June 15, 2020

Provider Notification: Complex Claim Review

The Center for Medicare and Medicaid Services (CMS) requires that Molina Healthcare of New York, Inc. ("Molina") review services to ensure program integrity, which includes both pre-payment and post-payment review of claims.

Molina conducts medical claim reviews on inpatient claims, as noted in the provider agreement, to ensure claims are reimbursed in accordance with generally accepted Federal, State, and AMA billing and coding guidelines.

The process includes review of claims from a pre-payment perspective to ensure claims are billed and paid appropriately. This process includes review of:

- Room and Board charges
- Items/services not included in the Room and Board category that are considered non-routine and patient specific
- Any billing errors identified.

Based on this review, Molina identifies disallowed charges and services to determine correct payment in accordance with Federal or State reimbursement methodology and/or provider specific contract terms.

As of 7/15/2020 please ensure that any claim associated with stop loss, or payment in excess of the DRG amount, is accompanied with an itemized statement in order to ensure timely processing of your claim.

If Molina identifies disallowable charges in your claim, you can dispute our decision by following the routine claim appeal/dispute process that is outlined in the provider manual and/or provider contract. If you have any questions or are not familiar with the appeals process, contact Provider Services at **1-877-872-4716** or via email at MHNYproviderservices@molinahealthcare.com.

Sincerely,

Provider Relations Team
Molina Healthcare of New York, Inc.