Molina Healthcare of Nevada, Inc. Claims Billing Guide 1500

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

The following information must be included on every Claim:

CMS 1500 Field #	NV Billing Requirement	CMS 1500 Field Name and Instructions
1	Not Required	**Type of health insurance coverage:** Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed. Enter "X" in the box noted "Other." Only one box can be marked.
1a	Required	**Insured ID Number:** Identification number on the Member's Health Plan I.D. Card.
2	Required	**Patient's Name:** Enter the patient's name as it appears on the Member's Health Plan I.D. card. Do not use nicknames.
3	Required	**Patient's Birth Date, Sex:** Enter the patient's eight (8) digit date of birth (MM/DD/YYYY) and mark the appropriate box to indicate the patient's sex/gender.
4	Recommended	**Insured's Name:** Enter the patient's name as it appears on the Member's Health Plan I.D. Card.
5	Recommended	**Patient's Address, City, State, Zip Code, Telephone**
6	Recommended	**Patient relationship to insured**
7	Recommended	**Insured's Address, City, State, Zip Code, Telephone**
8	Not Required	**This field is reserved for NUCC use**
9	Recommended	**Other insured name:** Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured.
9a	Situational	**Other insured 's policy or group number:** Patient has TPL with Medicare coverage: Enter the recipient's Medicare number. Patient has TPL with commercial coverage: Enter the Patient's identifier with their primary carrier.
9b	Not Required	**This field is reserved for NUCC use.**

CMS 1500 Field #	NV Billing Requirement	CMS 1500 Field Name and Instructions
9c	Not Required	**This field is reserved for NUCC use.**
9d	Situational	**Insurance plan name or program name:** REQUIRED if field 9 is completed. Enter the other insured's (name of person listed in field 9) insurance plan or program name.
10a-c	Situational	**Is Patient's condition related to:** Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line. When marked Yes, primary insurance information must then be shown in Item Number 11.
10d	Not Required	**Reserved for local use**
11	Situational	**Insured's policy group or FECA number**
11a	Situational	**Insured's date of birth** (MM/DD/YYYY) **sex**
11b	Situational	**Other Claim ID (Designated by NUCC)**
11c	Situational	**Insurance plan name or program name**
11d	Situational	**OR WORKERS' COMPENSATION OR PROPERTY & CASUALTY:** Required if known. Enter the claim number assigned by the payer.
12	Not Required	**Patient's or authorized person's signature**
13	Not Required	**Insured's or authorized person's signature**
14	Situational	**Date of current illness, injury or pregnancy:** Enter the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date.
15	Situational	**If patient has had same or similar illness**
16	Situational	**Dates patient unable to work in current occupation**
17	Situational	**Name of referring Provider**
17a	Not Required	**Not Labeled**
17b	Situational	**NPI of Referring Provider**

CMS 1500 Field #	NV Billing Requirement	CMS 1500 Field Name and Instructions
18	Situational	**Hospitalization dates related to current services**
19	Situational	**Additional Claim Information (Designated by NUCC)**
20	Not Required	
21	Required	**Diagnosis or nature of illness or injury:** Enter up to twelve (12) ICD-10 codes in the spaces indicated A through L. Please enter the codes across each line, not down.
22	Situational	**Resubmission Code:** Complete this field to adjust or void a previously paid claim. Otherwise, leave this field blank. - In the Code area, enter an adjustment or void reason code (see section Adjustment/Void reason codes for Field 22) - In the Original Reference Number area, enter the last paid Internal Control Number (ICN) of the claim. Adjustment and voids apply to previously paid claims only (including zero paid claims). Resubmitting a denied claim is not considered an adjustment. Enter 7 for Replacement of Prior Claim. Enter 8 for Void or Cancel Prior Claim.
23	Situational	**Prior authorization number:** If you obtained authorization for an item on this claim, enter your authorization number in this field. Enter only one authorization number per claim form. Complete additional forms if needed.

CMS 1500 Field #	NV Billing Requirement	CMS 1500 Field Name and Instructions
24a	Required	**Dates of Service:** *Dates:* In the bottom, white half of the claim line, enter the begin (From) and end (To) dates of service. If a service was provided on one day only, enter the same date twice. In the top, shaded half of the claim line, enter qualifier N4 followed by the drug's 11-digit NDC. The first, second and third sections of the NDC (separated by hyphens on the container label) must contain 5, 4 and 2 digits, respectively, when entered on the claim form. To facilitate this, you must add leading zeros to one or more sections of the NDC if the container label does not display: - 5 digits in the first section of the NDC - 4 digits in the second section of the NDC - 2 digits in the third section of the NDC. For example, using the 5-4-2 model described above: - 34-73-1 on the container label is expressed as 00034007301 on the claim. Or 654-3773-22 on the container label is expressed as 00654377322 on the claim. Or 1645-222-65 on the container label is expressed as 16457022265 on the claim. Or 12345-6-7 on the container label is expressed as 12345000607 on the claim. Or 86541-4885-77 on the container label is expressed as 86541488577 on the claim. For multi-ingredient compounds, list each component separately, on its own claim line with the 11-digit NDC is this field. For more information and examples on billing physician administered drugs, see the NDC Billing Reference on the Nevada Medicaid website.
24b	Required	**Place of Service:** Use the most appropriate Place of Service code in the bottom, white half of the claim line.
24c	Not Required	**EMG:** Enter Y (Yes) or N (No) to indicate if the service was an emergency.
24d	Required	**Procedures, services or supplies CPT/HCPCS modifier:** CPT/HCPCS Code: Enter one CPT or one HCPCS code and up to four modifiers on the bottom, white half of the claim line. In the top, shaded half of the claim line, enter the NDC quantity, i.e., the number of NDC units administered. Fractions of a unit should be expressed in decimal form using up to three decimal places. Do not include the NDC standard unit of measure on your claim, i.e., milliliters, grams or each.

CMS 1500 Field #	NV Billing Requirement	CMS 1500 Field Name and Instructions
24e	Required	**Diagnosis Pointer:** Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable. ICD-9-CM or ICD-10CM diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E.
24f	Required	**Charges:** Enter the charge amount for the claim line-item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to eight digits are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.
24g	Required	**Dates or units:** Enter quantity (days, visits, units). If only one service provided, enter a numeric value of one.
24h	Situational	**EPSDT/Family Planning:** Leave blank or enter "Y" if the services were performed as a result of an EPSDT referral.
24i	Required	**ID Qualifier:** Using NPI field in field 24j: Enter ZZ in the top, shaded half of claim line.
24j	Required	**Rendering Provider ID:** NPI Users: Enter the Provider's taxonomy code in the top, shaded half of the claim line. NPI Users: Enter the Provider's NPI in the bottom, white half of the claim line.
25	Required	**Federal Tax ID Number**
26	Recommended	**Patient's account number**
27	Situational	**Accept Assignment**
28	Required	**Total charge:** Add all amounts in column 24F. Enter the total in this field.

CMS 1500 Field #	NV Billing Requirement	CMS 1500 Field Name and Instructions
29	Situational	**Amount Paid**
30	Situational	**Balance Due** (Reserved for NUCC Use)
31	Required	**Signature of physician or supplier:** The billing Provider or authorized representative must sign and date this field. Original, rubber stamp and electronic signatures are accepted.
32	Situational	**Service Facility Location Information:** Service facility location information: Enter the name and full address of the location where service was rendered. If the service was rendered in the recipient's home, leave this field blank. Ambulance Providers: Do not enter From and To dates in this field.
32a	Not Required	**NPI #:** Enter the 10-character NPI ID of the facility where services were rendered.
32b	Not Required	**Other ID #**
33	Required	**Billing Provider Info & Ph #:** Enter the full address of the billing Provider.

UB-04

UB Field #	NV Billing Requirement	UB Field Name and Instructions
1	Required	**Billing Provider name and address**
2	Not Required	**Pay-to name and address (unlabeled on form)**
3a	Recommended	**Patient control number:** Although not required, you can use this field to enter the recipient's unique control number assigned by the Provider (internal patient account number).
3b	Not Required	**Medical/Health record number**
4	Required	**Type of Bill:** Enter the appropriate type of bill code. 1st Digit – Indicating the type of facility. 2nd Digit – Indicating the type of care. 3rd Digit- Indicating the bill sequence (Frequency code). Adjustments: Use 7 for the last digit in your Type of Bill code. Voids: Use 8 for the last digit in your Type of Bill code.
5	Recommended	**Federal Tax Number**
6	Required	**Statement covers period:** Enter the beginning service date in the From area and the last service date in the Through area of this field. For services received on a single day, use the same From and Through dates.
7	Not Required	**Reserved for assignment by the NUBC**
8a	Not Required	**Patient name identifier**
8b	Required	**Patient's Name:** Enter the patient's last name, first name, and middle initial as it appears on the Health Plan ID card.
9a-e	Not Required	**Patient's Address**
10	Not Required	**Patient's Date of Birth**
11	Not Required	**Patient sex or gender**
12	Required	**Admission/start of care date:** Enter the date of admission for inpatient claims and date of service for outpatient claims.

UB Field #	NV Billing Requirement	UB Field Name and Instructions
13	Recommended	**Admission hour (if applicable):** If inpatient, indicate the hour during which the recipient was admitted. If outpatient, enter the hour the episode of care began. If no admission hour is entered for an outpatient claim, the system will default to hour 1300 (1 p.m.).
14	Required	**Priority (type) of visit:** Indicate the priority of the admission/ visit 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma
15	Required	**Source of referral for admission or visit:** Indicate the source of referral for this admission or visit.
16	Situational	**Discharge Hour (if applicable):** If inpatient, indicate the hour in which the patient was discharged from inpatient care. If outpatient, enter the hour the episode of care concluded.

UB Field #	NV Billing Requirement	UB Field Name and Instructions
17	Required	**Patient discharge status:** Indicate the patient's disposition or discharge status at the end of service for the period covered on this bill, as reported in Field 6, Statement Covers Period. 01 Routine Discharge 02 Discharged to another short-term general hospital 03 Discharged to SNF 04 Discharged to ICF 05 Discharged to another type of institution 06 Discharged to care of home health service 07 Left against medical advice 08 Discharged/transferred to home under care of a Home IV Provider 09 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) 20 Expired or did not recover 30 Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG) 40 Expired at home (hospice use only) 41 Expired in a medical facility (hospice use only) 42 Expired—place unknown (hospice use only) 43 Discharged/Transferred to a federal hospital (such as a Veteran's Administration [VA] hospital) 50 Hospice—Home 51 Hospice—Medical Facility 61 Discharged/ Transferred within this institution to a hospital-based Medicare approved swing bed 62 Discharged/Transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital 63 Discharged/Transferred to a Medicare certified long-term care hospital (LTCH) 64 Discharged/Transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 Discharged/Transferred to a Psychiatric hospital or psychiatric distinct part unit of a hospital 66 Discharged/transferred to a critical access hospital (CAH)
18-28	Situational	**Condition Codes:** If applicable, indicate conditions or events relating to this claim.

UB Field #	NV Billing Requirement	UB Field Name and Instructions
29	Situational	**Accident State**
30	Not Required	**Reserved for assignment by the NUBC**
31-34	Situational	**Occurrence codes and dates:** REQUIRED when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing.
35-36	Situational	**Occurrence span codes and dates:** REQUIRED when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing.
37	Not Required	**Reserved for assignment by the NUBC**
38	Not Required	**Responsible party name and address**
39-41	Situational	**Value codes and amounts:** REQUIRED when applicable. Value codes are used to identify events relating to the bill that may affect payer processing.
42	Required	**Revenue Code:** Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient.

UB Field #	NV Billing Requirement	UB Field Name and Instructions
43	Situational	**Description:** In this field, enter qualifier N4 followed immediately by the drug's 11-digit NDC, followed by a space, and then the NDC quantity (not HCPCS units) of the drug. The first, second and third sections of the NDC (separated by hyphens on the container label) must contain 5, 4 and 2 digits, respectively, when entered on the claim form. Therefore, you must add leading zeros to one or more sections of the NDC if the container label does not display: - 5 digits in the first section of the NDC - 4 digits in the second section of the NDC - 2 digits in the third section of the NDC For example, using the 5-4-2 model described above: - 34-73-1 on the container label is expressed as 00034007301 on the claim - 654-3773-22 on the container label is expressed as 00654377322 on the claim - 1645-222-65 on the container label is expressed as 16457022265 on the claim - 12345-6-7 on the container label is expressed as 12345000607 on the claim - 86541-4885-77 on the container label is expressed as 86541488577 on the claim For multi-ingredient compounds, list each component separately, on its own claim line with the NDC and NDC quantity is this field. For more information and examples on billing outpatient facility administered drugs, see the NDC Billing Reference on the Hewlett Packard Enterprise website.
44	Situational	**HCPCS/Accommodation Rates/HIPPS Rate Codes:** Outpatient services: Enter the appropriate procedure code (HCPCS or CPT).
45	Situational	**Service Date:** REQUIRED on all outpatient claims. Enter the date of service for each service line billed (MMDDYY). Multiple dates of service may not be combined for outpatient claims.
46	Required	**Service Units:** Enter the number of units, days, or visits for the service. A value of at least "1" must be entered. For inpatient room charges, enter the number of days for each accommodation listed.

UB Field #	NV Billing Requirement	UB Field Name and Instructions
47	Required	**Total Charges:** Enter the total charge for each service line.
48	Recommended	**Non-covered Charges:** Enter the non-covered charges included in field 47 for the Revenue Code listed in field 42 of the service line. Do not list negative amounts.
49	Not Required	**Reserved for assignment by the NUBC**
50a-c	Line a Required Lines b & c Situational	**Payer Name** As applicable, enter the name of the patient's primary, secondary and tertiary insurance on Lines A, B and C, respectively. On claims with no TPL, Medicaid information is entered online A. If the recipient has Medicare coverage (primary, secondary or tertiary), enter the word Medicare followed by the Medicare plan name.
51a-c	Recommended	**Health Plan ID**
52a-c	Required	**Release of Information Certification Indicator (REL INFO):** REQUIRED for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter 'Y' (yes) or 'N' (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain 'Y.'
53a-c	Required	**Assignment of benefits certification indicator (ASG BEN):** Enter 'Y' (yes) or 'N' (no) to indicate a signed form is on file authorizing payment by the payer directly to the Provider for services.
54a-c	Situational	**Prior payments:** Enter the amount received from the primary payer on the appropriate line.
55a-c	Line a Required Lines b & c Situational	**Estimated amount due**
56	Required	**National Provider Identifier - Billing Provider (NPI):** Enter Provider's 10- character NPI number.
57a-c	Not Required	**Other(Billing) Provider identifier**

UB Field #	NV Billing Requirement	UB Field Name and Instructions
58a-c	Required	**Insured's Name:** For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial.
59a-c	Not Required	**Patient's Relationship to Insured**
60a-c	Line a Required Lines b & c Situational	**Insured's unique identifier:** Enter the patient's Insurance ID exactly as it appears on the patient's ID card. Enter the Insurance ID in the order of liability listed in field 50.
61a-c	Recommended	**Insured's group name**
62a-c	Recommended	**Insured's group number**
63a-c	Recommended	**Treatment authorization code**
64a-c	Situational	**Document control number:** Enter the original claim number of the paid/denied claim when submitting a replacement or void on the corresponding. Applies to claim submitted with a Type of Bill (field 4). Frequency of "7" (Replacement of Prior Claim) or Type of Bill. Frequency of "8" (Void/Cancel of Prior Claim).
65a-c	Not required	**Employer name (Of the insured)**
66	Not Required	**Diagnosis and procedure code qualifier (ICD Version Indicator)**
67	Required	**Principal Diagnosis code and Present on Admission Indicator:** Enter the diagnosis code for the recipient's primary condition.
67a-q	Situational	**Other diagnosis codes:** Enter a diagnosis code for each condition that coexists at the time of admission, that develops subsequently, or that affects the treatment received and/or the length of stay. Exclude diagnoses that relate to an earlier episode and have no bearing on the current hospital stay.
68	Not Required	**Reserved for assignment by the NUBC**
69	Situational	**Admitting diagnosis code:** Enter the diagnosis code describing the recipient's reason for admission. This is required on inpatient claims only.

UB Field #	NV Billing Requirement	UB Field Name and Instructions
70a-c	Situational	**Patient's reason for visit:** Enter the ICD-9/10-CM Code that reflects the patient's reason for visit at the time of outpatient registration. Field 70a requires entry; fields 70b-70c are conditional.
71	Not Required	**Prospective Payment System (PPS) Code**
72a-c	Situational	**External Cause of Injury (ECI) code**
73	Not Required	**Reserved for assignment by the NUBC**
74	Situational	**Principal Procedure Code and Date:** Enter the ICD-9/10 Procedure Code that identifies the principal/primary procedure performed.
	Situational	**Other procedure codes and dates:** Enter diagnosis codes to identify all significant procedures (other than the principal) and the dates on which each procedure was performed. This field is required on inpatient claims when additional procedures must be reported (not required on an outpatient claim).
	Situational	**Adjust or void a claim**
	Recommended	**Attending Provider name and identifiers:** Enter servicing (rendering) Provider's NPI.
	Situational	**Operating physician name and identifiers:** If a surgery was performed, enter the surgeon's NPI. In this field, Hospice, Long Term Care (Provider Type 65) claims, must enter the NPI of the nursing facility from which the recipient was transferred.
	Situational	**Other:** Enter the NPI of the ordering, prescribing or referring Provider, if applicable.
	Not Required	**Other Provider name and identifiers**
	Not Required	**Remarks field**
	Situational	**Code-code field:** Use this field to report additional value codes and/or taxonomy codes if applicable.

National Provider Identifier (NPI)

A valid NPI is required on all Claim submissions. Providers must report any changes in their NPI or subparts to Molina as soon as possible, not to exceed 30 calendar days from the change.

Paper Claim Submissions

Participating Providers should submit Claims electronically. If electronic Claim submission is not possible, please submit paper Claims to the following address:

Molina Healthcare of Nevada, Inc.
PO Box 22666
Long Beach, CA 90801

Please keep the following in mind when submitting paper Claims:

Paper Claims should be submitted on original red colored CMS 1500 Claims forms.

Paper Claims must be printed, using black ink.

Corrected Claim Process

Providers may correct any necessary field of the CMS 1500 and UB-04 forms. The descriptions of each field for a CMS 1500 can be found within this section.

Corrected Claims may be submitted electronically via EDI or the Provider Portal.

All corrected Claims:

- Must be free of handwritten or stamped verbiage (paper Claims).
- Must be submitted on a standard red and white UB-04 or CMS 1500 Claim form (paper Claims).
- Original Claim number must be inserted in field 64 of the 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 UB-04 and 22 of the CMS 1500.

Note: The frequency/resubmission codes can be found in the NUCC (National Uniform Claim Committee) manual for CMS 1500 Claim forms or the UB Editor (Uniform Billing Editor) for UB-04 Claim forms.

Corrected Claims must be sent within the following timeframes:

Contracted Providers: within 180 days from date of service
Non-contracted Providers: within 365 days from date of service

EDI (Clearinghouse) Submission of Corrected Claims

837P

In the 2300 Loop, the CLM segment (Claim information) CLM05-3 (Claim frequency type code) must indicate one of the following qualifier codes:
"1"-ORIGINAL (initial Claim)
"7"–REPLACEMENT (replacement of prior Claim)
"8"-VOID (void/cancel of prior Claim)

In the 2300 Loop, the REF *F8 segment (Claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN).

837I

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

In the 2300 Loop, the REF *F8 segment (Claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN).

Coordination of Benefits (COB) and Third-Party Liability (TPL)

COB

Medicaid is the payer of last resort. Private and governmental carriers must be billed prior to billing Molina. Provider shall make reasonable inquiry of Members to learn whether Member has health insurance, benefits or Covered Services other than from Molina or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Molina of said entitlement. In the event that coordination of benefits occurs, Provider shall be compensated based on the state regulatory COB methodology. Primary carrier payment information is required with the Claim submission. Providers can submit Claims with attachments, including explanation of benefits (EOB) and other required documents, by utilizing the Provider Portal. Providers can also submit this information through EDI and paper submissions.

TPL

Molina will make all reasonable efforts to identify instances of third-party liability and exert subrogation rights to pursue recoupment of funds. Molina will contract with a TPL vendor to subrogate third-party liability cases on our behalf and will pursue settlement and recoupment when applicable in collaboration with DHCFP. Reports will be provided timely and accurately as outlined in the Medicaid Service Manual and in accordance with contractual requirements.

Molina is the payer of last resort and will make every effort to determine the appropriate third-party payer for services rendered. Molina may deny Claims when Third Party has been established and will process Claims for Covered Services when probable TPL has not been established or third-party benefits are not available to pay a Claim. Molina will attempt to recover any third-party resources available to Members and shall maintain records pertaining to TPL collections on behalf of Members for audit and review.

Reimbursement Guidance and Payment Guidelines

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

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

Manuals and Relative Value Unit (RVU) files published by the Centers for Medicare & Medicaid Services (CMS), including:

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

Telehealth Claims and Billing

Providers must follow CMS guidelines as well as State-level requirements.

All telehealth Claims for Molina Members must be submitted to Molina with correct codes for the plan type. The Provider at the distant site must use Place of Service (POS) Code 02 when billing for services provided via telehealth. Use of the POS code certifies the service meets telehealth requirements. Note that for distant site services billed under Critical Access Hospital (CAH)

method II on institutional claims and billed by outpatient Providers on institutional claims, the GT modifier (telehealth service rendered via interactive audio and video telecommunications system) is required. Qualifying telehealth units of service for an originating site must be billed with Q3014 for reimbursement of facility fee.

National Correct Coding Initiative (NCCI).

CMS has directed all Federal agencies to implement NCCI as policy in support of Section 6507 of the Patient Affordable Care Act of March 23, 2010. Molina Healthcare, Inc. 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 the same physician and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures. NCCI editing also includes Medically Unlikely Edits (MUE) which prevent payment for an inappropriate number/quantity of the same service on a single day. An 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.

Hospital-Acquired Conditions and Present on Admission Program

The Deficit Reduction Act of 2005 (DRA) mandated that Medicare establish a program that would modify reimbursement for fee-for-service beneficiaries when certain conditions occurred as a direct result of a hospital stay that could have been reasonably prevented by the use of evidenced-based guidelines. CMS titled the program "Hospital-Acquired Conditions and Present on Admission Indicator Reporting" (HAC and POA).

The following is a list of CMS Hospital Acquired Conditions. CMS reduces payment for hospitalizations complicated by these categories of conditions that were not present on admission (POA):

1) Foreign Object Retained After Surgery
2) Air Embolism
3) Blood Incompatibility
4) Stage III and IV Pressure Ulcers
5) Falls and Trauma
    a) Fractures
    b) Dislocations
    c) Intracranial Injuries
    d) Crushing Injuries

e) Burn
f) Other Injuries

6) Manifestations of Poor Glycemic Control
   a) Hypoglycemic Coma
   b) Diabetic Ketoacidosis
   c) Non-Ketotic Hyperosmolar Coma
   d) Secondary Diabetes with Ketoacidosis
   e) Secondary Diabetes with Hyperosmolarity
7) Catheter-Associated Urinary Tract Infection (UTI)
8) Vascular Catheter-Associated Infection
9) Surgical Site Infection Following Coronary Artery Bypass Graft – Mediastinitis
10) Surgical Site Infection Following Certain Orthopedic Procedures:
   a) Spine
   b) Neck
   c) Shoulder
   d) Elbow
11) Surgical Site Infection Following Bariatric Surgery Procedures for Obesity
   a) Laparoscopic Gastric Restrictive Surgery
   b) Laparoscopic Gastric Bypass
   c) Gastroenterostomy
12) Surgical Site Infection Following Placement of Cardiac Implantable Electronic Device (CIED)
13) Iatrogenic Pneumothorax with Venous Catheterization
14) Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
   a) Total Knee Replacement
   b) Hip Replacement

What this means to Providers:

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

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

General Coding Requirements

Correct coding is required to properly process Claims. Molina requires that all Claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

CPT and HCPCS Codes

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

Modifiers

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

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

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

ICD-10-CM/PCS Codes

Molina utilizes International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and International Classification of Diseases 10th Revision, Procedure Coding System (ICD-10-PCS) billing rules and will deny claims that do not meet Molina's ICD-10 Claim Submission Guidelines. To ensure proper and timely reimbursement, codes must be effective on the dates of service (DOS) for which the procedure or service was rendered and not the date of submission. Refer to the ICD-10 CM/PCS Official Guidelines for Coding and Reporting on the proper assignment of principal and additional diagnosis codes.

Place of Service (POS) Codes

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

Type of Bill

Type of bill is a four-digit alphanumeric code that gives three specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies the

type of care. The fourth indicates the sequence of this bill in this particular episode of care, also referred to as a "frequency" code. For a complete list of codes, reference the National Uniform Billing Committee's (NUBC) Official UB-04 Data Specifications Manual.

Revenue Codes

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

Diagnosis Related Group (DRG)

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

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

National Drug Code (NDC)

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

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

Coding Sources

Definitions

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

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

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

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

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

Claim Auditing

Molina shall use established industry Claims adjudication and/or clinical practices, State, and Federal guidelines, and/or Molina's policies and data to determine the appropriateness of the billing, coding and payment.

Provider acknowledges Molina's right to conduct pre- and post-payment billing audits. Provider shall cooperate with Molina's Special Investigations Unit and audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting medical records, Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Providers are required to submit, or provide access to, medical records upon Molina's request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an overpayment.

In reviewing medical records for a procedure, Molina may select a statistically valid random sample, or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of Claims Molina paid in error. The estimated proportion, or error rate, may be projected across all Claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal claims review, client-directed/regulatory investigation and/or compliance reviews and may be vendor assisted. Molina asks that you provide Molina, or Molina's designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If Molina's Special Investigations Unit suspects that there is fraudulent or abusive activity, Molina may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Molina reserves the right to recover the full amount paid or due to you.

Timely Claim Processing

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

for service within 30 days after receipt of Clean Claims.The receipt date of a Claim is the date Molina receives notice of the Claim.

Electronic Claim Payment

Participating Providers are required to enroll for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers who enroll in EFT payments will automatically receive ERAs as well. EFT/ERA services allow Providers to reduce paperwork, provides searchable ERAs, and Providers receive payment and ERA access faster than the paper check and RA processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery. Additional information about EFT/ERA is available at MolinaHealthcare.com/providers/nv/ or by contacting our Provider Services department.

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of Claim payment, Molina determines that it has made an Overpayment to a Provider for services rendered to a Member, it will make a claim for such Overpayment.

A Provider shall pay a Claim for an Overpayment made by Molina which the Provider does not contest or dispute within the specified number of days on the refund request letter mailed to the Provider.

If a Provider does not repay or dispute the overpaid amount within the timeframe allowed Molina may offset the Overpayment amount(s) against future payments made to the Provider.

Payment of a Claim for Overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to Molina, or the date that the Provider receives a payment from Molina that reduces or deducts the Overpayment.

Claim Appeals/Disputes

A Provider Dispute is defined as both grievances and appeals.

An appeal is a request to review an action as an "action". The appeal process addresses payment disputes and instances when the Plan chooses to deny, reduce, suspend or terminate a Provider's privileges with the Plan. The appeal process also includes challenging the Plan's request for reimbursement for an overpayment of a claim.

A grievance is an expression of dissatisfaction with any aspect of the Medicaid managed care health plan's operations, activities or behavior, regardless of whether the communication requests any remedial actions.

Providers appealing a Claim previously adjudicated must request such action within 30 calendar days from the last date of determination or action. All Claim appeals must be submitted on the Provider Dispute Resolution Request Form or a Letter of Explanation. The Provider Dispute

Resolution Request Form found on Provider website and the Provider Portal. The form must be filled out completely in order to be processed. The Letter of Explanation must include all elements on the Provider Dispute Resolution Request Form such as the Provider name, identification number, and contact information, date of service, claim number, explanation of the appeal, and all required documentation or proof to support the appeal. Appeals with incomplete information or missing required documents will not be processed. Molina allows two resubmissions of a claim appeal.

Additionally, the item(s) being resubmitted should be clearly marked as appeal(s) and must include the following documentation:

- Any documentation to support the adjustment and a copy of the Authorization form (if applicable) must accompany the appeal request.
- The Claim number clearly marked on all supporting documents

How to Submit Provider Appeals:

- Availity Provider Portal: Provider.MolinaHealthcare.com
- Submitted via fax: (833) 412-3146
- Mail: U.S. Mail at the following address:

Molina Healthcare of Nevada, Inc.
Attention: Provider Dispute Resolution Unit
PO Box 22666 Long Beach, CA 90801

The Provider will be notified of Molina's decision in writing within 30 calendar days of receipt of the Claims Appeal request.

State Fair Hearing:

Providers seeking further recourse and have exhausted the Plan's internal appeals process, have the right to submit a written request to the State for a State Fair Hearing.

Disputes eligible for the State Fair Hearing process include:

- Denial or limited authorization of a requested service
- Reduction, suspension or termination of a previously authorized service
- Denial, in whole or part, of payment for a service
- Demand for recoupment
- Failure of the Plan to meet specified timeframes (e.g., authorization, claims processing, appeal resolution)

The request for a State Fair Hearing must be submitted in writing within 90 calendar days from the date of Molina's resolution of the appeal.

Nevada Division of Medicaid
Nevada Medicaid Hearings Unit
1100 East William Street-Suite 101
Carson City, NV 89701

Fax # (775) 684-3610
Email: mailto:dhcfphearings@dhcfp.nv.gov

Balance Billing

The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Molina to the Provider. Balance billing a Molina Member for Covered Services is prohibited, other than for the Member's applicable copayment, coinsurance and deductible amounts.

Fraud and Abuse

Failure to report instances of suspected Fraud and Abuse is a violation of the Law and subject to the penalties provided by Law. Please refer to the Compliance section of this Provider Manual for more information.