Molina Healthcare Audit/Recovery Policy: 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 resolutely committed to ensuring accuracy and fairness in provider payments. Through a structured Audit and Recovery Policy, we aim to maintain transparency, uphold the integrity of our payment systems, and foster equitable pricing. This policy outlines the meticulous process of reviewing, adjusting, and ensuring provider payments based on specific variables influencing discount payments. Our goal is to ensure claims are coded and processed accurately reimbursed for services that were rendered.

Purpose

This policy's primary objective is to assist with the accuracy and compliance of claims submitted to Molina Healthcare, which involve variable-based discount payments including but not limited to:

- CMS
- MMP
- State Medicaid Programs

Through a rigorous audit and recovery process, we aim to encourage and/or support correct coding practices, ascertain transparent and fair pricing, and ensure providers receive the appropriate discounts when claims are paid. This policy is applicable to all healthcare service providers submitting claims to Molina Healthcare.

- **Key Variables Influencing Payment Discounts**
  - **Facility vs. Non-Facility Place of Service**: Claims must accurately specify the service location. Distinct discounts are applied based on whether the service is provided in a facility or non-facility setting.
  - **Facility Place of Service:**
    - Refers to services provided in locations such as a hospital (inpatient or outpatient), ambulatory surgical center, nursing facility, or any other location that is not a non-facility setting.
    - The reimbursement rates for services rendered in a facility setting are typically lower than non-facility rates because the facility itself will bill separately for its overhead costs (like use of the room, equipment, nursing staff, etc.).
      - Examples of facility POS codes might include:
      - Hospital Inpatient (POS 21)
      - Outpatient Hospital (POS 22)

- Ambulatory Surgical Center (POS 24)

- **Non-Facility Place of Service:**

  - Refers to services provided in settings such as a doctor's office, clinic, or patient's home.
  - The reimbursement rates for services rendered in a non-facility setting are typically higher because they need to account for overhead costs that are included in the physician's fee, as there is no separate facility billing for those costs.
    - Examples of non-facility POS codes might include:
      - Office (POS 11)
      - Home (POS 12)
      - Independent Clinic (POS 49)

Billing and reimbursement rates for procedures can vary widely based on the POS. It is crucial for medical billing professionals to use the correct POS code to ensure accurate reimbursement and avoid potential billing errors or fraud allegations.

- **Bill Type vs. Patient Status:** Alignment between the bill type and the patient's status is crucial as discrepancies can influence discount application.
- **Bill Type:**
  - The bill type is a code used on hospital bills, particularly for Medicare and Medicaid, to describe the type of bill being submitted. It is a four-digit numeric code where:
    - The first digit indicates the type of facility.
    - The second digit indicates the bill classification (inpatient, outpatient, etc.).
    - The third and fourth digits represent the frequency of the bill (e.g., whether it is an initial claim, an adjustment, or a replacement).
  - For example, a bill type of "112" could indicate a hospital inpatient claim, while "131" might indicate an outpatient claim.
  - The bill type helps payers understand what kind of service was provided and in what setting.
- **Patient Status:**
  - Patient status codes, often called "discharge status codes," describe the patient's status at the time of discharge or the end of a billing cycle. These codes provide information about where the patient went or what happened to them after they received care.
  - Examples of patient status codes include:
    - 01: Discharged to home or self-care.
    - 02: Discharged/transferred to another short-term general hospital.
    - 03: Discharged/transferred to a skilled nursing facility.
    - 04: Discharged/transferred to an intermediate care facility.
    - 05: Discharged/transferred to another institution for outpatient services. and so, on
    - These codes are important for multiple reasons, such as determining appropriate reimbursement for post-acute care transfer cases or understanding the patient's care trajectory.
  - Both the Bill Type and Patient Status are crucial pieces of information on a hospital claim, as they help paint a picture of the type of care provided and the subsequent care or status of the patient. Properly coding these fields is essential for accurate billing and reimbursement.
- **Invalid Frequency Code:**
  - Claims with erroneous frequency codes may be adjusted or denied.

- Different frequency codes are used to indicate several types of billing actions, such as whether a claim is an initial submission for a particular episode of care, or whether it is an adjustment or replacement claim, among other categories.
    - 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:** Accurate patient status coding is paramount to ensure the correct discount application.
    - Patient status codes are crucial as they indicate the status of the patient at the time of the encounter or discharge. An invalid patient status might mean that the submitted code does not match any recognized patient status code in the system or that the code provided is inappropriate for the service or procedure billed.
      Typically, patient status codes are used in inpatient settings and relate to the patient's condition at discharge.

      For instance:
        - Discharged to home.
        - Discharged to another short-term general hospital.
        - Discharged to a skilled nursing facility.
        - Discharged to home with home health services.
        - Left against medical advice.
        - Expired (patient died)
        - And so on...
    - An "Invalid Patient Status" error could arise if:
        - The code entered does not exist in the official coding system.
        - The code provided is not appropriate for the patient's actual status.
        - There is a mismatch between the patient's status code and other information on the claim.
        - The code has been entered incorrectly (e.g., typographical error).

- **Modifiers:**
  Modifiers indicating distinct or additional services must be used accurately to ensure the correct discount application.

Audit and Recovery Process:

- **Review:** Claims will be meticulously examined against Molina Healthcare's standards.
- **Discrepancy Identification:** Any inconsistencies or errors identified will be documented.
- **Recovery:** Overpayments due to inaccuracies will be recovered either by offsetting from future payments or through direct refund requests.
- **Appeals:** Providers reserve the right to contest any claim adjustments or denials. Details of the appeal process will accompany the notification.

Compliance, Training, and Responsibilities:

- **Provider's Role:** Providers must ensure their billing practices align with our guidelines, particularly concerning accurate coding determining discount payments.
- **Molina Healthcare's Role:** We are committed to offering collaborative support, clarification, and education to providers. Regular communication and updates on coding standards and policies will be provided.

- **Policy Monitoring, Review, and Updates:**
  - The policy will undergo annual reviews or as required, ensuring its alignment with industry best practices, regulatory mandates, and Molina Healthcare's operational necessities. Any updates will be promptly communicated 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
Published		
Revised Date		