Provider notice

Thank you for participating with Molina Healthcare (Molina) to provide high quality health care services to our members.

Molina is committed to continuously improving our overall payment integrity program and administers payment rules based on generally accepted principles of correct coding.

Pre-payment processes identify correctly coded claims for reimbursement. The following outlines how Molina will process claims in support of correct coding and reimbursement.

Correct coding
Molina applies correct code edit practices during claims processing to ensure claims are coded and audited appropriately, according to state and federal guidelines, to reduce improper payment. Providers are responsible for submitting accurate claims. Molina requires coding of both diagnoses and procedures for all claims. The required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification ICD-10-CM for diagnoses. For procedures, the Healthcare Common Procedure Coding System Level 1 (CPT codes), Level 2 and 3 (HCPCS codes) are required for professional and outpatient claims. Inpatient hospital claims require ICD-10-PCS (International Classification of Diseases, 10th Revision, Procedure Coding System). Furthermore, Molina requires that all claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set:

- Manuals and relative value unit (RVU) files published by the Centers for Medicare & Medicaid Services (CMS), including:
    - National correct coding initiative (NCCI) edits, including procedure-to-procedure (PTP) bundling edits and medically unlikely edits (MUEs). In the event a state benefit limit is more stringent/restrictive than a federal MUE, Molina will apply the state benefit limit. Furthermore, if a professional organization has a more stringent/restrictive standard than a federal MUE or State benefit limit the professional organization standard may be used
    - In the absence of state guidance, Medicare National Coverage Determinations (NCDs)
    - In the absence of state guidance, Medicare Local Coverage Determinations (LCDs)
    - CMS physician fee schedule RVU indicators
- Current procedural technology (CPT) guidance published by the American Medical Association (AMA)
- ICD-10 guidance published by the National Center for Health Statistics
- State-specific claims reimbursement guidance
- Other coding guidelines published by industry-recognized resources
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than State and Federal guidelines

- Molina policies based on the appropriateness of health care and medical necessity
- Payment policies published by Molina

Please continue to refer to your provider portal for additional guidance and to review claim outcomes.

National Correct Coding Initiative (NCCI)
CMS has directed all federal agencies to implement NCCI as policy in support of Section 6507 of the Patient Affordable Care Act of March 23, 2010. Molina uses NCCI standard payment methodologies.

NCCI procedure-to-procedure edits prevent inappropriate payment of services that should not be bundled or billed together and promote correct coding practices.

Based on NCCI coding manual and CPT guidelines, some services/procedures performed in conjunction with an evaluation and management (E/M) code will bundle into the procedure when performed by same physician; and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures. NCCI editing also includes medically unlikely edits (MUEs) which prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

Medical records and itemized bill review
Health care professionals may be asked for medical records and itemized billing documents that support the charges billed. Molina utilizes widely acknowledged national guidelines for billing practices and supports the concept of uniform billing for all payers. These prepayment claims reviews will look for overutilization of services or other practices that directly or indirectly result in unnecessary costs to the health care industry. A health care professional's order must be present to support all charges, along with clinical documentation to support the diagnosis and services or supplies billed.

Health care professionals will receive detailed instruction regarding how to submit requested documentation. Health care professionals who do not submit the requested documentation may receive a denied claim until all information necessary to adjudicate the claim is received. If it is determined that a coding and/or payment adjustment is applicable, the health care professional will receive the appropriate claim adjudication. Health care professionals retain their right to dispute results of reviews.

Evaluation and management code review
E/M process will review codes to ensure the submitted E/M visit code is appropriate for the patient encounter. The E/M review will identify E/M codes billed to identify if the appropriate code was used. The review will:

- Consider members with more severe illnesses
- Compare providers within a specialty to other providers in the same specialty
- E/M review will identify the appropriate code and will be paid at the appropriate level

If you have any questions, you may contact the provider relations team by phone at the number below or by email at MCCVA-Provider@MolinaHealthcare.com.

- Commonwealth Coordinated Care Plus: (800) 424-4524
- Medallion 4.0: (800) 424-4518