Molina Healthcare Audit 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 recover any potential overpayments or underpayments, and to ensure that the level of care provided aligns with the reported diagnosis codes.

This policy applies 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.

  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:
  Claims for inpatient stays with a length of 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 conduct audits on claims submitted with non-emergent diagnosis codes to ensure that emergency services are utilized appropriately and not misused.

- ***DRG Coding Audit:***
  Molina Healthcare will undertake inpatient DRG (Diagnosis Related Group) audits centered on the inclusion or exclusion of diagnosis codes. This ensures that claims adhere to the 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. Underpayments identified will be duly reimbursed to the provider.

Enforcement and Compliance:

Providers repeatedly found to submit claims with trends of 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
Published		
Revised Date		