Claims and Billing Training

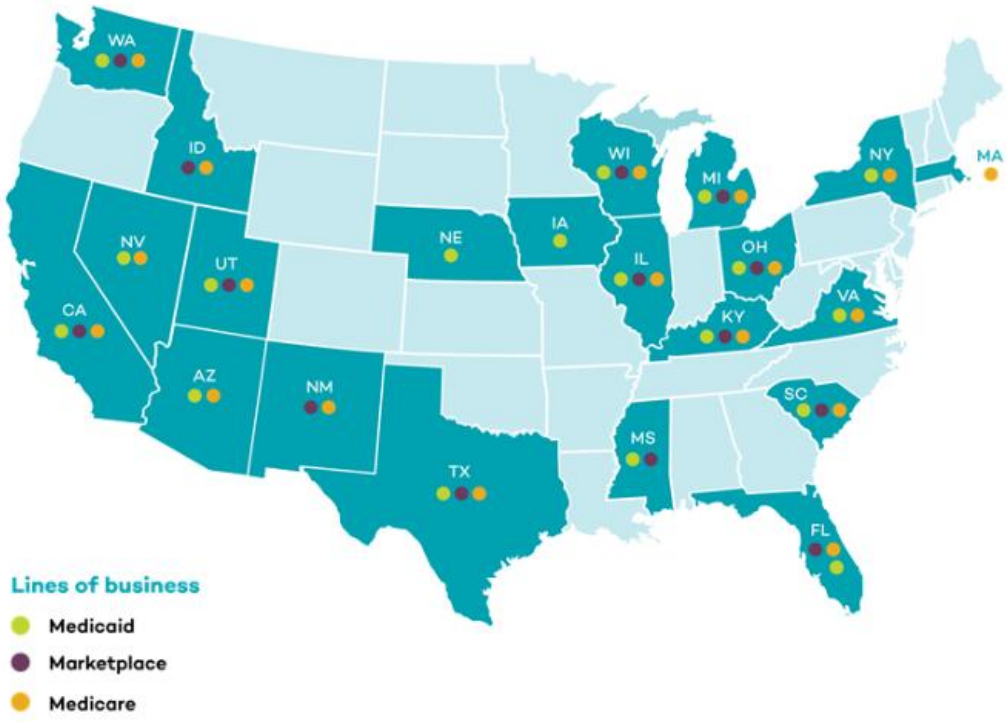
2026 | Molina Healthcare of South Carolina

MOLINA HEALTHCARE

MHO-4340
0724

Agenda

- Provider Resources
- Types of Claim Forms
- Claim Submission
- Coordination of Benefits
- Code Editing
- Corrected Claim
- Claim Attachments
- Appeals
- Potentially Preventable Readmissions
- Sepsis
- Itemzied Bills
- Contact Molina



Provider Resources

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

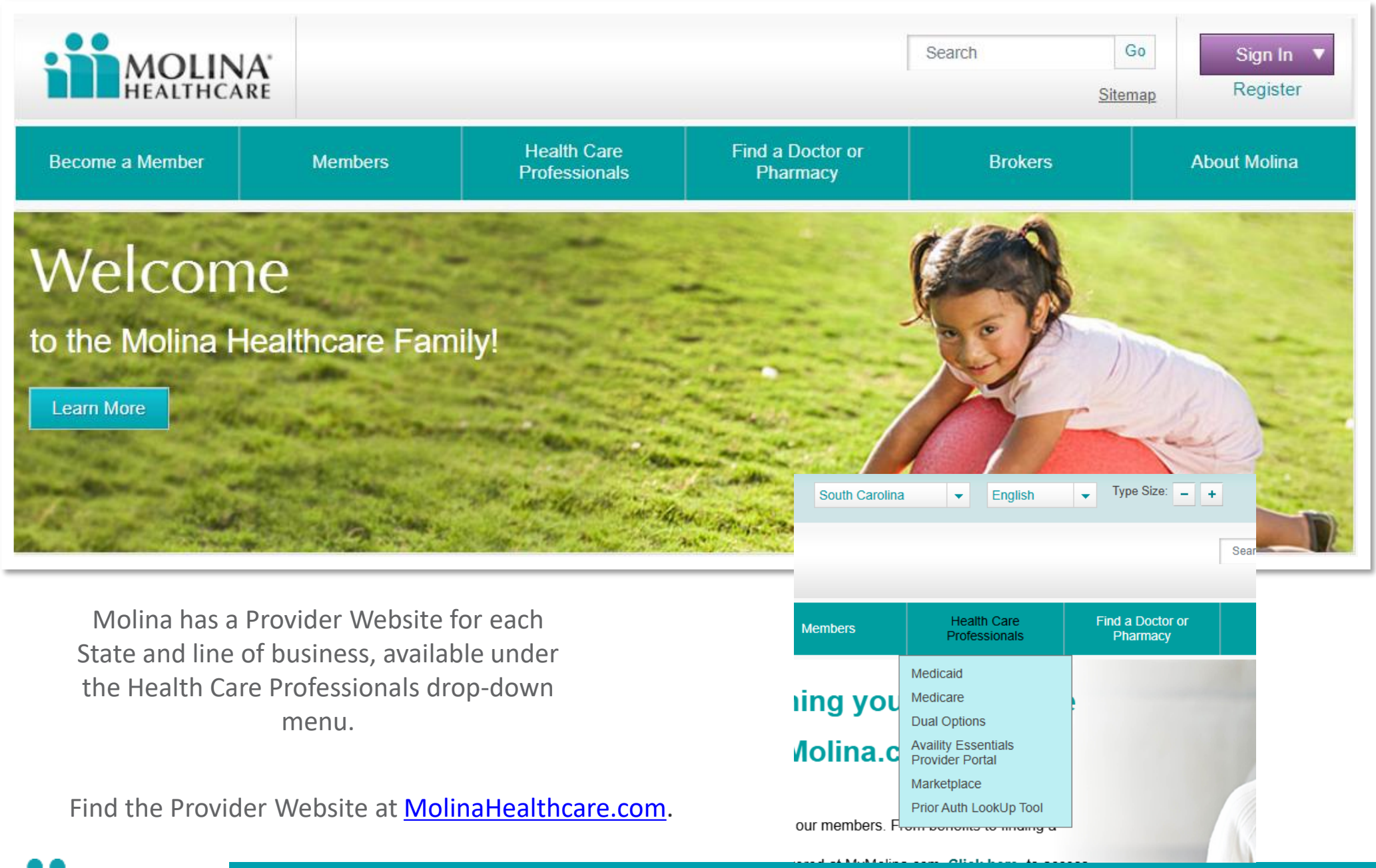
Communication

- 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

Provider Website



Molina has a Provider Website for each State and line of business, available under the Health Care Professionals drop-down menu.

Find the Provider Website at MolinaHealthcare.com.

Provider Online Resources

Molina's Provider Website has a variety of online resources:

- Provider Manual
- Dental Manual
- Claims Information
- You Matter to Molina 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
- 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

Provider Manual Highlights

Provider Manuals are specific to each line of business. Each Provider Manual is customarily updated annually but may be updated more frequently. Information in the Provider Manual includes:

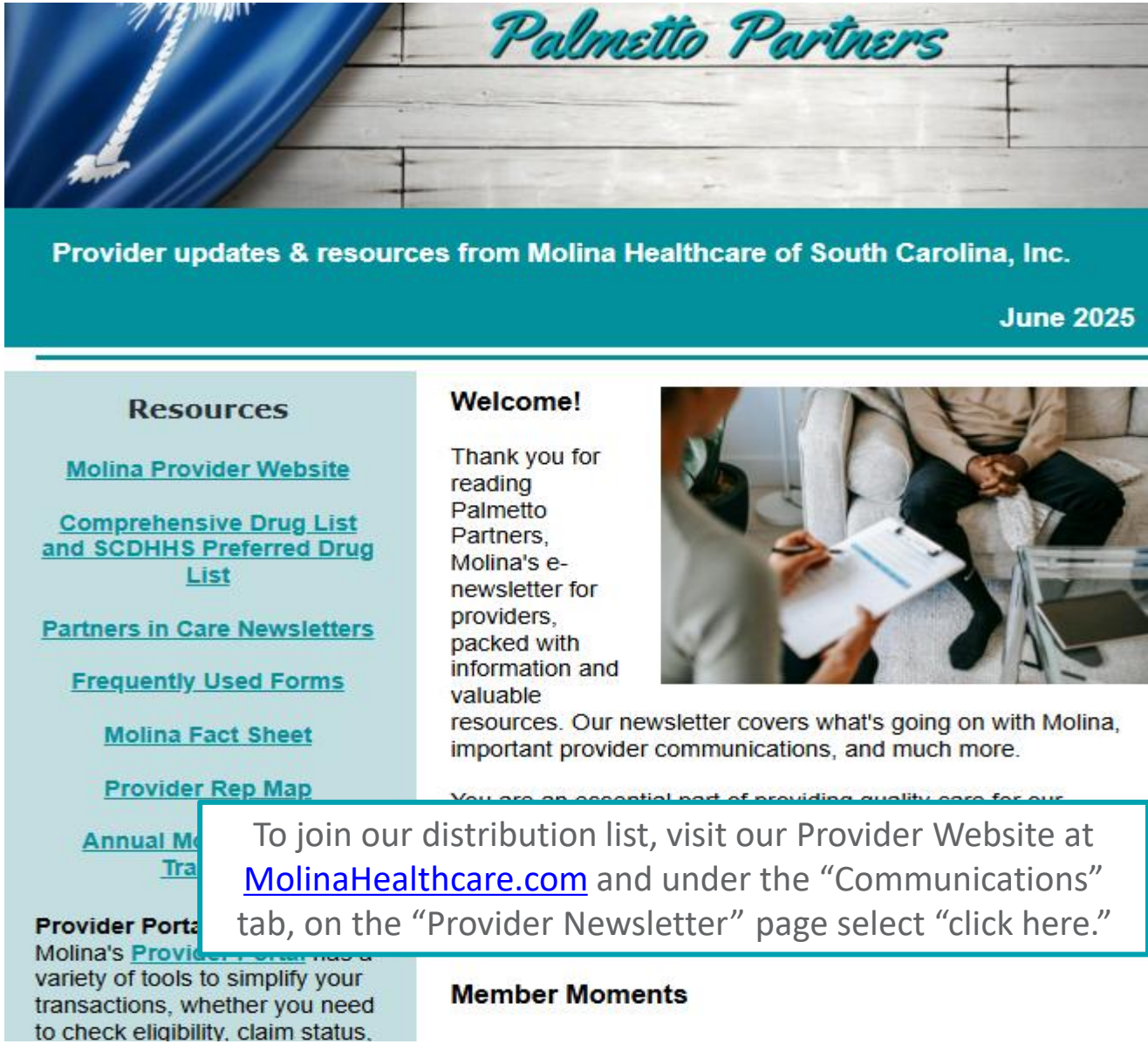
- Benefits and Covered Services
- Claims and Compensation
- Member Appeals and Grievances
- Credentialing and Recredentialing
- Delegation Oversight
- Enrollment and Disenrollment
- Eligibility
- Health Care Services
- Interpreter Services
- HIPAA
- Member Rights and Responsibilities
- Preventive Health Guidelines
- Quality Improvement
- Transportation Services
- Referral and Authorizations
- Provider Responsibilities
- Pharmacy
- Address and Phone Numbers
- Provider Data Accuracy
- Long-Term Services and Supports

Provider Newsletter

A Quarterly Provider Newsletter is sent to Molina's provider network to share news and updates.

The Provider Newsletter includes:

- Prior authorization changes
- Training opportunities
- Updates to the Availity Essentials Portal
- You Matter to Molina Corner
- Changes in policies that could affect:
  - Claim submissions
  - Billing procedures
  - Payment
  - Disputes & Appeals



Palmetto Partners

Provider updates & resources from Molina Healthcare of South Carolina, Inc.

June 2025

Resources

Molina Provider Website

Comprehensive Drug List and SCDHHS Preferred Drug List

Partners in Care Newsletters

Frequently Used Forms

Molina Fact Sheet

Provider Rep Map

Annual M… Tra…

Provider Porta…

Molina's Provi… has a variety of tools to simplify your transactions, whether you need to check eligibility, claim status,

Welcome!

Thank you for reading Palmetto Partners, Molina's e-newsletter for providers, packed with information and valuable resources. Our newsletter covers what's going on with Molina, important provider communications, and much more.

You are an essential part of providing quality care for our

Member Moments

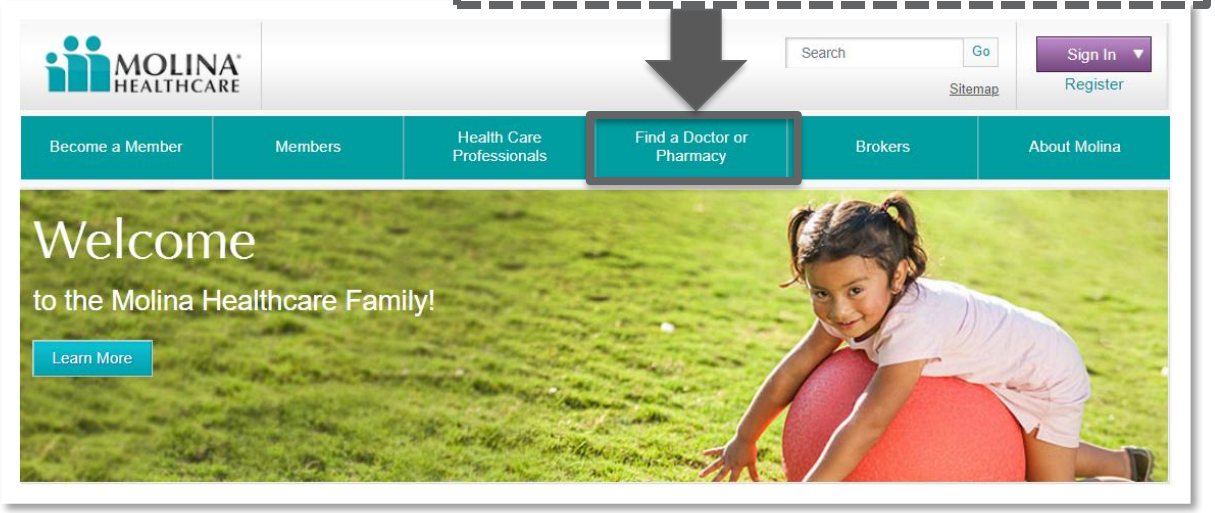
To join our distribution list, visit our Provider Website at MolinaHealthcare.com and under the "Communications" tab, on the "Provider Newsletter" page select "click here."

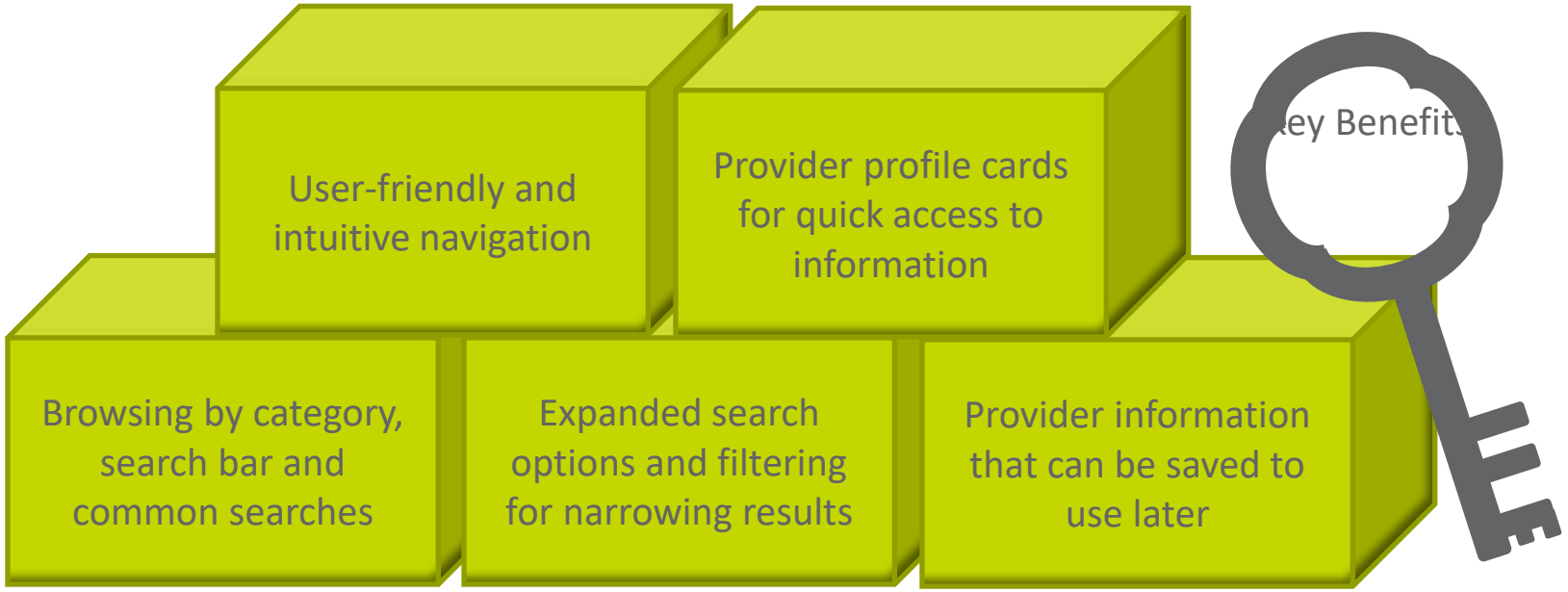
Molina Provider Online Directory

To find a Molina provider, click “Find a Doctor or Pharmacy”

The Molina Provider Online Directory offers enhanced search functionality, so information is available quickly and easily.

Providers are encouraged to use the Provider Online Directory linked on our Provider Website to find a network provider or specialist.

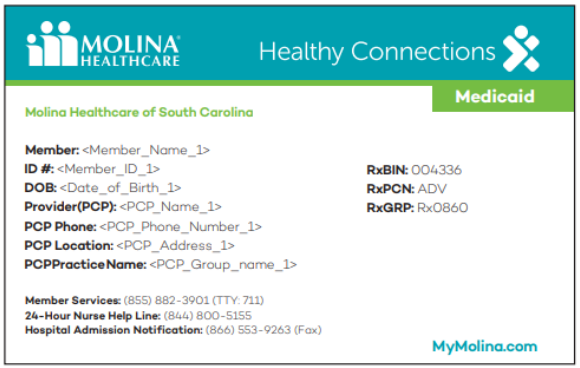




Reminder: Members should be referred to participating providers.

Molina Healthcare: Medicaid and Medicare Advantage

Medicaid

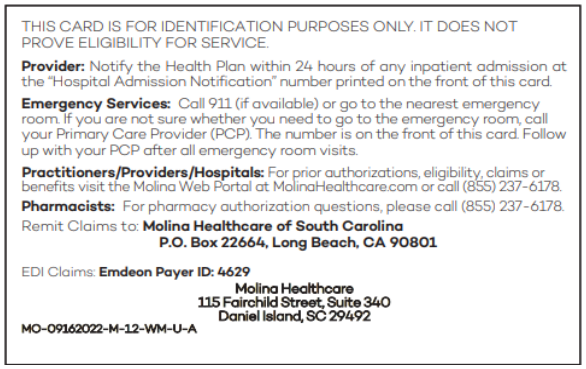

MOLINA HEALTHCARE
Healthy Connections
Medicaid
Molina Healthcare of South Carolina

Member: <Member_Name_1>
ID #: <Member_ID_1>
DOB: <Date_of_Birth_1>
Provider(PCP): <PCP_Name_1>
PCP Phone: <PCP_Phone_Number_1>
PCP Location: <PCP_Address_1>
PCPPracticeName: <PCP_Group_name_1>

RxBIN: 004336
RxPCN: ADV
RxGRP: Rx0860

Member Services: (855) 882-3901 (TTY: 711)
24-Hour Nurse Help Line: (844) 800-5155
Hospital Admission Notification: (866) 553-9263 (Fax)

MyMolina.com


THIS CARD IS FOR IDENTIFICATION PURPOSES ONLY. IT DOES NOT PROVE ELIGIBILITY FOR SERVICE.

Provider: Notify the Health Plan within 24 hours of any inpatient admission at the "Hospital Admission Notification" number printed on the front of this card.

Emergency Services: Call 911 (if available) or go to the nearest emergency room. If you are not sure whether you need to go to the emergency room, call your Primary Care Provider (PCP). The number is on the front of this card. Follow up with your PCP after all emergency room visits.

Practitioners/Providers/Hospitals: For prior authorizations, eligibility, claims or benefits visit the Molina Web Portal at MolinaHealthcare.com or call (855) 237-6178.

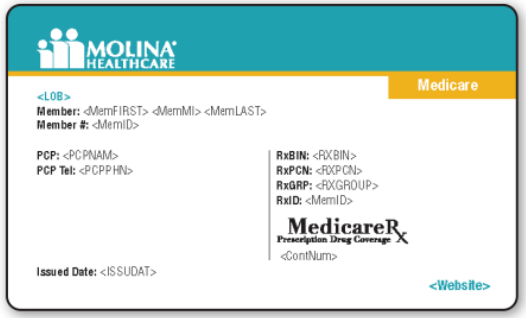
Pharmacists: For pharmacy authorization questions, please call (855) 237-6178.

Remit Claims to: **Molina Healthcare of South Carolina**
P.O. Box 22664, Long Beach, CA 90801

EDI Claims: **Emdeon Payer ID: 4629**
Molina Healthcare
115 Fairchild Street, Suite 340
Daniel Island, SC 29492

MO-09162022-M-12-WM-U-A

Medicare Advantage


MOLINA HEALTHCARE
Medicare

<LOB>
Member: <MemFIRST> <MemMI> <MemLAST>
Member #: <MemID>

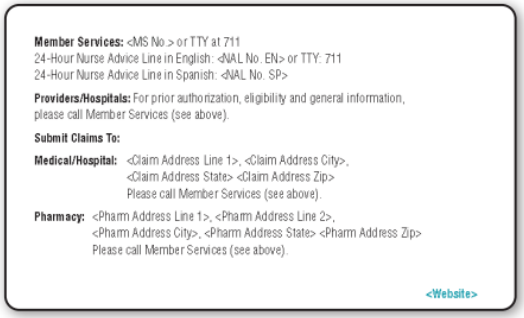
PCP: <PCPNAM>
PCP Tel: <PCPPHN>

RxBIN: <RXBIN>
RxPCN: <RXPCN>
RxGRP: <RXGROUP>
RxID: <MemID>

MedicareRx Prescription Drug Coverage
<ContNum>

Issued Date: <ISSUDAT>

<Website>


Member Services: <MS No.> or TTY at 711
24-Hour Nurse Advice Line in English: <NAL No. EN> or TTY: 711
24-Hour Nurse Advice Line in Spanish: <NAL No. SP>

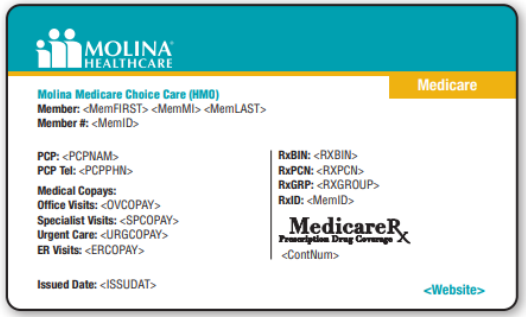
Providers/Hospitals: For prior authorization, eligibility and general information, please call Member Services (see above).

Submit Claims To:

Medical/Hospital: <Claim Address Line 1>, <Claim Address City>, <Claim Address State> <Claim Address Zip>
Please call Member Services (see above).

Pharmacy: <Pharm Address Line 1>, <Pharm Address Line 2>, <Pharm Address City>, <Pharm Address State> <Pharm Address Zip>
Please call Member Services (see above).

<Website>


MOLINA HEALTHCARE
Medicare

Molina Medicare Choice Care (HMO)
Member: <MemFIRST> <MemMI> <MemLAST>
Member #: <MemID>

PCP: <PCPNAM>
PCP Tel: <PCPPHN>

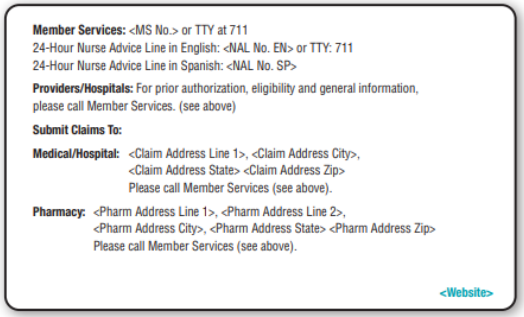
Medical Copays:
Office Visits: <OVCOPAY>
Specialist Visits: <SPCOPAY>
Urgent Care: <URGCOPAY>
ER Visits: <ERCOPAY>

RxBIN: <RXBIN>
RxPCN: <RXPCN>
RxGRP: <RXGROUP>
RxID: <MemID>

MedicareRx Prescription Drug Coverage
<ContNum>

Issued Date: <ISSUDAT>

<Website>


Member Services: <MS No.> or TTY at 711
24-Hour Nurse Advice Line in English: <NAL No. EN> or TTY: 711
24-Hour Nurse Advice Line in Spanish: <NAL No. SP>

Providers/Hospitals: For prior authorization, eligibility and general information, please call Member Services. (see above)

Submit Claims To:

Medical/Hospital: <Claim Address Line 1>, <Claim Address City>, <Claim Address State> <Claim Address Zip>
Please call Member Services (see above).

Pharmacy: <Pharm Address Line 1>, <Pharm Address Line 2>, <Pharm Address City>, <Pharm Address State> <Pharm Address Zip>
Please call Member Services (see above).

<Website>

Molina Healthcare: Marketplace

Marketplace members **do not** have out of network benefits, *except* in the event of an emergency.

Members must receive care from in network providers.

MOLINA HEALTHCARE

Marketplace

Subscriber:
Subscriber ID:
Plan:

Member:
Member ID:
Effective Date:

Cost Share
PCP:
Specialist:
Urgent Care:
ER Visit:
Pref. Generic Rx
Pref. Brand Rx:

Deductibles
Medical Indv Deductible:

RX Indv Deductible:

Annual Out of Pocket Maximum (OOPM)
Indv OOPM:

RxBIN: RxPCN: RxGRP:
HMO Molina Healthcare of South Carolina, Inc.

CVS caremark

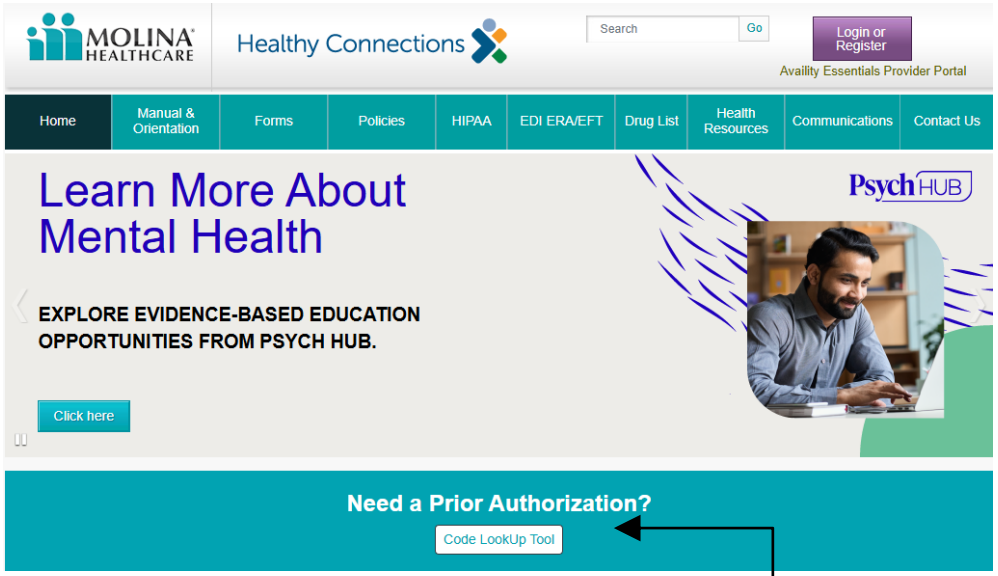
Member Numbers
Member Services: (855) 885-3176
TTY/TTD: 711
24/7 Nurse Advice: (844) 800-5155
24/7 Linea de Consejos de Enfermeras: (844) 800-5155
Billing and Payments: (800) 400-7957
Cost Shares are a summary only. Visit **MyMolina.com** for plan details.
Notice: Covered Services must be received from Participating Providers. Refer to your Agreement for exceptions.

Provider Numbers
CVS Caremark Help desk (888) 407-6425
Prior Authorization/Notification of Hospital Admission: (855) 237-6178
Medical Claims:
Molina Healthcare
PO BOX 22664
Long Beach, CA 90801
Inpatient Admissions: Provider to notify plan within 24 hours of admission.

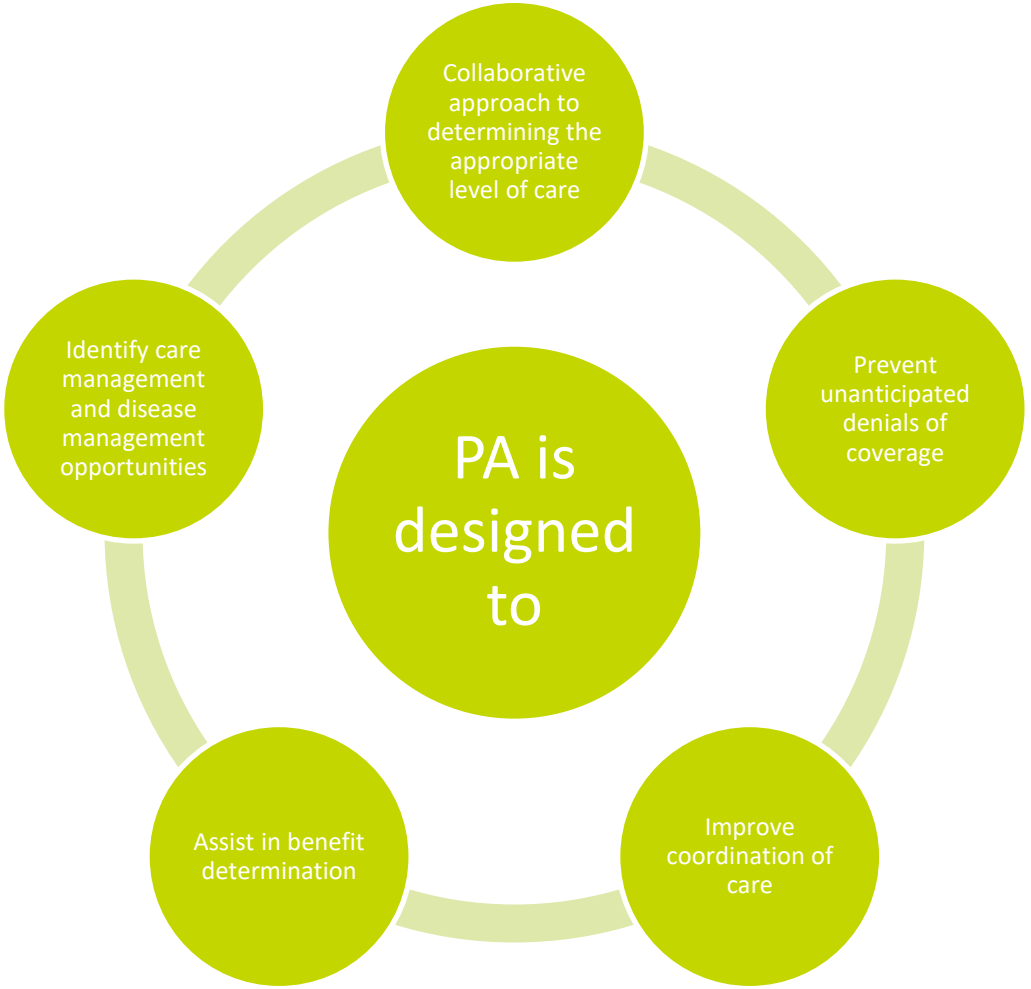
MyMolina.com This card is for identification purposes only and does not prove eligibility for service.

Prior Authorization (PA)

Prior Authorization (PA) is a request for prospective review. Requests for services on the PA Lookup Tool on our Provider Website and Provider Portal are evaluated by licensed nurses and trained staff.



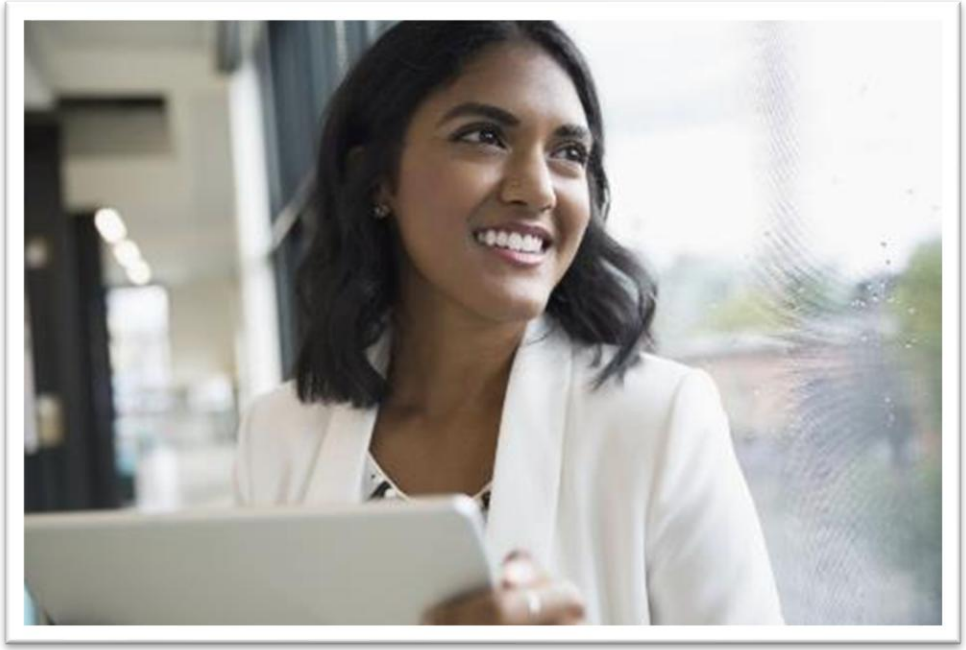
Utilize the PA Lookup Tool on our Provider Website and Provider Portal to determine if a PA is required



Provider Responsibilities

Molina expects our contracted providers will respect the privacy of Molina members (including Molina members who are not patients of the provider) and comply with all applicable laws and regulations regarding the privacy of patient and member Protected Health Information (PHI).

For additional information view the “Provider Responsibilities” section of the Provider Manual, located at MolinaHealthcare.com under the “Manual” tab. Topics include:



- Non-Discrimination of Health Care Service Delivery
- Provider Data Accuracy and Validation
- National Plan and Provider Enumeration System (NPPES) Data Verification
- Electronic Solutions/Tools Available to Providers
- Primary Care Provider (PCP) Responsibilities

You Matter to Molina

At Molina of South Carolina, our providers matter!
Through our program, “You Matter to Molina”, we stay directly connected to our entire provider network, working together to deliver high-quality and efficient health care for Molina members.

The program gives providers access to monthly Provider Bulletins, newsletters, trainings, surveys, presentations, videos, resource documents, reference guides and more.

- Access to the PsychHub platform offering free mental health educational courses and CEU opportunities for providers and patient-facing resources.
- Availity Essentials Portal and training resources.

Learn more now at [You Matter to Molina]

Thank you for being part of the MHSC family!

Medicaid Definitions of Terms: Authorization Appeal & Claim Disputes

Authorization Appeal

Provider Dispute for Prior Auth denial

To request an appeal, you may call:
(855) 882-3901
Fax:
(877) 823-5961

Send in writing to:
Molina Healthcare of South Carolina C/O Firstsource
PO Box 182273
Chattanooga, TN 37422

Availity Claim Payment Inquiry/ Reconsideration

A Claim Payment Inquiry or Reconsideration is a review of a claim you believe was paid incorrectly or denied due to a minor error.
These inquiries are typically straightforward and can be quickly resolved but are NOT CONSIDERED formal appeals so medical records are not reviewed.
This option consists of the following :

1. **Reconsideration – Authorization**
2. **Reconsideration – Eligibility**
3. **Reconsideration – Pricing Review**
4. **Reconsideration – Other**

Claims Appeal

Formerly known as a "claim reconsideration." This process is used only for disputing a payment denial, payment amount, or a code edit. Claim Appeal must be submitted on the Claim Appeal Form . May be submitted via Availity, or fax.

Types of Claim Forms

MOLINA HEALTHCARE

Professional & Institutional Claim Forms

The two claim forms used for billing Molina include:

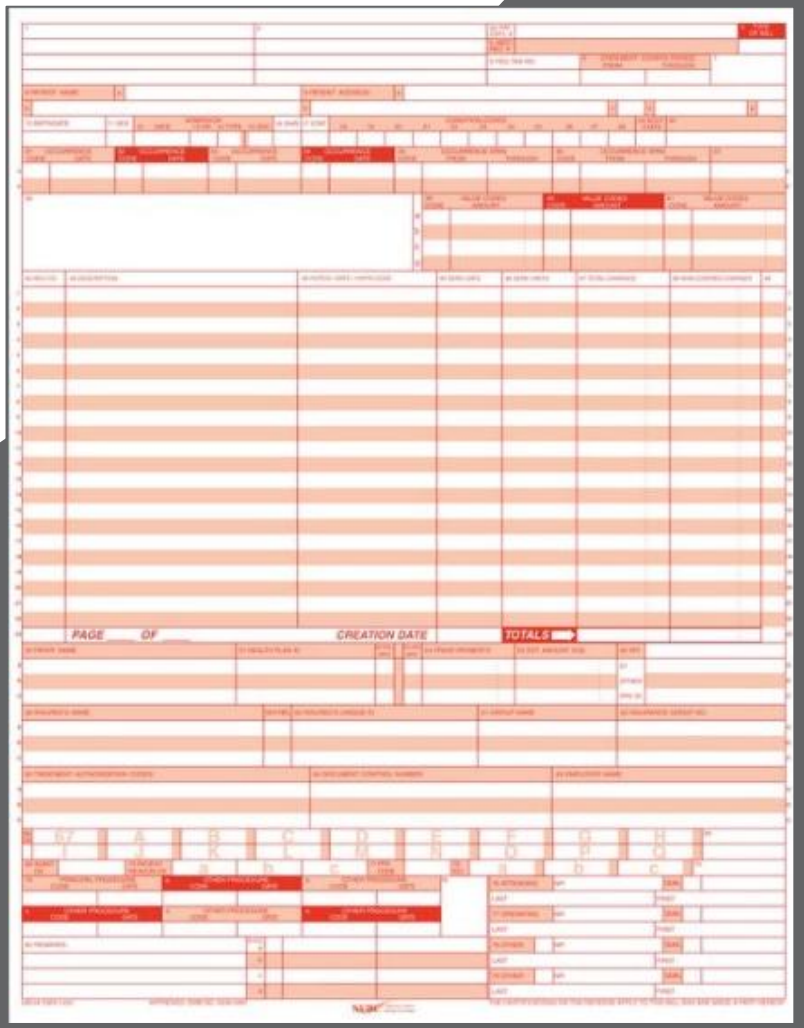
Providers should follow standard guidance for accurate completion of UB-04 and CMS-1500 claims prior to submission

The two form types do not always stand alone. For example, if a surgeon performs a procedure in a facility such as a hospital or Ambulatory Surgery Center (ASC), a CMS-1500 will be submitted for the surgeon's services only, while a separate UB-04 form will be submitted for the use of the facility. Both forms will be needed to fully bill out for a procedure.

MOLINA HEALTHCARE

UB-04 Claim Form

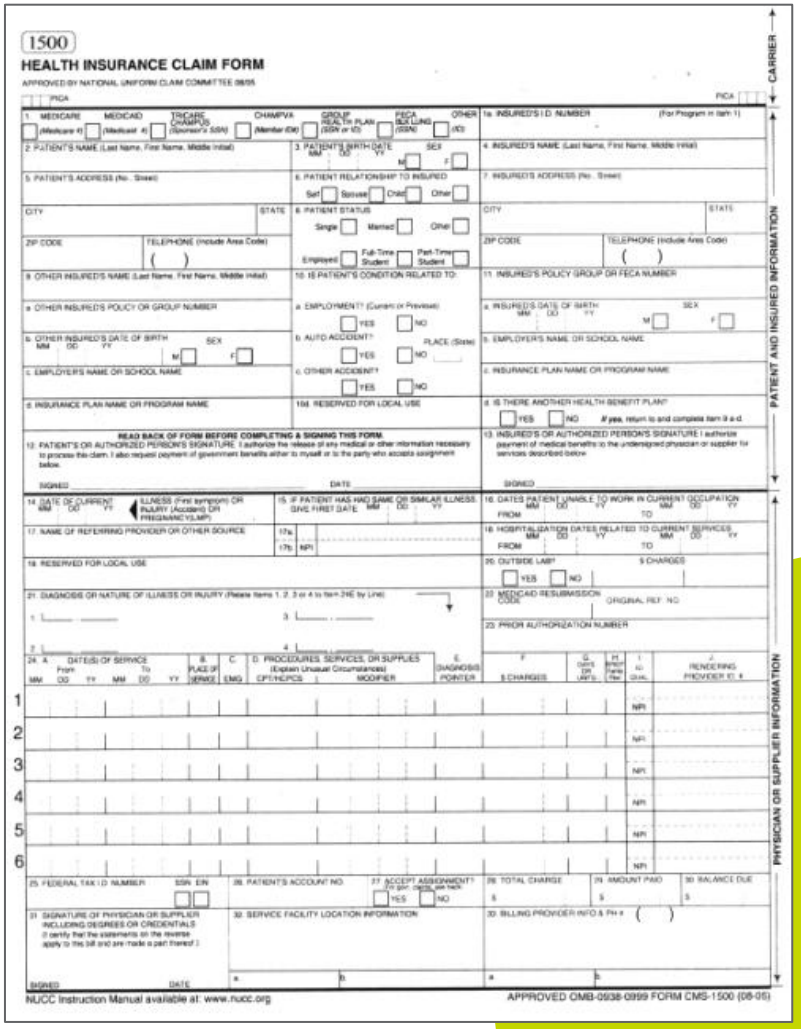
The National Uniform Billing Committee (NUBC) UB-04 claim form includes 81 fields and is used by facility providers, including:



Molina strongly encourages providers to submit claims electronically, including secondary claims.

CMS-1500 Claim Form

The National Uniform Billing Committee (NUBC) CMS-1500 claim form includes 33 fields and is used by non-institutional providers, up to and including:


1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) 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. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

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. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

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

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3. 2. 4.

22. MEDICAID 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. BALANCE DUE $

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. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

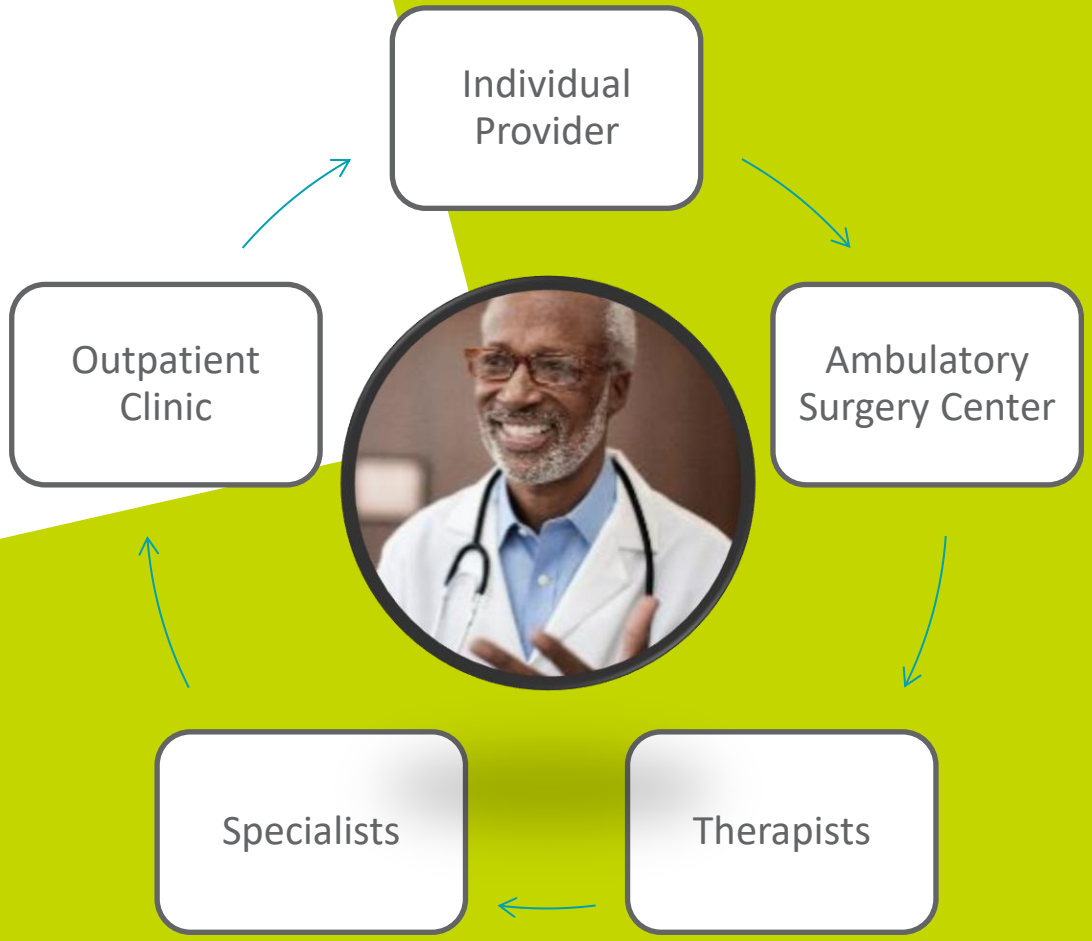
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)



Molina strongly encourages providers to submit claims electronically, including secondary claims.

Availity Essentials Portal

MOLINA HEALTHCARE

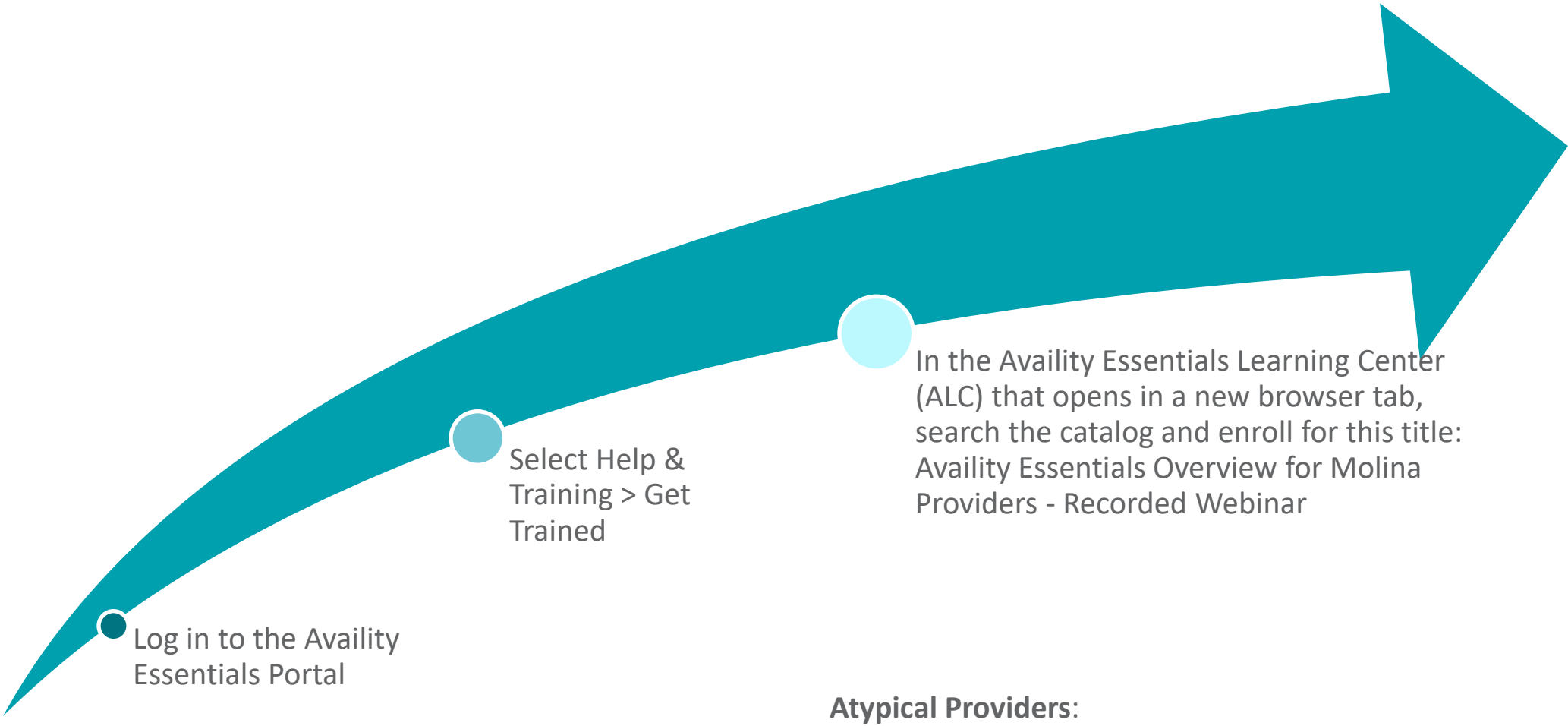
Availity Essentials (Availity) Provider Portal

Register for Availity at availity.com/provider-portal-registration and select your organization type.

Log into Availity

Availity Essentials Portal

Once registered providers will have access to the Availity Essentials Portal training by following these steps:



Atypical Providers:
Under “News and Announcements” select “Atypical Providers: Here’s your Ticket to Working with the Availity Essentials Portal” to view training sessions.

Availity Essentials Portal

The Availity Essentials Provider Portal is secure and available 24 hours a day, seven days a week. Self-service Provider Portal options include:

- Online Claim Submission
- Claims Status Inquiry
- Corrected Claims
- Member Eligibility Verification and Benefits
- Secure Messaging
- Check Status of Claim Dispute

- Manage Overpayment Request
- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Online Appeal Requests
- Care Coordination Portal
- Remittance Viewer
- View PCP Member Roster
- Submit and Check Status of PA Requests

Coordination of Benefits

MOLINA HEALTHCARE

Primary Insurance

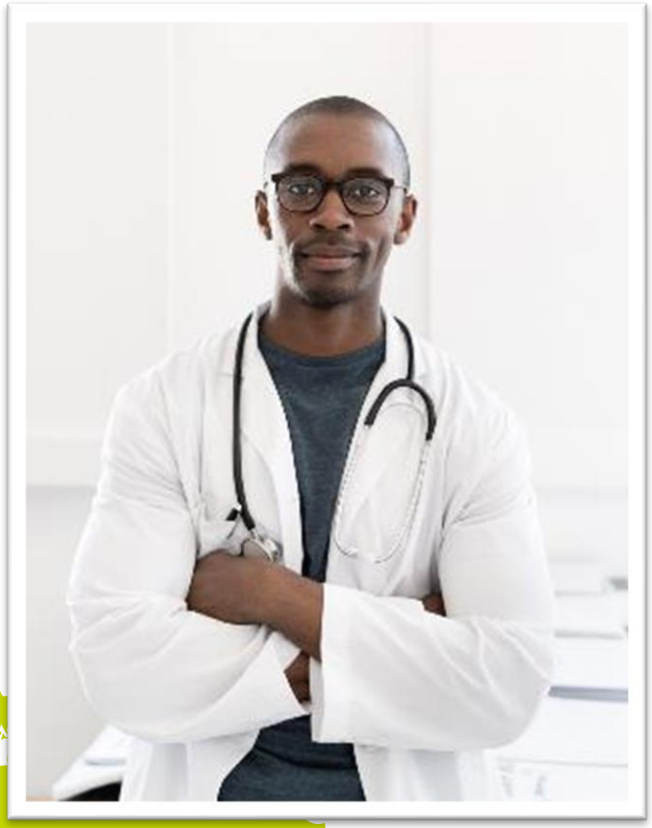
A Medicaid beneficiary may have a third-party resource (health insurance, another person or entity) that is liable to pay for the beneficiary's health care.

Third Parties could include:

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

Coordination of Benefits (COB) ensures that payment is not more than required and helps recover payments when a third party is responsible to pay for all or some of the health care received by a member.

Primary and Payer of Last Resort



When a person has Medicaid and there is another liable third party:

Health insurance, including Medicare and TRICARE generally pay first, to the limit of coverage liability.

Other third parties generally pay after settlement of claims.

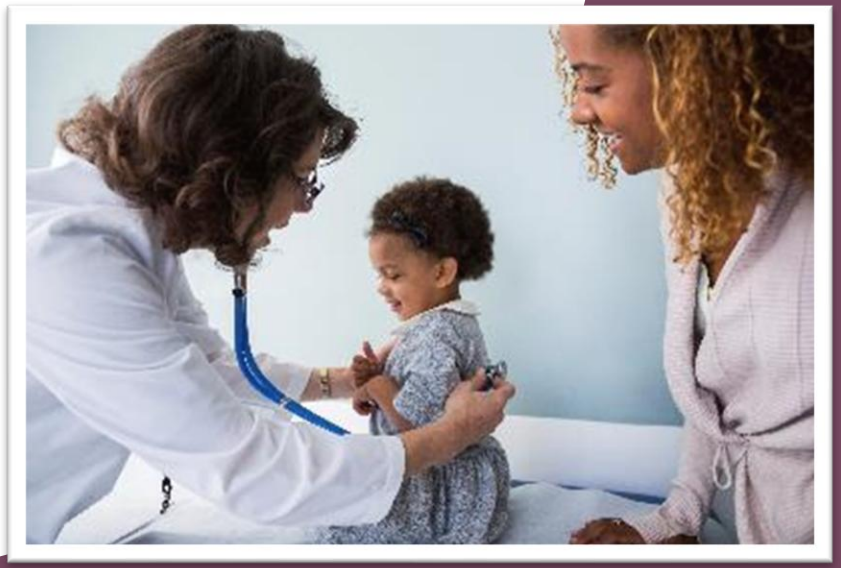
Medicaid is payer of last resort for services covered under Medicaid, except in those limited circumstances where there is a federal statute making Medicaid primary to a specific federal program.

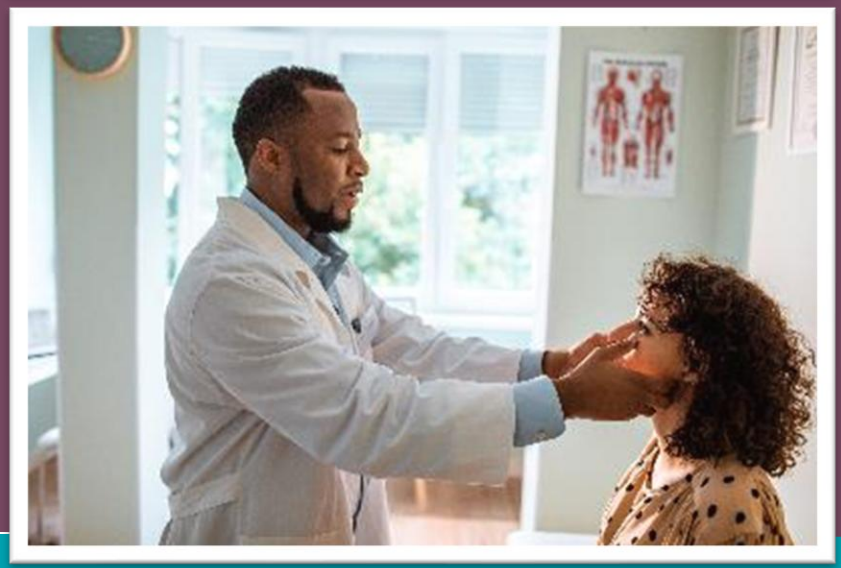
For members with an active waiver enrollment, the waiver is the payer of last resort.

Deficit Reduction Act of 2005: Impact on Claims, Continued

If Molina identifies commercial third-party liability within 270 days from the provider's payment date from Molina:

- Molina will issue a letter to the provider stating the details of the third-party payer identified by Molina as well as a request for refund of the impacted claims within 60 days.
- Provider to perform COB and bill the third-party payer identified.
- Provider should refund Molina for the amount paid on the impacted claim(s) within 60 days.





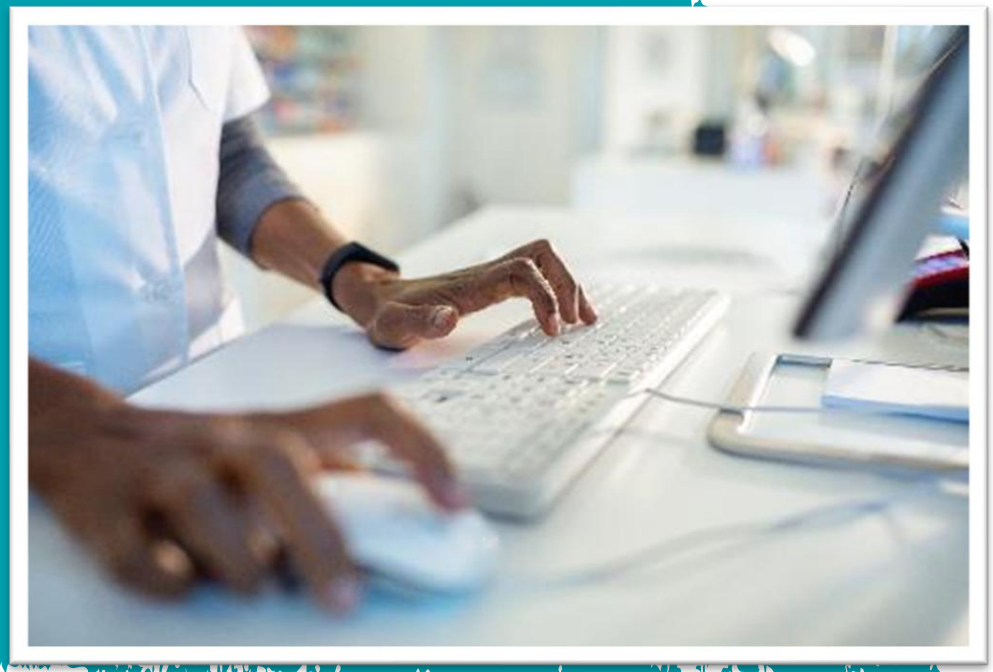
- If no refund is received from the provider within 60 days, Molina will recover the amount paid from future claim payments.
- Upon receipt of third-party payment, provider should submit the claim and third-party remittance to Molina for COB, subject to timely filing requirements.

Code Editing

MOLINA HEALTHCARE

Claim Editing Process

Coding edits are based on Current Procedural Terminology (CPT), Medicaid Purchasing Administration (MPA) guidelines, industry standard NCCI policy and guidelines and industry payment rules and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB).



Molina has a claim pre-payment auditing process that identifies frequent correct coding billing errors as such as:

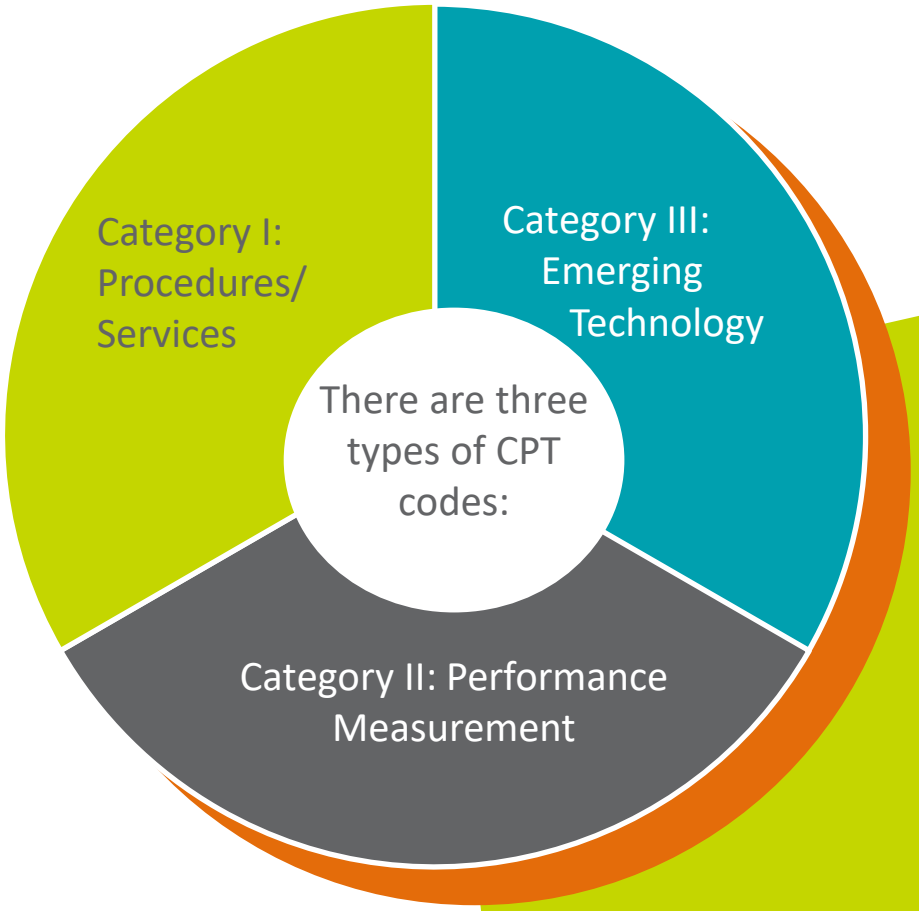
- Bundling and unbundling coding errors
- Duplicate claims
- Services included in global care
- Incorrect coding of services rendered

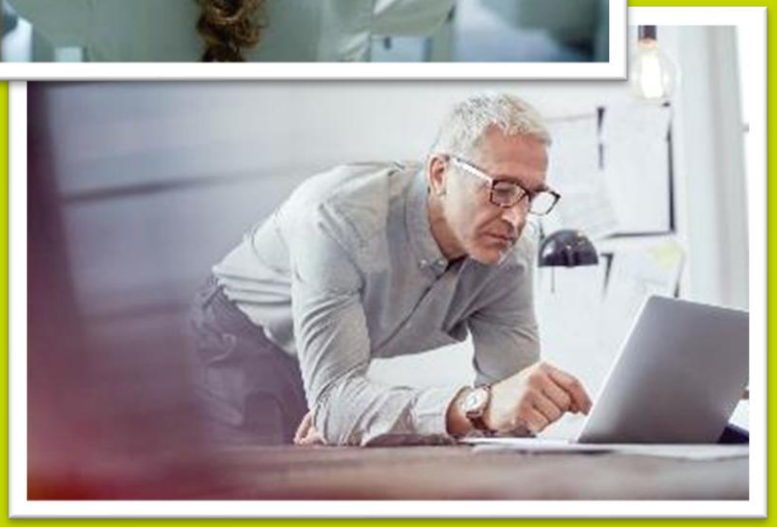
If you disagree with an edit, please follow the Claim Appeal process guidelines located in the Provider Manual.

Coding Sources: CPT

CPT is an American Medical Association (AMA) maintained uniform coding system.

CPT codes are five-digit numeric codes used to identify medical services and procedures furnished by physicians and other health care professionals.





Coding Sources: HCPCS

Health Care Common Procedure Coding System (HCPCS) is a CMS-maintained uniform coding system.

HCPCS codes are five-digit numeric codes used to identify procedure, supply and Durable Medical Equipment (DME) codes furnished by physicians and other health care professionals.

There are two types of HCPCS codes:

Level I:
Comprised of CPT codes

Level II:
Used to identify products, supplies and services not included in CPT codes (ex. ambulance services and DME)

Coding Sources: ICD-10 Diagnosis

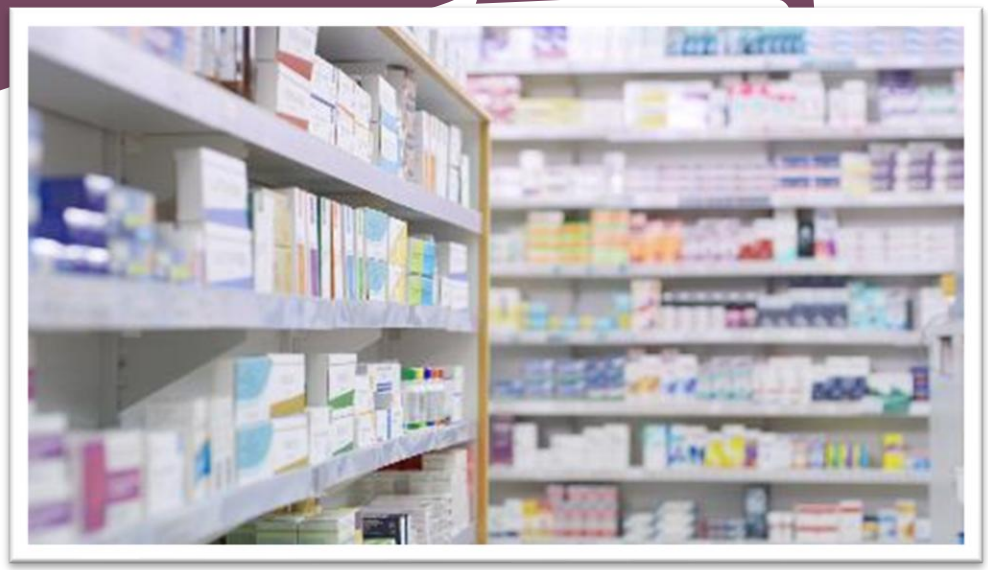
ICD-10-CM –
International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM) diagnosis codes are maintained by the National Center for Health Statistics (NCHS), Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).

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

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 medication 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.

10-Digit National Drug Code (NDC)

When the package of a drug only includes a 10-digit NDC number, the 10 digits must be converted to 11 digits by adding a leading zero to only one segment as indicated below:

Ex.
09999-9999-99

If the first segment contains only four digits, add a leading zero to the segment

Ex.
99999-0999-99

If the second segment contains only three digits, add a leading zero to the segment

Ex.
99999-9999-09

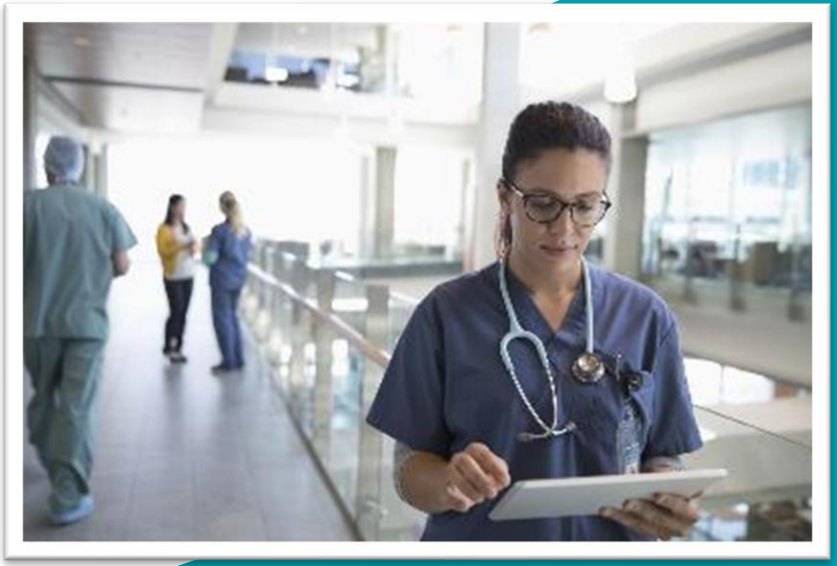
If the third segment contains only one digit, add a leading zero to the segment

National Correct Coding Initiative (NCCI)

CMS has directed all federal agencies to implement National Correct Coding Initiative (NCCI) as policy in support of Section 6507 of the Patient Affordable Care Act of March 23, 2010. Molina 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 same physician and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures.



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NCCI, Continued

NCCI editing also includes Medically Unlikely Edits (MUEs), which prevent payment for an inappropriate number/quantity of the same service on a single day. A 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.

For additional information on CMS guidelines for NCCI edits, visit the CMS NCCI page.

Evaluation and Management (E&M)

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

- The level of service for E&M service codes is based primarily 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 reported.

CMS Regulations and Guidance 30.6.1/Selection of Level of Evaluation and Management Services, A – Use of CPT Code (cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r178cp.pdf).

E&M Pre-Payment Review

Molina evaluates and reviews high-level E&M services for all lines of business.

The evaluation and review process will include claims that appear to have been incorrectly coded based on diagnostic information that appears on the claim and peer comparison.

Service codes included in the scope of this review include 99204, 99205, 99214 and 99215.

Claims that have been identified as incorrectly coded will include a remittance message that indicates that it was identified as incorrect coding.

If a provider disagrees with a claim finding, the provider can file an Appeal following the published guidelines.

Diagnosis Related Group (DRG)

Diagnosis Related Group (DRG) (both Medicare Severity-Diagnosis Related Group [MS-DRG] and All Patient Refined-Diagnosis Related Group [APR-DRG]) clinical validations are performed by Molina and a vendor.

The DRG and principal diagnosis are to be determined upon discharge and should not be based on the clinical suspicions at the time of admission.

The DRG clinical validation determination will be made using the medical record documentation available at the time of review, or upon request, and must support all diagnoses and procedures billed, including Major Complication or Comorbidity (MCC) and Complication or Comorbidity (CC).

Correct DRG assignment is in accordance with industry coding standards:

- Coding Clinics
- ICD Coding Manual
- ICD-10-CM Coding Guidelines
- Uniform Hospital Discharge Data Set

DRG, Continued

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

DRG, Continued

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

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

In the event providers do not submit requested documentation within 30 days, or the documentation submitted does not support the DRG clinical validation review, Molina may deny, reduce or recover claim payment consistent with the documentation provided.

Molina will send a notification explaining the results of the validation review.

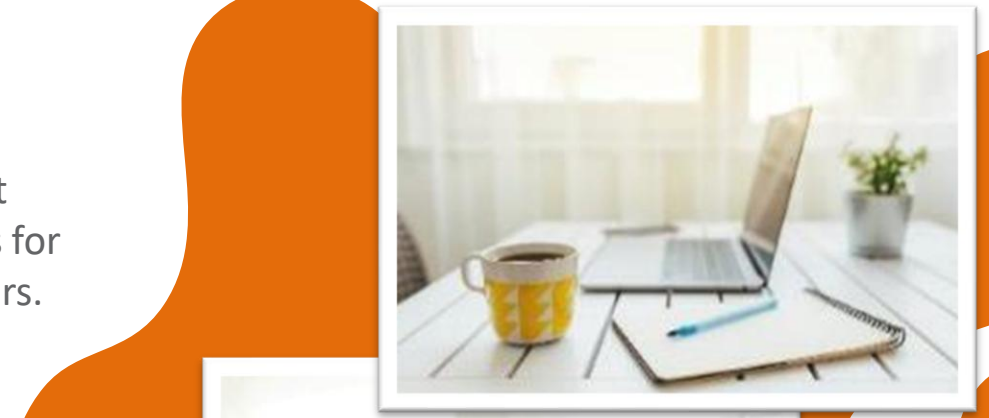
Providers retain their right to dispute the results of these reviews as outlined in the letter or in the Provider Manual.

Optum Prepay Audit

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

The prepayment claim reviews will ensure claims are billed accurately and coded correctly by reviewing state and federal policies sourced from Medicaid and Medicare rules utilized industry-wide.

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



Optum Pause + Prepay Review: Services Impacted

- Evaluation and Management
- Surgical Services
- Durable Medical Equipment
- Observation Stay
- Allergy Services
- Radiology

- Laboratory Services
- Behavioral Health
- Drugs and Biologics
- Add on Services
- Custom Fitted or Fabricated Orthotics
- Anesthesia Services

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Please note: This is not an all-inclusive list

National & Local Coverage Determinations

Through implementation of claims edits, Molina's claim payment system is designed to audit claims concurrently, to detect and prevent paying claims that are inappropriate.

In the absence of state specific guidelines, Molina applies additional guidelines to their claims' payment logic, including:

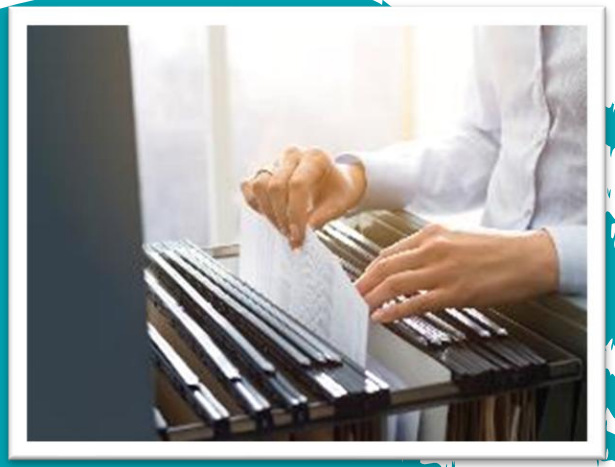
- National Coverage Determinations (NCDs)
- Local Coverage Determinations (LCDs)

NCDs and LCDs are decisions by Medicare and their administrative contractors that provide coverage information and determine whether services are reasonable and necessary on certain services offered by participating providers.

Note: NCDs supersede LCDs, but **LCDs** expand on coverage policies for each jurisdiction, and these coverage policies may vary, including information regarding appropriate coding, credentialing, diagnostic testing and treatment.

Code Edit Policy Disputes

When submitting an Appeal related to a code edit it is important to include the information below:



Include any supporting clinical documentation

Include trip documentation for ambulance services

Explanation of why the provider does not agree with Molina's current correct coding policy or interpretation

Include the supporting alternative policy information and the source where it can be found

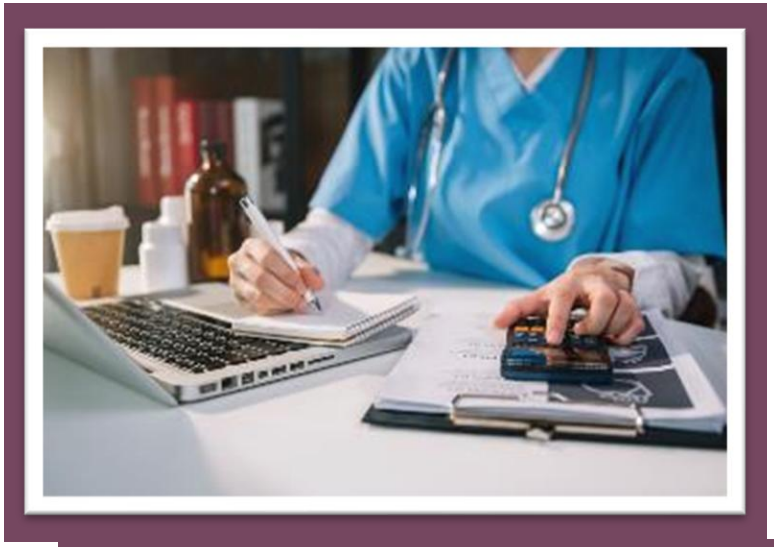
A provider can request an Appeal form regarding a code edit policy in situations where the provider's and Molina's correct coding policy sources conflict, or where they may have different interpretations of a common correct coding policy source.

Corrected Claims

MOLINA HEALTHCARE

Corrected Claims

Corrected claims are considered new claims for processing purposes. Corrected claim submissions are not adjustments and should be directed through the original submission process marked as a corrected claim or it may result in the claim being denied.



- Corrected claims must be submitted electronically with the appropriate fields on the 837I or 837P completed.
- The Provider Portal includes functionality to submit corrected Institutional and Professional Claims.
- Corrected claims must include the correct coding to denote if the claim is a replacement of prior claim or corrected claim for an 837I, or the correct resubmission code for an 837P, and include the original claim number.
- Claims submitted without the correct coding will be denied.

Corrected Claims, Continued

Corrected Claims must be received by Molina no later than the filing limitation stated in the provider contract or within 365 days of the original remittance advice. Claims submitted after the filing limit will be denied.

Reminders for the corrected claim process:

Corrected claims must be submitted with the Molina claim ID number from the claim being corrected, and with the appropriate corrected claim indicator based on claim form type.

Claim Submission Timelines

	Medicaid	Medicare	MMP (Duals)	Marketplace
Timely Filing Limit	**12 months/365 days** after the discharge for inpatient services or the date of service for outpatient services	**365** calendar days after the discharge for inpatient services or the date of service for outpatient services	**365** calendar days after the discharge for inpatient services or the date of service for outpatient services	**365** days from the date of service
Corrected Claims	**365** calendar days from the date of service	**365 calendar days** from the date of service or most recent adjudicated date of the claim	**365 calendar days** from the date of service	**365 calendar days** from the date of service
TPL/COB (Third Party Liability/Coordination of Benefits)	**12 months/365 days** from date of service after final determination by the primary payer	**365 calendar days** after final determination by the primary payer	**365 calendar days** after final determination by the primary payer	**365 calendar days** after final determination by the primary payer
Appeal	Requests must be made within **90 calendar days** of Molina's original remittance advice date	Requests must be made within **120 calendar days** of Molina's original remittance advice date or longer as stated in the Provider Agreement.	Requests must be made within **120 calendar days** of Molina's original remittance advice date or longer as stated in the Provider Agreement.	Requests must be made within **90 calendar days** of Molina's original remittance advice date.

Claim Attachments

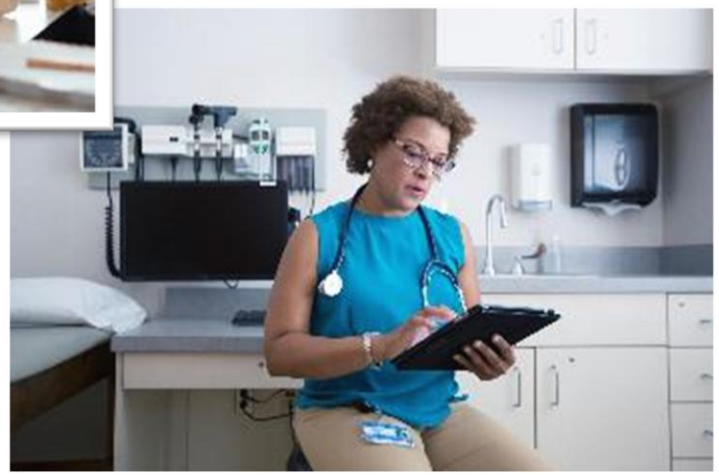
MOLINA HEALTHCARE

Attachments

Providers should include supporting documentation as an attachment with the initial claim, or with a corrected claim once the initial claim has been finalized.

Providers can upload documents to claims:

- Within the Provider Portal at the time of the claim submission
- Attach to a claim that was submitted through Electronic Data Interchange (EDI) while it is in adjudication using the PWK Indicator process



Note: Once the claim is in adjudication it is too late to add attachments.

Examples of attachments are consent forms, and Itemized Bills

Claim Appeal

MOLINA HEALTHCARE

Appeal

Submit a claim appeal when disputing a payment denial, payment amount or code edit.

Primary insurance EOB, corrected claims and itemized statements are not accepted via Appeal. Please refer to the Supporting Documents or Claim Submission process guidelines.

Molina allows providers to submit claim disputes verbally, in writing or through the Availity Essentials Portal. If the provider is submitting in writing, Molina requires an intake Form which the provider completes with the claim or authorization information, the member's identifiable information and a fax number to respond to the provider's dispute. This form is the same information captured verbally during a phone call and the same information captured through the provider portal electronic submission.

The form and supporting documents can be submitted through the Availity Essentials Portal or the form can be faxed to Molina.

Appeal Form

Request Requirements:

- Molina's form or similar document should be submitted for any dispute that is related to a claim denial that is not due to an authorization
- Requests must be fully explained as to the reason for appeal.
- The dispute must be submitted within the timeframes stated in the Provider Manual
- The submission should include previous claim/remittance advice, any other documentation to support the request and a copy of the authorization/referral form (if applicable)

This form is available on our Provider Website under the Forms tab.

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

Potentially Preventable Readmissions

Review PI Policy for additional information

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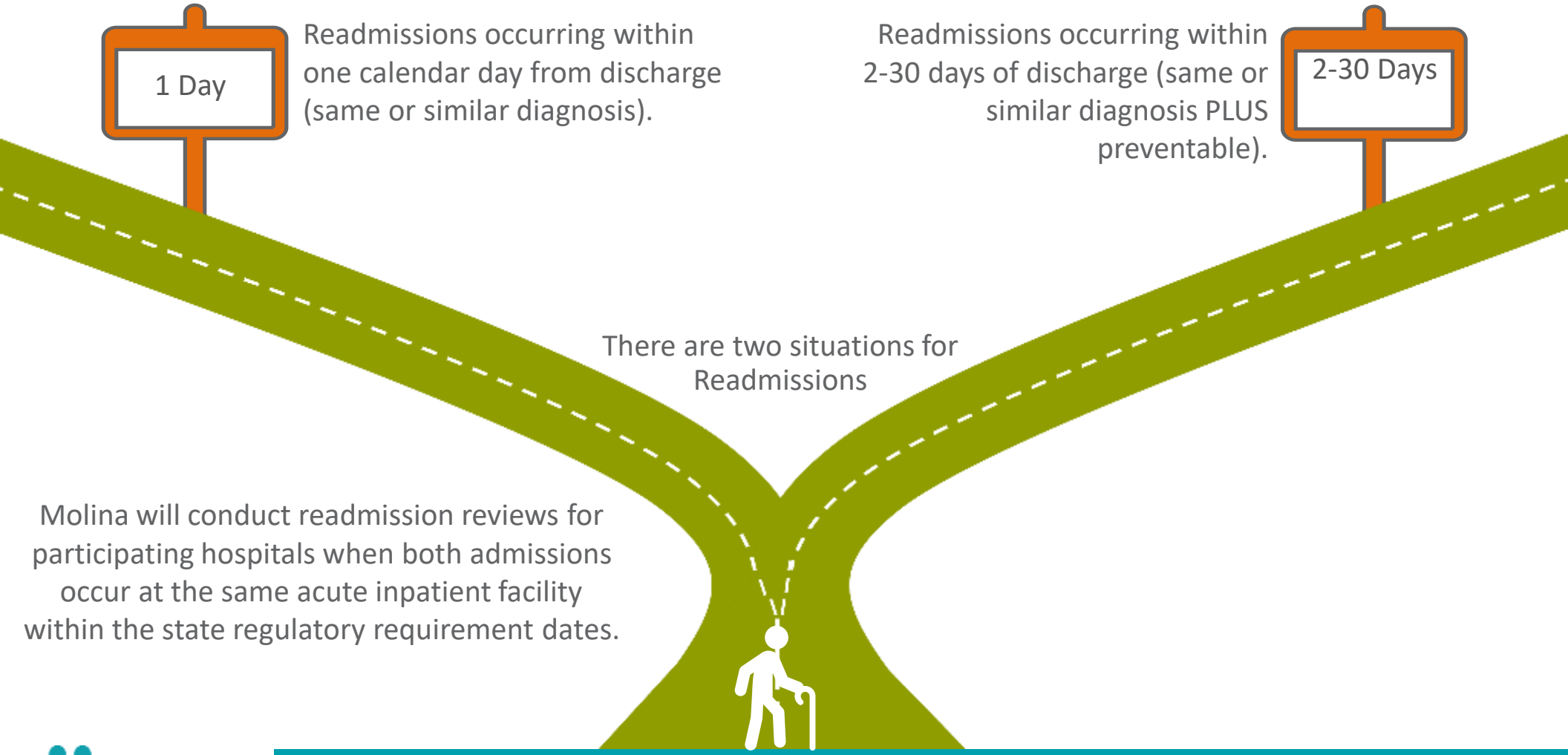
Readmissions

Readmission review is an important part of Molina's Quality Improvement Program to ensure that Molina members are receiving hospital care that is compliant with nationally recognized guidelines as well as federal and state regulations.



Molina will conduct readmission reviews for participating hospitals when both admissions occur at the same acute inpatient facility within the state regulatory requirement dates.

Readmissions, Continued

One Calendar Day

When a subsequent admission to the same facility with the same or similar diagnosis occurs within one calendar day of discharge, the hospital will be informed that the readmission should be combined with the initial admission and will be processed as a continued stay.

2-30 Days

When a subsequent admission to the same facility occurs within 2-30 days of discharge, if it is determined that the readmission is related to the first admission (readmission), or if it is determined to be preventable, then a single payment may be considered as payment in full for both the first and subsequent hospital admissions.

Provider can dispute with supporting documentation if they believe the readmission is unrelated or unpreventable based on published guidelines.

For additional information see the Readmission Payment Policy on the Provider Website.

Sepsis

Review PI Payment Policy 26 Sepsis for additional information

MOLINA HEALTHCARE

Sepsis and Septic Shock Payment Policy

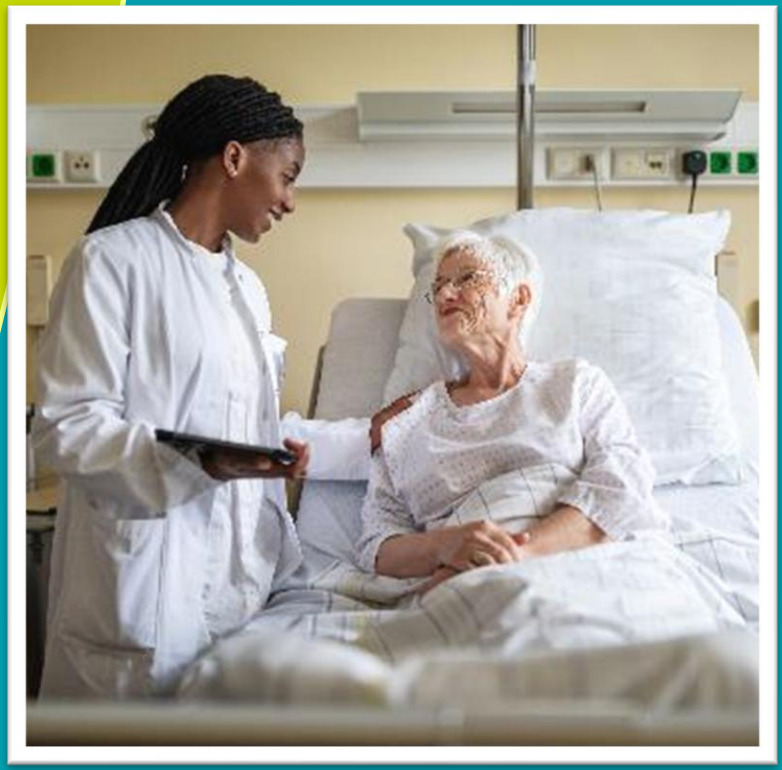
Molina uses the revised sepsis guidelines issued by the Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3).

The Sepsis-3 guidelines have consolidated three sepsis categories into two categories:

- Sepsis and severe sepsis have been merged into one category, now called sepsis.
- Septic shock (or Sepsis-3) have not changed significantly.

The Sepsis-3 definition will be used in clinical claim reviews to validate that sepsis was present and that related services were appropriately submitted as part of the member's claim.

If clinical documentation provided to and reviewed by Molina does not support Sepsis-3 definitions and associated services, hospital payments will be adjusted appropriately.



Sepsis and Septic Shock Payment Policy: Claims

Molina will review the clinical at the time of the claim receipt to determine if any diagnosis (primary or secondary) of sepsis or septic shock meet the Sepsis-3 guideline:

If clinical documentation meets Sepsis-3 guidance, the claim will be processed based on medical necessity and standard payment guidelines.

If clinical documentation does not meet Sepsis-3 guidance, the claim will be processed with the removal of the sepsis or septic shock diagnosis(es) when evaluating the payment.

If a sepsis or septic shock diagnosis is determined to be inappropriate, providers will have standard timelines via the Appeal Process for Molina to perform review of the additional documentation from providers.

Itemized Bills

Review PI Policy for additional information

Molina requires an Itemized Bill be submitted with all claims over 100k

How To Identify a Claim With an Itemized Bill Request

Remit codes 252 and N26 are used when processing a claim requiring an Itemized Bill.

Remit Code	Description
252	An attachment/other documentation is required to adjudicate this claim/service.
N26	Missing itemized bill/statement.

Claims Status

Whether you submit claims via clearinghouse or the Availity Provider Portal, the Portal will show the status as pend/in process, if not yet final. You can search for the claim via the member info and Date of Service, or the claim ID provided by their clearinghouse to verify status before attempting to attach documents.

Claims Attachments

When submitting a claim through a clearinghouse, you can add attachments (i.e., the Itemized Bill) via the Provider Portal if the claim is **not** finalized (i.e., the claim must be pending or in process). If the claim has moved to a finalized status (i.e., paid or denied), a corrected claim or dispute should be submitted **with** the Itemized Bill. For assistance with the process, contact Availity Client Services at (800) 282-4548.

How To Attach

1. In the Availity Portal, go to **Claims & Payments** and select appropriate bill type (e.g., Professional Claim).
2. You will be prompted to select your organization, transaction, and payer.
3. As you complete the form, you will come to the **Attachments** section. On the **Report Type** dropdown, Itemized Bill is not an option, so select "**Medical Record Attachment.**"

Important: Attachments can only be added:

- With the initial submission.
- When a claim is pending/in-process.
- With a corrected claim.

It is **always best** to attach an Itemized Bill with the initial claim.

If you are attaching to a **previously submitted claim** that is pending/in process:

1. Use Claim Status Inquiry to find the correct claim, click it, and view the **Claim Details** page.
2. You can access the **Attachments** section at the bottom of the Claim Details page.
3. Select the type of attachment, click Select File, browse your device for the correct file, and select Upload.
4. Repeat step 3 until all appropriate files are loaded, then click Submit Attachments.

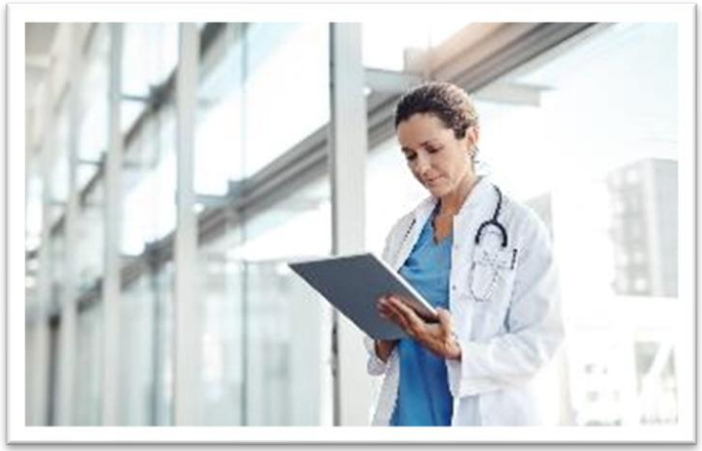
Contact Molina

MOLINA HEALTHCARE

Molina Provider Training Survey

The Molina Provider Relations Team hopes you have found this training session beneficial.

Please share your feedback with us so we can continue to provide you with excellent customer service!



Please take a few minutes to complete the Molina Provider Training survey to provide feedback on this session. The survey is located on the You Matter to Molina Page of our Provider Website, under the "Communications" tab.

Molina of South Carolina Provider Relations Contact Information

Molina Healthcare of South Carolina

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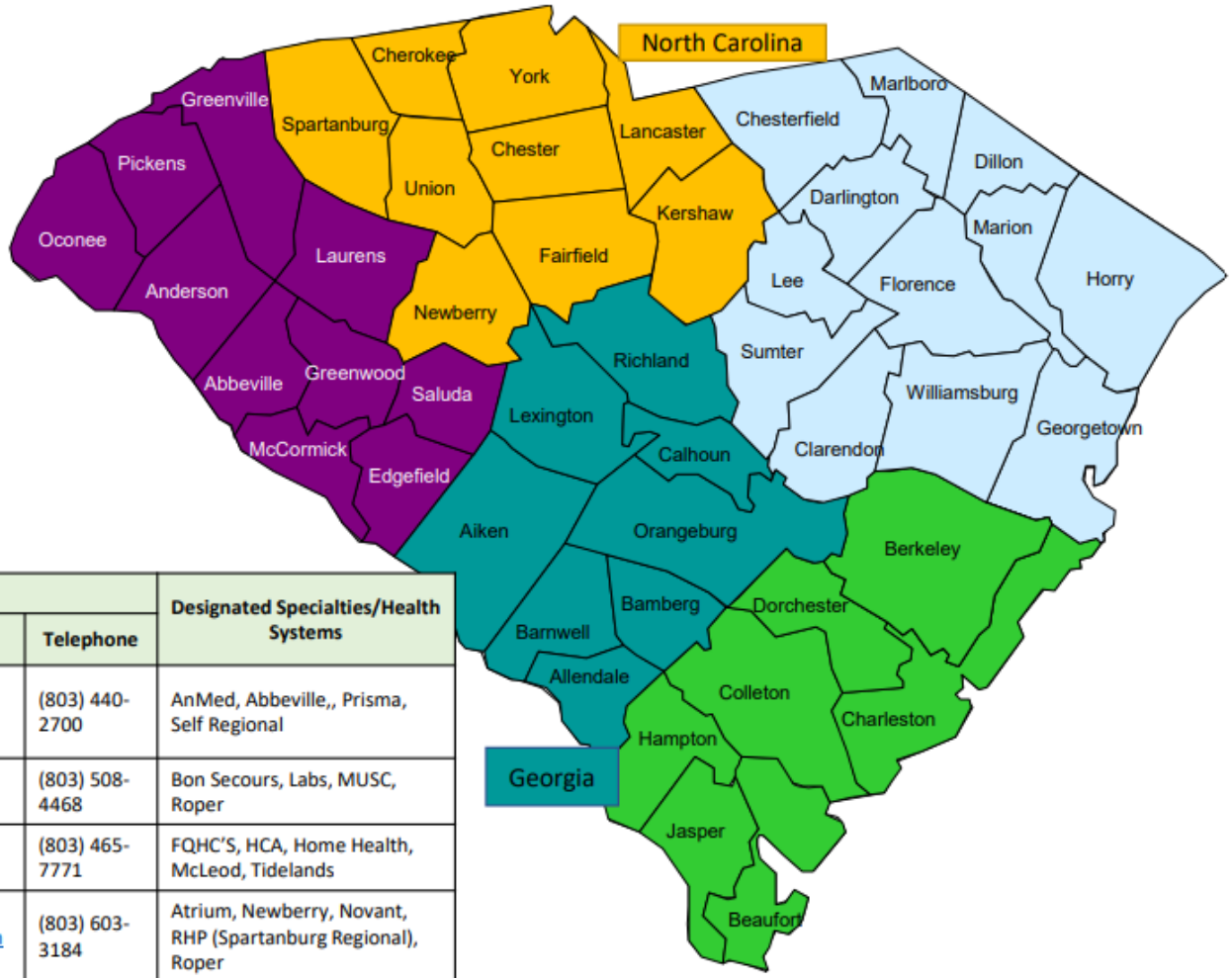

Representative	Contact Information		Designated Specialties/Health Systems
	Email	Telephone	
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Bethany Cook	Bethany.Cook@molinahealthcare.com	(803) 465-7771	FQHC'S, HCA, Home Health, McLeod, Tidelands
Kimberly Goodman	Kimberly.Goodman@molinahealthcare.com	(803) 603-3184	Atrium, Newberry, Novant, RHP (Spartanburg Regional), Roper
Kimberly Brown	Kimberly.Brown4@molinahealthcare.com	(803) 673-5039	Aiken, AU/Wellstar, LMC, SNF's, Uniphy

Thank You

YOUR VOICE MATTERS!

Questions

Open Discussion

MOLINA HEALTHCARE

Thank you for participating in today's meeting!