Paid Amount Exceeded Billed Amount

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 Reimbursement Guidelines

According to our contract language, reimbursements will be made based on the lesser of two specified amounts: the contract allowable or the charges billed unless otherwise stated in the contract language. This mechanism ensures that standard billed hospital charges are not exceeded. Note that this reimbursement is applied at the line level of the billed charges.

Claims processing will follow standard procedures, including:

- CMS National Correct Coding Initiative (NCCI)
- CMS Outpatient Prospective Payment System (OPPS)
- Correct Coding Validation Audits and Algorithms
- Established Molina Healthcare medical and reimbursement policies
- Freestanding ASC payment methodology based on the CMS ASC payment system
- Integrated Outpatient Code Editor (I/OCE) Clinical edits
- Inclusive Facility Fee Services (ASCs)
- Medically Unlikely Edits (MUEs)
- National Physician Fee Schedule Relative Value File (NPFSRVF) pricing rules

Any payment made by Molina Healthcare for a medically necessary procedure, service, or supply, along with the member's authorized responsibility (copayments, coinsurance, and deductibles), is considered full payment. It should not be viewed as partial payment, even if the total payment is less than the billed amount by the provider. Molina Healthcare's liability is determined after applying coordination of benefits (COB) and Third-Party Liability (TPL) to the claim.

We require adequate documentation of medical necessity and valid diagnosis codes for reimbursement of certain procedures. Claims submitted without sufficient proof of medical necessity or accurate diagnosis codes will not be included in the final claim payment calculation. For detailed coverage guidelines, limitations, and medical necessity criteria, please refer to the referenced document: CMS Financial Management Manual - Section 10.
Inaccurately billed claims may be denied or subject to recovery. Rates are determined based either on the applicable fee schedule or the provider contract agreement.

Molina Healthcare reserves the right to review all claim payments and reclaim any identified overpaid amounts based on contractual rates.

Supplemental Information

Definitions

Term	Definition
Allowable	The maximum payment the plan will pay for a covered health service
Claim level	Highest level of a claim
ASC	Ambulatory Surgery Center
MUE	Medically Unlikely Edits
NCCI	National Correct Coding Initiative
I/OCE	Integrated Outpatient Coder Edit
CMS	Center for Medicare and Medicaid
COB	Coordination of Benefits
Inpatient	A patient who stays in the hospital while under treatment
Line level	Lower level of a claim. Supersedes the data reported at the claim level.
LOBC	Lesser of billed charges
NPFSRVF	National Provider Fee Schedule Relative Value File
Okayed to pay	Approved for payment
OPPS	Outpatient Prospective Payment System
Outpatient	A Patient who is not hospitalized overnight
TPL	Third Party Liability
UB-04	A standard claim form used by long-term care facilities to bill for all services provided to residents

State Exceptions

State	Exception

Documentation History

Type	Date	Action
Effective Date	10/23/2023	New Policy
Revised Date	12/17/2023	Updated template

References

This policy was developed using.

- CMS
- State Medicaid Regulatory Guidance
- State Contracts

State/Agency	Document Name/Description	Link/Document
CMS	CMS Financial Management Manual	CMS Financial Management Manual - Section 10
CMS	Medicare overpayments	Medicare Overpayments (hhs.gov)
CMS	Medicare overpayments	MLN006379 – Medicare Overpayments (cms.gov)

***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.*