Recovery Policy for Diagnosis Codes

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

The Audit/Recovery Policy is established to ensure the accuracy, appropriateness, and integrity of diagnosis codes reported on claims submitted to Molina Healthcare. The policy aims to identify and rectify any potential overpayments or underpayments and to verify that the level of care provided corresponds with the reported diagnosis codes.

This policy is applicable to all healthcare providers and facilities submitting claims to Molina Healthcare.

Diagnosis Audit:

- Questioning Inclusion of Diagnosis Codes:

As part of the audit process, Molina Healthcare will review and may question the inclusion of any diagnosis code reported on a claim if discrepancies or potential inaccuracies are identified. All diagnosis codes billed must be active at the time of service and billed with appropriate indicators, when applicable.

- Questioning Exclusion of Diagnosis Codes:

Molina Healthcare will also review and may question the exclusion of diagnosis codes if a potentially relevant diagnosis code appears to have been omitted.

Level of Care Audit:

Based on the reported diagnosis codes, Molina Healthcare will review the appropriateness of the level of care provided. Specific areas of focus include:

- Inpatient Short Stays:
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Claims for inpatient stays lasting less than 72 hours will be scrutinized to verify if the level of care was justified based on the reported diagnosis codes.

Emergency Room Claims:

Molina Healthcare will audit claims for emergency room services used for non-emergent situations, ensuring such services are not misused for conditions that are not urgent in nature.

DRG Coding Audit:

Molina Healthcare will undertake inpatient DRG (Diagnosis Related Group) audits focusing on the inclusion or exclusion of diagnosis codes. This ensures that claims adhere to correct coding standards and are compensated according to the pertinent DRG.

Lab Services Audit:

Lab services claims provided to members that are missing the necessary diagnosis codes will be audited. It is imperative for providers to integrate all relevant diagnosis codes on lab services claims to prevent claim processing delays or potential rejections.

Recovery Process:

In instances where overpayments are identified during the audit process, Molina Healthcare will initiate a recovery process. This may involve recouping the overpaid amount from future payments or directly from the provider. Identified underpayments will be duly reimbursed to the provider.

Enforcement and Compliance:

Providers repeatedly found to submit claims with inaccurate or missing diagnosis codes, or inappropriate levels of care, may be subjected to further audits, mandatory training, claim denials, or other remedial actions deemed necessary by Molina Healthcare.

Review and Revisions:

Molina Healthcare will periodically review this policy, making updates as necessary to align with changes in coding standards, regulatory guidelines, or internal audit processes.

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.

State Exceptions

State	Exception

Documentation History

Type	Date	Action
Effective Date	10/23/2023	New Policy
Revised Date	12/17/2024	Updated language and 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.*