ODM Designated Provider and Non-Contracted Provider Guidelines

As an Ohio Department of Medicaid (ODM) Designated Provider and/or a non-contracted provider with Molina Healthcare of Ohio, Inc., it is important to understand Molina's operating guidelines, including prior authorization (PA) and claims processes, to avoid delays in claims payment. Molina knows efficient processes are important to providers, and we are committed to getting you the most current information.

Following the guidelines and reference links below will help ensure we receive all the information we need to process your requests as quickly as possible so you can focus on what's most important: providing excellent care to your patients.

OH|ID Reminder: Medicaid providers are required to have an OH|ID (Ohio Identification) to access the Provider Network Management (PNM) system and Single Pharmacy Benefit Manager (SPBM) secure web portal and do business with Ohio Medicaid.

As a reminder: All Medicaid providers must be active with ODM to be eligible for reimbursement. Visit ODM's PNM Website to learn more.

Provider Portal

Availity Essentials Portal (Availity): A no-cost online platform that offers a number of features, including:

- Claim processing features:
  - Submit Professional (CMS-1500), and Institutional (UB-04) claims with attached files
    - Note: At a future date to be determined by ODM, Medicaid direct data entry claims must be submitted via the ODM PNM portal
  - Correct/Void claims
  - Add attachments to submitted claims still in process
  - Check claims status
  - Create and manage claim templates
  - Create and submit a claim appeal (Clinical and Non-Clinical Claim Dispute) with attached files
- Check Member Eligibility & Benefits
- Submit and status check PA Request status
  - Note: At a future date to be determined by ODM, Medicaid PA must be submitted via the ODM PNM portal or Ohio Medicaid Enterprise System (OMES) Electronic Data Interchange (EDI).

In addition to the Availity Portal, providers may also contact Provider Services at (855) 322-4079 for eligibility verifications, claim status inquiries, referrals, PA and post-stabilization care services.

Member Eligibility Verification

- Availity Portal: provider.molinahealthcare.com
- ODM Integrated HelpDesk for Medicaid, at (800) 686-1516 via the interactive voice response (IVR) system
- ODM PNM system

- Molina Provider Services: (855) 322-4079 7 a.m. to 8 p.m. Monday through Friday for Medicaid, and 8 a.m. to 6 p.m. Monday through Friday for MyCare Ohio

OMES: The ODM OMES Fiscal Intermediary through EDI

Medicaid providers are required to submit the below-referenced EDI transactions through OMES.

- Providers utilizing EDI transactions must use the ODM OMES Fiscal Intermediary for the transaction types noted in the Payer ID grid below. At this time, PA requests will continue to be submitted following the processes providers use today. The below list of payer IDs must be used for the ODM OMES EDI transactions.

  Medical Claims Payer IDs:

Medical Claims	
Line of Business	Payer ID
Ohio Aged, Blind, or Disabled (ABD) (Medicaid)	0007316
Ohio Adult Extension (Medicaid)	0007316
Ohio Healthy Families (Medicaid)	0007316
Molina SKYGEN Dental	D007316
Molina March Vision	V007316
Ohio Marketplace Program	20149
Ohio Marketplace Program Primary with Ohio Medicaid Secondary (ABD, Adult Extension, Healthy Families)	20149
Medicare-Medicaid Plan (MMP) Medicare (MyCare Ohio)	20149
MMP Medicaid (MyCare Ohio)	20149
MMP Opt-Out/MMP Medicaid Secondary (MyCare Ohio)	20149
Medicare Advantage Prescription Drug (MAPD)	20149

PNM System: ODM PNM System: The PNM platform is only available for Medicaid and MyCare Ohio providers and allows for one front door for provider enrollment, centralized credentialing, provider self-service (demographic updates and group affiliations) and enhanced provider directory.

Note: At a future date to be determined by ODM, Medicaid providers will be required to comply with electronic service authorization submission requirements through ODM's PNM system or EDI transactions. For instructions and training resources about future OMES EDI and PNM system functionality, please visit the following ODM pages:

- OMES EDI
- PNM

Prior Authorization

All non-emergent services rendered by non-contracted providers require PA unless specified otherwise.

- Abortions, Hysterectomies and Sterilizations: PA is required for non-contracted providers
  - The appropriate ODM consent form must be signed by the member and submitted to Molina in the timeframes specified. The ODM Forms page links to the required ODM forms.
- Ambulance: PA is not required for emergent situations
- Emergency Room: PA is not required for services billed in conjunction with an emergency room visit
- Federally Qualified Health Center (FQHC): Exempt from PA requirements
- Rural Health Clinic (RHC): Exempt from PA requirements
- Qualified Family Planning Provider (QFPP): Exempt from PA requirements
- Urgent Care: PA is not required

Prior authorization can be submitted via the Availity Portal or via fax. The Molina Clinical Policies are available on the Provider Website.

- Information on how to submit via fax and to identify what services require PA can be found here.
- The Molina Clinical Policies are available on the Provider Website.

Authorization Appeal, Clinical Dispute and Non-Clinical Dispute Process Definitions

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- **Authorization Appeal**—Formerly known as an "authorization reconsideration." A provider dispute for the denial of a PA. The Authorization Appeal must be submitted pre-claim and within 30 days of the authorization denial. The Authorization Appeal should be submitted on the Authorization Reconsideration Form (Authorization Appeal and Clinical Claim Dispute Request Form) and submitted via fax. Decisions will be made within 48 hours for urgent requests and within 10 calendar days for all other requests. Once the claim is on file, providers must follow the **Clinical Claim Dispute** process.
- **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. The Clinical Claim Dispute must be submitted on the Authorization Reconsideration Form (Authorization Appeal and Clinical Claim Dispute Request Form). The Clinical Claim Dispute must be post-claim and submitted within 365 days of the date of service or 60 days from the remittance advice, whichever is greater. Providers may submit a Clinical Claim Dispute via the Availity Portal, fax or verbally. Decisions will be made within 30 business days.
- **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). The Non-Clinical Claim Dispute must be post-claim and submitted within

365 days of the date of service or 60 days from the remittance advice, whichever is greater. Providers may submit a Non-Clinical Claim Dispute via the Availity Portal, fax or verbally by calling the Provider Services Contact Center. Decisions will be made within 15 business days or with continued communication if Molina needs more time to address the dispute.

Authorization Appeal and Clinical Dispute (Authorization Reconsideration) Process

Submit an Authorization Appeal or Clinical Dispute only when disputing a level of care determination, a medical necessity denial with new/additional clinical information or a retro authorization for Extenuating Circumstances only.

Only one submission will be accepted. Any additional submissions for the same dispute reason will be denied, even if it includes new/additional information.

The Authorization Reconsideration Form (Authorization Appeal / Clinical Claim Dispute) can be found on the Molina Provider Website.

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

- Code of Federal Regulations 42 438.206
- Ohio Administrative Code 5160-26-05

Medicaid:

Find additional information in the following resources:

- Medicaid Authorization Appeal, and Clinical and Non-Clinical Dispute Guide
- Medicaid Provider Manual

MyCare Ohio: Inpatient Only:

Find information in the following resources:

- MyCare Ohio and Medicare Authorization and Claim Reconsideration Guide
- MyCare Ohio Provider Manual

Note: Due to regulatory requirements for outpatient decisions, an Authorization Reconsideration is not available. Please refer to member appeal rights noted in the posted Provider Manual.

Non-Clinical Claim Dispute (Claim Reconsideration) Process

Submit a Medicaid Non-Clinical Claim Dispute (MyCare Ohio Claim Reconsideration) only when disputing a payment denial, payment amount or a code edit. As a reminder: Primary insurance Explanation of Benefits (EOB), corrected claims and itemized statements are not accepted via the Non-Clinical Claim Dispute process. Please refer to the Corrected Claims submission guidelines below.

Find additional information in the following resources:

- Medicaid Authorization Appeal, and Clinical and Non-Clinical Dispute Guide
- MyCare Ohio and Medicare Authorization and Claim Reconsideration Guide

- Medicaid Provider Manual
- MyCare Ohio Provider Manual
- Molina Payment Policies
- Molina Payment Integrity Policies
- ODM Companion Guides

Prescription Drugs

Molina Medicaid Members: Payments will only be made for drugs covered by Ohio Medicaid and obtained from Ohio Medicaid contracted pharmacies or medical equipment suppliers. The Single Pharmacy Benefit Manager (SPBM) is a specialized managed care program operating as a prepaid ambulatory health plan (PAHP) that provides pharmacy benefits for the entire Medicaid managed care population. ODM selected Gainwell Technologies to serve as the SPBM. For more information on the SPBM, visit spbm.medicaid.ohio.gov.

Provider-administered medications supplied by non-pharmacy providers (such as hospitals, clinics and physician practices) will continue to be covered by the Managed Care Organizations (MCOs), Molina or the OhioRISE (Ohio Resilience through Integrated Systems and Excellence) plan, as applicable.

Find additional information in the following resources:

- Gainwell Preferred Drug List (PDL) for the SPBM
- Molina Medicaid Pharmacy Page

Molina Dual Options MyCare Ohio Members: Payment will only be made for drugs covered by Medicare or Ohio Medicaid and obtained from pharmacies, and medical equipment suppliers contracted with Molina.

Find additional information in the following resources:

- MyCare Ohio Drug Formulary
  - For codes not on the formulary, a provider must request PA or formulary exception.
  - Follow the guidelines for limits and PA requirements as outlined in the following:
    - Ohio Administrative Code (OAC) 5160-10-01 Durable Medical Equipment, Prostheses, Orthoses, and Supplies (DMEPOS): General Provisions
    - OAC 5160-9-02 Appendix A, Supplies Billed by Ohio Medicaid Pharmacy Providers

Contract Requests

- If interested in contracting with Molina, complete the Medical: Ohio Provider Contract Request Form
- Dental: Ohio Dental Provider Contract Request Form

Sample Provider contracts:

- Molina Healthcare Dental Provider Services Agreement
- Molina Healthcare Hospital Services Agreement
- Molina Healthcare Provider Services Agreement

Emergency Services

For emergency services, submit a CMS-1500 or UB-04 claim. Review the Provider Manual for current information about claims billing and payment guidelines.

- Medicaid Provider Manual
- MyCare Ohio Provider Manual

Post-Stabilization Services

For post-stabilization services, submit a CMS-1500 or UB-04 claim. Find additional information in the following resources:

- Medicaid Provider Manual
- MyCare Ohio Provider Manual

Referrals

A referral may become necessary when a provider determines medically necessary covered services are beyond the scope of the Primary Care Provider's (PCP) practice or it is necessary to consult or obtain services from other in-network specialty health professionals unless the situation is one involving the delivery of emergency services. Information is to be exchanged between the PCP and Specialist to coordinate the care of the patient to ensure continuity of care. Providers need to document referrals that are made in the patient's medical record. Documentation needs include the specialty, services requested and diagnosis for which the referral is being made.

PCPs are able to refer a member to an in-network specialist for consultation and treatment without a referral request to Molina. Providers should direct Molina Members to health professionals, hospitals, laboratories and other facilities and providers which are contracted with Molina.

- **Referring Patients to Participating Providers:** When referring a member to another provider for services, be sure to refer to a Molina participating provider. A complete list of Molina's participating providers, including pharmacies, laboratories, radiology and behavioral health (BH) providers, is available in our Provider Online Directory.

  When requesting PA for a service that will be rendered by another provider, complete a PA Request, including the name and address of the refer-to provider.

- **Referring Patients to Out-of-Network Providers**: There may be circumstances in which referrals may require an out-of-network provider. PA will be required from Molina except in the case of emergency services. In the case of urgent and emergency services, providers may direct members to an appropriate service, including, but not limited to, primary care, urgent care and hospital emergency room.

Find a complete list of participating providers, pharmacies, laboratories and radiology providers on the Molina Provider Online Directory.

Benefits and Payment Policy

Molina's benefits and payment policies adhere to OAC 5160. Additional OAC information is available at codes.ohio.gov/oac/.

Claim Submissions

Medicaid: Molina typically follows the ODM guidelines for claims processing and payment for the Healthy Families, Adult Extension (AEP) and Aged, Blind or Disabled (ABD) programs.

Find additional information in the following resources:

- Medicaid Provider Manual
- ODM Companion Guides

Molina Dual Options MyCare Ohio: Molina typically follows the Centers for Medicare & Medicaid Services (CMS) billing guidelines for Medicare Covered Services and ODM guidelines for non-Medicare Covered Services.

Find additional information in the following resources:

- MyCare Ohio Provider Manual
- CMS Medicare Claims Processing Manual
- ODM Companion Guides

EDI Payer IDs: Please refer to the OMES section above for the line of business-specific grid.

Timely Filing Guidelines for Medicaid and MyCare Ohio

- **Standard Timely Filing:**
  - **Medicaid (Contracted and Non-Contracted Providers):** 365 days from the date of service or 365 days from the discharge date for inpatient hospital claims to submit claims for reimbursement.
  - **MyCare Ohio**:
    - Molina Dual Options MyCare Ohio (Opt-In)
      - MMP Medicare: 120 days calendar days from the date of service
      - MMP Medicaid: 365 calendar days from the date of service
    - Molina MyCare Ohio Medicaid (Opt-Out): 365 calendar days from the date of service
    - Non-Contracted Providers: 365 calendar days from the date of service
- **Coordination of Benefits:** If a submitted claim has an EOB from the member's primary carrier, providers have up to 180 days to submit claims from the date of the EOB.
- **Corrected Claims:** All providers have 365 days from the date of service to submit corrected claims.

Note: Primary Insurance EOB and itemized statements are not accepted via the non-clinical dispute process. Please submit as new or corrected claims.

Non-Clinical Disputes (Claim Reconsideration):

Disputes may be submitted via the Availity Portal, fax or mail. Disputes for the Medicaid line of business may be filed verbally by calling Molina Provider Services.

- When appealing an authorization denial post-claim, submit an Authorization Reconsideration Form (Authorization Appeal / Clinical Claim Dispute).
- When disputing a claim payment or denial, submit a Request for Claim Reconsideration Form (Non-Clinical Claim Dispute).
- Additional information can be found in the following:

- Medicaid Authorization Appeal, and Clinical and Non-Clinical Dispute Guide
- MyCare Ohio and Medicare Authorization and Claim Reconsideration Guide

Medicaid Disputes: Providers can dispute a claim payment and/or denial up to 365 days from the date of service or 60 calendar days after the payment, denial or partial denial of a timely claim submission, whichever is later.

MyCare Ohio Disputes: Non-contracted **MyCare Ohio** providers can dispute a claim payment for 120 calendar days from the original remittance date.

Overpayments

Overpayments as a result of claims processing identified by Molina will receive a letter requesting recoupment. For dispute contact information and refund remittance address information, see the Cost Recovery section.

Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHC)

The following are Molina's Medicaid ID numbers for use when submitting documents for wrap-around payments.

- 0082414: Molina Dual Options MyCare Ohio Medicare-Medicaid Plan Opt-In and Opt-Out
- 0077182: Molina Medicaid – Aged, Blind or Disabled
- 0077186: Molina Medicaid – Healthy Families, formerly Covered Families and Children (CFC)

Sample Member Identification Cards

- Medicaid Provider Manual
  - Molina Medicaid Standard Member ID Card
  - Molina Medicaid CSP Member ID Card
  - Molina Medicaid OhioRISE Member ID Card
  - Molina Medicaid OhioRISE CSP Member ID Card
- MyCare Ohio Provider Manual
  - Molina MyCare Ohio Medicaid Only (Opt-Out) Member ID Card
  - Molina Dual Options MyCare Ohio (Opt-In) Member ID Card

Molina Contact Information

Provider Services

- Phone: (855) 322-4079 from 7 a.m. to 8 p.m. Monday through Friday for Medicaid and 8 a.m. to 6 p.m. Monday through Friday for MyCare Ohio
- Fax: (888) 296-7851

Frequently Used Phone Numbers:

- 24-Hour Nurse Advice Line (Medicaid):
  - English (888) 275-8750, Spanish (866) 648-3537, or TTY: 711
- 24-Hour Nurse Advice Line (MyCare Ohio):
  - English and Spanish (855) 895-9986, or TTY: 711
- Fraud, Waste, and Abuse Tip Line: (866) 606-3889

- Ohio Medicaid Integrated HelpDesk: (800) 686-1516

Cost Recovery

Phone: (866) 642-8999

Fax: (888) 396-1517

Disputes may be submitted via fax, mail, Availity Portal or verbally by contacting Provider Services. Verbal disputes are only accepted for the Medicaid line of business.

Please make checks payable to Molina of Ohio and send the check along with corresponding documentation to:

Molina Healthcare of Ohio, Dept. 781661
PO Box 78000
Detroit, MI 48278-1661

If returning a Molina-issued check, please send it to:

Molina Healthcare of Ohio
PO Box 349020
Columbus, OH 43234-9020

Use the Return of Overpayment Form to submit unsolicited refunds or check returns.

You Matter to Molina

At Molina of Ohio, our providers matter! That's why we developed our "You Matter to Molina" program: to connect directly to our entire network of providers and support you in delivering high-quality, efficient care to our members.

The program gives providers access to monthly bulletins with updates on operational and organizational news, provider trainings, surveys, presentations, videos and many other helpful tools and resources.

Molina providers are strongly encouraged to sign up for the Provider Bulletin to receive timely updates on ODM and Molina processes or policy changes. Sign up by selecting click here. An archive of Provider Bulletins is available on the Provider Bulletin page.

Learn more now on the You Matter to Molina page.