Provider Engagement Team

2024

You Matter to Molina

Topics

1. Billing Guidelines
2. Encounter Data
3. Appeals and Grievances
4. Taxonomy and Medicaid ID
5. Prior Auth Look-up Tool & How to Request a Prior-Auth

Important

- Molina Medicaid and Marketplace claims must be submitted by to Molina within six (6) months after the discharge for inpatient services or the date of service for outpatient services. When Molina is secondary, claims, whether paper or electronic, must be submitted within 90 days from the final determination by the primary insurance carrier per Florida statue:

  Statutes & Constitution :View Statutes : Online Sunshine (state.fl.us)

- If Medicare is the primary carrier, claims must be submitted to Molina within 36 months from discharge or 1 (one) year from Medicare's determination, whichever is later.

- Molina Medicare claims must be submitted to Molina with one (1) calendar year after the discharge date 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 one calendar year 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.

Billing Guidelines 2024

- How to submit a claim
- Timely Filing
- Balance Billing
- Claim Resubmissions/Corrected Claims

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Claim Submission

Submission

Providers may submit claims to Molina Healthcare on paper or electronically, using a current version CMS-1500/UB-04 or the electronic equivalent. Providers may also use our Availity Portal to submit claims.

Marketplace/Medicaid/LTC Claims Submission Address

Molina Healthcare of Florida
P.O. Box 22812
Long Beach, CA 90801

Medicare Claims Submission Address

Molina Medicare
P.O. Box 22811
Long Beach, CA 90801

EDI Claims Submission – All LOB's

Change Healthcare ID# 51062
Change Healthcare Telephone (877) 469-3263

Availity Portal https://provider.molinahealthcare.com/

MOLINA HEALTHCARE
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Before a claim is filed to Molina Healthcare, consider reviewing the following:

- Member eligibility and ID#
- Claim’s timely filing
- Primary versus secondary insurance
- Patient liability has been confirmed through DCF documentation or the DCF website
- Rendered services are covered
- Rendered services were authorized (if applicable)

Before a claim is filed to Molina Healthcare, consider reviewing the following:

Whether paper or electronic, 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 Page 2 of 2 Date: 5/2/22
- Total billed charges
- Place and type of service code

Before a claim is filed to Molina Healthcare, consider reviewing the following:

Services are not reimbursed when any of the following apply:

- Services does not meet medical necessity criteria
- Authorization was not obtained for a service requiring prior authorization
- Member is not active at the time services were rendered
- Services duplicate another provider's service

For additional information on claims submission, please visit our website at www.molinahealthcare.com and review our provider handbook.

Providers may also call Molina Healthcare at 866-472-4585

Before a claim is filed to Molina Healthcare, consider reviewing the following:

- Days or units, as applicable
- Provider tax identification number (TIN)
- 10-digit National Provider Identifier (NPI)
- Rendering Provider name as applicable
- Billing/Pay-to Provider name and billing address
- Billing/Pay-to Provider Zipcode+4 (as registered on the Medicaid portal)
- Billing/Pay-to Provider Taxonomy (as registered on the Medicaid portal)
- Place of service and type (for facilities)
- Disclosure of any other health benefit plans and submission of remittance advice from primary payer
- Explanation of payment for crossover claims
- E-signature
- Service Facility Location information

Inaccurate, incomplete, or untimely submissions and re-submissions may result in denial of the claim.

Balance Billing

Participating providers shall accept Molina Healthcare's payments as payment in full for covered services. Providers may not balance bill the Member for any covered benefit, except for applicable copayments, coinsurance, and deductibles, if any.

Your office is responsible for verifying eligibility and obtaining approval for those services that require authorization.

In the event of a denial of payment, providers shall look solely to Molina Healthcare for compensation for services rendered.

Claim Resubmissions/Corrected Claims

Providers may correct any necessary field of the CMS-1500 and CMS-1450 (UB-04) forms.

Molina strongly encourages participating Providers to submit Corrected Claims electronically via EDI or the Availity Essentials portal.

All Corrected Claims:

- Must be free of handwritten or stamped verbiage (paper Claims).
- Must be submitted on a standard red and white CMS-1450 (UB-04) or CMS-1500 Claim form (paper Claims).
- Original Claim number must be inserted in field 64 of the CMS-1450 (UB-04) or field 22 of the CMS-1500 of the paper Claim, or the applicable 837 transaction loop for submitting corrected claims electronically.
- The appropriate frequency code/resubmission code must also be billed in field 4 of the CMS-1450 (UB-04) and 22 of the CMS-1500.

Corrected Claims must be sent within six months of Date of Service or most recent adjudicated date of the Claim.

Corrected Claims submission options:

- Submit Corrected Claims directly to Molina via the Availity Essentials portal.
- Submit corrected Claims to Molina via your regular EDI clearinghouse.

EDI (Clearinghouse) Submissions for Corrected Claims

Corrected Claim information submitted via EDI submission are required to follow electronic Claim standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for Compliance SNIP levels 1 to 5. The 837 Claim format allows you to submit changes to Claims that were not included on the original adjudication.

The 837 Implementation Guides refer to the National Uniform Billing Data Element Specifications Loop 2300 CLM05-3 for explanation and usage. In the 837 formats, the codes are called “Claim frequency codes.” Using the appropriate code, you can indicate that the Claim is an adjustment of a previously submitted finalized Claim. Use the below frequency codes for Claims that were previously adjudicated.

Claim Frequency Code	Description	Action
7	Use to replace and entire claim.	Molina will adjust the original Claim. The corrections submitted represent a complete replacement of the previously processed Claim.
8	Use to eliminate a previously submitted Claim.	Molina will void the original Claim from records based on request.

When submitting Claims, Claims noted with Claim frequency code 7 or 8, the original Claim number, must be submitted in Loop 2300 REF02 – Payer Claim Control Number with qualifier F8 in REF01. The original Claim number can be obtained from the 835 Electronic Remittance Advice (ERA). Without the original Claim number, adjustment requests will generate a compliance error and the Claim will reject.

Claim corrections submitted without the appropriate frequency code will deny as a duplicate and the original Claim number will not be adjusted.

Billing Forms 2024

- CMS 1500
- UB04

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CMS 1500 form

Professional Paper Claim Form

Link: [cms1500.pdf](cms1500.pdf)

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) 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. RESERVED FOR NUCC USE
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. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? YES NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

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

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.
15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. B. C. D.
E. F. G. H.
I. J. K. L.
22. 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. Rsvd for NUCC Use
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. NPI b.
33. BILLING PROVIDER INFO & PH # ( )
a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

NUCC Instruction Manual available at: www.nucc.org *PLEASE PRINT OR TYPE* APPROVED OMB-0938-1197 FORM 1500 (02-12)

UB-04 form

Institutional Paper Claim Form
Link: [ub-40-P.pdf (cdc.gov)]
Instructions: [App L - UB04 Form Instructions.xls (myflorida.com)]

Encounter Data

Encounter Claims

Each capitated provider/organization delegated for claims processing is required to submit Encounter data to Molina for all adjudicated claims.

Encounter data must be submitted at least once per month, and no later than seven (7) days following the date on which Molina adjudicates the claims in order to meet State and CMS encounter submission threshold and quality measures. Encounter data must be submitted via HIPAA compliant transactions, including:

- 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. 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.

Provider Appeals and Grievances

You Matter to Molina

Molina Healthcare is committed to the timely resolution of all provider complaints. Provider disputes are typically disputes related to overpayment, underpayments, untimely filing, and bundling issues. Any disagreement regarding the processing, payment or non-payment of a claim is considered a Provider Dispute.

To file a provider dispute, providers may contact Customer Service at (855) 322-4076, submit via the Availity portal at www.availity.com/molinahealthcare, or send the request for review in writing to Molina Healthcare, along with any supporting documentation.

As of July 15, 2023 Molina Healthcare will change the Dispute resolution address to:

Molina Healthcare of Florida
Appeal and Grievance Unit
P.O Box 36030
Louisville, KY 40233-6030

Provider disputes must be received within one (1) year of the date of payment or denial of the claim. All provider disputes will be reviewed confidentially, and the outcome will be communicated in writing within sixty (60) days or receipt of the provider dispute.

Provider dispute form:
Provider Dispute/Appeal Form (molinahealthcare.com)

Provider Disputes and Appeals – Quick Tips

Disputes (Underpayments, Bundling)

Claim disputes are typically disputes related to overpayment, underpayments, untimely filing, missing documents (i.e. consent forms, primary carrier explanation of benefits) and bundling issues.

- Overpayment & Underpayments are based on the individual contract and /or Medicaid Fee Schedules
- Disputes can be submitted via phone, fax, provider portal, or by mail.
- Our Molina provider portal is our preferred method of delivery. It's important that all supporting documents are included.

Disputes impacting more than 10 claims can be submitted via email to:
MFLClaimsDisputesProjects@MolinaHealthCare.com

Appeals (Authorization, Medical Necessity)

- Apeals are those related to dental of authorization.
- Appeals can only be submitted in writing (fax, email, mail) or in-person.
- Our Molina provider portal is our preferred method of delivery. Its important that all supporting documents are included

Appeals can be submitted via email to:
MFL_ProviderAppeals@MolinaHealthCare.com

CD Format are always preferred, in order, to reduce large printing and cost of shipping.

Capitol Bridge

If the Provider Dispute/Appeal results in an unfavorable decision, and the provider has additional documentation supporting their position, the provider may resubmit the Provider Dispute/Appeal for secondary review. Providers may request a review of their original appeal by the State's independent dispute resolution organization:

Capito Bridge
Email Submissions to: FLCDR@capitolbridge.com
Tel: (800) 889-0549

Quick Facts

- Must be received within (1) year of payment or denial
- Disputes/Appeals shall be resolved within 60 days
- Provider Disputes/Appeals Fax (877)553-6504
- Provider Toll-Free Number (855)322-4076
- New and Corrected Claims* mail to:

  P.O. Box 22812
  Long Beach, CA 90801

*A corrected claim is not a dispute or an appeal.

Taxonomy/NPI

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Taxonomy and NPI match

As stated in the communication to providers dated February 6, 2023, all claims submitted to Molina must include an appropriate taxonomy code in order to avoid claim denial. **Effective May 1, 2023, any claims with taxonomy information that doesn't match your provider enrollment data entered with the Agency for Health Care Administration (AHCA) will deny.** The denial will be reflected on the Explanation of Payment (EOP) as follows:

DENY REMIT ID REMIT MESSAGE 6818 N255 Missing/Incomplete/Invalid billing provider taxonomy 6819 N288 Missing/Incomplete/Invalid rendering provider taxonomy

Providers can visit the AHCA's NPI to Medicaid ID search engine to verify their State enrollment information:
http://portal.flmmis.com/FLPublic/Provider_ProviderServices/Provider_ProviderSupport/Provider_Pro viderSupport_ClaimNPI/tabId/133/Default.aspx

To make corrections to an enrollment record, providers can log into their account via the Medicaid Portal and update their information.
For specific updates to a provider's Molina record, providers should contact Molina at 855-322-4076 or MFLProviderServiceManagement@Molinahealthcare.com.

Authorization lookup tool

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Prior-Auth look up tool

Need a Prior Authorization?

Code LookUp Tool

State

Health Plan Benefit

LOB

CPT / HCPCS Code

Lookup

[Florida Providers Home (molinahealthcare.com)](molinahealthcare.com)

How to Request Prior-Auth

Prior authorization requirements are designed to assure the medical necessity of service, prevent unanticipated denials of coverage, ensure participating Providers are utilized and ensure that all services are provided at the appropriate level of care for the Member's needs. Molina Healthcare's Prior Authorization guidelines and Service

Request Form are available on our website at:
http://www.molinahealthcare.com/medicaid/providers/fl/forms/Pages/fuf.aspx

Molina will only process completed request forms. Molina's decisions are based upon the information included with the PA request. Clinical notes are recommended.

- The following information MUST be included for the request form to be considered complete:
- Member First name, Last Name, Date of Birth and Identification number
- Prescriber first name, last name, NPI, phone number and fax number
- Drug name, strength, quantity and directions of use
- Diagnosis

Requesting Prior Authorizations

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Prior Auth Requests

Send requests for prior authorizations to the Utilization Management Department using the Molina Healthcare of Florida Prior Authorization Guide and Service Request Form included in your Welcome Kit and also available on our website, at:

Medicaid: https://www.molinahealthcare.com/providers/fl/medicaid/forms/-/media/Molina/PublicWebsite/PDF/Providers/fl/medicaid/2022-PA-Guide-Updated-MCG---Eff-060122.pdf

Marketplace: https://www.molinahealthcare.com/providers/fl/marketplace/forms/Pages/fuf.aspx

Medicare: https://www.molinahealthcare.com/providers/common/medicare/-/media/Molina/PublicWebsite/PDF/Providers/common/medicare/Medicare_PA_Form.pdf

Service Request Forms may be faxed to the Utilization Management Department to the numbers listed below or submitted via the provider Availity portal https://provider.molinahealthcare.com/

Medicaid/Marketplace Fax: (866)-440-9791
Medicare Fax: (866) 472-9509 Prior Authorization Requests

Modes of Submission

Online (preferred):

Providers should register on the Availity Portal at https://availity.com/molinahealthcare to avoid any disruption in accessibility and functionality.

Mail:

Molina Healthcare of Florida, Inc. Healthcare Services Authorizations & Inpatient Census
8300 NW 33rd Street, Suite 100
Doral, FL 33122

Fax: (866) 440-9791

Pharmacy Prior-Auth

Some medications, such as those listed with (SP) Specialty on the Preferred Formulary require clinical notes for review. If clinical information and/or medical justification is missing, Molina will either fax or call your office to request that the clinical information be sent for review. To avoid delays in decisions, be sure to complete the PA form in its entirety, including medical justification and/or supporting clinical notes.

Fax a completed Pharmacy Prior Authorization/Exception Form to Molina at (866)236-8531. A blank Pharmacy Prior Authorization/Exception Form may be obtained by accessing www.MolinaHealthcare.com or by calling (855)- 322-4076.

Please refer to the provider handbook at www.molinahealthcare.com for additional information regarding prior authorizations or contact Molina Healthcare of Florida at 855-322-4076. Thank you for your continued care to our members!

If you have further questions, please contact your Provider Services Manager
or
e-mail MFLProviderServicesManagement@MolinaHealthCare.Com

Access contact information for our Provider Services Managers by Regions:

MolinaHealthcare.com/providers/fl/medicaid/contacts/contact_info.aspx

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