Molina Healthcare Cross-Departmental Audit and Recovery Policy

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 serves to define a comprehensive framework for conducting cross-departmental audits and recoveries concerning claims, enrollments, providers, and other relevant sectors. It ensures accurate reimbursement, maintains Molina HealthPlan's financial integrity, and aligns with federal and state regulations.

Scope

This policy is applicable to all Molina Health plan contracted providers and departments involved in the claims processing and auditing, including Claims Processing, Enrollment Management, Provider Relations, Utilization Management, Data Analytics, and Compliance and Legal Affairs.

Statements and Procedures

- ***Claims and Enrollments:***

  Retro-Terminations:
  - Periodic reviews will identify claims paid during retroactive termination of membership.
  - Overpayments identified will be recovered following CMS guidelines and state Medicaid policies.

  Retro-Enrollment Plan Changes:
  - Monitor changes in enrollment affecting claims already paid under a differing plan.
  - Claims will be re-processed under the appropriate plan, and recoveries or adjustments will be initiated as required.

- ***COB/TPL Payments:***
  - Data analytics will help identify cases missing Coordination of Benefits (COB) or Third-Party Liability (TPL) payments.
  - Providers will receive notifications with a specific timeframe to rectify missing information.
  - Recovery of overpayments will commence post-notification.

- ***Providers:***

  Terminated Providers:
  - Claims by providers who've been terminated from the network will be flagged.
  - Recovery of payments made post-termination will be initiated.

  Sanctioned Providers:
  - Claims linked to sanctioned providers will be identified using the OIG's List of Excluded Individuals/Entities.
  - Payments made to sanctioned providers will be reclaimed.

Contract Percentages Validations:

- Validate if payment percentages in provider contracts are consistent with processed claims.
- Rectify discrepancies and recover any overpayments.

❖ ***Claims and Authorizations:***

Approved vs. Billed Units:

- Units approved by Utilization Management (UM) will be compared against billed units in the claim.
- Overpayments for units billed beyond the approved units will be recovered.

HIE vs. Claims Data Validations:

- Regular validations will ensure Health Information Exchange (HIE) data is consistent with claims data.
- Discrepancies will be reconciled, and necessary adjustments will be made.

❖ ***Overlapping Scenarios:***

Room and Boarding:

- Identify instances where room and boarding charges coincide with other services.
- Adjust payments and recover any overpayments.

Services Overlapping during Room and Boarding Stays:

- Detect overlapping services during room and boarding stays, especially considering inclusive vs. exclusive payments.
- Overpayments for services already incorporated in room and boarding charges will be recovered.

❖ ***Compliance and Enforcement:***

- This policy adheres to CMS guidelines, MAC regulations, and State Medicaid policies. Providers must uphold accurate records and fully cooperate during audits. Non-compliance may lead to corrective measures, including termination of the provider contract and potential legal repercussions.

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.
Retro-Term	Retroactive termination of a claim or enrollment
COB/TPL	Coordination of Benefits/Third-Party Liability.
HIE	Health Information Exchange
UM	Utilization Management

Documentation History

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