Molina Healthcare Audit. Recovery Policy for Billed Units (service Accumulator)

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 ensuring accurate and compliant coding and billing practices, consistent with federal and state regulations and industry standards. This policy outlines the framework for conducting reviews of claims that are billed Molina healthcare to ensure the appropriateness and accuracy of coding for services provided to members on the same day or within a specified number of days.

II. Purpose

The purpose of this policy is to define the guidelines and procedures for auditing and recovering funds as necessary through the review of the billing units, to ensure that the claim was, accurately coded, and billed.

III. Scope

This policy applies to all coding and billing activities related to the treatment of Molina Healthcare members.

- By Day
- By Week
- By Month
- By Year.

V. Procedure

- ***Initiation of Audit:***
  - Molina Healthcare may initiate a Billing Units (service Accumulator) review when there are questions regarding the treatments provided to a member on the same day or within a specified number of days.
  - Reviews may be triggered by, but not limited to, high frequency of services, outlier billing practices, or complaints.
- ***Audit Process:***
  - The review will include an examination of medical records, billing records, and any other relevant documentation.
  - The focus will be on identifying inaccuracies in coding and Billing of the Billed Units (service Accumulator).

- When Number of Units that are submitted on a claim line for a service that is rendered for members.
  - By day
  - By week
  - By Month
  - By Year

- ***Recovery:***
  - In cases where inaccuracies are identified, recovery of funds will be initiated in accordance with federal, state, and contractual regulations.
  - Providers will be notified of any discrepancies and will have the opportunity to respond and/or correct the inaccuracies.

- ***Compliance:***
  - Molina Healthcare will monitor compliance with this policy and take corrective action as necessary to ensure ongoing adherence to coding and billing standards.

This policy ensures that Molina Healthcare operates in a manner that is compliant with all applicable laws and regulations and maintains the integrity and accuracy of billing and coding practices.

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		