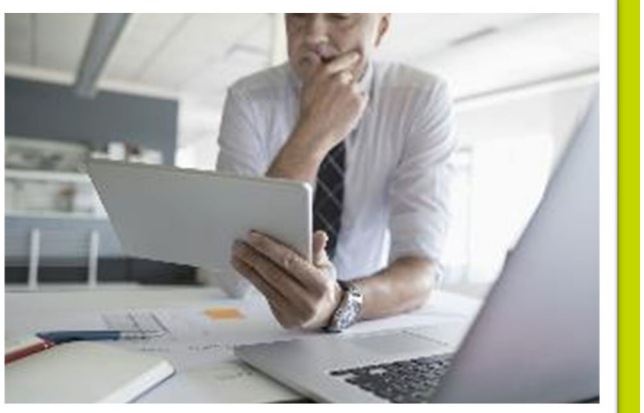
In the value code field, the number of covered days must be entered to the left of the dollars/cents delimiter

Value Code 80 and corresponding units exclude non-covered days, leave of absence days or the day of discharge or death

Review the Appendix G – Value Codes in the ODM Hospital Billing Guidelines for additional information.

Non-Covered Days: Value Code 81

Claims with non-covered days must bill value code 81 (Medicaid Non-Covered Days) to indicate the total number of full days that are not reimbursable.



- Units billed with value code 81 must correspond with units billed on the room and board Claim line
- Charges would be reported under Total Charges and Non-Covered Charges on the room and board Claim line
- The discharge date or day of death should not be included as a non-covered day in the value code or the room and board line
- Claims reporting non-covered days must report an occurrence code of 74 with the date span of the non-covered days. Claims billed with 81 but not 74 will be denied even if 81 is 0 units

Note: If non-covered days are equal to 0 then 81 is not required.

Reminder for Covered and Non-Covered Days:

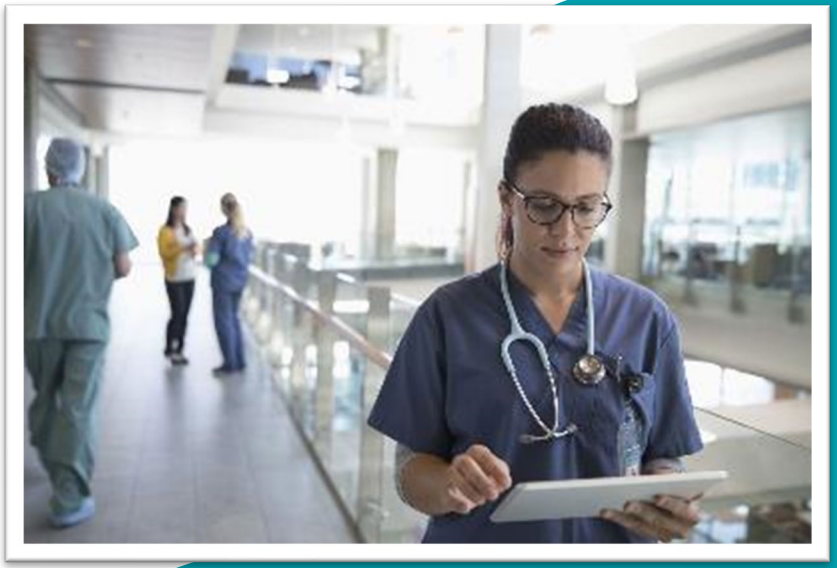
- If the covered and non-covered days' values are not reported on separate lines, the claim will be denied
- The total covered days and non-covered days billed must match at the line and header level and should not include the discharge day in the count of covered and non-covered days

National Correct Coding Initiative (NCCI)

CMS has directed all federal agencies to implement National Correct Coding Initiative (NCCI) as policy in support of Section 6507 of the Patient Affordable Care Act of March 23, 2010. Molina uses NCCI standard payment methodologies.

NCCI Procedure to Procedure edits prevent inappropriate payment of services that should not be bundled or billed together, and to promote correct coding practices.

Based on NCCI Coding Manual and CPT guidelines, some services/procedures performed in conjunction with an Evaluation and Management (E&M) code will bundle into the procedure when performed by same physician and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures.



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NCCI, Continued

NCCI editing also includes Medically Unlikely Edits (MUEs), which prevent payment for an inappropriate number/quantity of the same service on a single day. A MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same provider for the same patient on the same date of service.

Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

For additional information on CMS guidelines for NCCI edits, visit the CMS NCCI page.

Evaluation and Management (E&M)

Providers should report E&M services in accordance with the AMA CPT Manual and the CMS guidelines for billing E&M service codes: Documentation Guidelines for E&M.

- The level of service for E&M service codes is based primarily on the member's medical history, examination and medical decision-making.
- Counseling, coordination of care, the nature of the presenting problem and face-to-face time are considered contributing factors.
- Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.
- It would not be medically necessary or appropriate to bill a higher level of E&M service when a lower level or service is warranted.
- The volume of documentation should not be the primary influence upon which a specific level of service is billed and should support the level of service reported.

CMS Regulations and Guidance 30.6.1/Selection of Level of Evaluation and Management Services, A – Use of CPT Code (cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r178cp.pdf).

E&M Pre-Payment Review

Molina evaluates and reviews high-level E&M services for all lines of business.

The evaluation and review process will include claims that appear to have been incorrectly coded based on diagnostic information that appears on the claim and peer comparison.

Service codes included in the scope of this review include 99204, 99205, 99214 and 99215.

Claims that have been identified as incorrectly coded will include a remittance message that indicates that it was identified as incorrect coding.

If a provider disagrees with a claim finding, the provider can file a Non-Clinical Claim Dispute (Claim Reconsideration) following the published guidelines.

Diagnosis Related Group (DRG)

Diagnosis Related Group (DRG) (both Medicare Severity-Diagnosis Related Group [MS-DRG] and All Patient Refined-Diagnosis Related Group [APR-DRG]) clinical validations are performed by Molina and a vendor.

The DRG and principal diagnosis are to be determined upon discharge and should not be based on the clinical suspicions at the time of admission.

The DRG clinical validation determination will be made using the medical record documentation available at the time of review, or upon request, and must support all diagnoses and procedures billed, including Major Complication or Comorbidity (MCC) and Complication or Comorbidity (CC).

Correct DRG assignment is in accordance with industry coding standards:

- Coding Clinics
- ICD Coding Manual
- ICD-10-CM Coding Guidelines
- Uniform Hospital Discharge Data Set

DRG, Continued

DRG clinical validation includes, but is not limited to, verification of the following:

Diagnostic code assignments

Procedural code assignments

Sequencing of codes

DRG grouping assignment

Major Complication or Comorbidity (MCC) and Complication or Comorbidity (CC), if reported

DRG, Continued

In the event that DRG clinical validation does not substantiate the billed DRG, or it is inconsistent with standards and requirements, Molina will:

- Update the incorrect DRG to the correct DRG assignment
- Adjust payment or request refunds as appropriate
- Send a notification of the result

In the event providers do not submit requested documentation within 30 days, or the documentation submitted does not support the DRG clinical validation review, Molina may deny, reduce or recover claim payment consistent with the documentation provided.

Molina will send a notification explaining the results of the validation review.

Providers retain their right to dispute the results of these reviews as outlined in the letter or in the Provider Manual.

Optum Prepay Audit

Molina, in partnership with Optum, performs prepayment reviews utilizing widely acknowledged national guidelines for billing practices and to support uniform billing for all payers.

The prepayment claim reviews will ensure claims are billed accurately and coded correctly by reviewing state and federal policies sourced from Medicaid and Medicare rules utilized industry-wide.

The concepts utilized for the pre-pay reviews align with correct coding practices and incorporate a review of medical records to determine whether they support the services and codes billed.

Optum Pause + Prepay Review: Services Impacted

- Evaluation and Management
- Surgical Services
- Durable Medical Equipment
- Observation Stay
- Allergy Services
- Radiology

- Laboratory Services
- Behavioral Health
- Drugs and Biologics
- Add on Services
- Custom Fitted or Fabricated Orthotics
- Anesthesia Services

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Please note: This is not an all-inclusive list

Optum Prepay Audit: Avalon

Molina is collaborating with Avalon on a laboratory benefit management program to provide consistent application of laboratory policies.

Marketplace went live on March 1, 2023

Medicare went live on May 1, 2023

Medicaid go live TBD

- A post-service automated review of lab charges will be conducted for services performed in an office, hospital outpatient and independent laboratory places of service.
- Providers should continue to submit claims for lab services to Molina. Disputes will follow the standard claim dispute process.

NCDs and LCDs

Through implementation of claims edits, Molina's claims payment system is designed to audit claims concurrently, in order to detect and prevent paying claims that are inappropriate.

In the absence of state specific guidelines, Molina applies additional guidelines to their claims' payment logic, including:

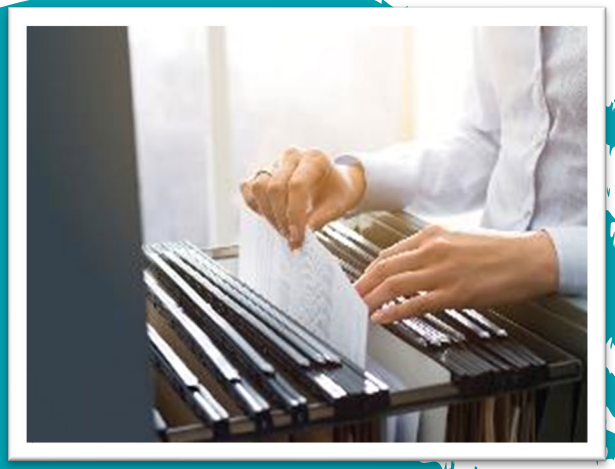
- National Coverage Determinations (NCDs)
- Local Coverage Determinations (LCDs)

NCDs and LCDs are decisions by Medicare and their administrative contractors that provide coverage information and determine whether services are reasonable and necessary on certain services offered by participating providers.

Note: NCDs supersede LCDs, but **LCDs** expand on coverage policies for each jurisdiction, and these coverage policies may vary, including information regarding appropriate coding, credentialing, diagnostic testing and treatment.

Code Edit Policy Disputes

When submitting a Non-Clinical Claim Dispute (Claim Reconsideration) related to a code edit it is important to include the information below:



- Include any supporting clinical documentation
- Include trip documentation for ambulance services
- Explanation of why the provider does not agree with Molina's current correct coding policy or interpretation
- Include the supporting alternative policy information and the source where it can be found

A provider can request a Non-Clinical Claim Dispute (Claim Reconsideration) regarding a code edit policy in situations where the provider's and Molina's correct coding policy sources conflict, or where they may have different interpretations of a common correct coding policy source.

Corrected Claims

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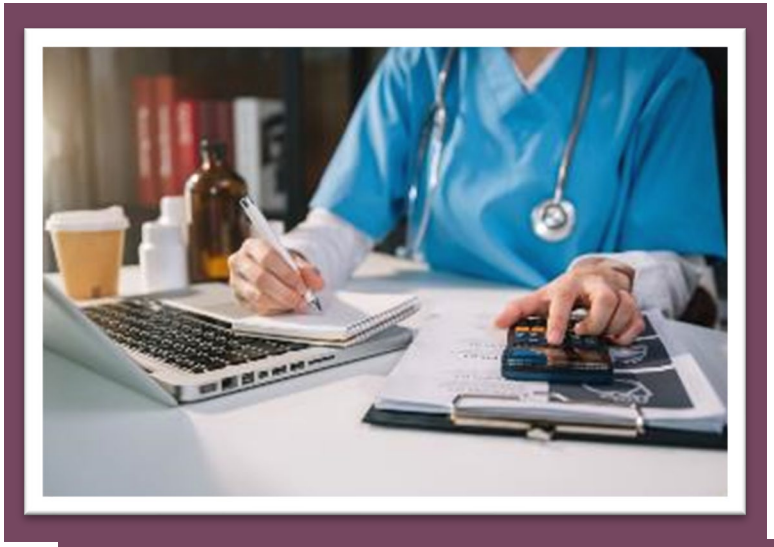
Corrected Claims

Corrected claims are considered new claims for processing purposes. Corrected claim submissions are not adjustments and should be directed through the original submission process marked as a corrected claim or it may result in the claim being denied.

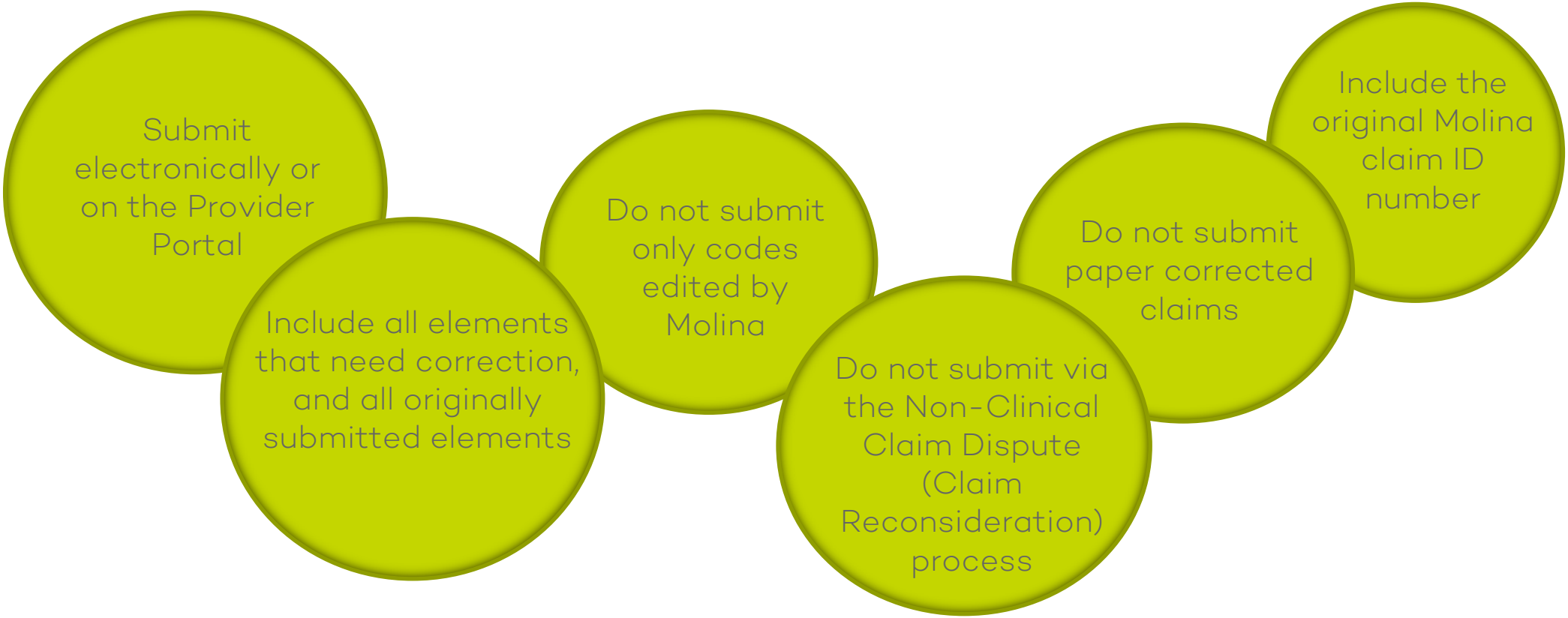


- Corrected claims must be submitted electronically with the appropriate fields on the 837I or 837P completed.
- The Provider Portal includes functionality to submit corrected Institutional and Professional Claims.
- Corrected claims must include the correct coding to denote if the claim is a replacement of prior claim or corrected claim for an 837I, or the correct resubmission code for an 837P, and include the original claim number.
- Claims submitted without the correct coding will be denied.

Corrected Claims, Continued

Corrected Claims must be received by Molina no later than the filing limitation stated in the provider contract or within 365 days of the original remittance advice. Claims submitted after the filing limit will be denied.

Reminders for the corrected claim process:



Corrected claims must be submitted with the Molina claim ID number from the claim being corrected, and with the appropriate corrected claim indicator based on claim form type.

Claim Attachments

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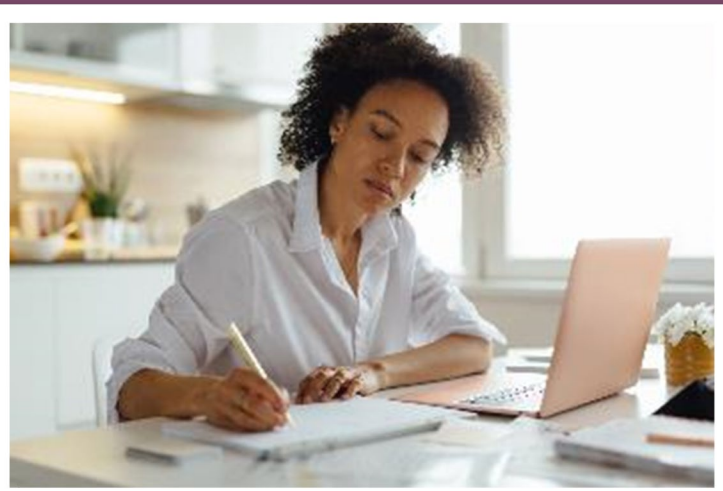
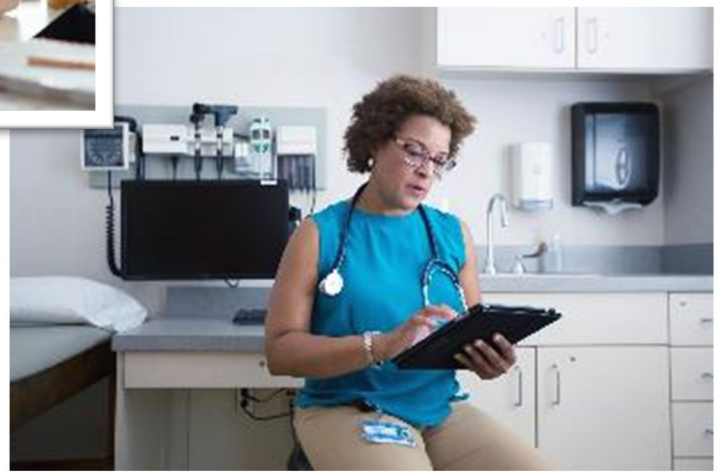
Attachments

Providers should include supporting documentation as an attachment with the initial claim, or with a corrected claim once the initial claim has been finalized.



Providers have the ability to upload documents to claims:

- In the Provider Portal at the time of the claim submission
- Attach to a claim that was submitted through Electronic Data Interchange (EDI) while it is in adjudication using the PWK Indicator process



Note: Once the claim is in adjudication it is too late to add attachments.

For additional information on the types of services or claims that require attachments for processing view the Reference Guide for Supporting Documentation for Claims resource on the Provider Website.

Medicaid and MyCare Ohio Consent Forms

The sterilization, hysterectomy and abortion consent forms must be submitted in advance of the claim, or with the claim when the service is billed. If the form is missing or incomplete the claim will be denied.

Claims for these services are paid only if the following required criteria is met:

Consent to Sterilization Form:

Required except in unique circumstances of an unscheduled clinical event that requires sterilization because of a life-threatening emergency

Abortion Certification Form:

Abortion is not covered, except when medically necessary to save the life of the member or in instances of reported rape or incest

Consent to Hysterectomy Form:

Required except in unique circumstances of an unscheduled clinical event that requires a hysterectomy because of a life-threatening emergency

Note: CPT codes 58661, 58700, 58720 and 58940 require an operative report.

For specific procedure codes where a Consent Form is required see OAC 5160-21 Reproductive Health Services.

Find additional information in the Provider Manual. The Provider Manual and consent forms are available on the Provider Website.

Non-Clinical Claim Dispute (Claim Reconsideration)

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Non-Clinical Claim Dispute (Claim Reconsideration) Not Related to an Authorization

Submit a claim reconsideration only when disputing a payment denial, payment amount or code edit. Claim reconsiderations are applicable for disputes unrelated to clinical appeals or reconsiderations associated with pre-service and post-service authorization.

Primary insurance EOB, corrected claims and itemized statements are not accepted via claim reconsideration. Please refer to the Supporting Documents or Claim Submission process guidelines.

Molina allows providers to submit claim disputes verbally, in writing or through the Availity Essentials Portal. If the provider is submitting in writing, Molina requires an intake Form which the provider completes with the claim or authorization information, the member's identifiable information and a fax number to respond to the provider's dispute. This form is the same information captured verbally during a phone call and the same information captured through the provider portal electronic submission.

The form and supporting documents can be submitted through the Availity Essentials Portal or the form can be faxed to Molina.

Non-Clinical Claim Dispute (Claim Reconsideration) Form

Request Requirements:

- Molina's form or similar document should be submitted for any dispute that is related to a claim denial that is not due to an authorization
- Requests must be fully explained as to the reason for dispute/ reconsideration
- The dispute must be submitted within the timeframes stated in the Provider Manual
- The submission should include previous claim/remittance advice, any other documentation to support the request and a copy of the authorization/referral form (if applicable)

This form is available on our Provider Website under the Forms tab.

Note: According to Ohio regulations, health care providers are not permitted to balance bill Medicaid members for services or supplies provided.

Non-Clinical Claim Dispute (Claim Reconsideration) Additional Resources

Please confirm the line of business the member is eligible under and reference the correct guide for the reconsideration process and appeal rights.

Please refer to the:

- Medicaid Auth Appeal, Clinical and Non-Clinical Claim Disputes Guide
- MyCare Ohio and Medicare Authorization and Claim Reconsideration Guide
- Marketplace Authorization and Claim Reconsideration Guide

Potentially Preventable Readmissions

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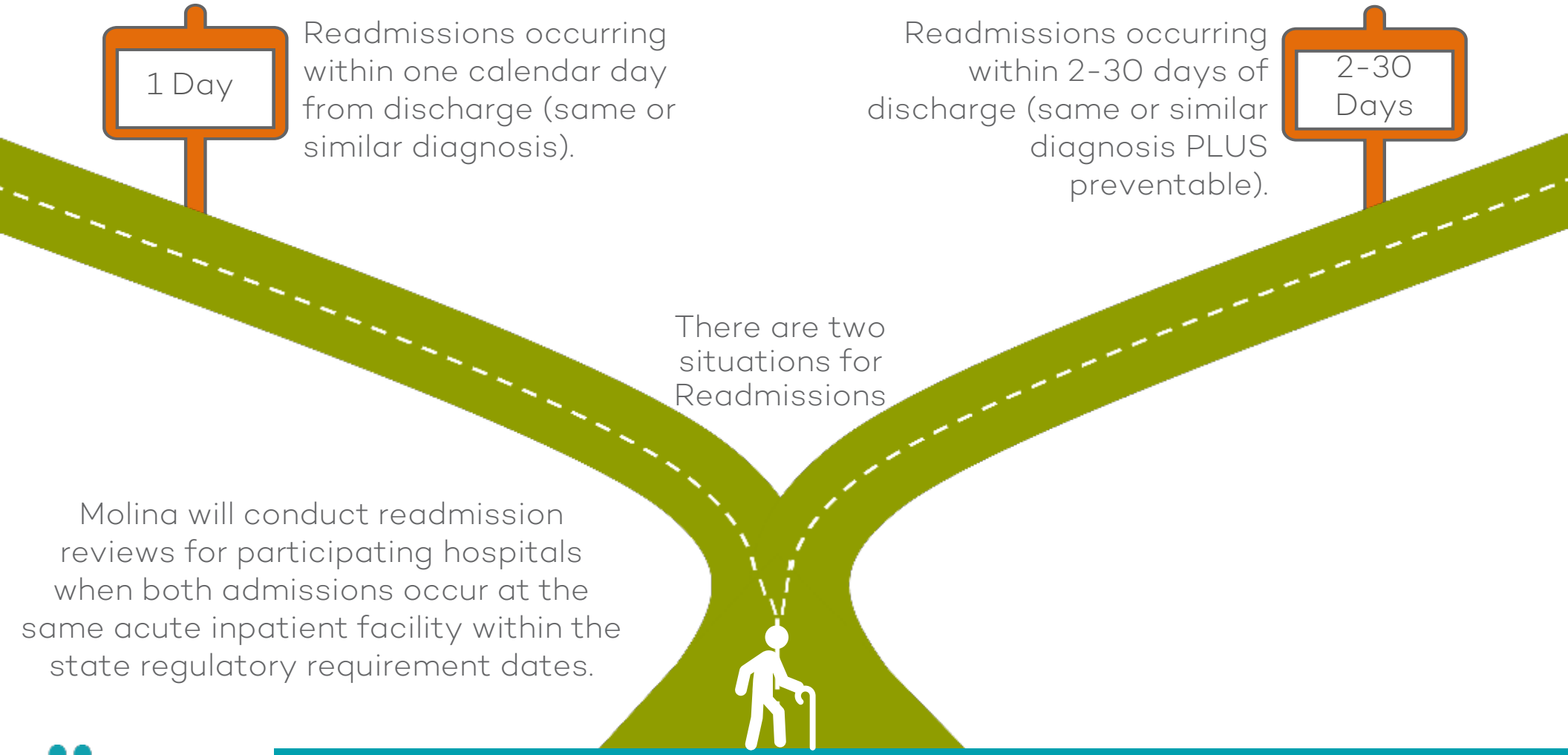
Readmissions

Readmission review is an important part of Molina's Quality Improvement Program to ensure that Molina members are receiving hospital care that is compliant with nationally recognized guidelines as well as federal and state regulations.



Readmissions, Continued

One Calendar Day

When a subsequent admission to the same facility with the same or similar diagnosis occurs within one calendar day of discharge, the hospital will be informed that the readmission should be combined with the initial admission and will be processed as a continued stay.

2-30 Days

When a subsequent admission to the same facility occurs within 2-30 days of discharge, if it is determined that the readmission is related to the first admission (readmission), or if it is determined to be preventable, then a single payment may be considered as payment in full for both the first and subsequent hospital admissions.

Provider can dispute with supporting documentation if they believe the readmission is unrelated or unpreventable based on published guidelines.

For additional information see the Readmission Payment Policy on the Provider Website.

Sepsis

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Sepsis and Septic Shock Payment Policy

Molina uses the revised sepsis guidelines issued by the Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3).

The Sepsis-3 guidelines have consolidated three sepsis categories into two categories:

- Sepsis and severe sepsis have been merged into one category, now called sepsis.
- Septic shock (or Sepsis-3) have not changed significantly.

The Sepsis-3 definition will be used in clinical claim reviews to validate that sepsis was present and that related services were appropriately submitted as part of the member's claim.

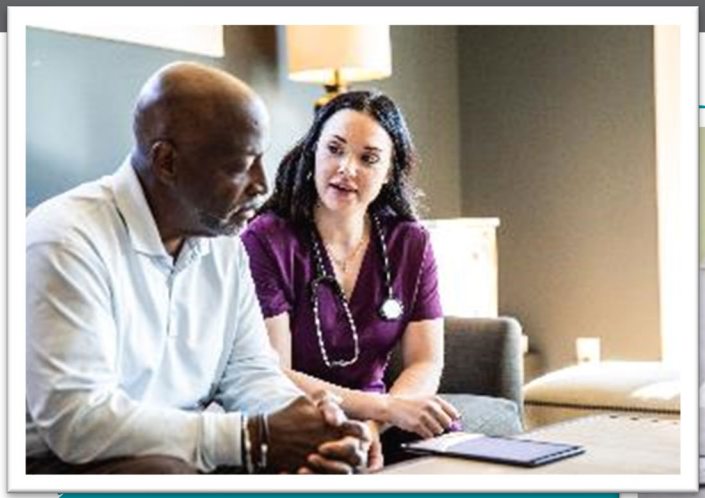
If clinical documentation provided to and reviewed by Molina does not support Sepsis-3 definitions and associated services, hospital payments will be adjusted appropriately.

Sepsis and Septic Shock Payment Policy: Claims

Molina will review the clinical at the time of the claim receipt to determine if any diagnosis (primary or secondary) of sepsis or septic shock meet the Sepsis-3 guideline:

If clinical documentation meets Sepsis-3 guidance, the claim will be processed based on medical necessity and standard payment guidelines.

If clinical documentation does not meet Sepsis-3 guidance, the claim will be processed with the removal of the sepsis or septic shock diagnosis(es) when evaluating the payment.



If a sepsis or septic shock diagnosis is determined to be inappropriate, providers will have standard timelines via the Non-Clinical Claim Dispute (Claims Reconsideration) Process for Molina to perform review of the additional documentation from providers.

Contact Molina

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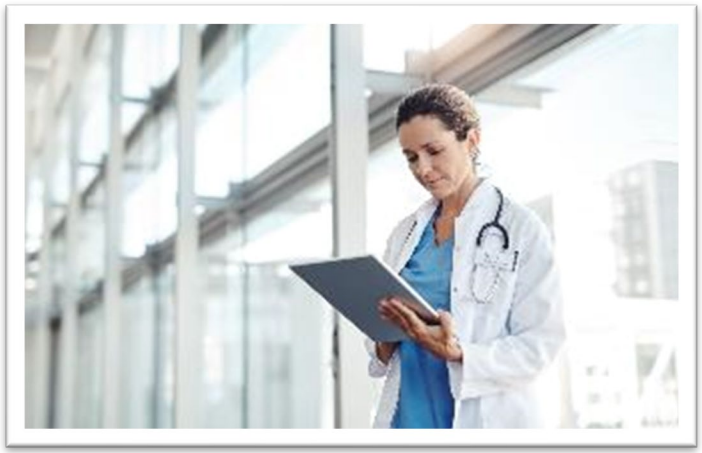
Molina Provider Training Survey

The Molina Provider Relations Team hopes you have found this training session beneficial.

Please share your feedback with us so we can continue to provide you with excellent customer service!



Please take a few minutes to complete the Molina Provider Training survey to provide feedback on this session. The survey is located on the You Matter to Molina Page of our Provider Website, under the "Communications" tab.

Molina wants to hear about what other topics you'd like training on in the future.

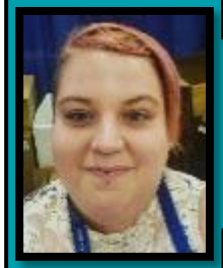
Molina of Ohio Provider Relations Contact Information

Molina has designated email addresses based on provider types to help get your questions answered more efficiently or to connect you to training opportunities:


Jeanneen


Yvonne


Alex


Mariah


Sarah

Provider Type	PS Rep.	Email Address
Physician groups, Specialists, FQHC Non-BH Providers, Advanced Imaging/ Radiology, Ambulatory Surgical Centers, Anesthesiologists and Hospitalists	Jeanneen Williams	OHProviderRelationsPhysician@MolinaHealthcare.com
Skilled Nursing, Long Term Acute Care, Hospice and Assisted Living Facilities	Yvonne Mitchell	OHProviderRelationsNF@MolinaHealthcare.com
Home Health Agencies, Waiver (LTSS), Laboratories, Ancillary Dialysis Centers and Durable Medical Equipment	Alexandrea Grier	OHMyCareLTSS@MolinaHealthcare.com
BH Providers (ODMHAS, CMHC, 84/95) and FQHC BH Providers	Mariah Vinson	BHProviderRelations@MolinaHealthcare.com
Multi-Specialty and assists with all provider types	Sarah Stevens	OHProviderRelations@MolinaHealthcare.com

Molina Provider Relations Contact Information, Continued

Jeremy

Christopher

Andrea

Crysta

Bill

Contact information for hospital-affiliated providers or groups:

Hospital Region	Representative	Email Address
All State	Jeremy Swingle	OHProvider.RelationsHospital@MolinaHealthcare.com
All State	Christopher Jones	OHProvider.RelationsHospital@MolinaHealthcare.com
East Region	Andrea Williams	OHProvider.RelationsHospital@MolinaHealthcare.com
West Region	Crysta Davis	OHProvider.RelationsHospital@MolinaHealthcare.com

Contact information for our Provider Advisory Council (PAC):

Provider Region	Representative	Email Address
All State	William Caine	OHProviderRelations@MolinaHealthcare.com

For general inquiries, questions or to identify your specific representative:

Email Address
OHProviderRelations@MolinaHealthcare.com

Contact information for Provider Engagement Team providers or groups:

Provider Region	Representative	Email Address
All State	Sonya Adams	OHProviderServicesPET@MolinaHealthCare.Com
All State	Shard'e Stubbs	OHProviderServicesPET@MolinaHealthCare.Com

Thank You

Questions

Open Discussion

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Thank you for participating in today's meeting!