Instructions for processing claims to Medicaid for retro eligibility

The Memorandum of Understanding for County/Welfare Combined Medical Applications states:

> *"It is understood that the staff of all parties will adhere to the Confidentiality rules and guidelines of the Department, IDAPA 16, Title 5, Chapter 1, "Rules Governing the Protection and Disclosure of Department Records" and all applicable state and federal laws, rules and regulations pertaining to the confidentiality of, the disclosure of, information and records, as it relates to the activities of any party and the provisions of this agreement."*

This effectively means the Counties and CAT administration staff **cannot share screen shots from IBES or copies of notices from IBES with any provider.** However, the dates of eligibility may be given to the providers.

Counties and CAT administration should send providers the attached published timely filing rules (pages 3 to 5). If providers cannot obtain the NOA from the applicant, they are required to submit whatever supporting documentation they have to establish timeliness based on when they became aware of the eligibility. For example, a letter attesting to when/how the provider was notified of the eligibility. All the information they have should be included in the attestation letter. Notes on the claim are not processed into the system and will not be visible to adjudicators.

Recent changes allow Molina the ability to access the NOA to verify the information submitted by the provider. These changes should improve the retro claims process.

If the Counties, CAT Administration, and providers have followed this procedure and the attached timely filing rules and their claim is denied, they should follow the **Claim Review Request process** below which is documented in the Provider Handbook:

Idaho MMIS Provider Handbook General Billing Instructions

2.14.5. Claim Review Request

The Claim Review Request process is available to providers who want someone to physically review their claim. Timely filing, recoupment, and Coordination of Benefits (COB) payment are some examples of types of reviews that a provider may request.

To request a Claim Review, submit **a Claim Review Request** form found online on the Molina Medicaid Web site. Click on the link in the left navigation pane and follow the procedure outlined below.

Check **Claim Review Request** on the **Claim Review Request** form, and complete the necessary information:

- New or corrected claim form

• Original claim ID requiring review
• Provider information
• Participant information
• Comments – any explanation needed to help in review
• Attachments – any attachments you feel will help support your request as well as any required documentation (such as EOB with remark codes, timely filing, medical records, chart notes, or reports).

Mail the Claim Review Request form and attachments to:

Molina Provider Correspondence
P. O. Box 70082
Boise, ID 83707

2.14.6. Medicaid Review of Claim Determination

A pre-appeal process is available to providers who want someone at the Medicaid Central Office to physically review their claim. To initiate a pre-appeal follow the procedure outlined below.

Check **Medicaid Review** on the **Claims Review Request** form, and complete the necessary information:

• Original claim ID requiring review
• Provider information
• Participant information
• Comments – any explanation needed to help in review
• Attachments – any attachments you feel will help support your request as well as any required documentation (such as timely filing, medical necessity, notes, or reports)
• ***You must include a copy of the Molina claim Review Determination Letter***

Mail the Claim Review Request form and attachments to the following address.

Molina Provider Correspondence
P. O. Box 70082
Boise, ID 83707

For additional information, providers may contact the Idaho Medicaid MMIS Operations Team at MMISOperations@dhw.idaho.gov