# Recovery Policy for Variable Discount Payments for Providers

## 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 Healthcare is steadfast in its commitment to ensuring accuracy and fairness in provider payments. Guided by a comprehensive Audit and Recovery Policy, we strive to maintain transparency, uphold the integrity of our payment systems, and promote equitable pricing. This policy delineates the thorough process of reviewing, adjusting, and validating provider payments based on specific variables that affect discount payments. Our primary objective is to ensure claims are coded and settled accurately, thereby precisely reflecting the services rendered.

## Purpose

The primary objective of this policy is to ensure the accuracy and compliance of claims submitted to Molina Healthcare that involve variable-based discount payments. By implementing a thorough audit and recovery process, we aim to promote correct coding practices, ensure transparent and fair pricing, and guarantee that providers receive the appropriate discounts upon claim settlement. This policy applies to all healthcare service providers submitting claims to Molina Healthcare.

### Key Variables Influencing Payment Discounts

### Facility vs. Non-Facility Place of Service

**Facility**: Services in hospitals, surgical centers, or nursing facilities with lower reimbursement rates due to separate facility billing for overhead (e.g., POS 21: Hospital Inpatient, POS 22: Outpatient Hospital, POS 24: Ambulatory Surgical Center).

**Non-Facility**: Services in doctor's offices, clinics, or homes with higher reimbursement rates covering overhead costs included in the physician's fee (e.g., POS 11: Office, POS 12: Home, POS 49: Independent Clinic).

### Bill Type vs. Patient Status

**Bill Type**: Codes on hospital bills describe the type of bill (e.g., "112" for inpatient, "131" for outpatient).
**Patient Status**: Discharge status codes indicate where the patient goes after care (e.g., 01: Home, 02: Another hospital, 03: Skilled nursing facility).

### Invalid Frequency Code

Claims may be adjusted or denied if frequency codes indicating types of billing actions are incorrect (e.g., 1: Admit Through Discharge Claim, 2: Interim - First Claim, 3: Interim - Continuing Claim, 4: Interim - Last Claim, 7: Replacement of Prior Claim, 8: Void/Cancel of Prior Claim).

**Invalid Patient Status**

Errors arise if the patient status code is unrecognized, inappropriate, or mismatched with claim details.

**Modifiers**

Accurate use of modifiers indicating distinct/additional services ensures correct discount application.

**Audit and Recovery Process**

**Review**: Claims examined against standards.
**Discrepancy Identification**: Document errors.
**Recovery**: Recoup overpayments via future payment offsets/direct refunds.
**Appeals**: Providers can contest adjustments or denials.

**Compliance, Training, and Responsibilities**

**Provider's Role**: Align billing practices with guidelines and accurate coding.
**Molina Healthcare's Role**: Offer support, clarification, training, and updates on coding standards and policies.

**Policy Monitoring, Review, and Updates**

Annual reviews ensure alignment with best practices and regulatory mandates. Updates communicated promptly to providers.

## Supplemental Information

**Definitions**

| Term | Definition |
|---|---|
| CMS | the Centers for Medicare & Medicaid Services. It is a federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards. |
| Facility | Refers to locations where services are performed within institutional settings such as hospitals, nursing homes, or ambulatory surgical centers. |
| Non-Facility | Refers to non-institutional settings like a physician's office, patient's home, or a clinic |

## State Exceptions

| State | Exception |
|---|---|
| | |

## Documentation History

| Type | Date | Action |
|---|---|---|
| Effective Date | 10/23/2023 | New Policy |
| Revised Date | 12/16/2024 | Updated Template |