BILLING AND CODING TIPS & TRICKS

The following are examples of common billing issues that may result in claim denial or claim recovery. This is not an all-inclusive list and does not replace Molina policies. This is intended to provide additional reference material, based on observations of billing trends. Please note that this information is subject to change. It is important to monitor updates made to NCCI, MUE, as well as Nebraska DHHS policies and Molina policies.

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LABORATORY / TESTING/ STUDIES

Diagnostic Laboratory Services

- Diagnostic laboratory services must include a valid ICD-10-CM diagnosis code that clearly indicates the reason for the lab service.
- "Screening" is testing for disease or disease precursors so that early detection and treatment can be provided for those who test positive for the disease. Screening tests are performed when no specific sign, symptom, or diagnosis is present, and the beneficiary has not been exposed to a disease.
  Diagnostic testing is to rule out or to confirm a suspected diagnosis because of a sign and/or symptom in the beneficiary. In these cases, the sign or symptom should be used to explain the reason for the test.

Screening for Gonorrhea:

- Women (nonpregnant) and Men: Claim must contain dx code Z11.3 (Encounter for screening for infections with a predominantly sexual mode of transmission) and one of the following high risk dx codes: Z72.89, Z72.51, Z72.52, Z72.53
- Pregnant Women: Claim must contain dx code Z11.3 and a pregnancy-related diagnosis code.

Vitamin D Assay Testing – 82306, 82652

- Documentation and the diagnosis billed must justify the test(s) chosen for a particular disease entity. A claim billed for Vitamin D Testing service must include a valid ICD-10-CM diagnosis code. If a valid ICD-10-CM diagnosis code is not billed, the Vitamin D service will be denied or recouped.
  Vitamin D deficiencies are the result of dietary inadequacy, impaired absorption and use, increased requirement, or increased excretion. Vitamin D deficiency can occur when usual intake is lower than the recommended levels over a period of time, or when exposure to sunlight is limited. Vitamin D deficiency can also result from the inability of the kidneys to convert Vitamin D to its active form

Respiratory Pathogen Panel Test

- A respiratory pathogen panel test is a single service with a single unit of service (UOS=1). A respiratory pathogen panel test must not be unbundled and billed as individual components although the panel reports multiple individual pathogens and/or targets. The term "panel" refers to all respiratory pathogens tested in the

outpatient setting on a single date of service from a single biologic specimen, not ordered as a reflex test.

Non-Invasive Abdominal/Visceral Vascular Studies

- Diagnostic tests must be ordered by the physician who is treating the member and who will use the results in the management of the member's specific medical problem. Services are deemed medically necessary when all the following conditions are met:
    - Signs/symptoms of ischemia or altered blood flow are present.
    - The information is necessary for appropriate medical and/or surgical management.
    - The test is not redundant of other diagnostic procedures that must be performed. Although, in some circumstances, non-invasive vascular tests are complimentary, such as MRA and duplex, where the latter may confirm an indeterminate finding or demonstrate the physiological significance of an anatomic stenosis such as in renal, iliac, and/or femoral arteries.

Gastrointestinal Pathogen Panels

- A Gastrointestinal Pathogen GIP test panel is a single service with a single unit of service (UOS=1). A GIP test panel must not be unbundled and billed as individual components although the GIP test panel reports multiple individual pathogens and/or targets. Additionally, there are certain ICD-10 codes that should be referenced when reporting a GIP panel test.

Allergy Testing

- CMS states that when billing for Allergy Testing, a specific diagnosis (DX) should be reported to support medical necessity to provide coverage.

Serum Iron

- Claims for serum iron studies must contain a valid medically necessary ICD-10-CM diagnosis code. If a valid ICD-10-CM diagnosis code is not billed, the lab service will be denied or recouped.

Thyroid

- A claim for a thyroid function study must include a valid medically necessary ICD-10-CM diagnosis code. If a valid ICD-10-CM diagnosis code is not billed, the lab service will be denied or recouped.

Polysomnography & Other Sleep Studies:

- Molina complies with CMS LCD L36839 for coverage criteria:
- Diagnostic testing will be considered for coverage if the patient has the symptoms or complaints of one of the conditions listed in L36839.
- Patients who undergo the diagnostic testing are not considered inpatients, although they may come to the facility in the evening for testing and then leave after testing is over. The overnight stay is considered an integral part of the0se tests. Documentation must support indications if the patient is admitted.
- Ordinarily, a single polysomnogram and electroencephalogram (EEG) can diagnose sleep apnea. If more than one such testing session is claimed, the carrier will require persuasive medical evidence justifying the medical necessity for the additional test (*CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 70*).
- Ordinarily, a diagnosis of narcolepsy can be confirmed by three sleep naps. If more than three sleep naps are claimed, the A/B MAC (B) will require persuasive medical evidence justifying the medical necessity for the additional test(s). (*CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 70*.)
- More than one HST per year would not be expected. If more than one HST session is performed for suspected OSA, persuasive medical evidence justifying the medical necessity for the additional tests will be required. Similarly, more than two PSG per year interval would not be expected. If more than two PSG sessions are performed for the diagnosis or adjustment of treatment of sleep, pervasive medical evidence justifying the medical necessity for the additional tests will be required upon request. When services are performed more than established parameters, they may be subject to review for medical necessity.
- The routine use of more than one PSG to titrate CPAP therapy would not be considered reasonable and necessary. If more than one CPAP titration PSG is claimed, persuasive medical evidence justifying the medical necessity for the additional tests may be requested.
- 95805 MSLT- includes all the naps done in a single day. Only one (1) unit of service should be submitted.

OBSTETRICAL BILLING

Global OB Billing

- Members must have at least 6 months of continuous eligibility with Molina for the global OB codes to be billed.

OB Delivery Admissions

- Hospital claims submitted that include ICD-10 PCS procedure codes for cesarean and vaginal deliveries must also include diagnosis codes reporting the outcome of the delivery. One of the following diagnosis codes is required, in any position:

Z37.0	Z37.1	Z37.2	Z37.3	Z37.4
Z37.50	Z37.51	Z37.52	Z37.53	Z37.54
Z37.59	Z37.60	Z37.61	Z37.62	Z37.63
Z37.64	Z37.69	Z37.7	Z37.9	

HOSPITAL BILLING

Outpatient Hospital to Inpatient within 24 Hours

- Excluding Critical Access Hospitals, outpatient hospital visits occurring within 1 day prior to an inpatient admission at the same facility must be included in the inpatient hospital claim and will not be reimbursed separately. A hospital may attest to specific non-diagnostic services as being unrelated to the inpatient claim by adding condition code 51 to the separately billed outpatient non-diagnostic services claim.

Hospital Observation Services

- Observation services G0378 must be reported by facilities utilizing the following guidelines:
    - Observation services are submitted with type of bill 13X
    - Report HCPCS code G0378 (hospital observation service, per hour) under the appropriate revenue code (0762) with units that represent the hours in observation care (rounded to the nearest hour).
    - Observation service code G0378 will only be considered for reimbursement when the observation period meets or exceeds 8 hours.
- Observation services code G0378 should only be reported when one of the following services was also provided on the same date of service or the day before the date reported for observation.
    - Emergency Department visit (99281-99285, G0380-G0384), or
    - Clinic visit (HCPCS code G0463), or

  - Critical care (CPT code 99291), or
  - Direct referral for observation care reported with HCPCS code G0379 which must be reported on the same date of service as the date reported for observation.
- Observation services must be reported on a single line and the date of service for that line is the date that observation care begins. Observation services should not be reported with a date span or on separate claim lines even when the period of observation care spans more than one calendar day.

Repeat Inpatient Admissions within 24 Hours at the Same Hospital:

- Inpatient claims (bill type 11X) from the same pay-to provider with overlapping claim dates of service should be consolidated into one inpatient admission and claim. This excludes hospitals paid on a per diem basis.

Institutional Claims with Type of Bill (TOB) Ending in 0

- Frequency code 0 (zero) (Non-payment/Zero Claim) is used in the third position (XX0) or fourth position (0XX0) of the type of bill (TOB) and is used when it does not anticipate payment from payer for the bill. Frequency code zero should be used if all services on the claim are non-covered. Medicare Crossovers are excluded.

DRUGS AND DME

Remicade NDC Limits

- Infliximab (Remicade is one brand, Infliximab is a biosimilar) is a tumor necrosis factor (TNF) blocker. This drug has clinical requirements that must be met for administration, such as frequency, dosage, and diagnosis. If these requirements are not met, the administration is considered an overpayment. The diagnosis requirement is cross referenced from IDP Analytics, the FDA Label, and the clinical studies. These limits have been reviewed by Molina Pharmacist for accuracy. In instances where the billed quantity exceeds the dosage limit, only the payment of excess quantity is recouped; but, in instances of administering the dosage too soon or missing a valid diagnosis the entire payment may be recouped.

Entyvio NDC Limits

- The drug Entyvio is an Integrin receptor antagonist for inflammatory bowel disease (Crohn's disease and Ulcerative Colitis) and administered intravenously. This drug has clinical requirements that must be met for administration, such as frequency, dosage, and diagnosis. If these requirements are not met, the administration is

considered an overpayment. The Dosage limit is set as a CMS Medically Unlikely Edit. The diagnosis requirement is cross referenced from IDP Analytics, the FDA Label, and the clinical studies. These limits have been reviewed by Molina Pharmacist for accuracy. In instances where the billed quantity exceeds the dosage limit, only the payment of excess quantity is recouped; but, in instances of administering the dosage too soon or missing a valid diagnosis the entire payment is recouped.

Billing for Continuous Glucose Monitoring (CGM) Supplies

- The supply allowance (code A4238 or A4239) is a monthly allowance that may be billed up to a maximum of three (3) units of service (UOS) per ninety (90) days at a time, or 1 unit per 30 days. ****Note: Molina allows billing at 28 days vs. 30.*

MISCELLANEOUS

Bariatric Surgical Management of Morbid Obesity

- Bariatric Surgery refers to a series of medical procedures designed to aid individuals in losing weight, particularly those who are severely obese and have failed to lose weight through diet and exercise. These surgeries alter the digestive system, promoting weight loss by limiting the amount of food the stomach can hold or by reducing the absorption of nutrients. Bariatric surgeries are often recommended for individuals with obesity-related health issues, such as diabetes or hypertension, to improve their overall health and quality of life.

Invalid Place of Service and Procedure Code Combination

- Place of Service (POS) must be considered appropriate based on the CPT/HCPCS code description or available coding guidelines when reported by a physician. For example:
    - Emergency department E&M codes 99281-99285 should only be billed in an emergency department place of service
    - Nursing home E&M codes 99304-99310 should only be billed in a nursing facility place of service.

Medicaid MUEs for Practitioner Services and DME Services

- Molina complies with the Medicaid MUE limits for practitioner and DME services. The MUE files are published quarterly and thus may change quarterly.