Fee Schedule

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In the event of a conflict, federal and state guidelines, as applicable, as well as the member's benefit plan document supersede the information in this policy. Additionally, to the extent there are any conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

Molina Healthcare maintains the authority to assess and evaluate any changes made to the Fee Schedule. We reserve the right to review and audit, restricted to the look-back period agreed upon for your state. Please refer to the grid below to determine your state's look-back period. Kindly note that all look-back periods are based on the last paid date.

State	Marketplace	Medicaid	Medicare
AZ	365	365	1095
CA	365	365	1095
FL	912	912	1095
ID	1095	1095	1095
IL	547	365	1095
KY	730	730	1095
MA	1095	1095	1095
MI	1095	1095	1095
MS	180	1095	1095
NM	637		1095
NV	1095	1095	1095
NY	1095	1095	1095
OH	730	730	1095
SC	547	1095	1095
TX	180	730	1095
UT	365	1095	1095
VA	365	365	1095
WA	730	730	1095
WI	365	365	1095

Supplemental Information

Definitions

Term	Definition
CMS	Center for Medicare and Medicaid

State Exceptions

State	Exception
TX	Molina must comply with reimbursement and fee schedule requirements in Tex. Ins. Code § 1451.451 and 1458.101–102. As required by Texas Government Code § 533.005(a)(25), the MCO cannot implement significant, non-negotiated, across-the-board Provider and NEMT Services provider reimbursement rate reductions unless: (1) it receives HHSC's prior approval, or (2) the reductions are based on changes to the Medicaid fee schedule or cost containment initiatives implemented by HHSC. Further, the MCO must give Providers at least 30 Days' notice of changes to the MCO's fee schedule, excluding changes derived from changes to the Medicaid fee schedule, before implementing the change. If the MCO fee schedule is derived from the Medicaid fee schedule, the MCO must implement fee schedule changes after the Medicaid fee schedule change, and any retroactive claim adjustments must be completed within 60 Business Days after HHSC retroactively

Documentation History

Type	Date	Action
Effective	09/01/2023	New Policy
Revised	12/12/2024	Updated Template, and verified the timelines

References

This policy was developed using:

- CMS
- State Medicaid Regulatory Guidance
- State Contracts

***CODING DISCLAIMER**. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.*