Billing Guidelines
Provider Engagement Team Training

Topics

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Important

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

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

- Except as otherwise provided by Law or provided by Government Program requirements, any claims that are not submitted to Molina within these timelines shall not be eligible for payment and Provider hereby waives any right to payment.

Billing Guidelines

- How to submit a claim

- Timely Filing

- Balance Billing

- Claim Resubmissions/Corrected Claims

Claim Submission

Providers may submit claims to Molina electronically or on paper.

Availity Portal (preferred): Provider.MolinaHealthcare.com

Marketplace/Medicaid/LTC Claims Submission Address
Molina Healthcare of Florida
P.O. Box 22812
Long Beach, CA 90801

EDI Claims Submission (All LOBs)

SSI Group: (844) 750-4274
Payer ID: 51062

Transaction Type/Format
CMS-1500 - Professional (837P)
UB04 - Institutional (837I)
Eligibility Batch Inquiry/Response (270/271)
Claims Status Batch Inquiry/Response (276/277)

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

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

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

Whether paper or electronic, the following information must be included on every Claim:

- Member name, date of birth and Molina Member ID number
- Member's gender
- Member's address
- Date(s) of service
- Valid International Classification of Diseases diagnosis and procedure codes
- Valid revenue, CPT or HCPCS for services or items provided
- Valid Diagnosis Pointers Page 2 of 2 Date: 5/2/22
- Total billed charges
- Place and type of service code

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

Services are not reimbursed when any of the following apply:

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

For additional information on claims submission, please visit MolinaHealthcare.com and review our provider handbook.

Providers may also call Molina Healthcare at (855) 322-4076

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

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

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

Balance Billing

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

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

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

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Claim Resubmissions/Corrected Claims

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

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

All Corrected Claims:

• Must be free of handwritten or stamped verbiage (paper Claims).

• Must be submitted on a standard red and white CMS-1450 (UB-04) or CMS-1500 Claim form (paper Claims).

• Original Claim number must be inserted in field 64 of the CMS-1450 (UB-04) or field 22 of the CMS-1500 of the paper Claim, or the applicable 837 transaction loop for submitting corrected claims electronically.

• The appropriate frequency code/resubmission code must also be billed in field 4 of the CMS-1450 (UB-04) and 22 of the CMS-1500.

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

Corrected Claims submission options:

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

EDI (Clearinghouse) Submissions for Corrected Claims

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

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

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

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

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

Billing Forms

- CMS 1500

- UB04

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CMS 1500 form

Professional Paper Claim Form Sample

Link: cms1500.pdf

UB-04 form

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

Encounter Data

Encounter Claims

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

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

• ANSI X12N 837I – Institutional,
• 837P – Professional

Data must be submitted with claims level detail for all non-institutional services provided. For institutional services, only those services covered by Molina should be reported. Providers must correct and resubmit any encounters which are rejected (non-HIPAA compliant) or denied by Molina. Encounters must be corrected and resubmitted within fifteen (15) days from the rejection/denial.

Provider Appeals and Grievances

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

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

On July 15, 2023, Molina Healthcare changed the Dispute resolution address to:

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

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

Provider dispute form:
Frequently Used Forms

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Provider Disputes and Appeals – Quick Tips

Disputes (Underpayments, Bundling)

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

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

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

Appeals (Authorization, Medical Necessity)

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

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

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

Capitol Bridge

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

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

Quick Facts

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

  P.O. Box 22812
  Long Beach, CA 90801

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

Provider tip sheet with the above information is available here: Provider Tip Sheet

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Taxonomy/NPI

Taxonomy and NPI match

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

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

Providers can visit the AHCA website to verify their State enrollment information: Registration | Florida Medicaid Web Portal

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

Authorization lookup tool

Prior-Auth look up tool

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

How to Request Prior-Auth

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

Request Form are available on our website at: [Frequently Used Forms](#)

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

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

Requesting Prior Authorizations

Prior Auth Requests

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

Medicaid: MolinaHealthcare.com/Providers/FL/Medicaid/Forms/FUF.aspx

Marketplace: MolinaMarketplace.com/Marketplace/FL/en-us/Providers/Provider-Forms.aspx

Service Request Forms may be faxed to the Utilization Management Department to the numbers listed below or submitted via the provider Availity portal Provider.MolinaHealthcare.com

Medicaid/Marketplace Fax: (866) 440-9791

Modes of Submission

Online (preferred):

Providers should register on the Availity Portal at Provider.MolinaHealthcare.com to avoid any disruption in accessibility and functionality.

Mail:

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

Fax: (866) 440-9791

Pharmacy Prior-Auth

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

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

Please refer to the provider handbook at Provider Manual and Orientation for additional information regarding prior authorizations or contact Molina Healthcare of Florida at (855) 322-4076. Thank you for your continued care to our members!

If you have further questions, contact your provider services manager

or

e-mail MFLProviderServicesManagement@MolinaHealthCare.Com

Access contact information for our Provider Services Managers by Regions:

Contact Us