CHAPTER 6: BILLING AND PAYMENT

UNIT 8: PAYMENT REVIEW *Updated!*

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What Is My Service Area?

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**

The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.

The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.

The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

6.8 FINANCIAL INVESTIGATIONS AND PROVIDER REVIEW (FIPR)

FIPR overview

Highmark's Financial Investigations and Provider Review (FIPR) department's mission is to support Highmark's vision of providing affordable, quality health care by ensuring that provider reimbursements are appropriate and to protect Highmark's assets by investigating and resolving suspected incidents of health care insurance *fraud, waste, abuse, or material misrepresentation ("FWAM")*.

In addition to conducting post-payment practice pattern reviews, FIPR also investigates potential member and provider FWAM. Highmark's FIPR unit takes a proactive approach to detecting and investigating potential health care FWAM. When necessary, FIPR takes internal and/or external corrective action regarding fraudulent activity that impacts Highmark, its customers, or members.

For more information on FIPR, please visit **highmark.com.** (Click on **Fraud Prevention** in the blue area at the bottom of the page.)

Why blue italics?

Highmark's Fraud Hotline

Highmark established a fraud hotline so that members and providers can notify FIPR of potential fraud. The fraud hotline is answered live during working hours, Monday through Friday 8 a.m. to 4 p.m. During non-working hours, the fraud hotline is automated and allows anyone to leave a message.

If you suspect fraud, contact your local FIPR department within Highmark:

- Pennsylvania and Delaware: **1-800-438-2478**
- West Virginia: **1-800-788-5661**

What Is My Service Area?

6.8 DEFINING THE ISSUES: FRAUD, WASTE, ABUSE, AND MATERIAL MISREPRESENTATION ("FWAM")

Fraud

Fraud *is defined by state and federal laws and typically occurs when a provider or consumer intentionally submits, or causes someone else to submit, false or misleading information to a health insurance company for the purpose of receiving payments that an individual or entity is not eligible to receive.*

Example: Billing for services not rendered.

Why blue italics?

Waste

Waste is defined as the overutilization of professional medical services or the misuse of resources by a health care provider.

Example: A provider's belief is that every patient should receive an X-ray every time they have an appointment.

Abuse

Abuse is defined as incidents or practices of providers, physicians, or suppliers of services and equipment that are inconsistent with accepted sound medical, business, or fiscal practices.

Example: Billing separate services that should be bundled under one service code.

Material Misrepresentation

When a provider submits claims to Highmark for reimbursement, the provider is contractually obligated to ensure that the information in the claim accurately reflects the services performed as documented in the provider's records. Claims that do not accurately reflect the services performed are misrepresentations; when a misrepresentation results in an overpayment to the provider, it is a material misrepresentation.

Because the provider is contractually obligated to submit claims that accurately reflect the services performed, Highmark may retroactively adjust payments to reflect the services actually performed following a review of the provider's records or receipt of other information that indicates a claim materially misrepresents the services performed. Highmark may retroactively adjust payments in these circumstances and seek recoupment even where there is no evidence that the provider or entity intentionally submitted claims containing misrepresentations.

Example: *Coding claims to reflect that a more complicated, higher level office visit was performed when a lower office visit code was more appropriate.*

Note: *These four definitions are not mutually exclusive and may overlap. For example, billing unbundled services that should be bundled under one service code may be both abuse and a misrepresentation or even fraud.*

6.8 PAYMENT REVIEW PROCESS

What Is My Service Area?

Overview

Payment review[1] is a key element of the screening process Highmark uses to assure that members receive health care services that are medically necessary and that the claims for these services are submitted properly. This process also ensures that claims are being paid in accordance with provider agreements, while at the same time addressing the integrity of the payment calculated by Highmark.

History of payment review

Highmark initiated payment review in 1962 in cooperation with the Pennsylvania Insurance Department. Since that time, it has increased in importance not only at Highmark but in the entire health care industry.

Payment reviews are now conducted in all Highmark service areas due to regulations established by Federal and State regulatory agencies, such as the Centers for Medicare & Medicaid Services (CMS), Federal Employee Program, and the respective State insurance departments. In addition, the national Blue Cross and Blue Shield Association (BCBSA) and the contracts we have with our group clients also require Highmark to monitor provider claims billing.

Ultimate goals of payment review

The ultimate goals of payment review are to:

- Be a deterrent to *fraud, waste, abuse, and material misrepresentation ("FWAM")* by performing advanced analytical and investigational payment reviews.
- Educate our provider community on appropriate reporting of services in accordance with industry standard and "Best Practice" guidelines.
- Ensure that payments are being made in accordance with contracted provider agreements.
- Ensure that payments are made consistent with medical policy and other Highmark guidelines.
- Identify, control, and eliminate aberrant and inappropriate claim coding.

In rare instances of suspected fraud, Highmark's Financial Investigations and Provider Review (FIPR) tracks claim reporting to collect information that may become evidence for law enforcement officials or the courts. Professional physician consultants support and advise Highmark personnel in pre- and post-payment review activities.

Why blue italics?

[1] Unless otherwise specifically noted, when used in this Manual the term "payment review" is meant to also refer to the following processes, including but not limited to: provider audit/review, audit, claim(s) audit/review, post-payment audit/review, retroactive post-payment audit/review, coding audit/review, E/M audit/review, pre-payment audit review, post-payment practice pattern review, and pre-payment practice pattern review.

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6.8 PAYMENT REVIEW PROCESS, Continued

Three phases of payment review

1. **Initial claims review:** Highmark staff screens each claim received for easily identifiable errors and services claimed for payment that are not covered in a customer's benefit package. Frequently, Highmark pays for eligible services even though a more extensive review of a provider's practice pattern may take place at a later time.
2. **Pre-payment practice pattern review:** Staff looks closely at selected claims before the claims are paid in order to determine appropriateness of services billed and/or the medical necessity of the services reported.
3. **Post-payment practice pattern review:** Staff looks closely at selected claims after the claims have paid in order to determine appropriateness of claim coding, services billed, and medical necessity, if applicable. This involves long-term tracking and monitoring of many services rendered by providers.

Which providers are reviewed?

Highmark is required to monitor all providers in our participating, preferred, and managed care networks throughout Pennsylvania, Delaware, and West Virginia. The claims being reviewed are for Highmark members and also for when Highmark is acting as the intermediary for contracted pricing for other Blue Cross and Blue Shield Plan members.

Who is conducting payment reviews?

Highmark's FIPR team is comprised of experienced health care professionals with expertise in clinical, financial, revenue cycle, health information management, and coding specializations. These individuals include nurses, financial and IT analysts, investigators, medical coders, consultants, and auditors.

Due to the complexity of facility billing and payment methodologies, Highmark also uses external firms to assist in payment reviews of paid claims. These reviews are conducted to ensure that providers are complying with industry standards on appropriate billing and that payments are monitored for accuracy.

Professional consultants are also engaged to support and advise Highmark personnel in the identification of problematic billing and coding issues.

For purposes of this Chapter and unless otherwise noted, if a section refers to "FIPR" it is also referring to external firms and professional consultants that may assist or support Highmark's payment review processes.

Why blue italics?

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6.8 PAYMENT REVIEW PROCESS, Continued

When problems are identified

When a potential FWAM problem is identified, what actions are taken to correct the provider's reporting?

1. FIPR performs an investigation of the potential FWAM.
2. FIPR notifies the provider of the findings.
3. FIPR educates the provider on proper coding and billing and expects the provider to adhere to such education on any future billing.
4. FIPR collects identified overpayments.
5. If potential fraud is detected, FIPR refers the issue to the appropriate law enforcement agency.

6.8 TECHNIQUES USED FOR INVESTIGATION

Overview

In the payment review process, Highmark employs various techniques to investigate potential issues of *fraud, waste, abuse, and material misrepresentation ("FWAM")*.

Why blue italics?

Routine surveys of paid claims

Financial Investigations and Provider Review (FIPR) staff routinely surveys a percentage of all claims it receives. FIPR staff verifies the accuracy of claims by gathering information from hospital medical records departments, professional provider offices, or members.

Statistical review of cumulative claims payment data

FIPR utilizes an internal system to investigate unusual utilization. Highmark developed this web-based application to gain faster access to claims data and also to enhance reporting capabilities. The system is able to generate both summary and detailed reports from seven years of available data.

The reporting capabilities of the system allow for comparison of a provider's utilization to the utilization of other providers within the same geographic region and specialty. This type of comparison allows FIPR to analyze utilization quickly and effectively, and it is these analyses that identify overutilization and potential fraudulent behavior.

Pre-payment review

FIPR employs predictive analytic software to search for and screen potentially aberrant claims. This software works by identifying patterns of suspicious behavior and provides a score based on that claim's degree of risk; the higher the score, the higher the fraud risk. Claims identified by this process are then reviewed for accuracy and appropriateness of payment and, if necessary, FIPR will open an investigation of the specific claim or the provider.

Highmark continually updates the FWAM detection tools based on improvements in technology and data analysis techniques.

Special research studies

FIPR frequently conducts special studies to identify new areas for review and to assess the adequacy of our present claims systems to ensure cost-effective quality health care for our members.

Ongoing investigations

FIPR continues to closely monitor claims after the claims have been paid in order to determine the appropriateness of the services reported. This involves long-term trending and monitoring of many services.

6.8 WHEN A CASE IS IDENTIFIED

Process when a potential problem is identified

When a potential problem is identified, a case investigation is initiated. Claims data is generated and reviewed.

Analysis of claims processed: A statistical analysis of the claims processed for a particular provider will be conducted. This analysis will compare all phases of a provider's billing patterns to those of his or her peers.

Financial Investigations and Provider Review (FIPR) may select specific claims for a detailed review and also may select a statistical sample of claims. If a statistical sampling approach is used, FIPR would randomly select a population of claims and extrapolate the results over all the claims paid to a provider for a given period.

If irregularities are found during the investigation (for example, the provider is performing more of one particular service than his or her peers), FIPR will notify the provider of the potential irregularity and request a response.

On-site review: If warranted, an on-site review may be conducted. This usually includes obtaining copies of clinical records.

Patient interviews: Patients may also be interviewed to verify that services were performed as reported. If the patient's age or condition precludes an interview, the investigator(s) may interview the patient's relatives, as appropriate. These interviews may be necessary in all types of investigations conducted by FIPR. FIPR investigators are trained to avoid making improper comments about the provider or the quality or appropriateness of treatment the member received.

Discrepancies between information reported on the claim form and the member's recollection of the services performed are pursued carefully. FIPR investigators make every effort to assess the reliability of persons interviewed and the accuracy of their statements. Whenever possible, all interviews are recorded to memorialize the details of any statements made. The recording will protect the member as well as the investigator(s) from misinterpreted information, avoiding the change of specific details at a later time, and potentially provide evidence for use in all proceedings. (Warnings of audio recording are given to the interviewees to avoid potential wiretap violations.)

FIPR informs the provider of the final results of the case investigation if a change in behavior or a refund appears to be appropriate.

Review by FIPR investigators

It is the responsibility of FIPR investigators to examine and summarize hospital and office records and reports of on-site reviews. They also review statistical information on payments made and compare claim coding to Highmark medical and payment policies.

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6.8 WHEN A CASE IS IDENTIFIED, Continued

Review by professional consultants

Although not required in every case, a professional consultant may be used to review documentation and provide a written opinion. The professional consultant program involves over 250 independent health care professionals who provide their perspective on issues of medical policy, clinical guidelines, and unusual claims.

A professional consultant is contracted as a Business Associate of Highmark. The consultants are typically actively practicing health care professionals, representing major professional specialties and disciplines. The consultants are required to:

- Provide written medical opinions regarding medical claims;
- Provide written medical opinions regarding medical policy;
- Provide written input for use in the development of reimbursement amounts for medical service; and
- Provide written medical opinions regarding provider practice patterns and utilization.

Referrals to consultants involve two separate and distinct types of reviews: pre-payment and post-payment. Pre-payment investigations are performed on the medical necessity or appropriateness of a service(s) or procedure code(s) prior to claims payment. Post-payment investigations involve utilizing professional consultants to review overall practice patterns and specific claims as necessary.

In these situations, the consultants are generally providing their opinion as to whether the documentation in the medical records supported the services billed and the level of care. If there is a lack of supportive documentation, the consultants advise what services, or level of care, should have been reported.

In order to assure the credibility of these reviews, every effort is made to use a consultant of the same specialty or subspecialty and similar practice. A consultant from a different geographic location is typically used in an attempt to ensure that the provider being reviewed receives a completely unbiased review. Additionally, the consultants are currently in active practice to assure they are aware of the latest developments in their specialties.

Provider contact and education

Following review, the provider may be contacted by a FIPR representative to discuss several items such as: the statistical data; the individual treatment patterns; the professional consultant's opinion; education on future reporting; and, if necessary, obtain a refund of overpaid monies.

6.8 POST-PAYMENT CLAIM REVIEW

Introduction

This section summarizes how Financial Investigations and Provider Review (FIPR) staff conducts post-payment reviews of claim submissions and processing for potential *fraud, waste, abuse, and material misrepresentation (FWAM)*.

Why blue italics?

Post-payment review

FIPR staff periodically performs post-payment reviews of providers who have been selected based on their utilization and billing patterns, relative to their peers. Providers and members may also be selected for review based on various other criteria including, but not limited to, potential allegations of wrongdoing, systemic billing errors, and Fraud Hotline tips.

A statistically random sample of records for the questioned services is reviewed. Typically, a certified professional coder and/or registered nurse perform the reviews. However, qualified external consultants may on occasion be contracted to perform such reviews on behalf of Highmark.

Similarly, FIPR staff may on occasion pend and review a provider or member's claim on a pre-payment basis.

Criteria used in E/M reviews

In the performance of E/M (evaluation and management) reviews (whether pre- or post-payment), the reviewer will use the following criteria to assess adequacy of documentation to support the level of service billed:

- Applicable E/M guidelines published by the American Medical Association (AMA) in the Current Procedural Terminology ("CPT") book and Documentation Guidelines for E/M Services published by the Centers for Medicare & Medicaid Services (CMS).
- Provider or business owner must state in writing (by letter or email) which E/M guidelines will be used to perform the review.
- The representations in each record must support the service billed and the level of care provided on each unique date. **Records that contain cloned documentation, conflicting information, or other such irregularities may be disallowed for reimbursement.** Reimbursement for any record containing such questioned documentation will be represented in overpayment calculations with zero reimbursement allowed.
- Each entry in the record must be made such that the documenter is obvious (name and credentials) and must include the date and specific time performed, including accurate start and stop time for the time-based procedures. Hard copy records must be signed on each page by the person providing the services (e.g., a physician assistant providing the services must sign their name and credentials in the medical records).

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6.8 POST-PAYMENT CLAIM REVIEW, Continued

Criteria used in E/M reviews (continued)

- Electronic medical records (EMR) must be recorded in order to specifically substantiate who performed each unique service, along with the date and specific time performed.

What Is My Service Area?

Treatment of under coding

FIPR reviewers document determinations of both over coding and under coding. In the event a FIPR reviewer determines that documentation supports a higher level code than billed, the reviewer gives credit for the underpayment.

Review of results

At the conclusion of a payment review, the results are submitted in writing to the provider via certified mail, and facsimile if applicable. The provider is afforded the opportunity to rebut review findings by providing clarification and/or supporting documentation **within thirty (30) calendar days**.

For providers in West Virginia responding to the receipt of a retroactive denial, please refer to the Prompt Pay Act "Provider recovery process" information on the next page.

Copies of review worksheets may be made available to the provider upon written request. Additionally, the provider may request a meeting with FIPR staff to:

- Ensure the provider understands the review process and results.
- Answer questions regarding correct billing and documentation.
- Afford the provider an opportunity to furnish additional supporting documentation and/or clarification.
- Discuss repayment arrangements, if applicable.

Why blue italics?

6.8 RETROACTIVE DENIALS AND OVERPAYMENTS

Introduction

If Highmark's Financial Investigations and Provider Review (FIPR) identifies an overpayment, recovery of the overpayment is subject to each service region's respective retroactive denial or overpayment collection laws as applicable.

What Is My Service Area?

The Prompt Pay Act

Under the Ethics and Fairness in Insurance Business Practices Act, W.Va. Code § 33-45-1 et seq. (the "Prompt Pay Act"), Highmark West Virginia may retroactively deny an entire previously paid claim insured by Highmark West Virginia for a period of one (1) year from the date the claim was originally paid. See also **Chapter 6.1: General Claim Submission Guidelines** *for additional information about the Prompt Pay Act.*

The Prompt Pay Act does not apply:

- *To services furnished by providers not contracted with Highmark West Virginia;*
- *To contracted providers outside of West Virginia;*
- *To claims paid under an ERISA self-funded plan;*
- *To government programs such as the Federal Employee Health Benefit Program, Medicare Advantage, and Public Employees Insurance Agency (PEIA);*
- *To claims submitted fraudulently or which contain material misrepresentations;*
- *When a good faith dispute about the legitimacy of the amount of the claim is involved (e.g., disputed review findings during the resolution process);*
- *Where Highmark West Virginia's failure to comply with the time limit is caused in material part by the person submitting the claim or Highmark West Virginia's compliance is rendered impossible due to matters beyond its reasonable control (e.g., fire, pandemic flu);*
- *Where the provider is obligated by law or other reason to return payment to Highmark West Virginia or a Highmark West Virginia member (e.g., Unclaimed Property Act);*
- *To BlueCard claims;*
- *To claims that are not covered under the terms of the applicable health plan (e.g., Workers' Compensation exclusions); or*
- *A partial adjustment to an amount paid that is not a denial of an entire previously paid claim.*

Why blue italics?

Provider recovery process

Under the Prompt Pay Act, upon receipt of a retroactive denial, the provider has forty (40) days to either: (1) notify Highmark West Virginia of the provider's intent to reimburse the plan; or (2) request a written explanation of the reason for the denial.

Upon receipt of an explanation, a provider must: (1) reimburse Highmark West Virginia within thirty (30) days; or (2) provide written notice that the provider disputes the denial. The provider should state reasons for disputing the denial and include any supporting information or documentation. Highmark West Virginia will review as an appeal and

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6.8 RETROACTIVE DENIALS AND OVERPAYMENTS, *Continued*

Provider recovery process *(continued)*

notify the provider of its final decision within thirty (30) days after receipt of the provider's notice of dispute. Please see the section titled **Post-Payment Dispute Resolution Process – Appeals & External Review**.

If the retroactive denial is upheld, the provider must pay the amount due within thirty (30) days or the amount will be offset against future payments unless the provider notifies Highmark West Virginia in writing that the provider is disputing the review findings. The dispute resolution process shall be in accordance with the procedures outlined in this unit for West Virginia providers or, if there is a conflict, in accordance with the terms of the applicable provider agreement.

For overpayments and refunds not initiated by FIPR, see the section on "Overpayments and Refunds" in the manual's **Chapter 6.7: Payment/EOBs/Remittances**.

What Is My Service Area?

The Retroactive Denial of Reimbursement Act

The Retroactive Denial of Reimbursement Act, 40 Pa. C.S. § 3801 et seq. (the "Retroactive Denial Act"), prohibits the retroactive denial of a reimbursement to a health care provider (hereinafter "provider") as a result of an overpayment determination more than twenty-four (24) months after the date the insurer initially paid the provider. The Retroactive Denial Act does not apply:

- *To claims in which the information submitted therein constitutes fraud, waste, or abuse as those terms are defined in the Retroactive Denial Act;*
- *To duplicate claims;*
- *To claims in which denial was required by a Federal or State government plan;*
- *To claims where the services were subject to coordination of benefits with another insurer, the medical assistance program, or the Medicare program; or*
- *To services furnished by providers that are not licensed, certified, or approved by the Commonwealth of Pennsylvania to provide health care or professional medical services.*

NOTE: *If Highmark submits a written request for medical or billing records to the provider, the provider has up to sixty (60) days to provide the requested records, and the period of time for which it takes the provider to collect the requested records shall be added to the twenty-four (24) month period.*

Why blue italics?

Provider recovery process

Under the Retroactive Denial Act, if Highmark retroactively denies reimbursement to a provider, Highmark shall give the provider a written statement specifying the basis for the retroactive denial. If the provider disputes the retroactive denial, the provider shall notify Highmark in writing that the provider is disputing the findings. The dispute resolution process shall be in accordance with the procedures outlined in this unit for

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6.8 RETROACTIVE DENIALS AND OVERPAYMENTS, Continued

Provider recovery process *(continued)*

Pennsylvania providers or, if there is a conflict, in accordance with the terms of the applicable provider agreement.

For overpayments and refunds not initiated by FIPR, see the section on "Overpayments and Refunds" in the manual's **Chapter 6.7: Payment/EOBs/Remittances**.

What Is My Service Area?

Collection Overpayment Act

Title 18, Chapter 27 of the Delaware Code, 18 Del. C. § 2730 (the "Collection Overpayment Act"), prohibits the initiation of collection of overpayments from a health care provider (hereinafter "provider") by a health insurer or health plan more than twenty-four (24) months after the original payment for the claim was made. The Collection Overpayment Act does not apply:

- *When the health insurer or health plan overpayment recovery efforts are based on a reasonable belief that fraud, abuse, or other intentional misconduct was committed;*
- *When the recovery of the overpayment is required by, or initiated at the request of, a self-insured plan;*
- *When the recovery of the overpayment is required by a state or federal government plan; or*
- *To certain coverages excluded by the Collection Overpayment Act's definition of health plan (e.g., accident-only, credit, Medicaid plans, long-term care or disability income insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance).*

Why blue italics?

Provider recovery process

Under the Collection Overpayment Act, if Highmark Delaware seeks to collect an overpayment, the provider shall be given written notice identifying the error and providing justification for the overpayment recovery. If the provider disputes the overpayment, the provider shall notify Highmark Delaware in writing that the provider is disputing the findings. The dispute resolution process shall be in accordance with the procedures outlined in this unit for Delaware providers or, if there is a conflict, in accordance with the terms of the applicable provider agreement. During the dispute resolution process, the provider will be entitled to any relevant claims information pursuant to the Collection Overpayment Act.

For overpayments and refunds not initiated by FIPR, see the section on "Overpayments and Refunds" in the manual's **Chapter 6.7: Payment/EOBs/Remittances**.

6.8 POST-PAYMENT DISPUTE RESOLUTION PROCESS – APPEALS & EXTERNAL REVIEW

Overview

The post-payment review dispute resolution process is intended to address a multitude of disputes and provides a means whereby Highmark and the provider will resolve any disputes related to claims for services submitted to Highmark.

Any provider that treats a Highmark member has the right to dispute claims payment decisions made by Highmark. It is important to note that the dispute will be governed by the terms of the provider's contract with Highmark and not under the plan through which a member receives benefits. A provider's request for payment of services will be made directly to Highmark rather than the plan providing the member's benefits. This includes plans governed by either the Employee Retirement Income Security Act of 1974 (ERISA) or the Patient Protection and Affordable Care Act of 2010 (PPACA). Therefore, any claim dispute between a provider and Highmark arising from a provider's request for payment is solely a contract dispute between the provider and Highmark, and does not involve any other party.

In addition, benefit plans and plan sponsors are not parties to any contracts with providers. Providers are bound to the terms of their respective contracts with Highmark. Such provider contracts are not binding upon any benefit plan or plan sponsor.

Why blue italics?

What is a post-payment review dispute?

A post-payment review dispute is a dispute that arises as a result of one or more claims reviews conducted by Highmark and/or its designated agents. Post-payment review disputes include, but are not limited to, coding disputes.

A coding dispute shall mean a dispute that arises as a result of one or more claims coding reviews as conducted by Highmark and/or its designated agent and that: (a) result in a disagreement as to the appropriate code(s) assigned to a particular diagnosis and/or service rendered or supplied by Provider to a Member; and (b) has not been resolved by the parties through informal means.

Disputes regarding benefit coverage are not claim review disputes.

Anti-assignment provision

All Highmark insurance policies for members contain anti-assignment provisions. As a result, a provider cannot dispute a claim with benefit plans or plan sponsors in the event a member's benefits are denied in whole or in part unless the provider follows the appropriate steps to be the member's authorized representative for purposes of a member appeal. An assignment of benefits form is not enough, is not valid under member policies, and will not be recognized by Highmark. In addition, member appeals are separate and apart from the claim review dispute process outlined in this unit.

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6.8 POST-PAYMENT DISPUTE RESOLUTION PROCESS – APPEALS & EXTERNAL REVIEW, Continued

What Is My Service Area?

When a provider disagrees with the review findings

If the provider disagrees with the review findings, they have the opportunity to appeal the findings to Highmark and may also have external review options.

Please refer to the region-specific sections below for additional information for consideration as well as the section titled **Retroactive Denials and Overpayments**.

Appeal rights in Pennsylvania

Professional health service doctors, as defined in 40 Pa. C.S.A. § 6302, in Pennsylvania may have the right to appeal their case to the Medical Review Committee (MRC). Determinations made by the MRC are binding on both the health service doctor and Highmark. For additional information, please refer to the **Highmark Medical Review Committee (PA Only)** *section of this unit.*

The appeal rights of facility providers in Pennsylvania vary based on the type of review that was conducted:

- *Cases involving coding issues are referred to an independent review organization (IRO). For additional information, please refer to the* **Independent Review Organization (IRO)** *section in this unit.*
- *Cases involving non-coding issues are handled through Mediation or Arbitration in accordance with the terms of the provider's contract with Highmark.*

Why blue italics?

Appeal rights in Delaware

The appeal rights of professional providers in Delaware vary based on the type of review that was conducted:

- *The denial, in whole or part, of claims based on medical necessity may be appealed to the Highmark Delaware Utilization Management Program Appeal Process.*
- *The denial, in whole or part, of claims based on reasons other than medical necessity may be appealed to the Highmark Delaware Provider Services Department.*

If professional providers in Delaware are not satisfied with Highmark Delaware's final appeal decision, they have a right to appeal their case to the Delaware Department of Insurance. Determinations made by the Delaware Department of Insurance are binding on both the provider and Highmark Delaware, except the losing party in such an arbitration shall have a right to trial de novo in the Delaware Superior Court so long as notice of appeal is filed with that Court in the manner set forth by Superior Court rules within thirty (30) days of the date of the arbitration decision being rendered. For additional information, please refer to the **Delaware Department of Insurance (DE Only)** *section of this unit.*

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6.8 POST-PAYMENT DISPUTE RESOLUTION PROCESS – APPEALS & EXTERNAL REVIEW, Continued

What Is My Service Area?

Appeal rights in Delaware *(continued)*

The appeal rights of facility providers in Delaware vary based on the type of review that was conducted:

- *The denial, in whole or part, of claims based on medical necessity may be appealed to the Highmark Delaware Utilization Management Program Appeal Process.*
- *The denial, in whole or part, of claims based on reasons other than medical necessity may be appealed to Highmark Delaware Provider Services Department.*
- *Cases involving coding issues may be appealed to an independent review organization (IRO). For addition information, please refer to the* **Independent Review Organization (IRO)** *section in this unit.*

If facility providers in Delaware are not satisfied with the final appeal decision, they have a right to appeal their case to the Delaware Department of Insurance. Determinations made by the Delaware Department of Insurance are binding on both the facility provider and Highmark Delaware except the losing party in such an arbitration shall have a right to trial de novo in the Delaware Superior Court so long as notice of appeal is filed with that Court in the manner set forth by Superior Court rules within thirty (30) days of the date of the arbitration decision being rendered. For additional information, please refer to the **Delaware Department of Insurance (DE Only)** *section of this unit.*

Why blue italics?

Appeal rights in West Virginia

Professional Providers:

Professional providers who do not agree with FIPR review findings must request an appeal within the time frame stated in the Notice of Review Results Letter. Following review of the appeal, the provider will receive a determination letter explaining the findings.

If a professional provider in West Virginia is not satisfied with the appeal determination, they may have the right to request review by an independent review organization (IRO). Determinations made by the IRO are binding on both the provider and Highmark West Virginia. For additional information, please refer to the **Independent Review Organization (IRO)** *section of this unit. All available review options are subject to the terms of the Provider/Network Agreement.*

Facility Providers:

Facility providers that do not agree with the review findings must request an appeal within the time frame stated in the Review Findings Letter. Following review of the appeal, the provider will receive a determination letter explaining the findings.

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6.8 POST-PAYMENT DISPUTE RESOLUTION PROCESS – APPEALS & EXTERNAL REVIEW, Continued

What Is My Service Area?

Appeal rights in West Virginia *(continued)*

If a facility provider in West Virginia is not satisfied with the appeal determination, additional review options vary based the type of review that was conducted:

- *Cases involving coding issues are referred to an IRO. For additional information, please see the* **Independent Review Organization (IRO)** *section in this unit.*
- *Cases involving non-coding issues are handled through Mediation or Arbitration.*

All available review options are subject to the terms of the Provider/Network Agreement.

Why blue italics?

6.8 INDEPENDENT REVIEW ORGANIZATION (IRO)

Why blue italics?

Use of an independent review organization

When a provider disputes a coding decision made by Highmark or its designated agent, the provider and Highmark shall make a good faith effort to resolve the dispute by first exhausting available appeal options and shall discuss the matter with the appropriate representative(s).

Subject to the applicable Provider/Network Agreement, following exhaustion of available appeal option(s), if the provider remains in disagreement with the findings, the provider may request review by an Independent Review Organization (IRO), which may be referred to as a certified review entity ("CRE"), to perform a review and conclusively resolve the dispute.

The provider must state its intention to either accept Highmark's or its designee's findings or request review by an IRO within the time period as set forth in written correspondence, i.e., the Appeal Determination Letter. The letter will also include a list of two (2) IRO entities from which the provider must choose. All listed IROs shall be independent entities from Highmark (other than with respect to any contract with Highmark to provide IRO services).

If the provider fails to timely respond with its intention to appeal and its selection of an IRO from the list, then the parties agree that the provider shall be deemed to have accepted the decision made by Highmark or its designee, and Highmark will initiate repayment efforts up to and including performing automatic offset against future payments to recoup the stated overpayment.

The resolution process set forth herein is the sole means for resolving coding disputes.

What Is My Service Area?

Binding decision

*For providers in **Pennsylvania**, in instances where an agreement between the provider and Highmark states that the decision by the IRO shall be **final and binding on, and non-appealable by, Highmark and the provider/business owner**, each party waives its right to commence litigation as to the coding review dispute in a court of law as well as appeal the determination by the IRO of a coding review dispute to a court of law.*

*For providers in **West Virginia**, the decision of the IRO shall be final and binding on Highmark and the provider/business owner.*

Continued on next page

6.8 INDEPENDENT REVIEW ORGANIZATION (IRO), Continued

IRO fees and costs

*For **Pennsylvania** providers where a contractual agreement or a letter of agreement is in place regarding the use of an IRO, when the IRO's decision is **fully in favor of one party, the other party shall pay the entire fees and costs** associated with the IRO's review and decision. If the IRO's decision is **partly in favor of each party, the parties shall share equally the cost of the review**. If required by the IRO, Highmark and the provider shall make escrow deposits to cover the costs of the review by the IRO.*

What Is My Service Area?

IRO fees and costs

*For **West Virginia** providers, when the IRO's decision is **fully in favor of one party, the other party shall pay the entire fees and costs** associated with the IRO's review and decision. If the IRO's decision is **partly in favor of each party, the parties shall share equally the cost of the review**. If required by the IRO, Highmark and the provider shall make escrow deposits to cover the costs of the review by the IRO.*

Limitation time period

All disputes not resolved by negotiation as described in this section of this unit must be submitted to an IRO within the time period provided by the applicable limitation of time for bringing such action or proceeding as contained in the network agreement, hospital agreement, or, where applicable, federal or state law.

Why blue italics?

6.8 HIGHMARK MEDICAL REVIEW COMMITTEE (PA ONLY)

MRC overview

In Pennsylvania, any claims review dispute involving claims submitted by a health service doctor that remains unresolved may be referred to the Medical Review Committee (MRC) for consideration as required by law or the health service doctor's contract with Highmark. The MRC is made up of a variety of medical specialties and lay members.

The MRC is charged with hearing matters, disputes, or controversies relating to the professional health services rendered by health service doctors, or any questions involving professional ethics.

What Is My Service Area?

FOR MORE INFORMATION

For additional information regarding the Medical Review Committee, please see the manual's **Chapter 5.5: Denials, Grievances, and Appeals**.

Why blue italics?

6.8 DELAWARE DEPARTMENT OF INSURANCE (DE ONLY)

Appeals to Highmark Delaware

In Delaware, any provider review conducted by Financial Investigations and Provider Review (FIPR) staff that remains unresolved can be referred to the Delaware Department of Insurance (DOI) for consideration.

What Is My Service Area?

Arbitration

If a provider is not satisfied with a Highmark Delaware final appeal decision regarding reimbursement, the provider may have a right to arbitration.

If the provider is a provider as defined by 18 Del. C. §333(a)(1), the provider has the right to seek review of Highmark Delaware's decision regarding the final disposition of a claim(s). The Delaware Department of Insurance provides claim arbitration services, which are in addition to, but do not replace, any other legal or equitable right the provider may have to review this decision or any right of review based on the provider's contract with Highmark Delaware.

The provider may contact the Delaware Department of Insurance for information about arbitration by calling the Arbitration Secretary at **1-302-674-7322**.

All requests for arbitration must be filed **within sixty (60) days** from the date the provider receives the adverse determination from Highmark Delaware; otherwise, the Highmark Delaware decision will be final.