Molina Healthcare Billing Requirements

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 the event of a conflict, federal and state guidelines, as applicable, as well as the member's benefit plan document supersede the information in this policy. Additionally, to the extent there are any 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 mandates that all providers adhere to the prescribed billing guidelines as delineated by the AAPC (American Academy of Professional Coders), CMS (Centers for Medicare and Medicaid Services), NUCC (National Uniform Claim Committee), NUBC (National Uniform Billing Committee), and the applicable state-specific requirements.

Molina Healthcare conducts thorough claims reviews to verify compliance with the following criteria:

1. Admission dates and times.
2. Discharge dates and times.
3. Accurate utilization of value codes and occurrence codes, notably:
    a. Value code 54 for measurements in grams.
    b. Value code A8 for measurements in kilograms.
    c. Value code A9 for measurements in centimeters.
    d. Occurrence code 55 (date of death) when the patient's status falls under the following categories:
        i. 20
        ii. 22
        iii. 40
        iv. 41
        v. 42

Failure to meet these stipulated criteria may lead to various consequences, including claim rejections, denials, or audits. Such outcomes can result in delayed or reduced reimbursement and the potential recoupment of previously disbursed payments. Providers are strongly encouraged to familiarize themselves with Molina Healthcare's precise billing requirements and guidelines to ensure the accurate submission of claims and to prevent potential reimbursement issues.

Supplemental Information

Definitions

Term	Definition
CMS	stands for Centers for Medicare and Medicaid Services. It is a federal agency within the United States Department of Health and Human Services (HHS). CMS administers the Medicare program, which provides health insurance coverage for individuals aged 65 and older, as well as certain younger individuals with disabilities. Additionally, CMS oversees the Medicaid program, which offers health coverage to low-income individuals and families. CMS plays a crucial role in the regulation and oversight of various healthcare programs and initiatives in the United States, including the development of billing requirements, quality measures, and reimbursement policies
NUBC	stands for National Uniform Billing Committee. The NUBC is an organization that develops and maintains the UB-04 claim form, which is used for submitting institutional healthcare claims. It is a standardized billing form used by hospitals, skilled nursing facilities, and other institutional providers to bill for services rendered to patients. The NUBC works to ensure consistency and uniformity in healthcare billing practices across the United States.
AAPC	stands for the American Academy of Professional Coders. It is a professional organization that provides education, certifications, and resources for medical coding, billing, and auditing professionals. AAPC offers various certifications, such as Certified Professional Coder (CPC), Certified Outpatient Coding (COC), and Certified Professional Medical Auditor (CPMA), among others. These certifications validate the expertise and knowledge of individuals in medical coding and related areas. AAPC also provides continuing education opportunities, networking opportunities, and industry updates to support the professional growth and development of its members.
NUCC	stands for the National Uniform Claim Committee. It is a voluntary organization comprised of representatives from various healthcare industry stakeholders, including healthcare providers, payers, and regulatory bodies. The NUCC's primary purpose is to develop and maintain uniform standards and guidelines for healthcare transactions, specifically related to electronic healthcare claims. The committee works to streamline and standardize the submission of healthcare claims across different payers and providers, promoting consistency and efficiency in healthcare billing processes. The NUCC is responsible for maintaining and updating the CMS-1500 claim form, which is used for submitting professional healthcare claims.
Value Codes	are alphanumeric codes used in healthcare billing to indicate specific values or conditions related to a particular service or item. They are used to provide additional information or context about a claim. Value codes are typically included on claim forms, such as the UB-04 or CMS-1500, in designated fields. The values represented by value codes can vary depending on the specific billing requirements or guidelines of the payer or regulatory body. For example, value codes may be used to indicate the weight of a patient (in grams or kilograms), the length of a stay, the number of visits, or other relevant information. Providers and billers must ensure accurate and appropriate use of value codes based on the specific requirements of the payer or billing guidelines to facilitate proper reimbursement and claims processing.
Occurrence codes	are alphanumeric codes used in healthcare billing to report specific events or circumstances related to a patient's care or the provision of healthcare services.

	These codes are typically included on claim forms, such as the UB-04 or CMS-1500, in designated fields. Occurrence codes provide additional information or context about a claim and help explain the reason for a particular service or the occurrence of certain events. They are used to indicate events such as accidents, injuries, surgeries, diagnostic procedures, complications, or other relevant occurrences. The specific codes and their meanings may vary depending on the payer or regulatory guidelines. Providers and billers must accurately report occurrence codes based on the specific requirements to ensure proper reimbursement and claims processing.

References

This policy was developed using

Reference source	Link
CMS	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf
NUCC	National Uniform Claim Committee - Home (nucc.org)
AAPC	https://www.aapc.com/
NUBC	https://www.nubc.org/
All	State Medicaid Regulatory Guidance

State Exceptions

State	Exception

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