Recovery Policy for CPT-to-CPT Code Review 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

Molina Healthcare is committed to maintaining precise and compliant coding and billing practices in accordance with federal and state regulations, as well as industry standards. This policy establishes the framework for reviewing Clinical Procedure Terminology (CPT) codes to ensure the appropriateness and accuracy of coding for services provided to members on the same day or within a specified timeframe.

The purpose of this policy is to:

- Ensure treatments are medically necessary, accurately coded, and properly billed.
- Outline guidelines and procedures for auditing and, when necessary, recovering funds.
- Promote compliance with applicable laws, regulations, and industry standards.

Audits may be initiated when there are questions regarding treatments provided on the same day or within a defined timeframe. Reviews may be triggered by high frequency of services, unusual billing practices, or member/provider complaints.

Auditors will examine medical records, billing records, and other relevant documentation. The focus will include identifying issues such as mutually exclusive codes, bundling/unbundling errors, incorrect use of add-on or replacement codes, global surgery code errors, and improper application of multiple procedure or surgery discounts. Audits will follow the most current coding guidelines and industry standards.

Molina Healthcare will continuously monitor compliance with this policy and take corrective actions as necessary to maintain the integrity of billing and coding practices.

Reimbursement Guidelines

- **Authorization to Audit**: Molina Healthcare may conduct CPT-to-CPT code reviews to ensure claims are billed appropriately and services meet medical necessity requirements.
- **Trigger for Review**: Reviews may result from billing outliers, excessive service frequency, or complaints regarding coding accuracy.
- **Provider Notification**: When discrepancies are identified, Molina Healthcare will notify providers and allow them the opportunity to respond or correct errors.

- **Fund Recovery**: If inaccurate billing or coding is confirmed, Molina Healthcare will recover overpayments in accordance with federal, state, and contractual requirements.

- **Compliance Obligation**: Providers are expected to adhere to the latest CPT coding guidelines and industry standards. Non-compliance may result in audits, recovery actions, and corrective measures.

Supplemental Information

Definitions

Term	Definition
CMS	The Centers for Medicare & Medicaid Services
Mutually Exclusive Codes	Codes that cannot be billed together for a single patient on a single date of service as they represent overlapping services
Bundling/Unbundling	The practice of consolidating multiple related procedures into a single billing code or separating a single procedure into multiple billing codes
Add-On Codes	Codes that represent additional services performed in conjunction with a primary procedure
Replacement Codes	New codes that replace old codes for more accurate billing and reporting
Global Surgery Codes	Codes that include the surgical procedure and the pre-operative and post-operative care
Multiple Procedure Discounts	Reductions in reimbursement for additional procedures performed during the same session

State Exceptions

State	Exception

Documentation History

Type	Date	Action
Initial Creation Date	09/08/2023	New Policy
Revised Date	12/17/2024	Updated template and verified links
Revised Date	08/08/2025	Updated template and verified links
Revised Date	08/20/2025	Updated page number; changed Coding Disclaimer from 9 point to 10 point; added Reimbursement Guidelines section; refined References section.

References

This policy was developed using:

- CMS
- State Medicaid Regulatory Guidance
- State Contracts

Reference	Link

***CODING DISCLAIMER**. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.*