Claims/Payment

New Claims Submissions

All claims must be submitted and received by Molina Healthcare of New Mexico, Inc. (Molina Healthcare) within ninety (90) days from the date of service when Molina Healthcare is the Member's primary insurance. All claims must be submitted within one (1) year from the date of service when Molina Healthcare is the secondary carrier when the primary carrier's filing limit is one (1) year, and within ninety (90) days of the other carrier's Explanation of Benefit (EOB).

Timely Filing Suggestions

Please follow these *suggestions* in order to facilitate timely reimbursement of claims and to avoid timely filing issues:

- Submit your claims within thirty (30) days of providing the service;
- Check the status of your claims no sooner than thirty (30) days from the date of your original submission;
- If, after forty-five (45) days from submission of your claim(s), you have not received payment/denial, please call Member Services to confirm receipt of your claim(s) and be certain to document the name of the person you spoke with and the date of the call; and
- If Molina Healthcare does not have record of receipt of your claim(s), please immediately resubmit. Resubmission should only occur if Molina Healthcare does not have record of your original claim submission.

Claim Resubmission/Adjustments

ALL requests must include any/all documentation to support the request. The Provider Reconsideration Review Request Form (PRR) is included in this Section for your convenience.

All claims resubmission or adjustment requests must be submitted and received by Molina Healthcare within:

- One Hundred Eighty (180) days of dated correspondence from Molina Healthcare referencing the claim (correspondence must be specific to the referenced claim);
- One (1) year from the date of service when Molina Healthcare is the secondary payor when the primary carrier's filing limit is one (1) year, and ninety (90) days of the other carrier's EOB; and
- Ninety (90) days of the other carrier's EOB when submitted to the wrong payor.

Claims/Payment (*continued*)

Acceptable Proof of Timely Filing

Acceptable proof of timely filing includes, but is not limited to any one item or combination of:

- EOB issued by Molina Healthcare;
- Practitioner/provider statements/ledgers indicating the original submission date as well as all follow-up attempts;
- Dated copy of Molina Healthcare correspondence referencing the claim (correspondence must be specific to the referenced claim);
- Other carrier's EOB when Molina Healthcare is the secondary payor (one [1] year from the date of service);
- Other carrier's EOB when submitted to the wrong carrier (ninety [90] days); and
- Documentation of inquiries (calls or correspondence) made to Molina Healthcare for follow-up that can be verified by Molina Healthcare.

"Clean" Claim Criteria

The following items **must** be included to be considered a "clean" claim:

- Member's name;
- Member's correct date of birth;
- Provider's National Provider Identifier (NPI);
- Complete diagnosis code carried out to the highest degree (4th or 5th digit);
- Valid date of service;
- Valid Current Procedural Terminology (CPT-4) code or Health Care Procedure Coding System (HCPCS) code;
- Valid Revenue (REV) codes – please refer to Section K-5;
- Valid modifiers (if appropriate); and
- All other requirements as specified in Subsection L of 8.305.1.7 NMAC.

Claims/Payment (*continued*)

Electronic Claims Submission

The State of New Mexico Human Services Department requires that all of Molina Healthcare practitioners/providers file all claims electronically for the following reasons:

- Claims filed electronically are processed more efficiently;
- Saves mailing time, postage, and paper;
- Provides an electronic record of claims sent; and
- Allows instant feedback on claims that require correction(s).

All contracted practitioners/providers that are unable to file claims electronically must notify Provider Services with the reason(s).

In order for practitioners/providers to file claims electronically the following will be required:

- A personal computer (PC) system where Practice Management Software resides;
- The ability to produce a print image for a claim or an electronic claim or file (the clearinghouse technical representative will help to determine this); and
- A modem or internet connection.

Some clearinghouses provide web based claim submission. Clearinghouses may also provide eligibility validation so health care practitioners/providers may check patient eligibility easily.

Molina Healthcare is contracted with a single Electronic Data Interchange (EDI) vendor, Emdeon. All other EDI vendors must submit through Emdeon.

Emdeon (aka) Medifax
Toll free: (800) 296-3736
Payer ID: Salud: 9824
UNM SCI: 4423

Please contact Member Services or your Provider Service Representative if you are a current EDI customer and have questions regarding:

- The receipt of a claim submitted via the clearinghouse; and/or
- The confirmation of practitioner/provider number(s).

Please contact your vendor if you have questions and/or problems with your clearinghouse reports.

Molina Healthcare requests our EDI vendors edit all EDI claims for valid insured identification and dates of birth and whether the patient is eligible with a report(s) identifying those claims that did and did not pass the edit.

Claims/Payment (*continued*)

Coordination of Benefits (COB)

Practitioners/providers should maintain current coverage information on all Members.

Order of Benefit Determination

COB is a method of determining who has primary responsibility when there is more than one insurance coverage available to pay benefits. The combined payments provided by the primary and secondary plans cannot be more than the total of charges. When benefits are coordinated by Medicaid (the payor of last resort), the total payments will not exceed the Medicaid eligible payment.

Molina Healthcare follows the "Order of Benefit Determination Rules" to identify the primary insurance carrier. These rules are explained below:

- The program that covers the patient as an employee is primary;
- If an individual is a covered Member by more than one (1) group program as an active employee and as a retired employee, the program covering the individual as an active employee is primary. this rule also applies to dependents of the Member;
- If an individual is enrolled in a group retiree program and also as a dependent on an active working spouse's coverage, the dependent's active coverage is primary;
- Molina Healthcare will be the payor of last resort. Salud claims will represent the balance of the billed amount minus the payment from the primary insurance company. The combined payments will not exceed what would normally have been paid by Molina Healthcare in the absence of other coverage. If the payment from the primary insurance company is equal to or greater than the Medicaid Fee Schedule, no payment will be made by Molina Healthcare. The practitioner/provider is **not** permitted to bill the Salud Member for the balance.
- When two (2) plans cover the same child as a dependent (parents NOT separated or divorced), and neither plan is a Medicaid program:
  - The plan of the parent whose birthday falls earlier in the year is primary over the plan of the parent whose birthday falls later in the calendar year; but
  - If both parents have the same birthday, the plan that covered one (1) parent longer is primary over the plan that covered the other parent for a shorter time; or
  - If the other coverage plan does not use the birthday rule described above, but instead uses a rule based on the gender of the parent, the rule of the other plan will determine the order of benefits.
- When two (2) plans cover the same child as a dependent (parents are separated or divorced), the primary payor is determined in this order:
  - First (1st), the plan of the parent who has custody of the child;
  - Second (2nd), the plan of the spouse of the parent who has custody of the child;
  - Third (3rd), the plan of the natural parent not having custody of the child; or

Claims/Payment (*continued*)

- If the specific terms of a court decree require one parent to be responsible for the dependent's health care expenses, that parent's plan will be primary over any other plan covering the child as a dependent. This applies as long as the plan designated as primary has actual knowledge of those terms.
- If none of the above rules establishes an order of benefits, the plan that covered the person longer is primary over the plan that covered the person for a shorter time; and
- If it is determined that a Salud Member has Medicare, their coverage will terminate with the Salud managed care organization. All claims should be submitted to Medicare as the primary carrier, than to Fee-For-Service Medicaid for secondary payment.

Submitting COB Claims

When submitting claims for Members for which Molina Healthcare is not the primary insurance, you must attach a copy of the primary payor's EOB with the exception of home services billed by Early, Periodic Screening, and Diagnostic Treatment (EPSDT) providers for waiver children. The primary payor's EOB must match the submitted claim, and include descriptions of all associated remit messages so that Molina Healthcare may appropriately consider the charges.

Claim Edits

Molina Healthcare is contracted with HealthCare Insight (HCI) to perform prepayment claim audits. HCI uses Medicare (i.e., CMS) claim edits and other industry standard coding guidelines (i.e., Current Procedural Terminology [CPT] & Health Care Procedure Coding System [HCPCS]) to ensure proper handling of claims.

Revenue Codes

Practitioners/providers are required to use industry standard billing forms and coding. Claims submitted on a UB-04 form should include the appropriate type of bill, specific revenue codes and HCPCS or other codes as appropriate for services.

Skilled nursing facility (SNF), sub-acute care, or psychiatric services should be billed with the appropriate specific revenue codes and should not be billed using general medical surgical revenue codes.

Claim Submission *(Copies of claim forms can be found in this section)*

Molina Healthcare requires that all professional claims are submitted on a CMS-1500 Form, and all technical/facility claims are submitted on a UB-04 Form with the National Provider Identifier (NPI). Please refer to Section H for additional information regarding NPI.

Claims/Payment (*continued*)

CMS-1500 (08/05) Form *(Copy of form can be found in this section)*

For professional practitioners/providers who submit paper claims, the Centers for Medicare & Medicaid Services (CMS)-1500 (08/05) form is required. When submitting the CMS-1500 form, be sure all applicable fields are completed, including your NPI. Claims with missing or invalid required fields will be rejected and returned for correction and re-submission.

EDI/Electronic submissions are included in the requirements listed below.

The blocks with an asterisk (*) are required, if applicable.

Block 1:
Type of Health Insurance
Show the type of health insurance coverage applicable to this claim by checking the appropriate box.

Block 1A*: **Insured's Unique ID Number Assigned by the Payor Organization.**
Enter the ID number of the Member exactly as shown on the identification card.
EDI - Enter the ID number of the Member exactly as shown on the ID card minus the dashes.

Block 2*:
Patient's Name
Enter the last name, first name, and middle initial (if known) of the patient exactly as shown on the identification card.

Block 3*:
Patient's Birth Date and Gender
Enter the month, day, and year of the patient's birth. Check the appropriate box to identify the patient's Gender.

Block 4*:
Insured's Name
Enter the last name, first name and middle initial of the Member as shown on the identification card (ID). If the patient is the insured, enter the word "same".

Block 5*:
Patient's Address
Enter the patient's complete address and telephone number (if available).

Block 6:
Patient's Relationship to Insured
Check correct box: self, spouse, child or other.

Block 7:
Insured's Address
Complete if patient is not the Member and phone number (if available).

Claims/Payment (*continued*)

Block 8:
Patient status
Check the appropriate box(s).

Block 9*:
Other Insured's Name
Enter the name of the insured with the name of his/her insurance company.

Block 9A*:
Other Insured's Policy or Group Number
Enter the policy and/or group number of the other insurance coverage.

Block 9B:
Other Insured's Date of Birth
Enter the information available to you.

Block 9C*:
Employer's Name or School Name
Enter the complete name.

Block 9D*:
Insurance Plan Name or Program Name
Enter the name of the insurance plan.

Block 10:
Is Patient's Condition Related?
Check the correct boxes in a., b. and c.

Block 10D:
Reserved For Local Use
Leave Blank.

Block 11*:
Recipient's Group Number
Enter the identification number, control number or code assigned by the carrier or administrator to identify the group under which the individual is covered. The group number can be found on the Member's ID card.
EDI - same as above

Block 11A:
Insured's Date of Birth and Gender

Block 11B:
Employer's Name or School Name

Block 11C:
Insurance Plan Name or Program Name

Block 11D:
Is there another Health Benefit Plan?

Claims/Payment (*continued*)

Block 12*:
Patient's Authorized Person's Signature
Have patient sign if your office requires.

Block 13*:
Insured's or Authorized Person's Signature
Have patient sign.

Block 14:
Date of Current Illness
Enter the date of the current illness, injury or pregnancy.

Block 15:
If Patient Has Had Same or Similar Illness
Enter the date the patient first consulted you for this condition.

Block 16:
Dates Patient Unable to Work in Current Occupation
Leave blank.

Block 17*:
Name of Referring Physician or Other Source
Show the name of the referring or ordering physician.

Block 17A:
ID Number of Referring Physician
Enter the referring Primary Care Practitioner (PCP) tax identification number (TIN) or Unique Physician Identification Number (UPIN).

Block 17B*:
NPI Number of Referring Physician
Enter the NPI.

Block 18:
Hospitalization Dates Related to Current Services
For inpatient services, enter the admission date of the hospitalization (and discharge date if available).

Block 19:
Reserved for Local Use
Additional information for paper and EDI submission.

Block 20:
Outside Lab
If your patient had lab work done, check the correct box regardless of whether or not you are actually billing for the lab work. You need not list charges in this block.

Claims/Payment (*continued*)

Block 21*:
Diagnosis or Nature of Illness or Injury
Identify the diagnosis/condition of the patient by entering the International Classification of Diseases 9th Revision (ICD-9)-CM codes. Up to four (4) codes may be listed and should be shown in order of relevance.
The diagnosis code must be carried out to the highest degree of detail (4th or 5th digit).

Block 22:
Medicaid Re-submission

Block 23:
Prior Authorization Number
Enter the authorization number, if applicable.

Block 24A*:
Date(s) of Service
Enter the date(s) of service. If only one service is provided, the date should be entered in "from date." If there are multiple dates, they should be entered as a "from date" through "to date" or listed on individual lines.

Block 24B*:
Place of Service
Indicate where the services were provided by entering the appropriate two-digit place of service code. (See list in this section.)

Block 24C*:
EMG
EDI - HIPAA - Not Available

Block 24D*:
Procedure Code
Enter the most specific procedure code which best describes each service. Explaining unusual services or situations may help speed up processing of the claim. If both a Current Procedural Terminology (CPT) code and a Health Care Procedure Coding System (HCPCS) code describe the same service, submit a CPT code. Claims with missing procedure codes or modifiers will be denied for correction and re-submission. Claims billed with by report codes or miscellaneous codes, must be accompanied by appropriate documentation for consideration.

Block 24E*:
Diagnosis Pointer
Enter the diagnosis code reference number (i.e., up to four ICD-9-CM codes) as shown in Block 21, to relate the date of service and the procedures performed to the appropriate diagnosis. Show a maximum of four (4) diagnosis codes.

Block 24F*:
Charges
Enter your charge for each listed service.

Claims/Payment (*continued*)

Block 24G*:
Days or Units
Enter the number of services billed on the line. For anesthesia services report the total number of minutes and report modifier units on separate lines.

Block 24H*:
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Family Planning

Block 24I:
ID QUAL

Block 24J:
Rendering Provider ID#
Enter rendering provider NPI in unshaded field.

Block 25*:
Federal Tax ID Number
Enter the practitioner/provider's tax identification number as given by the Internal Revenue Service.

Block 26:
Your Patient's Account Number
If you use patient account numbers, enter the number for this patient.

Block 27:
Accept Assignment - used for government claims refer to the back of the claim form
Indicate whether you accept assignment.

Block 28*:
Total Charge
Enter the total of all charges submitted on this claim.

Block 29:
Amount Paid
Enter the amount that the patient and/or other insurance carrier has paid to you.

Block 30:
Balance Due
Enter the difference between Block 28 and Block 29.

Block 31*:
Signature of Practitioner or Supplier (must be legible)

Block 32*:
Service Facility Location Information
Enter the name and address of facility where services were rendered.

Claims/Payment (*continued*)

Block 32a*:
NPI
Enter NPI.

Block 32b:
Other ID Numbers
Enter other ID numbers.

Block 33*:
Billing Provider Info - *This information must match your TIN from your W-9 form.*

Block 33a*:
Billing Provider NPI.

Block 33b:
Billing Provider Other ID numbers.

Claims/Payment (*continued*)

Completing a UB-04 Form *(Copy of form can be found in this section)*

For facility charges submitted on paper claims, the UB-04 form is required. When you submit the UB-04 form, be sure all applicable fields are completed. Claims with missing or invalid required fields will be rejected and returned for correction and resubmission.

EDI/Electronic submissions are included in the requirements listed below.

The blocks with an asterisk (*) are required, if applicable.

Block 1:*
Facility Name, Address, and Phone Number
The name of the provider submitting the bill and the complete mailing address to which the provider wishes payment sent. *This information must match your TIN from your W-9 form.*

Block 2:
Pay-to Name and Address
Required only if different from the data reported in Block 1.

Block 3a:*
Patient Control Number
Patient's unique alphanumeric number assigned by the provider to facilitate retrieval of individual financial records and posting of the payment.

Block 3b:*
Medical/Health Record Number
Enter the number assigned to the patient's medical or health record.

Block 4:*
Type of Bill
A three (3)-digit code indicating the specific type of bill (inpatient, outpatient, adjustments, voids, etc.)

Block 5:*
Federal Tax Identification Number (TIN)
The number assigned to the provider by the federal government for tax reporting purposes.

Block 6:*
Statement Covers Period
The beginning and ending service dates of the period included on the bill.

Block 7:
Not Used

Block 8:*
Patient Name/Identifier
a. Last name, first name, and middle initial of the patient – b. patient identification if different from the subscriber ID.

Claims/Payment (*continued*)

Block 9*:
Patient Address
The patient's full mailing address, including street number and name, post office box number, city, state and zip code.

Block 10*:
Patient Date of Birth
The patient's month, day and year of birth (MMDDCCYY).

Block 11*:
Patient Gender
Enter an "M" (male) or an "F" (female).

Block 12*:
Admission Date/Start of Care date
Enter the date the patient was admitted for inpatient care, outpatient services or other start of care.

Block 13*:
Admission Hour
The hour during which the patient was admitted for inpatient or outpatient care.

Block 14*:
Type of Admission
A code indicating the priority of this admission.

Block 15*:
Point of Origin for Admission or Visit
A code indicating the source of this admission. This is required for inpatient, outpatient hospital, home health and inpatient Skilled Nursing Facility claims.

Block 16:
Discharge Hour
Hour that the patient was discharged from inpatient care.

Block 17*:
Patient Discharge Status
A code indicating patient status as of the ending service date of the period covered on this bill, as reported in Block 6, *Statement Covers Period*.

Blocks 18-28*:
Condition Codes
A code(s) used to identify conditions relating to this bill that may affect payor processing.

Block 29:
Accident State

Block 30:
Not Used

Claims/Payment (*continued*)

Blocks 31-34:
Occurrence Codes and Dates
The code and associated date defining a significant event relating to this bill that may affect payor processing.

Blocks 35- 36:
Occurrence Span Code and Dates
A code and the related dates that identify an event that relates to the payment of the claim.

Block 37:
Not Used

Block 38:
Responsible Party Name and Address
The name and address of the party responsible for the bill.

Blocks 39-41:
Value Codes and Amounts
A code structure to relate amounts or values to identified data elements necessary to process this claim as qualified by the payor organization.

Block 42:*
Revenue Code
A code that identifies a specific accommodation, ancillary service, or billing calculation.

Block 43:*
Revenue Description
A narrative description of the related revenue categories included on this bill.

Block 44:*
HCPCS/Rates
The accommodation rate for inpatient bills and the HCPCS applicable to ancillary service and outpatient bills.

Block 45:*
Service Date
The date the indicated service was provided.

Block 46:*
Units of Service
A quantitative measure of services rendered by revenue category to or for the patient to include, but not limited to items such as number of accommodation days, miles, pints of blood, or renal dialysis treatments.

Block 47:*
Total Charges (by Revenue Code Category)
Total charges pertaining to the related revenue code for the current billing period as entered in the "statement covers" period. Total Charges includes both covered and non-covered charges.

Claims/Payment (*continued*)

Block 48:
Non-Covered Charges
To reflect non-covered charges for the primary payor pertaining to the related revenue code.

Block 49:
Reserved
This unlabeled field is reserved for national use.

Block 50*:
Payer Identification
    a. Payer Name Primary;
    b. Payer Name Secondary; or
    c. Payer Name Tertiary.

Block 51*:
Health Plan ID
a.b. & c. Health Plan's ID.

Block 52*:
Release of Information Certification Indicator
A code indicating whether the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim.

Block 53*:
Assignment of Benefits Certification Indicator
A code showing whether the provider has a signed form authorizing the third party payor to pay the provider.

Block 54:
Prior Payments
    a. Primary;
    b. Secondary; or
    c. Tertiary.
The amount the provider has received toward payment of this bill prior to the billing date by the indicated payor.

Block 55:
Estimated Amount Due
    a. Primary;
    b. Secondary; or
    c. Tertiary.
The amount estimated by the provider to be due from the indicated payor (estimate responsibility less prior payments).

Block 56:
NPI
Provider's NPI.

Claims/Payment (*continued*)

Block 57:
Other Provider ID
   a. Primary;
   b. Secondary; or
   c. Tertiary.

Block 58*:
Insured's Name
   a. Primary;
   b. Secondary; or
   c. Tertiary.

Block 59:
Patient's Relationship to Insured
   a. Primary;
   b. Secondary; or
   c. Tertiary.

Block 60*:
Insured's Unique ID
   a. Primary;
   b. Secondary; or
   c. Tertiary.

Insured's unique identification number assigned by the payor organization. Enter the identification number of the Member exactly as shown on the identification card.

EDI - Enter the identification number of the Member exactly as shown on the identification card minus the dashes.

Block 61*:
Insured Group Name
   a. Primary;
   b. Secondary; or
   c. Tertiary.
Name of the group or plan through which the insurance is provided to the insured.

Block 62*:
Insurance Group Number
   a. Primary;
   b. Secondary; or
   c. Tertiary.

The ID number, control number or code assigned by the carrier or administrator to identify the group under which the individual is covered. The group number can be found on the Member's identification card.

EDI - same as above.

Claims/Payment (*continued*)

Block 63:
   a.   Primary;
   b.   Secondary; or
   c.   Tertiary.

Treatment Authorization Code
A number or other indicator that designates that the treatment covered by this bill has been authorized by the payor.

Block 64:
Document Control Number

Block 65:
Employer Name
   a.   Primary;
   b.   Secondary; or
   c.   Tertiary;

Block 66*:
Diagnosis and Procedure Code Qualifier
This code identifies the version of the Internal Classification of Diseases (ICD) being reported.

Block 67*:
The Principal Diagnosis Code
The ICD-9-CM codes describing the principal diagnosis. **The Diagnosis code must be carried out to the highest degree of detail (4th or 5th digit).**

Block 67A-67Q*:
Other Diagnosis Codes

The ICD-9-CM codes corresponding to additional conditions that coexist at the time of admission, or develop subsequently and which have an effect on the treatment received or the length of stay. **The Diagnosis code must be carried out to the highest degree of detail (4th or 5th digit).**

Blocks 68:
Unlabeled

Block 69*:
Admitting Diagnosis
The ICD-9-CM code provided at the time of admission as stated by the physician. **The Diagnosis code must be carried out to the highest degree of detail (4th or 5th digit.)**

Block 70*:
Patient's Reason for Visit Code

Block 71:
Prospective Payment System Code

Claims/Payment (*continued*)

Block 72*:
External Cause of Injury Code ("E" Code)
The ICD-9-CM Code for the external cause of an injury, poisoning, or adverse effect.

Block 73:
Unlabeled

Block 74*:
Principal Procedure Code and Date
The code that identifies the principal procedure performed during the period covered by this bill and the date on which the principal procedure described on the bill was performed.

Block 74a – 74e*:
Other Procedure Codes and Dates
The ICD-9-CM codes corresponding to additional significant procedures that are performed during the length of the stay, and the corresponding dates on which the procedures were performed.

Block 75:
Unlabeled

Block 76*
Attending Physician NPI & Name
NPI of attending physician and First and Last Name.

Block 77*:
Operating NPI & Name
NPI of operating physician and First and Last Name.

Block 78*:
Other Physician ID & Name
TIN of the licensed physician and First and Last Name.

Block 80:
Remarks
Notations relating specific state and local needs providing additional information necessary to adjudicate the claim or otherwise fulfill State reporting requirements.

Block 81:
Code-Code Field
Situational – To report additional codes related to a Form Locator or to report an external code list.

Claims/Payment (*continued*)

Key to EOB Messages

Explanation of benefits (EOB) is defined on the EOB document sent with claims (i.e. payments, adjustments, denials, etc). Please call Member Services if additional information is needed. The EOB is a single document with pages clearly and consecutively numbered.

The EOB includes:

- The check, if applicable, is printed on the lower third of the first page;
- All settled claims within the Remittance Advice (RA) run cycle appear in alphabetical order first by rendering practitioner/provider, then by patient last name, first name, and middle initial. If there are multiple claims for the same patient, they are presented in the order they were processed;
- Reason codes are conveniently displayed at the charge line or summarized at the end of the remittance advice or directly below the explanation of payment for the specified claim; and
- Each claim has a heading, which includes the practitioner/provider internal patient account number (control number).

Claims/Payment (*continued*)

Claims EOB Messages

Sequential order of information as shown on the Remittance Advice

Patient Name
Last name, first name, middle initial of patient

Payer Claim Ctrl#
Our system generated claim number

Patient Control #
Patient account number on claim

Rendering Provider Name
Servicing/Rendering practitioner/provider

Health Plan
Health Plan to which the patient belongs

Service From/Service To
Dates of service specific to the claim line (From and to)

Rev Code/CPT/HCPC
Revenue Code Billed (if applicable)/CPT, HCPC, DRG or state code and description service

Units
The Number of Units Billed per Line Item

Mod1/Mod2/Mod3/Mod4
Modifiers billed specific to claim line

Billed Amount
Amount Billed

Allowed Amount
Allowed Amount for Claim Line

Disallow Amount
Disallowed Amount or Difference Between Amount Billed and Contract Allowable Amount

COB Amt
Primary Insurance Paid Amount for Claim Line

Claims/Payment (*continued*)

Co-Pay Applied
Applies Only on Children's Health Insurance Program Reauthorization Act (CHIPRA) and State Coverage Insurance (SCI) and University of New Mexico State Coverage Insurance (UNM SCI)

Net Plan Payable
The amount to be paid/reversed prior to adjustment

Interest
Interest Paid for Late Payment of Claim

Ovp/Refund
Amount received from the provider as a refund, or the overpaid amount requested by the health plan from the provider.

Total Paid/Reversed
The total amount paid/reversed with this remittance advice

FFS/CAP
Defines Type of Payment for Line Item

Line Status
Status of Line (Paid or Denied)

Adj Grp Code
HIPAA compliant Adjustment Type defined at the end of the Remittance Advice

Adj Rsn Code
HIPAA compliant Reason Code defined at the end of the Remittance Advice

Rmk Code
Remit Message Applicable to Line

Message
Explanation of Remit Messages for Denied Lines

Provider Reconsideration Review

Provider Reconsideration Review Request Form

Please use the Molina Healthcare Provider Reconsideration Review Request (PRR) Form when submitting a claim adjustment request.

A copy of this form is included at the end of this section.

- A PRR Form is required for each claim;
- This form must be completely filled out, or it will be returned;
- Attach a legible copy of the claim and remittance advice;
- Upon receipt of this form and additional necessary information, the request will be reviewed and sent for processing if appropriate;
- If the request is declined, a letter will be sent with the denial reason;
- If you disagree with the PRR denial, you will have ninety (90) days from the date of the denial letter to appeal; and
- Mail the PRR Form (faxes will not be accepted) and the necessary attachments to:

   Molina Healthcare of New Mexico, Inc.
   P.O. Box 3887
   Albuquerque, NM 87190-9859
   Attention: Provider Services

If you have any questions or need additional copies of the PRR Form, please contact Member Services in **Albuquerque at (505) 341-7493 or** t**oll free at (888) 825-9266** and a representative will be glad to assist you. This form is also available on our website at www.molinahealthcare.com