Claims

Provider Cheat Sheet

Use this Cheat Sheet to assist your office with identifying important information regarding Claims. For complete guidelines, refer to our *MSCAN and CHIP Provider Manuals* available at: https://www.molinahealthcare.com/providers/ms/medicaid/home.aspx. Our websites are best viewed using Google Chrome as the browser.

Claims Submission Timeframes

Claims Submission	Time Frame
Initial Claim	**180 Days from the DOS/180 Days from the Date of Discharge**
Reconsideration/ Correction/Adjustment	**90 Days from the date of denial/EOP**
COB	**180 Days from the Primary Payer's EOP**

For more information, please refer to the Provider Manuals.

Claim Submission Methods

Our preferred method of submission is via electronic methods.

The Provider Portal

https://www.availity.com/molinahealthcare

(available free of charge and allows for attachments to be included)

Clearinghouse

Providers may use the Clearinghouse of their choosing. *(Note that fees may apply).*

ClaimsNet is Molina Healthcare's chosen clearinghouse. When submitting EDI Claims (via a clearinghouse) to Molina Healthcare, providers must use the applicable **payer ID # 77010**

Claims Mailing Address

Molina Healthcare of Mississippi, Inc.
PO Box 22618
Long Beach, CA 90801

Claims are mailed to our Jackson, MS office will be returned unprocessed.

Paper Claim Billing Tips

Providers must be mindful of the following when submitting paper claims to avoid rejections, denials, or delays in processing these submissions.

- Handwritten claims are not accepted
- Black & White CMS 1500 claims are not accepted
- Copies of claim forms are not accepted
- Printouts of electronic claims are not accepted
- White-Out on claim forms is not accepted
- Please do not submit information that is typed, then crossed out and corrected
- Print should not be too dark or too light
- Check alignment of data
- Do not write or stamp in data fields
- Claim total at the end of the page indicates end of claim
- Staples in claim forms are not accepted

EDI and EFT/ERA

Providers may access our website to find information regarding EDI benefits, contact information, and frequently asked questions. https://www.molinahealthcare.com/providers/common/medicaid/ediera/edi/benefits.aspx

Contracted Providers are required to register for EFT within 30 days of entering the Molina Network. Providers enrolled in EFT payments will automatically receive ERAs as well. Molina partners with Change Healthcare ProviderNet for EFT and ERA services. Additional information regarding EFTs and ERAs will be available under the "EDI, ERA/EFT" tab on the Molina website at https://www.molinahealthcare.com/providers/ms/medicaid/home.aspx

Benefits of EFT/ERA:

Faster payment (as little as 3 days from the day the claim was electronically submitted)

Search historical ERAs by claim number, member name, etc.

View, print, download and save PDF ERAs for easy reference

Providers can have files routed to their ftp and/or their associated clearinghouse

Payment and Coding Policies

Providers may reference these policies at the following link: https://www.molinahealthcare.com/providers/ms/medicaid/home.aspx (Access the "Policies" tab)

Corrected Claims Billing Requirements

Providers can submit corrected claims when changing or adding information. There are three ways to submit a corrected claim to Molina Healthcare:

- Electronic Data Interchange (EDI)
- Molina Healthcare's Provider Portal
- Paper Claims

When submitting corrected claims to Molina Healthcare, follow these billing requirements:

- **Always** submit through the Provider Portal or EDI, payer ID: 77010, as indicated in the steps below
- **Do not** submit corrected claims through the claim(s) reconsideration process
- **Always** include the original claim in its entirety with the corrections made
- **Do not** submit a corrected claim with only codes that were edited by Molina Healthcare on the original claim

CMS 1500 (837P)

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

UB04 (837I)

Bill type for UB claims are billed in loop 2300/CLM05-1In Bill Type for UB, the 7 or 8 goes in the third digit for "frequency"

The 2300 Loop, the REF segment (claim information), must include the original claim number of the claim being corrected, found on the remittance advice

CMS 1500

Providers should submit with resubmission code 7 in Box 22.

For Paper CMS 1500 claim form: Enter "RESUBMISSION" on the claim in the Additional Claim Information section (Box 19) of the form.

UB04

Types of bill XX7 (replacement of prior claim).

Enter "RESUBMISSION" in the Remarks section (Box 80) of the form.

MOLINA HEALTHCARE

Common Claim Denials

Denial Description	Additional Information related to the denial	What to do
Missing Explanation of Benefits (Coordination of Benefits from Primary Payer)	Member has other primary insurance. Primary EOB was not submitted by Provider.	**The provider should confirm if an EOB was submitted:** **If an EOB was not submitted - Please submit a corrected claim with the EOB attached.** Please review our Molina Provider Manual for correct claims instructions. https://www.molinahealthcare.com/providers/ms/medicaid/manual/medical.aspx **If an EOB was submitted - Please file a Dispute/Reconsideration** Providers can visit the link below to access our Molina Reconsideration Form: https://www.molinahealthcare.com/providers/ms/medicaid/forms/fuf.aspx
Incomplete/invalid Explanation of Benefits (Coordination of Benefits for Primary Payer).	Member has other primary insurance. Provider submitted EOB but the information on the EOB is missing or has invalid information.	Please verify the codes and billed amount for the claim(s). **If a corrected claim should be submitted, please review our Molina Provider Manuals for corrected claims instructions.** https://www.molinahealthcare.com/providers/ms/medicaid/manual/medical.aspx
Exact/Duplicate Claim Service	Services were previously submitted and paid	Confirm if there is a claim previously paid for the same DOS, member, and charges or if a corrected claim should be submitted. If a correct claims should be submitted, please review our Molina Provider Manual for correct claims instructions. https://www.molinahealthcare.com/providers/ms/medicaid/manual/medical.aspx
Missing/Incomplete/Invalid Claim Information	New or additional information submitted after a previously submitted claim, however, provider failed to submit the appropriate resubmission code/bill type and/or original claim ID	The provider should file a corrected claim. **Please review our Molina Provider Manuals for corrected claims instructions:** https://www.molinahealthcare.com/providers/ms/medicaid/manual/medical.aspx

Common Claim Denials

Denial Description	Additional Information related to the denial	What to do
The time limit for filing has expired	Claim was submitted after timely filing requirements	The provider should submit a reconsideration documenting proof that claim(s) were submitted timely. If the provider does not agree with the dispute decision, the provider can file an appeal. **Post-Service Appeals** For providers seeking to appeal a denied claim only, fax Provider Claim Disputes/Appeals at (844) 808-2409. If a provider rendered services without obtaining an approved PA first, providers must submit the claim and wait for a decision on the claim prior to submitting a dispute/appeal to Molina. Visit the link below to access our Molina Reconsideration Form: https://www.molinahealthcare.com/providers/ms/medicaid/forms/fuf.aspx
Missing/incomplete/invalid condition code.	Condition code information not submitted or invalid	Refer to the Medicaid Billing Handbook for instructions regarding the Condition Codes. Please submit a correct claim. **Medicaid Billing Handbook** https://medicaid.ms.gov/providers/billing-manual/
Missing/incomplete/invalid value code(s) or amount(s).	Value code information not submitted or invalid	Refer to the Medicaid Billing Handbook for instructions regarding the Condition codes. Please submit a correct claim. **Medicaid Billing Handbook** https://medicaid.ms.gov/providers/billing-manual/
Ordering/Referring NPI is not associated with the physician provider type.	Invalid Ordering/Referring NPI submitted	The provider should file a corrected claim with the correct NPI. **Please review our Molina Provider Manuals for corrected claims instructions:** https://www.molinahealthcare.com/providers/ms/medicaid/manual/medical.aspx
This provider was not certified/eligible to be paid for this procedure/service on this date of service.	Provider is not active with Molina on the date services were rendered	The provider should verify their registration with MS DOM. If their registration is correct, the provider should file a reconsideration with supporting documentation. Providers can visit the link below to access our Molina Reconsideration Form: https://www.molinahealthcare.com/providers/ms/medicaid/forms/fuf.aspx

MOLINA HEALTHCARE

Remit Code Descriptions

Rule Description	Action	Remit Reason ID	Remit Reason Description
Annual Benefit Amount Exceeded	DENY	119	Benefit maximum for this time period or occurrence has been reached.
Individual Lifetime Visits Exceeded	DENY	149	Lifetime benefit maximum has been reached for this service/benefit category.
Excluded Contract Term for Service	DENY	N381	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.
Excluded Contract Term for Service	DENY	N381	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.
Benefit has age restriction	DENY	N129	Not eligible due to the patient's age.
Invalid Service Code on DOS	DENY	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
Member does NOT meet age criteria for term	DENY	N129	Not eligible due to the patient's age.
Claim and contract term modifiers do NOT match	DENY	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Diagnosis on claim does NOT match terms valid range	PEND	N569	Not covered when performed for the reported diagnosis.
Location specific term does NOT match claim	DENY	N428	Not covered when performed in this place of service.
Benefit Day Limit Exceeded	DENY	N640	Exceeds number/frequency approved/allowed within time period.
Benefit is excluded from benefit plan	DENY	204	This service/equipment/drug is not covered under the patient’s current benefit plan
Benefit Visit Limit Exceeded	DENY	N640	Exceeds number/frequency approved/allowed within time period.
Member NOT enrolled on DOS	DENY	N52	Patient not enrolled in the billing provider's managed care plan on the date of service.
Provider is not part of network required for benefit	DENY	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Invalid NDC Code	DENY	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).

Remit Code Descriptions

Rule Description	Action	Remit Reason ID	Remit Reason Description
Member does not have coverage code required on benefit	DENY	272	Coverage/program guidelines were not met.
Contract Term Restriction Group Validation Failed	DENY		No Reason
Invalid CPT/HCPCS code	DENY	N657	This should be billed with the appropriate code for these services.
Invalid Revenue Code	PEND	M50	Missing/incomplete/invalid revenue code(s).
Revenue Code Requires HCPCS	PEND	M20	Missing/incomplete/invalid HCPCS.
Invalid Revenue Code for Bill Type	DENY	M50	Missing/incomplete/invalid revenue code(s).
Diagnosis code does not exist	DENY	M76	Missing/incomplete/invalid diagnosis or condition.
Diagnosis code is not valid on DOS	DENY	N314	Missing/incomplete/invalid diagnosis date.
CPT Code is Bundled with Other CPT	IGNORE	236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule.
Claim Line Submission Window Exceeded	IGNORE	29	The time limit for filing has expired.
Authorization Line Denied	DENY	39	Services denied at the time authorization/pre-certification was requested.
Invalid Place of Service Code	DENY	M77	Missing/incomplete/invalid/inappropriate place of service.
Invalid Bill Type for claim start date	DENY	MA30	Missing/incomplete/invalid type of bill.
Invalid For Male	DENY	MA39	Missing/incomplete/invalid gender.
Invalid For Female	DENY	MA39	Missing/incomplete/invalid gender.
Claim has been manually denied	DENY		No Reason
iHT-Not Medically Necessary-MEDNS	PEND	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.