Claims 101

July 30, 2024

MOLINA® HEALTHCARE

Agenda

Welcome and Provider Updates

Allie Govek
Mgr, Provider Relations
Molina Healthcare of Wisconsin

Claims 101

- **Introduction**
- **Claims Lifecycle**
- **Claim Operations & Validation**
- **Best Practices**

Questions

MOLINA HEALTHCARE

Provider Relations

Satisfaction

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

Communication

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

Technology

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

MOLINA® HEALTHCARE

Provider Website

Molina has a provider website for each line of business, available under the Health Care Professionals drop-down menu. The provider website includes many resources such as:

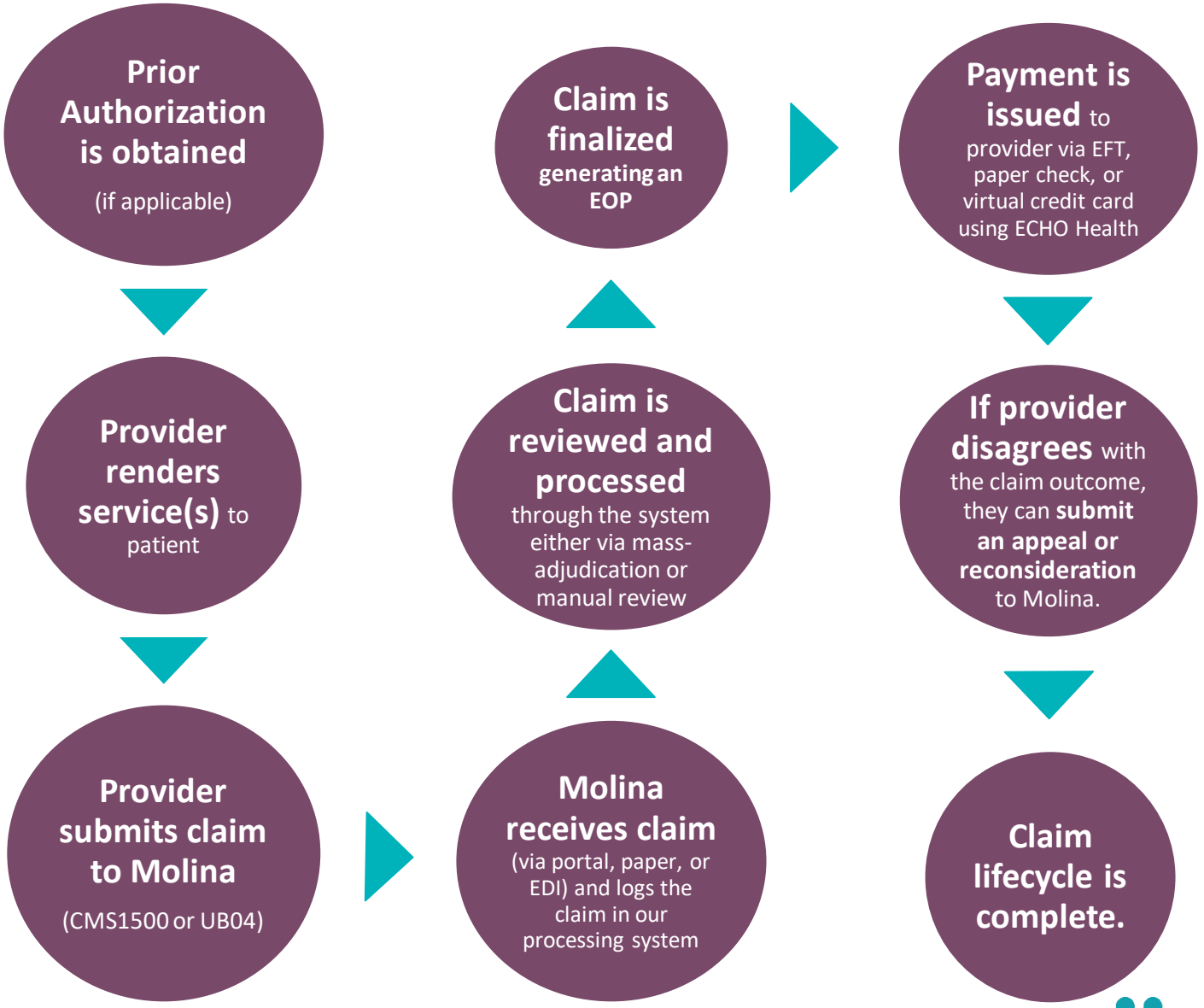
- Provider Manual
- Dental Manual
- Claims Information
- You Matter to Molina Page and a Claims Payment Systemic Errors (CPSE) Page
- Contact Information
- Provider Online Directory

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

Claims Lifecycle

MOLINA HEALTHCARE

Overview



MOLINA HEALTHCARE

Pre-Adjudication Steps

1. Provider verifies if prior authorization is needed by using the **PA LookUp Tool** on the Molina website.
   - If prior auth is required, submit a request via fax or the **Availity portal**.
   - Prior Authorization request forms:
     - Marketplace
     - Medicare
     - Medicaid
2. E&B is verified; services are rendered to the Molina member/patient.
3. Properly coded and billed claim is sent to Molina for processing.
   - Claims can be submitted via EDI (**Payer ID ABRI1**), Availity portal, or paper mail.
   - It is the responsibility of the provider to ensure that claims are received by Molina.

Billing & Coding Guidelines

Molina follows State and Federal guidelines for coding and billing.

- **WI Medicaid: ForwardHealth** & DHS requirements
- **Marketplace & Medicare: CMS**
- Molina offers additional guidance on payment policies on our website as well.
  - Payment Policies
  - Clinical Policies

Clean claims must be submitted to Molina within timeframes outlined in your provider agreement and/or the Molina Provider Manual.

MOLINA® HEALTHCARE

Claims Processing Steps

1. **Claims are received by Molina and validated through our gateway processor, MCG.**
   - Claims that can be validated move through the processing steps listed below.
   - Claim that cannot be validated are rejected and notice is sent to the provider.

2. **Claims are loaded into Molina systems and processed through defined edit steps.**
   - This can include DRG pricing, E&B, COB, CPT/Diagnosis/Modifier validation, and auth validation.
   - Molina uses vendors (such as MCG, Optum, Cotiviti) to assist with claims monitoring and review.
     - During this review, you may be asked to provide medical records.
     - You **must** submit the requested medical records to the location specified in the medical record request document.
   - If the claim cannot be processed through auto or mass adjudication, it will fall to manual review.
     - High Dollar Claims will always be manually reviewed and may require medical records.

3. **Once the claim has been finalized, the claim status will finalize and payment will be issued.**
   - Claims payment will be sent out via ECHO Health as an EFT, paper check, or virtual credit card.
     - An EOP will also be available for your records.
     - EOPs can be located directly on ECHO, in Availity, or via ERA.
   - To change your payment preferences, contact **ECHO Health** at any point in time.

MOLINA HEALTHCARE

Post Processing Steps

- **Providers should review their claims, payment and remittance for accuracy regularly.**

- **If you disagree with a claim payment or denial, you should appeal the claim or request a reconsideration.**
  - Appeals can be submitted via email, fax, or the Availity portal.
  - Appeals must be submitted within the timeframe outlined in your provider agreement and/or the provider manual.
  - Appeals should not be submitted via email to **MHWIProviderNetworkManagement@MolinaHealthcare.com**.
  - For Medicaid, appeals must be sent to the health plan for review and resolution before they can be escalated to the State.
  - For more information on appeals, check out our **Appeals webinar**.

- **Post-Payment Validation**: Molina uses vendors and our clinical / payment policies to validate accurate claims payment. If we identify an over or under payment, Molina will notify you.
  - If you disagree with the over/under payment notification, you **must** follow the process outlined on the notification letter.
  - Notification letters can be located in **Availity**.

More information on Appeals, Recoveries and Overpayments can be found in the Provider Manuals.

- Marketplace
- Medicare
- Medicaid

MOLINA HEALTHCARE

Claim Operations & Validation

MOLINA HEALTHCARE

Member Eligibility & Coordination of Benefits

Primary Insurance. A member may have multiple coverage sources for their health care.

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

- **Coordination of Benefits (COB)** ensures payment is not made for more than is required.
- It also helps recover payments when a third party is responsible for paying for all or some of a member's health care.
- Molina monitors member eligibility and COB daily, and updates records and claims processing as needed/impacted.

Medicaid will always be the payer of last resort for services covered under Medicaid.

MOLINA HEALTHCARE

Claims Coding: ICD-10 Diagnosis

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

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

MOLINA HEALTHCARE

Claims Coding: 11-Digit National Drug Code (NDC)

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

Providers will need to submit claims with both HCPCS and NDC codes with the exact NDC that appears on the Medicaid packaging in the 5-4-2 digit format (i.e. XXXXX-XXXX-XX) as well as the NDC units and descriptors.

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

MOLINA HEALTHCARE

Evaluation & Management (E&M)

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

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

CMS Regulations and Guidance 60.3.1/Selection of Level of Evaluation and Management Services, A – Use of CPT Code (**Medicare (cms.gov)**).

MOLINA HEALTHCARE

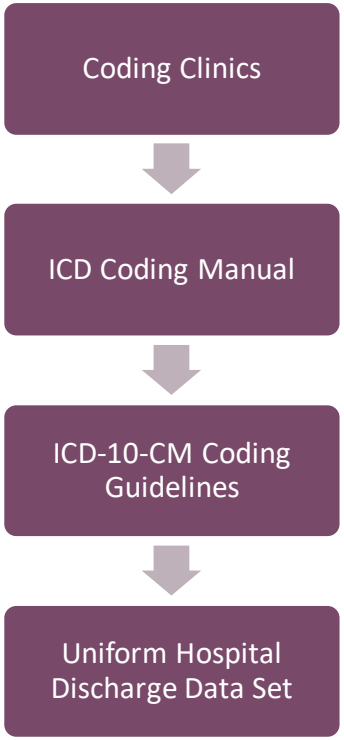
Diagnosis Related Group (DRG)

Diagnosis Related Group (DRG) clinical validations are performed by Molina and a vendor.

- The DRG clinical validation determination and principal diagnosis must:
  - Be determined upon discharge - not based on the clinical suspicions at the time of admission
  - Be made using the medical record documentation available at the time of the review.
  - Support all diagnosis and procedures billed, including the Major Complication or Comorbidity (MCC) and Complication or Comorbidity (CC).

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

- Diagnostic code assignments
- Procedural code assignments
- Sequencing of codes
- DRG grouping assignment
- Major Complication or Comorbidity (MCC) and Complication or Comorbidity (CC), if reported



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

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

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

MOLINA® HEALTHCARE

Optum Prepay

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

The prepayment claim reviews will ensure claims are billed accurately and coded correctly by reviewing state/federal policy sources from Medicaid and Medicare rules used industry-wide.

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

OPTUM™

Best Practices

MOLINA HEALTHCARE

Best Practices

Leverage Molina Provider Manuals

Our Provider Manuals are designed to help you succeed with all your Molina interactions, including claims.

- Marketplace
- Medicare
- Medicaid

Reference State and Federal Websites

Molina relies on ForwardHealth for lots of information including provider certification and type/specialty, claims coding & modifiers, policies, etc.

- ForwardHealth
- CMS

Use Electronic Tools, Communication Channels & Resources

For timely communication, next steps, and accurate transmission, we recommend using Availity, EDI/EFT/ERA methods whenever possible.

- Availity Resources and Information
  - Managing Claims
  - Secure Messaging
  - Accessing Remittance Information
  - Regardless of submission method, you can monitor authorization/claims/appeal status throughout the lifecycle in Availity.
- EDI/ERA/EFT

  Molina Payer ID: **ABRI1**

Availity - Managing claims

Molina Healthcare and Availity Essentials™ are offering providers new features for managing claims to help facilitate the timely processing of your claims. There are three categories for managing claims described below — corrected claims, claims reconsideration and claims appeal. Corrections and reconsiderations are a quick and efficient way to get a response for your finalized claim.

Corrected claims → Demo

Three days to process a corrected claim

A claim has been previously submitted and adjudicated by Molina and is being resubmitted by the provider due to an error or omission. A corrected claim allows the providers to submit the claim with additional or correct information.

Examples of corrected claims:

- ✓ Change to any information previously billed: code, date, diagnosis, units, etc.
- ✓ Claims denied due to another insurance — primary Payer Explanation of Payment required.
- ✓ Claims denied because of missing required invoice
- ✓ Claims denied for itemized bill required.
- ✓ Claims denied because of billing an unlisted procedure code.

Claims reconsideration

Info guide

3-5 days to receive a response and possible adjustment

A claim reconsideration is a request by a provider to have Molina review a claim that was previously paid, denied or reduced.

Examples of reconsideration requests:

- ✓ The provider perceives their claim to have been paid incorrectly or incompletely.
- ✓ The provider perceives their claim was denied based on incorrect or incomplete information.
- ✓ The provider perceives their claim payment to have been reduced incorrectly based on incorrect criteria.
- ✓ The provider perceives Molina failed to follow the applicable policies, rules or regulations.

Claims appeal

Demo

30-90 days to complete, and appeals require supporting documentation

A provider appeal/dispute is the adjustment request of the processing, payment or nonpayment of a claim by Molina.

Examples of appeal requests:

- ✓ A reduction, suspension or termination of a previously authorized service.
- ✓ A denial, in whole or in part, of payment for a service.
- ✓ Failure to provide services in a timely manner.
- ✓ Failure to make a coverage decision in a timely manner.

MOLINA® HEALTHCARE

Frequently Used Provider Forms

- Provider Appeal form
- Provider Information Update form
- Provider Roster template
- Wisconsin W9
- Credentialing applications: Practitioner | Facility | CAQH checklist
- Claim Overpayment form
- Peer-to-Peer Reconsideration guide/form
- Care Management Referral form A complete list of frequently used forms can be found here.

Contact Us

- MHWIProviderNewtorkManagement@MolinaHealthcare.com
  - General inbox for provider questions, concerns, contracting, credentialing, and demographic information.

MOLINA HEALTHCARE

Questions?

MOLINA® HEALTHCARE