CHAPTER 6: BILLING AND PAYMENT

UNIT 8: PAYMENT REVIEW

IN THIS UNIT

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 maybe 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 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, or abuse.

In addition to conducting post-payment practice pattern reviews, FIPR also investigates potential member and provider fraud and abuse. Health insurance fraud 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 intention of changing the amount of health care benefits paid. Highmark's FIPR unit takes a proactive approach to detecting and investigating potential health care fraud and abuse. 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.)

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**

6.8 PAYMENT REVIEW PROCESS

Overview

Payment review 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.

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.

What is My Service Area?

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.

Audits are now conducted due to regulations established by Federal and State regulatory agencies, such as the Centers for Medicare & Medicaid Services (CMS), Federal Employee Program, and the 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.

Who is conducting audits?

Highmark's Financial Investigations and Provider Review (FIPR) audit 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, and auditors.

Due to the complexity of facility billing and payment methodologies, Highmark also uses external audit firms to assist in audit reviews of paid claims. These audits 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.

Continued on next page

6.8 PAYMENT REVIEW PROCESS, Continued

Ultimate goals of payment review

The ultimate goals of payment review are to:

- Be a deterrent to fraud, waste, and abuse by performing advanced analytical and investigational audits.
- 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, 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.

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.

When problems are identified

When a potential fraud, waste, or abuse (FWA) problem is identified, what actions are taken to correct the provider's reporting?

1. FIPR performs an investigation of the potential FWA.
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 DEFINING THE ISSUES: FRAUD, WASTE, & ABUSE

Fraud	**Fraud** is defined by state and federal laws and can include actions such as intentional misrepresentation or deception for the purpose of receiving payments that an individual or entity is not eligible to receive. **Example:** Billing for services not rendered.
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.

6.8 TECHNIQUES USED FOR INVESTIGATION

Overview	In the payment review process, Highmark employs various techniques to investigate potential issues of fraud, waste, and abuse.
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 fraud, waste, and abuse 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 audit 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 audits. They also review statistical information on payments made and compare claim coding to Highmark medical and payment policies.

Continued on next page

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 audits: 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

At this time, 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.

Continued on next page

6.8 WHEN A CASE IS IDENTIFIED, Continued

When a provider disagrees with the findings

If the provider disagrees with the audit findings, they have the opportunity to provide additional clinical documentation in support of their position and have this information considered. Or, since the initial review may have been based on a limited sampling, the provider may request an expanded, statistically-valid review involving a larger number of records. The provider may be asked to sign a Tolling Agreement under certain circumstances.

Note: Any additional clinical documentation submitted by a Delaware provider after the initial audit findings will be reviewed by a reviewer that was not involved in the initial audit findings.

Providers in Pennsylvania also have the right to appeal their case to the Medical Review Committee (MRC). Determinations made by the MRC are binding on both the provider and Highmark. For additional information, please refer to the **Highmark's Medical Review Committee – PA ONLY** section of this unit.

Providers in Delaware 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. For additional information, please refer to the **Delaware Department of Insurance – DE ONLY** section of this unit.

Providers in West Virginia have the right to appeal their case to a certified review entity. Determinations made by the certified review entity are binding on both the provider and Highmark West Virginia. For additional information, please refer to the **Certified Review Entity (CRE) – WV ONLY** section of this unit.

6.8 CLAIM AUDITS

Introduction

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

Post-payment audits

FIPR staff periodically performs retroactive post-payment audits of practices and/or specific providers who have been selected based on their utilization and billing patterns, relative to their peers. Practices, specific providers, and members may also be selected for audit 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 audited. Typically, a certified professional coder and/or registered nurse perform the audits. However, qualified external consultants may on occasion be contracted to perform such audits on behalf of Highmark.

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

Criteria used in E/M audits

In the performance of E/M (evaluation and management) audits (whether pre- or post-payment), the auditor 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).
- Practice or business owner must state in writing (by letter or email) which E/M guidelines will be used to perform the audit.
- 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).

Continued on next page

6.8 CLAIM AUDITS, Continued

Criteria used in E/M audits (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.

Treatment of under coding

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

Review of results

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

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

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

6.8 CLAIM AUDIT DISPUTE PROCESS

Claim audit dispute resolution process

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.

What is a claim audit dispute?

A claim audit dispute is a dispute that arises as a result of one or more claims audits conducted by Highmark and/or its designated agents. Claim audit disputes include, but are not limited to, disagreements between Highmark and the practice as to the appropriate code(s) assigned to a particular service or services rendered or supplied and/or diagnosis made of a Highmark member that has not been resolved by the parties through informal means. Disputes regarding benefit coverage are not claim audit disputes.

The claim audit dispute resolution process is intended to address a multitude of disputes and provides a means whereby Highmark and the practice will resolve any disputes related to claims for services submitted to Highmark.

Whenever a practice disputes a coding audit decision made by Highmark or its designated agent, the practice and Highmark shall make a good faith effort to resolve the dispute by first discussing the matter with the appropriate representative(s).

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 audit dispute process outlined in this unit.

6.8 CERTIFIED REVIEW ENTITY (WV ONLY)

What Is My Service Area?

Use of a certified review entity (CRE)

Whenever a claim audit dispute arises which cannot be resolved through discussions between the parties, the practice will receive a letter from Highmark West Virginia or its designee requesting the practice to state its intention to either accept or appeal Highmark West Virginia's or its designee's decision. The practice shall comply with all written requests for the practice's intention to accept or appeal a coding decision within a specified time period, which is **ten (10) business days**.

If the practice fails to respond to the written request to state its intention to accept or appeal a coding decision by Highmark West Virginia or its designee within the specified time period, then the parties agree that the practice shall be deemed to have accepted the decision made by Highmark West Virginia or its designee by default, and Highmark West Virginia will perform automatic offset against future payments to recoup the stated overpayment.

If the practice chooses to appeal Highmark's or its designee's audit decision, the practice shall indicate its choice to appeal and have the claim audit dispute thereafter submitted to a certified review entity ("CRE") to perform a review and conclusively resolve the dispute.

Within ten (10) business days, Highmark West Virginia shall provide the practice with a written list of two (2) CREs from which the practice may choose one CRE. The practice shall designate which of the CREs it has selected in writing (by letter or email) to Highmark West Virginia **within ten (10) business days** of its receipt of the list of potential CREs from Highmark West Virginia. If the practice fails to select a CRE **within ten (10) business days**, Highmark West Virginia shall have the sole discretion to choose the CRE by default.

The CRE shall be independent (other than with respect to any contract with Highmark West Virginia to provide CRE services). The parties agree that the resolution process set forth here is the sole means for resolving claim audit disputes.

Provision of files and additional information

Within ten (10) business days of receiving the practice's formal written request for the use of a CRE to resolve a claim audit dispute and the practice's formal written choice of a CRE, Highmark West Virginia must forward to the selected CRE a sub-sample of five (5) disputed audit records (or a greater number of audit records if mutually agreed to by both parties) pertaining to the claim audit dispute and provide notice of such action to the practice.

Within ten (10) business days of the practice's receipt of the notice that the file has been forwarded to the CRE, the practice may supply additional information to

Continued on next page

6.8 CERTIFIED REVIEW ENTITY (WV ONLY), Continued

Provision of files and additional information (continued)

the CRE for consideration and shall simultaneously provide copies of the information to Highmark West Virginia.

Highmark West Virginia shall have **ten (10) business days** after receipt of the practice's additional information to provide any further information or comments it deems relevant to the dispute to the CRE for consideration and shall simultaneously provide copies of the information to the practice.

Note: This is not intended to restrict the practice/business owner or Highmark West Virginia from providing the CRE with additional information for consideration with respect to information submitted by the other party. Copies of such additional information shall be provided simultaneously to the other party.

CRE decision

The CRE shall review and issue its decision **within thirty (30) calendar days** of receipt of the last information submitted. The decision shall be in writing and shall include:

1. A list of the information considered in reaching the decision;
2. The basis and clinical rationale for the decision; and
3. A brief statement of the decision.

What Is My Service Area?

Binding decision

The decision by the CRE shall be **final and binding on, and non-appealable by, Highmark West Virginia and the practice/business owner**. Each party waives its right to commence litigation as to the claim audit dispute in a court of law as well as appeal the determination by the CRE of a coding audit dispute to a court of law.

CRE fees and costs

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

Limitation time period

All disputes not resolved by negotiation as described in this section of this unit must be submitted to a CRE 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.

6.8 HIGHMARK'S MEDICAL REVIEW COMMITTEE (PA ONLY)

MRC process

In Pennsylvania, any provider audit conducted by Financial Investigations and Provider Review (FIPR) staff which remains unresolved can be referred to the Medical Review Committee (MRC) for consideration. The committee is made up of a variety of medical specialties and lay members.

The Medical Review Committee is charged with the following responsibilities:

- Consider unresolved matters, disputes, or controversies arising out of the relationship between the Corporation and any provider, including any questions involving professional ethics.
- Review any matter affecting the status of a health care professional as a network provider of the Corporation.
- Conduct hearing to resolve disputes involving the status of health care professionals as Participating Providers in accordance with Article IX of the Bylaws of the Corporation.
- Consider appeals by providers who are rejected or terminated as network providers in any network provider panel operated by the Corporation under Pennsylvania's preferred provider legislation.

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**.

6.8 DELAWARE DEPARTMENT OF INSURANCE (DE ONLY)

Appeals to Highmark Delaware

In Delaware, any provider audit 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.