Payment Integrity Administrative Policy:

Pre/Post Claims Payment Reviews

EFFECTIVE DATE:	APPROVED BY
8/1/2021	**HCCI (Health Care Cost Initiatives Committee)**

Policy Statement:

We (or our designees) routinely evaluate claims for coding, billing accuracy, and appropriateness. Reviews may apply to all claims including facilities, laboratories, and professional services. In these reviews, we look at applicable coverage and reimbursement policies, as well as your patient's benefit plan, and we review utilization of services and items, such as supplies, durable medical equipment, and implants.

As a part of the review, we may request supporting claim payment information, such as itemized bills and medical records – for example, operative and procedure reports, implant logs, histories and physicals, office notes, laboratory and radiology reports, or other documents.

When records are received in response to the records request, the items received are considered to be the complete documentation needed to support the services billed; any items later received are deemed not to have existed at the time the claim was submitted. It is the responsibility of the billing provider to ensure that their responses to records requests are both prompt and complete.

Note: *Neither additional records nor amended records will be accepted once the audit review is complete*

The Treatment, Payment and Health Care Operations (TPO) exception under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (45 CFR 164.506) allows the release of medical records containing protected health information (PHI) between covered entities without additional authorization for the payment of healthcare claims.

Pre-Payment reviews look for overutilization of services or other practices that directly or indirectly result in unnecessary costs to the healthcare industry, including the Medicare and Medicaid programs.

Examples include, but are not limited to:

- Selection of the wrong code(s) for services or supplies (e.g. DRG/APC Validation, CPT, ICD-10 and HCPCS selections).
- Excessive Charges.
- Billing for items or services that should not have been or were not provided based on documentation supplied.
- Unit errors, duplicate charges, and redundant charges.
- Insufficient documentation in the medical record submitted to support the charges billed.

- Experimental and investigational items billed.
- Lack of medical necessity to support services or days billed.
- Services billed are not covered per the member's benefit plan, payer policies, Medicare policies or Medicaid policies, such as National Coverage Determinations and Local Coverage Determinations.
- Lack of clinical information in the medical record to support condition for which services are billed.
- Items not separately payable or included in another charge, such as routine nursing, capital equipment charges, reusable items, etc.
- Payment for services that fail to meet professionally recognized standards/levels of care.
- Improper payment for services.

If we, or our designees, determine that a coding and/or payment adjustment is applicable, the healthcare provider will receive the appropriate claim adjudication, an explanation of remittance (EOR) and/or a findings letter. Healthcare providers may have the right to dispute results of reviews based on explanation, findings or payments as stated in the provider manual.

The documentation submitted for appeal reconsideration should include a written explanation of how the records submitted for the original review support the items and quantities billed. The explanation should also include how the number of billed units was calculated based on the physician's orders and medical records.

Note: *Additional records that were not submitted for the original review cannot be considered in the appeal process.*

Revision History

Company(ies)	DATE	REVISION
EmblemHealth and ConnectiCare	4/2021	New Policy