Payment Integrity Audit

Reimbursement Policy

Purpose

To identify, prevent and correct fraud, waste and abuse and to facilitate accurate claim payments through prepayment and post-payment audit review processes that include medical review.

Community Health Options (Health Options) will analyze claims to determine provider compliance with Centers for Medicare & Medicaid Services (CMS) coding and billing rules, Health Options' policies, any in-place Contractual Agreement(s), and take appropriate corrective action when Health Care providers are non-compliant. The goal is to "correct the behavior in need of change and prevent future inappropriate billing" (Medicare Program Integrity).

Definitions

- Audit: a qualitative or quantitative review of claims, itemized bills, and medical documentation provided by Health Care providers for the purpose of ensuring such health care services are billed and reimbursed appropriately under the terms of the Contractual Agreement after all appropriate claim edits.
- Health Care providers: health care providers of service, suppliers, or facilities that have submitted claims to Health Options.
- Post-payment: a claim determination made after the claim has been paid.
- Prepayment: a claim determination made before claim payment.
- Unsupported or undocumented charges: services billed on a claim is not supported by the Health Care provider's medical documentation (also known as over-charge).

Policy

Health Options has the authority to review any claim at any time. Health Options will target error prevention efforts toward services and items that pose the greatest financial risk and that represent the best investment of resources.

Health Options or its designee may request medical documentation and/or full bill itemization to substantiate the treatment items, services, and supplies provided and billed by Health Care providers, in the course of conducting reviews and audits. Resources utilized include, but are not limited to, the following:
- Health Options' policies
- Centers for Medicare & Medicaid Services (CMS) guidelines as stated in manuals, transmittals, articles, etc.
- CMS National Coverage Determinations (NCD) and Local Coverage Determinations (LCD)
- Statues and Regulations
- American Medical Association Current Procedure Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) rules
- Industry-standard utilization management criteria and/or care guidelines, such as MCG guidelines
- National Uniform Billing Committee guidelines
- International Classification of Diseases (ICD) codes
- Food and Drug Administration

Additional Documentation Request

Health Care providers are required to submit additional documentation for claims identified for prepayment or post payment audit within 30 days from the dated Health Options request notice. For post payment reviews and audits, if additional documentation is not received, Health Options will complete the payment recoupment process.

Health Options is not liable for interest or penalties when Health Care providers fail to submit required/requested documentation for claims prepayment or post payment audit.

Claim Edits

Claim edits focus on service dates, revenue codes, procedure codes (CPT® and HCPCS), modifiers, Type of Bill (TOB), units of service, diagnosis, member eligibility, historical claims data, etc. Edits shall include, but are not limited to:

- **Non-Covered Services**
  The service(s) is a non-covered service according to plan/policy terms and provisions.
- **Authorization (Days, Level of Care, etc.)**
  Services billed without prior authorization or inconsistent with the approved authorization on file will be denied. Services billed should match the medical documentation equivalent with the medically necessary care provided.
- **Procedures/Charges unlisted, undocumented, or incorrectly coded**
  Unlisted, undocumented, or incorrectly coded procedures/charges must be adequately described to complete a diligent bill review.
- **Duplicative Procedures/Charges**
  A charge that duplicates another service or supply in the billing on the same date of service.
- **Coordination of Benefits**
- **Insurance Liability and Recovery (Subrogation)**
- **CMS National Coding Correct Initiative (NCCI)**
  "The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment" (CMS).
  Source Documents: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
- **CMS Medically Unlikely Edits (MUE)**
  "The CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate…An MUE for a HCPCS/CPT® code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. All HCPCS/CPT® codes do not have an MUE" (CMS).
  Source Documents: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html
- **Medicare Procedure-to-Procedure (PTP)**
  "Each edit table contains edits which are pairs of HCPCS/CPT® codes that in general should not be reported together. Each edit has a column one and column two HCPCS/CPT® code. If a provider reports the two codes of an edit pair, the column two code is denied, and the column one code is eligible for payment. However, if it is clinically appropriate to utilize an NCCI-associated modifier, both the column one and column two codes are eligible for payment" (CMS).
  Source Document: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html
- **Medicare Add-on Code Edits**
  "An add-on code is a HCPCS/CPT® code that describes a service that, with one exception (see CR7501 for details), is always performed in conjunction with another primary service. An add-on code with one

exception is eligible for payment only if it is reported with an appropriate primary procedure performed by the same practitioner. An add-on code with one exception is never eligible for payment if it is the only procedure reported by a practitioner" (CMS).

Source Document: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits.html

- **CMS Professional Component/Technical Component (PC/TC)**

   CMS National Physician Fee Schedule (NPFS) Relative Value File, Professional Component (PC)/Technical Component (TC) Indicators are used to determine if a CPT® or HCPCS procedure code is eligible for separate reimbursement.

   Source Documents: https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/ and https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3903CP.pdf

- **CMS Global Surgery**

   CMS Global Surgery status indicators are used to determine if reimbursement is appropriate as identified in field 16 of the Addendum B. "This field provides the postoperative time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service" (CMS).

   Source Document:
   https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html

Bill Audit Review Denial Coding

Upon completion of an Internal Savings Review (ISR), a Bill Audit Review Summary Report will be sent to the Health Care provider that identifies the billing and coding errors not eligible for reimbursement. Line item denial codes include, but are not limited to the following:

Code	Short Description	RARC	CARC
9b1	LOCM is unbundled from the diagnostic test performed.	M15	97
15a3	Unbundled from the global surgery procedure charge.	M15	97
16g	Diluent solution unbundled	M15	97
25a	Charges not adequately coded or described.	N56	181
pc0	Not billable by Medicare guideline	N34	57
1a1	Drug Admin unbundled from Nursing Incremental	M15	97
4b1	Routine supplies unbundled from the global OR charge	M15	97
16F	Med dispensed outside of paradigm or clinical guide.	N372	50
pc5	Not billable by Medicare guideline	N19	57
dup	Duplicate Charge	N522	18
8b	Unbundled from Global Anesthesia Charge	M15	97
unbl	Unbundled from primary Code per NCCI	M15	97
1c3	Component equipment, Unbundled from Room	M15	97
2b1	Oxygen should not be billed in ICU/CCU/NICU	M15	97
1b	Unbundled from Global Anesthesia Charge	M15	97
1A2	Unbundled from Nursing Incremental	M15	97
1c	Routine equipment, Unbundled from room charge	M15	97
16h	Basic IV support supplies and solutions	M15	97
2a	Unbundled from Global ICU/CCU/NICU room.	M15	97
4r1	Routine Equipment, Unbundled from Room Chg.	M15	97
26c	Charges not adequately coded or described.	N56	181

2a1	Drug Admin unbundled from Nursing Incremental	M15	97
5b	Routine Supplies unbundled from recovery charge	M15	97
4a1	Unbundled from global OR services	M15	97
4cs	Unbundled from global OR services	M15	97
4b3	Routine Supplies, Unbundled from OR Charge	M15	97
1c2	Hospital Owned Equipment	M15	97
4c1	Portable and stat diagnostic charges in the OR not billable.	M15	97
NCS	Non-covered Benefit	M15	50
DD	Denied Days	N54	198
5a1	Unbundled from Nursing Incremental	M15	97
LOC	Level of Care Inconsistent	N188	186
PA	No Prior Authorization	N54	197-198

Provider Notification and Feedback

Health Options notifies the Health Care provider of bill audit review findings and makes appropriate referrals for provider outreach and education, in a collaborative effort to reduce improper billing. Health Care provider notification comes in the form of a claim remittance advice and in many cases an ISR. "Direct communication between [Health Options] and the provider is an essential part of solving problems. This process is carried out through written communication or by telephone as a result of specific claims or a group of reviewed claims. The overall goal of providing notification and feedback is to ensure proper billing practices and appropriate consideration of coverage criteria so claims will be submitted and paid correctly" (Medicare, Program Integrity, Chapter 3).

Health Care providers (facilities, physicians and other health care professionals) are responsible for accurately and timely: documenting, coding and, billing, by following CMS guidelines, enabling appropriate claims review processing by Health Options.

References/Resources

CMS National Correct Coding Initiative Edits:
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

Medicare Program Integrity Manual, Chapter 3: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf

Related Policies

Itemized Bill Submission Policy
Appeals Processing Policy

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