Recovery Policy for Revenue 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

This policy aims to guarantee the accuracy and compliance of claims submitted to Molina Healthcare by aligning Revenue Codes with CPT (Current Procedural Terminology) Codes. All healthcare service providers are required to submit claims to Molina Healthcare in accordance with this alignment.

Review Guidelines:

Revenue Code to CPT Code Mismatches:

- Molina Healthcare will periodically review claims to ensure that the Revenue Codes used align appropriately with the associated CPT Codes.
- Any discrepancies identified between the Revenue Code and the CPT Code may result in the claim being flagged for further review and potential adjustment or denial.
- Providers are expected to ensure that their billing staff are adequately trained in the correct usage of Revenue and CPT Codes to minimize discrepancies.

Itemized Bill Review:

- Providers are required to submit itemized bills upon request by Molina Healthcare.
- The itemized bill should clearly list all services rendered, associated CPT Codes, and corresponding Revenue Codes.
- Any discrepancies noted during the review of the itemized bill may lead to further investigation and potential claim adjustment.

Invoice Validations (Facility Claim Detail Billing):

- Molina Healthcare may request providers to submit detailed facility claim invoices to validate the accuracy of the billed amounts.
- These detailed invoices should include a breakdown of all services rendered, the associated charges, CPT Codes, and Revenue Codes.
- Discrepancies between the detailed invoice and the claim submitted may result in adjustments to the claim.

Procedure:

Molina Healthcare will conduct random audits on a predetermined percentage of claims submitted by providers to identify any potential discrepancies.

- Providers will be notified in writing if a discrepancy is identified and may be required to submit additional documentation, such as itemized bills or detailed facility claim invoices.

Failure to provide the requested documentation within the specified time frame, as listed in the notification, may result in the adjustment or denial of the claim.

Providers have the right to appeal any claim adjustments or denials resulting from this audit and recovery process. Details of the appeal process will be provided in the notification letter.

Responsibilities:

Providers must ensure accurate billing practices, correct use of Revenue and CPT Codes, and compliance with state-specific guidelines when applicable. Molina Healthcare aims to maintain a transparent and fair audit/recovery process and will offer support and clarification to providers as needed.

Review and Updates:

This policy will be reviewed annually or as necessary to ensure it is up-to-date and compliant with best practices and regulatory requirements.

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.
Revenue Code	A code used to identify specific items being billed.
CPT Code	A medical code set used to report medical, surgical, and diagnostic procedures and services
Itemized Bill Review	An analysis of the detailed charges on a bill
Invoice Validation:	The process of verifying that billing details on facility claims are accurate and complete

State Exceptions

State	Exception

References

This policy was developed using.

- CMS
- State Medicaid Regulatory Guidance
- State Contracts

State/Agency	Document Name/Description	Link/Document
Texas Medicaid	Texas Medicaid Provider Procedures Manual: Section 4.5.5 Outpatient Hospital Revenue Codes	2_11_Inpatient_Outpatient_Hosp_Srvs.fm

Documentation History

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