Recovery Policy for CPT-to-CPT Code Review

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 committed to maintaining precise and compliant coding and billing practices in accordance with federal and state regulations, as well as industry standards. This policy sets forth the framework for conducting reviews of Clinical Procedure Terminology (CPT) codes to ensure the appropriateness and accuracy of coding for services rendered to members on the same day or within a specified timeframe.

The purpose of this policy is to outline the guidelines and procedures for auditing and recovering funds as necessary through the review of CPT coding, ensuring that the treatments provided are medically necessary, accurately coded, and billed. This policy applies to all coding and billing activities related to the treatment of Molina Healthcare members.

Initiation of Audit:

Molina Healthcare may initiate a CPT-to-CPT code review when there are questions regarding the treatments provided to a member on the same day or within a specified number of days.
Reviews may be triggered by, but not limited to, high frequency of services, outlier billing practices, or complaints.

Audit Process:

The review will include an examination of medical records, billing records, and any other relevant documentation.

The focus will be on identifying inaccuracies in coding, including but not limited to, mutually exclusive codes, bundling/unbundling issues, incorrect use of add-on codes, replacement codes, global surgery codes, and improper application of multiple procedure or surgery discounts.

Auditors will adhere to the latest coding guidelines and industry standards.

Recovery:

In cases where inaccuracies are identified, recovery of funds will be initiated in accordance with federal, state, and contractual regulations.

Providers will be notified of any discrepancies and will have the opportunity to respond and/or correct the inaccuracies.

Compliance:

Molina Healthcare will monitor compliance with this policy and take corrective action as necessary to ensure ongoing adherence to coding and billing standards.

This policy ensures that Molina Healthcare operates in a manner that is compliant with all applicable laws and regulations and maintains the integrity and accuracy of billing and coding practices.

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.
Mutually Exclusive Codes	Codes that cannot be billed together for a single patient on a single date of service as they represent overlapping services
Bundling/Unbundling	The practice of consolidating multiple related procedures into a single billing code or separating a single procedure into multiple billing codes
Add-On Codes	Codes that represent additional services performed in conjunction with a primary procedure
Replacement Codes	New codes that replace old codes for more accurate billing and reporting
Global Surgery Codes	Codes that include the surgical procedure and the pre-operative and post-operative care
Multiple Procedure Discounts	Reductions in reimbursement for additional procedures performed during the same session
Multiple Surgery Discounts	Reductions in reimbursement for additional surgical procedures performed during the same session

State Exceptions

State	Exception

Documentation History

Type	Date	Action
Effective Date	10/23/2023	New Policy
Revised Date	12/17/2024	Updated template

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.*