

Dear Provider,

As a non-contracted provider, it is important to understand Molina Healthcare's billing guidelines, and how the claims process works, to avoid delays in claims payment. Molina knows efficient processes are important to our providers and we are committed to getting you the most current information.

Refer to the Non-Contracted Providers Billing Guidelines, which are enclosed and available on our website at www.MolinaHealthcare.com/OhioProviders under the "Forms" tab.

The Non-Contracted Provider Billing Guidelines outline the following:

- Prior Authorization (PA)
- Medicaid Authorization Reconsideration Process
- MyCare Ohio Authorization Reconsideration Process: Inpatient Only
- Prescription Drugs
- Contract Requests
- Emergency Services
- Post-Stabilization Services
- Referrals
- Benefits and Payment Policy
- Claim Submission (Medical and Behavioral Health Services)
- Timely Filing Guidelines for Medicaid and MyCare Ohio
- Overpayments
- Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs)
- Member Eligibility Verification
- Sample Member Identification (ID) Cards
- Contact Information
- Cost Recovery

Following these guidelines will help ensure we receive all the information we need to process your requests as quickly as possible, so you can focus on what's most important: providing excellent care to your patients.

Referring Patients to Participating Providers: When referring a member to another provider for services, be sure to refer to a Molina participating provider. A complete list of Molina's participating providers, including pharmacies, laboratories, radiology and behavioral health (BH) providers, is available in our Provider Online Directory at <https://providersearch.molinahealthcare.com>. You can also contact Molina Provider Services at (855) 322-4079.

Provider Portal: The Provider Portal is a no cost online platform that offers a number of features:

- Online Claim Submission
- Online Claim Reconsideration Requests
- Correct Claims
- Check Member Eligibility
- Submit and Check Claim Status and PA Request(s)

Questions? If you have any questions, please call Provider Services at (855) 322-4079. Representatives are available to assist you from 8 a.m. to 5 p.m. Monday through Friday for Medicaid, and 8 a.m. to 6 p.m. Monday through Friday for MyCare Ohio.

Non-Contracted Provider Billing Guidelines

Prior Authorization

All non-emergent services rendered by non-contracted providers require prior authorization (PA), unless specified otherwise.

- Abortions, Hysterectomies and Sterilizations: PA is required for non-contracted providers
 - The appropriate Ohio Department of Medicaid (ODM) consent form must be signed by the member and submitted to Molina in the timeframes specified. Find the consent form at www.MolinaHealthcare.com/OhioProviders under the “Forms” tab.
- Ambulance: PA is not required for emergent situations
- Emergency Room: PA is not required for services billed in conjunction with emergency room visit
- Federally Qualified Health Center (FQHC): Exempt from PA requirements
- Rural Health Clinic (RHC): Exempt from PA requirements
- Qualified Family Planning Provider (QFPP): Exempt from PA requirements
- Urgent Care: PA is not required

Use the Molina Prior Authorization Request Form and Instructions to submit a PA request. The PA Request Form and Instructions is posted at www.MolinaHealthcare.com/OhioProviders under the “Forms” tab.

Medicaid Authorization Reconsideration Process

Submit an authorization reconsideration only when disputing a level of care determination, a medical necessity denial with new/additional clinical information, or a retro authorization for Extenuating Circumstances only.

Below is the list of Extenuating Circumstances that apply to both inpatient and outpatient authorization requirements. Within 180 days of the claim denial, a non-contracted provider may file for an authorization reconsideration for the extenuating circumstances listed below; even if the authorization was not requested in advance of the service(s) being provided.

The specific circumstance the provider feels was applicable to the request should be noted on the reconsideration form, documentation to support the Extenuating Circumstance, as well as the applicable clinical information should be included with the request. In accordance with Molina policy, please remember to always verify enrollment using the Ohio Medicaid Program’s Eligibility System (MITS).

Extenuating Circumstances:

- A newborn remains an inpatient longer than the mother and needs a separate authorization
- Member was brought into facility unconscious and/or unable to provide insurance carrier information
 - Requires provider to submit copy of registration face sheet and full description of why the documentation could not be obtained from the member. In addition, Molina will review claims/authorizations history for the past 6 months for validation purposes.
- Retro-enrollment/retro coordination of benefits (COB) change makes Molina the primary carrier
- Transition of Care/Continuity of Care
- Abortion, Sterilization and Hysterectomy (operative reports are required)
- The service is not an included benefit in the primary insurance coverage (example: no maternity care benefits)
- A baby is born to a member with other third-party primary coverage and the baby is not covered under such coverage

- Add-on codes, or changes in coding during the procedure (operative reports are required as applicable)
- Other circumstances as determined by Molina

An Authorization Reconsideration can be submitted via the Provider Portal (submission option available only if a claim has been filed) or fax within 30 calendar days of the date on the authorization denial notification.

The Provider Portal is a no cost online platform that offers a number of claim processing features:

- Submit Professional (CMS-1500) and Institutional (UB04) Claims with attached files
- Correct/Void Claims
- Add attachments to previously submitted Claims
- Check Claims status
- Create and manage Claim Templates
- Create and submit a Claim Appeal with attached files

Instructions for Fax Submissions, requests must include:

- The Authorization Reconsideration Form must be filled out entirely and include the following details, or it will not be processed, and the provider will be notified:
 - Molina-Assigned Claim Number (if applicable)
 - Molina-Assigned Authorization Number
 - Line of Business
 - Member Name
 - Member ID Number
 - Date(s) of Service
 - Justification for the Reconsideration
 - Encrypted Disc
 - If sending an encrypted disc, provide your password on the Authorization Reconsideration Form
- Appropriate medical documentation supporting an overturn of the decision. This must be new or additional information to the original request. If this detail is not included, the request will be denied, and no further review will be completed. Only one submission will be accepted. Any additional submissions for the same service will be denied even if it includes new/additional information.
- Disc Submission: Larger files may not be able to process through the Provider Portal or fax. These large files can be submitted by disc to ensure they are received and processed timely. Follow the policy below when submitting as a disc:
 - Submit one medical record per disc. Those discs received with more than one medical record will not be processed and the provider will be notified.
 - Complete an Authorization Reconsideration Form (if submitting via fax).
 - If you will be submitting an encrypted disc, please write the password on the completed Authorization Reconsideration Form and indicate that the disc is to follow.
 - If the Authorization Reconsideration Form submission is received with incomplete or missing information, it will not be processed, and the provider will be notified.
 - Place the Molina-assigned claim ID number on the disc.
 - Discs will not be processed and the provider will be notified if we cannot access the data.

Mail discs to: Molina Healthcare of Ohio
Attn: Provider Inquiry Research and Resolution
P.O. Box 349020

Columbus, OH 43234-9020

The Authorization Reconsideration Form can be found on the Molina website at www.MolinaHealthcare.com/OhioProviders.

Only one submission will be accepted. Any additional submissions for the same dispute reason will be denied; even if it includes new/additional information.

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

MyCare Ohio Authorization Reconsideration Process: Inpatient Only

Note: Due to regulatory requirements, for outpatient decisions, an Authorization Reconsideration is not available. Please refer to member appeal rights noted in the posted Provider Manual.

Submit an Authorization Reconsideration only when disputing a level of care determination, a medical necessity denial with new/additional clinical information, or a retro authorization for Extenuating Circumstances only. Below is the list of Extenuating Circumstances that apply to both inpatient and outpatient authorization requirements. Within 60 days of the organizational determination to deny the service, the provider may file for an Authorization Reconsideration for the Extenuating Circumstances listed below; even if the authorization was not requested in advance of the service(s) being provided. The specific circumstance the provider feels was applicable to the request should be noted on the reconsideration form, documentation to support the Extenuating Circumstance, as well as the applicable clinical information should be included with the request. In accordance with Molina policy, please remember to always verify enrollment using the Ohio Medicaid Program's Eligibility System (MITS).

Extenuating Circumstances:

- A newborn remains an inpatient longer than the mother and needs a separate authorization
- Member was brought into facility unconscious and/or unable to provide insurance carrier information
 - Requires provider to submit copy of registration face sheet and full description of why the documentation could not be obtained from the member. In addition, Molina will review claims/authorizations history for the past 6 months for validation purposes.
- Retro-enrollment/retro COB change makes Molina the primary carrier
- Transition of Care/Continuity of Care
- Abortion, Sterilization and Hysterectomy (operative reports are required)
- The service is not an included benefit in the primary insurance coverage (example: no maternity care benefits)
- A baby is born to a member with other third-party primary coverage and the baby is not covered under such coverage
- Add-on codes, or changes in coding during the procedure (operative reports are required as applicable)
- Other circumstances as determined by Molina

An Authorization Reconsideration can be submitted via the Provider Portal (submission option available only if a claim has been filed) or fax within 60 calendar days of the date on the authorization non-approval notification or until the claim is processed.

Instructions for Provider Portal submissions (if a claim has been filed):

- You can access the Provider Portal at www.MolinaHealthcare.com/Provider
- You will need to log in with your User ID and Password
- Open the claims drop-down menu from the home page

- Search for the claim associated with the authorization you would like to have reconsidered by the claim ID or patient information
- Once the search function has identified the claim, select the claim ID number to populate the claim details
- At the bottom of the claim details will be the “Appeal Claim” button
- Once selected, the appeal forms to be completed will appear with some information pre-populated, please add a brief explanation of what is being requested noting the submission is an “Authorization Reconsideration” and you will have the option of adding supporting documents as an attachment
- For more details please find our Claim Features Training on our website under the “Manual” tab

Instructions for Fax Submissions

- The Authorization Reconsideration Form must be filled out entirely and include the following details, or it will not be processed, and the provider will be notified:
 - Molina-Assigned Claim Number (if applicable)
 - Molina-Assigned Authorization Number
 - Line of Business
 - Member Name
 - Member ID Number
 - Date(s) of Service
 - Justification for the Reconsideration
 - Encrypted Disc
 - If sending an encrypted disc, provide your password on the Authorization Reconsideration Form
- Appropriate medical documentation supporting an overturn of the decision. This must be new or additional information to the original request. If this detail is not included, the request will be denied, and no further review will be completed.
- Disc Submission: Larger files may not be able to process through the Provider Portal or fax. These large files can be submitted by disc to ensure they are received and processed timely. Follow the policy below when submitting as a disc:
 - Submit one medical record per disc. Those discs received with more than one medical record will not be processed and the provider will be notified.
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 - If you will be submitting an encrypted disc, please write the password on the completed Authorization Reconsideration Form and indicate that the disc is to follow.
 - If the Authorization Reconsideration Form submission is received with incomplete or missing information, it will not be processed, and the provider will be notified.
 - Place the Molina-assigned claim ID number.
 - Discs will not be processed, and the provider will be notified if we cannot access the data.

Mail discs to:

Molina Healthcare of Ohio

Attn: Provider Inquiry Research and Resolution

P.O. Box 349020

Columbus, OH 43234-9020

The Authorization Reconsideration Form can be found on the Molina website at www.MolinaHealthcare.com/OhioProviders.

Only one submission will be accepted. Any additional submissions for the same dispute reason will be denied; even if it includes new or additional information.

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

Prescription Drugs

Molina will pay for medically necessary prescription drugs and certain medical supplies dispensed by a pharmacy (diabetic supplies, inhaler spacers, peak flow meters, syringes, needles, alcohol wipes and condoms).

For Molina Medicaid members: Payments will only be made for drugs covered by Ohio Medicaid and obtained from pharmacies or medical equipment suppliers contracted with Molina.

For Molina Dual Options MyCare Ohio members: Payment will only be made for drugs covered by Medicare or Ohio Medicaid and obtained from pharmacies and medical equipment suppliers contracted with Molina.

Find a complete list of participating providers and pharmacies in the Molina Provider Online Directory at www.MolinaHealthcare.com/ProviderSearch, or call Provider Services at (855) 322-4079.

For a list of covered Medicare codes, visit www.MolinaHealthcare.com/OhioProviders and view the Drug Formulary. Select “MyCare Ohio” from the drop-down menu at the top of the page, then look under the “Drug List” tab. For codes not on the formulary, a provider must request PA or formulary exception.

For a list of codes covered under the Medical benefit, see Ohio Administrative Code (OAC) [5160-10-01](#) Durable medical equipment, prostheses, orthoses, and supplies (DMEPOS).

Please follow the guidelines for limits and PA requirements as outlined:

- **For Molina Medicaid members:** The Preferred Drug List (PDL) posted under the “Rx Info” tab at www.MolinaHealthcare.com/OhioProviders.
- **For Molina Dual Options MyCare Ohio members:** The Drug Formulary posted to www.MolinaHealthcare.com/OhioProviders. Select “MyCare Ohio” from the drop-down menu at the top of the page, then look under the “Drug List” tab.
- [OAC 5160-10-01](#) Durable Medical Equipment, Prostheses, Orthoses, and Supplies (DMEPOS): General Provisions
- [OAC 5160-9-02](#) Appendix A, Supplies Billed by Ohio Medicaid Pharmacy Providers

Contract Requests

If interested in contracting with Molina, complete the Ohio Provider Contract Request Form at www.MolinaHealthcare.com/OhioProviders under the “Forms” tab.

Emergency Services

For emergency services, submit a CMS-1500 or UB-04 claim. Review the Provider Manual for current information about claims billing and payment guidelines under the “Manual” tab, at www.MolinaHealthcare.com/OhioProviders. You can also call Provider Services for assistance at (855) 322-4079.

Post-Stabilization Services

For post-stabilization services, submit a CMS-1500 or UB-04 claim. Review the Provider Manual for current information about claims billing and payment guidelines under the “Manual” tab, at www.MolinaHealthcare.com/OhioProviders. You can also call Provider Services for assistance at (855) 322-4079.

Referrals

Molina will not approve referrals to non-contracted providers. PA is not required for referrals to contracted providers. Find a complete list of participating providers in the Molina Provider Online Directory at www.MolinaHealthcare.com/ProviderSearch, or call Provider Services at (855) 322-4079.

When requesting PA for a service that will be rendered by another provider, fill out the PA Request Form completely, including the name and address of the refer-to provider.

Benefits and Payment Policy

Molina's benefits and payment policy adhere to the OAC. For more information, visit <http://codes.ohio.gov/oac/>.

Claim Submissions (Medical and Behavioral Health Services)

Review the Provider Manual for current information about claims billing and payment guidelines posted to www.MolinaHealthcare.com/OhioProviders under the "Manual" tab. You can also call Provider Services for assistance at (855) 322-4079.

Submit electronic claims using EDI payer ID 20149.

Timely Filing Guidelines for Medicaid and MyCare Ohio

Standard timely filing: Non-contracted providers have up to 365 days from the date of service to submit claims for reimbursement.

Coordination of Benefits: If a submitted claim has an Explanation of Benefits (EOB) from the member's primary carrier, providers have up to 180 days to submit claims from the date of the EOB.

Corrected Claims: Non-contracted providers have 365 days from the date of service to submit corrected claims.

PLEASE NOTE: Primary Insurance EOB, corrected claims, and itemized statements are not accepted via claim reconsideration; they should be submitted through the corrected claim process.

Disputes: Non-contracted providers can dispute a claim payment and/or denial up to 180 days from the original remittance date by submitting one of the following documents posted at www.MolinaHealthcare.com/OhioProviders under the "Forms" tab:

- When appealing an authorization denial post-claim, submit an Authorization Reconsideration Form
- When disputing a claim payment or denial, submit a Request for Claim Reconsideration Form

Overpayments

Overpayments as a result of claims processing are automatically recouped from future claims for non-contracted providers in lieu of notification letters being sent. For dispute contact information and refund remittance address information, see page 9 for "Cost Recovery" under the "Contact Information" section.

Federally Qualified Health Centers (FQHCs)/Rural Health Clinic (RHC)

The following are Molina's Medicaid Identification (ID) numbers for use when submitting documents for wrap-around payments for dates of service on and after July 1, 2013.

- 0082414: Molina Dual Options MyCare Ohio Medicare-Medicaid Plan Opt-In and Opt-Out
- 0077182: Molina Medicaid – Aged, Blind or Disabled
- 0077186: Molina Medicaid – Covered Families and Children (CFC)

Member Eligibility Verification


Provider Portal: <https://Provider.MolinaHealthcare.com>

Molina Provider Services: (855) 322-4079 Monday through Friday 8 a.m. to 6 p.m. for MyCare Ohio Dual Options MyCare, or 8 a.m. to 5 p.m. for Medicaid


Ohio Medicaid Information System (MITS): (800) 686-1516

Sample Member Identification Cards


Molina Healthcare Medicaid

 <p>Member: JOHN SMITH Identification #: 00000001 Date of Birth: XX/XX/XXXX Effective Date: XX/XX/XXXX</p> <p>Primary Care Provider: JANE DOE Primary Care Provider Phone: (XXX) XXX-XXXX MMIS#: 00000001 Issue Date: XX/XX/XXXX</p> <p style="text-align: right;">Molina Medicaid</p> <p style="text-align: right;">RxBIN: BIN 1 RxPCN: PCN I RxGRP: RX Group 1</p> <p style="text-align: right;">MyMolina.com</p>	<p>MEMBER SERVICES: (800) 642-4168 TTY: (800) 750-0750 or 711 7 a.m. to 7 p.m., Monday to Friday</p> <p>TRANSPORTATION: (866) 642-8279 24 hours a day, 7 days a week Call 2 business days before your appointment</p> <p>24-HOUR NURSE ADVICE LINE: English: (888) 275-8750 Español: (866) 648-3537 TTY: (866) 735-2929</p> <p>EMERGENCY SERVICES: Call 911 or go to the nearest emergency room (ER). If you're not sure if you should go to the ER, call your Primary Care Provider or our Nurse Advice Line.</p> <p>Providers/Hospitals: Visit http://Provider.MolinaHealthcare.com or call (855) 322-4079 for prior authorization, eligibility, claims or benefits. Hospitals must have authorization prior to all non-emergency admissions.</p> <p>Pharmacists: For questions, call (855) 322-4079. Claims Submissions: P.O. Box 22712, Long Beach, CA 90801 EDI Claims: WebMD-Payor #20149</p> <p style="text-align: right;">MolinaHealthcare.com</p>
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Molina MyCare Ohio Medicaid Only (opt-out)

 <p>Molina Dual Options MyCare Ohio Medicaid</p> <p>Member Name: JOHN SMITH Member ID: 00000001 Health Plan ID: 80840 Medicaid ID: 00000001</p> <p>PCP Name: JANE DOE PCP Phone: (XXX) XXX-XXXX</p> <p style="text-align: right;">MyCareOhio <small>Connecting Medicare+Medicaid</small></p> <p style="text-align: right;">RxBIN: BIN 1 RxPCN: PCN I RxGRP: RX Group 1</p> <p style="text-align: right;">MyMolina.com</p>	<p>IN CASE OF AN EMERGENCY: Call 911 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your PCP or the 24-Hour Nurse Advice Line.</p> <p>Member Services: (855) 687-7862 TTY 711 Monday - Friday 8 a.m. to 8 p.m. Care Management: (855) 687-7862, TTY 711 Monday - Friday 8 a.m. to 5 p.m. 24-Hour Nurse Advice Line: (855) 895-9986, TTY 711 24-Hour Behavioral Health Crisis: (855) 895-9986, TTY 711 24-Hour Care Management: (855) 895-9986, TTY 711 Website: www.MolinaHealthcare.com/Duals</p> <p>Pharmacists/Pharmacy Help Desk: (800) 364-6331 (for Pharmacist use only) Providers/Hospitals: For prior authorization, eligibility, claims or benefits, visit the Molina Web Portal at www.MolinaHealthcare.com or call (855) 322-4079</p> <p>Hospital Admissions: Authorization must be obtained by the hospital prior to all non-emergency admissions. Send claims to: P.O. Box 22712, Long Beach, CA 90801 EDI Submissions: Payer ID #20149</p> <p style="text-align: right;">MolinaHealthcare.com</p>
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Molina Dual Options MyCare Ohio (full benefits)

 <p>MyCareOhio <small>Connecting Medicare+Medicaid</small></p> <p>Member Name: <Cardholder Name> Member ID: <Cardholder ID#> MMIS Number: <Medicaid Recipient ID#></p> <p>MEMBER CANNOT BE CHARGED Copays: \$0</p> <p>PCP Name: <PCP Name> PCP Phone: <PCP Phone></p> <p style="text-align: right;">MyCareOhio <small>Connecting Medicare+Medicaid</small></p> <p style="text-align: right;">RxBIN: <RxBIN #> RxPCN: <RxPCN#> RxGRP: <RxGRP#> RxDI: <RxDI#></p> <p style="text-align: right;">MedicareR <small>Prescription Drug Coverage</small></p> <p style="text-align: right;">MyMolina.com</p>	<p>In an emergency, call 911 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your PCP or the 24-Hour Nurse Advice line.</p> <p>Member Services: (855) 665-4623, TTY: 711 Eligibility Verification: (855) 665-4623 Pharmacy Help Desk: (855) 665-4623 Behavioral Health Crisis: (855) 895-9986 Transportation Reservation: (844) 491-4761 Care Management: (855) 665-4623 24-Hour Nurse Advice: (855) 895-9986, TTY: 711</p> <p>Website: MolinaHealthcare.com/Duals Send Claims To: P.O. Box 22712, Long Beach, CA 90801 EDI Submission Payer ID: 20149</p> <p style="text-align: right;">MolinaHealthcare.com/Duals</p>
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Contact Information



Provider Services

- Phone: (855) 322-4079 Monday through Friday 8 a.m. to 6 p.m. for MyCare Ohio Dual Options MyCare, or 8 a.m. to 5 p.m. for Medicaid
- Fax: (888) 296-7851

Follow prompts for the following departments and services:

- Authorization
- Claim
- Eligibility
- Pharmacy
- Non-Pharmacy
- Admissions
- Case Management
- Contracting/Credentialing
- Dental

Frequently Used Phone Numbers:

- 24-Hour Nurse Advise Line (Medicaid):
 - English (888) 275-8750 or Spanish (866) 648-3537
 - TTY: 711
- 24-Hour Nurse Advise Line (MyCare Ohio):
 - English and Spanish (855) 895-9986
 - TTY: 711
- Fraud, Waste and Abuse Tip Line: (866) 606-3889
- Ohio Medicaid Eligibility: (800) 686-1516

Frequently Used Fax Numbers:

- Claims Reconsideration: (800) 499-3406
- Pharmacy: Medicaid (800) 961-5160 or MyCare Ohio (866) 290-1309
- Prior Authorization:
 - Medicaid/MyCare Ohio Opt-In: Inpatient and Home Health (877) 708-2116 or Outpatient (844) 251-1450
 - Medicaid/MyCare Ohio Out-Out: (866) 449-6843

Cost Recovery

Phone: (866) 642-8999, select the option for Ohio 10 a.m. to 7 p.m., Monday through Friday

Please make checks payable to Molina of Ohio and send the check along with corresponding documentation to:

Molina Healthcare of Ohio, Dept. 781661
P.O. Box 78000
Detroit, MI 48278-1661

If returning a Molina check, please send to:

Molina Healthcare of Ohio
P.O. Box 349020
Columbus, OH 43234-9020

Use the Return of Overpayment Form to submit unsolicited refunds or check returns. The form is posted to www.MolinaHealthcare.com/OhioProviders under the "Forms" tab.