Molina Healthcare General Billing and Coding Policy

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 a conflict, federal and state guidelines, as applicable, and the member's benefit plan document supersede the information in this policy. Also, to the extent of 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 has a pre/post payment claims auditing process that identifies frequent coding billing errors to ensure claims are coded appropriately according to State and Federal coding guidelines. Coding edits and relationships are based on guidelines from specific State Medicaid Guidelines, Centers for Medicare and Medicaid Services (CMS), Federal CMS guidelines, AMA, and published specialty-specific coding rules. Code Edit Rules are based on information received from the National Physician Fee Schedule Relative File (NPFS), the Medically Unlikely Edit table, the National Correct Coding Initiative (NCCI) files, Local Coverage Determination/National Coverage Determination (LCD/NCD), and State-specific policy manuals and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB).

General Coding Requirements

Correct coding is required to properly process claims. Molina requires that all claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set. Edits and audits follow State and Federal requirements as well as administer payment rules based on generally accepted principles of correct coding. These payment rules include, but are not limited to, the following:

- Manuals and Relative Value Unit (RVU) files published by the Centers for Medicare & Medicaid Services (CMS), including:
    - National Correct Coding Initiative (NCCI) edits, including procedure-to-procedure (PTP) bundling edits and Medically Unlikely Edits (MUEs). In the event a Medicaid State benefit limit is more stringent/restrictive than a Federal Medicaid MUE, Molina will apply the State benefit limit for Medicaid Lines of Business. Furthermore, if a professional organization has a more stringent/restrictive standard than a Federal MUE or State benefit limit, the professional organization standard may be used.
    - In the absence of State guidance, Medicare National Coverage Determinations (NCDs).
    - In the absence of State guidance, Medicare Local Coverage Determinations (LCDs).
    - CMS Physician Fee Schedule RVU indicators.
- Current Procedural Technology (CPT) guidance published by the American Medical Association (AMA).
- ICD-10 guidance published by the National Center for Health Statistics.
- State-specific claims reimbursement guidance.
- Other coding guidelines published by industry-recognized resources.
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than State and Federal guidelines.
- Molina policies based on the appropriateness of health care and medical necessity.
- Payment policies published by Molina.

CPT and HCPCS Codes

Codes must be submitted in accordance with the chapter and code-specific guidelines set forth in the

current/applicable version of the AMA CPT and HCPCS codebooks. To ensure proper and timely reimbursement, codes must be effective on the date of service (DOS) for which the procedure or service was rendered and not the date of submission.

Modifiers

Modifiers consist of two alphanumeric characters and are appended to HCPCS/CPT codes to provide additional information about the services rendered. Modifiers may be appended only if the clinical circumstances justify their use. For example, modifiers may be used to indicate whether a:

- Service or procedure has a professional component.
- Service or procedure has a technical component.
- Service or procedure was performed by more than one physician.
- Unilateral procedure was performed.
- Bilateral procedure was performed.
- Service or procedure was provided more than once.
- Only part of a service was performed.

For a complete listing of modifiers and their appropriate use, consult the AMA CPT and the HCPCS code books.

ICD-10-CM/PCS Codes

Molina utilizes International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) billing rules and will deny claims that do not meet Molina's ICD-10 Claim Submission Guidelines. To ensure proper and timely reimbursement, codes must be effective on the dates of service (DOS) for which the procedure or service was rendered and not the date of submission. Refer to the ICD-10 CM/PCS Official Guidelines for Coding and Reporting on the proper assignment of principal and additional diagnosis codes.

Place of Service (POS) Codes

Place of Service Codes (POS) are two-digit codes placed on health care professional claims (CMS 1500) to indicate the setting in which a service was provided. CMS maintains POS codes used throughout the health care industry. The POS should be indicative of where that specific procedure/service was rendered. If billing multiple lines, each line should indicate the POS for the procedure/service on that line.

National Correct Coding Initiative (NCCI)

CMS has directed all Federal agencies to implement NCCI as policy in support of Section 6507 of the Patient Affordable Care Act of March 23, 2010. Molina Healthcare, Inc. uses NCCI standard payment methodologies.

NCCI Procedure-to-Procedure edits prevent inappropriate payment of services that should not be bundled or billed together and promote correct coding practices. Based on NCCI Coding Manual and CPT guidelines, some services/procedures performed in conjunction with an evaluation and management (E&M) code will bundle into the procedure when performed by the same physician, and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures.

NCCI editing also includes Medically Unlikely Edits (MUEs), which prevent payment for an inappropriate number/quantity of the same service on a single day.

An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

Molina Healthcare mandates that all providers adhere to the prescribed billing guidelines as delineated by the AAPC

(American Academy of Professional Coders), CMS (Centers for Medicare and Medicaid Services), NUCC (National Uniform Claim Committee), NUBC (National Uniform Billing Committee), and the applicable state-specific requirements.

Molina Healthcare conducts thorough claims reviews to verify compliance with the following criteria:

- Admission dates and times.
- Discharge dates and times.
- Accurate utilization of value codes and occurrence codes, notably:
    - Value code 54 for measurements in grams.
    - Value code A8 for measurements in kilograms.
    - Value code A9 for measurements in centimeters.
    - Occurrence code 55 (date of death) when the patient's status falls under the following categories:

i. 20
ii. 22
iii. 40
iv. 41
v. 42

Failure to meet these stipulated criteria may lead to various consequences, including claim rejections, denials, or audits. Such outcomes can result in delayed or reduced reimbursement and the potential recoupment of previously disbursed payments. Providers are strongly encouraged to familiarize themselves with Molina Healthcare's precise billing requirements and guidelines to ensure the accurate submission of claims and to prevent potential reimbursement issues.

Molina (or its authorized representative) conducts post-payment reviews of healthcare providers' records related to services provided to Molina members. During these reviews, healthcare providers must grant access to medical records and billing documents upon Molina's request. These reviews serve to ensure the following:

- The provision of the most suitable and cost-effective services and supplies.
- Verification that the records and documentation substantiate the setting or level of service provided to the patient.

These reviews are carried out in accordance with the Treatment, Payment, and Health Care Operations (TPO) exception under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule (45 CFR 164.506). This exception allows for the release of medical records containing protected health information between covered entities without the need for additional authorization for the purpose of payment and healthcare claims review. However, if a healthcare provider believes an additional release authorization is necessary for this review, they should obtain authorization from Molina members, along with the healthcare provider's consent-to-treatment forms, unless permitted by law to waive this requirement.

Molina employs various resources for these reviews, including but not limited to:

- Centers for Medicare & Medicaid Services (CMS) guidelines as stated in Medicare manuals.
- Medicare local coverage determinations and national coverage determinations.
- All Molina policies, including medical coverage policies, Molina provider manuals, claims payment policies, Molina PI Department policies published on Molina.com, and code-editing policies.
- National Uniform Billing Guidelines from the National Uniform Billing Committee.
- American Medical Association Current Procedural Terminology (CPT®) guidelines.
- Healthcare Common Procedure Coding System (HCPCS) rules.
- ICD-10-CM Official Guidelines for Coding and Reporting.
- American Association of Medical Audit Specialists National Health Care Billing Audit Guidelines.
- Industry-standard utilization management criteria and/or care guidelines, including MCG care guidelines (formerly Milliman Care Guidelines) and Interquel: current edition on the date of service.
- UB-04 Data Specifications Manual.
- American Hospital Association Coding Clinic Guidelines.
- Social Security Act.
- Food and Drug Administration guidance.
- National professional medical societies' guidelines and consensus statements.
- Publications from specialty societies such as the American Academy Pediatrics, American Society for

Parenteral and Enteral Nutrition, American Thoracic Society, Infectious Diseases Society of America, etc.
- Department of Health and Human Services final rules, regulations, and instructions published in the Federal Register.
- Nationally recognized, evidence-based published literature from sources such as UpToDate®, World Health Organization, Modified Framingham Criteria, Academy of Nutrition and Dietetics, American Society for Parenteral and Enteral Nutrition, Medscape, American Association for the Study of Liver Diseases, Society for Healthcare Epidemiology of America, Kidney Disease: Improving Global Outcomes, Clinical Practice Guideline for Acute Kidney Injury, The Third International Consensus Definitions for Sepsis and Septic Shock, Journal of the American Society of Nephrology (JASN).

Molina's pre- and post-payment reviews aim to identify and address practices that may lead to unnecessary costs in the healthcare industry, including Medicare and Medicaid programs. These practices may include, but are not limited to:

- Improper payment for services.
- Payment for services that do not meet professionally recognized standards/levels of care.
- Excessive billed charges or incorrect code selection for services or supplies.
- Billing for items or services that were not provided or should not have been provided based on documentation.
- Unit errors, duplicate charges, and redundant charges.
- Insufficient documentation in the medical record to support billed charges.
- Billing for experimental and investigational items.
- Lack of medical necessity to support billed services or days.
- Services billed that are not covered by the member's benefit plan, Molina policies, Medicare policies, or Medicaid policies, including National Coverage Determinations and Local Coverage Determinations.
- Absence of objective clinical information in the medical record to support the billed condition.
- Items that are not separately payable or included in another charge, such as routine nursing, capital equipment charges, reusable items, etc.

Supplemental Information

Definitions

Term	Definition
CPT	Current Procedural Terminology 4th Edition: An American Medical Association (AMA) maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. There are three types of CPT codes: • Category I Code – Procedures/Services • Category II Code – Performance Measurement • Category III Code – Emerging Technology
HCPCS	HealthCare Common Procedural Coding System: a CMS maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify procedure, supply and durable medical equipment codes furnished by physicians and other health care professionals.
ICD-10-CM	International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM diagnosis codes are maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).
CMS	stands for Centers for Medicare and Medicaid Services. It is a federal agency within the United States Department of Health and Human Services (HHS). CMS administers the Medicare program, which provides health insurance coverage for individuals aged 65 and older, as well as certain younger individuals with disabilities. Additionally, CMS oversees the Medicaid program, which offers health coverage to low-income individuals and families. CMS plays a crucial role in the

	regulation and oversight of various healthcare programs and initiatives in the United States, including the development of billing requirements, quality measures, and reimbursement policies
NUBC	stands for National Uniform Billing Committee. The NUBC is an organization that develops and maintains the UB-04 claim form, which is used for submitting institutional healthcare claims. It is a standardized billing form used by hospitals, skilled nursing facilities, and other institutional providers to bill for services rendered to patients. The NUBC works to ensure consistency and uniformity in healthcare billing practices across the United States.
AAPC	stands for the American Academy of Professional Coders. It is a professional organization that provides education, certifications, and resources for medical coding, billing, and auditing professionals. AAPC offers various certifications, such as Certified Professional Coder (CPC), Certified Outpatient Coding (COC), and Certified Professional Medical Auditor (CPMA), among others. These certifications validate the expertise and knowledge of individuals in medical coding and related areas. AAPC also provides continuing education opportunities, networking opportunities, and industry updates to support the professional growth and development of its members.
NUCC	stands for the National Uniform Claim Committee. It is a voluntary organization comprised of representatives from various healthcare industry stakeholders, including healthcare providers, payers, and regulatory bodies. The NUCC's primary purpose is to develop and maintain uniform standards and guidelines for healthcare transactions, specifically related to electronic healthcare claims. The committee works to streamline and standardize the submission of healthcare claims across different payers and providers, promoting consistency and efficiency in healthcare billing processes. The NUCC is responsible for maintaining and updating the CMS-1500 claim form, which is used for submitting professional healthcare claims.
Value Codes	are alphanumeric codes used in healthcare billing to indicate specific values or conditions related to a particular service or item. They are used to provide additional information or context about a claim. Value codes are typically included on claim forms, such as the UB-04 or CMS-1500, in designated fields. The values represented by value codes can vary depending on the specific billing requirements or guidelines of the payer or regulatory body. For example, value codes may be used to indicate the weight of a patient (in grams or kilograms), the length of a stay, the number of visits, or other relevant information. Providers and billers must ensure accurate and appropriate use of value codes based on the specific requirements of the payer or billing guidelines to facilitate proper reimbursement and claims processing.
Occurrence codes	are alphanumeric codes used in healthcare billing to report specific events or circumstances related to a patient's care or the provision of healthcare services These codes are typically included on claim forms, such as the UB-04 or CMS-1500, in designated fields. Occurrence codes provide additional information or context about a claim and help explain the reason for a particular service or the occurrence of certain events. They are used to indicate events such as accidents, injuries, surgeries, diagnostic procedures, complications, or other relevant occurrences. The specific codes and their meanings may vary depending on the payer or regulatory guidelines. Providers and billers must accurately report occurrence codes based on the specific requirements to ensure proper reimbursement and claims processing

Documentation History

Type	Date	Action
Effective Date	11/20/2020	New Policy
Revised Date	10/19/2022	Reviewed and updated links
Revised Date	08/16/2023	Verified links- TP
Revised Date	12/12/2024	Verified links, updated template and combined the General billing and coding policy

References

This policy was developed using

Reference source	Link
CMS	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf
NUCC	National Uniform Claim Committee - Home (nucc.org)
AAPC	https://www.aapc.com/
NUBC	https://www.nubc.org/
All	State Medicaid Regulatory Guidance
CMS	NCCI for Medicaid | CMS
CMS	Medicaid NCCI Methodologies | CMS
CMS	NCCI for Medicare | CMS
CMS	Medicare NCCI Procedure to Procedure (PTP) Edits | CMS
NCCI	Table of Contents | How to Use the Medicare National Correct Coding Initiative (NCCI) Tools (cms.gov)
CMS	ICD-10 Resources | CMS