Payment Integrity Administrative Policy:
Claim Review Program

ANNUAL APPROVAL DATE	APPROVED BY
1/1/2020	MPC (Medical Cost Steering Committee)

Overview

ConnectiCare continues its commitment to correct coding by implementing programs that result in fair, widely recognized and transparent payment policies. Utilizing a recognized industry clinical and statistical methodology, ConnectiCare evaluates the appropriateness of claims submitted to ensure they are supported by the billed CPT, HCPCS, Revenue Codes, ICD-10 code(s) and/or modifiers. ConnectiCare will review claims submitted for possible errors which may result in possible payment adjustments or denials. Providers, including facilities, will be able to submit reconsideration or appeal requests.

ConnectiCare reviews can be internal or external (also known as vendor reviews). ConnectiCare contracts with a number of vendors with expertise in areas related to coding, documentation and claim payment validation. Claim reviews may be performed on a pre-payment or post-payment review.

Claim Review Program:

ConnectiCare(CCI) actively promotes correct claims coding, including the appropriate use of Evaluation and Management (E/M) codes. To support this effort and our goal of improved physician education, CCI is initiating a claims review and education program for providers billing higher volume of high level evaluation and management codes in comparison to their like-specialty peers. We will also implement claims review for outlier or suspect claims such as surgical procedures, laboratory/pathology and modifier use. The selection of claims reviewed will be identified through analytics based on lower risk score and higher percentage of potentially up-coded visits for providers in comparison to their peers. A statistically valid sample of claims will be selected from the group of providers identified and the provider will receive a request for medical records to support the billed services.

Upon receipt of those documents, CCI will review and review the sample against billed services to determine appropriateness of level billed.
The primary concept of E/M coding is that documentation must support the services being reported (i.e., if it was not documented, it was not done). In addition to appropriate documentation, the level of service must be considered reasonable and necessary and be compliant with the standards of good medical practices.
For example, doing a complete history, physical examination, and diagnostic work up would not be appropriate for a follow-up visit involving a minor problem.

Consistent with CMS, medical necessity is the overarching criteria for code selection and must be clearly documented. Please refer to our ConnectiCare Evaluation and Management Reimbursement Policy for more detailed information.
Please Note: All modifier use must follow CMS and AMA guidelines for appropriate designation and will be reviewed.
Surgical, Operative and Pathological documentation must be complete, dictated reports that include at a minimum the following:

- Patients Name/ Date
- Name of the primary surgeon, co-surgeons and assistants
- Assistants role during procedure must be detailed for reimbursement consideration
- Procedures performed and a description of each procedure
- Findings
- Estimated blood loss
- Specimens removed
- Pre and post-operative diagnosis/indications for surgery

Laboratory and Pathology reports must include:
- Referring provider
- Rendering provider
- Specimen numbers/labels
- Clinical history
- Specimen and biopsy site/sample site information
- Diagnosis/results and gross description.

All records must be signed timely by the rendering physician and the rendering provider NPI must be included on all claims.

If CCI determines that the medical documentation submitted supports an Evaluation and Management (E&M) or other code of a lower level than what was originally paid, we will adjust the claim and recoup the incremental amount. Alternatively, if the claim does not support the service as billed, we may retract the entire payment and deny the claim. A remittance advisory describing the payment details of the adjusted claim will be sent to the mailing address we have on file for the provider. Providers who disagree with the outcome of the review may appeal.

Furthermore, Post Review documentation education may be assigned and required by the rendering provider. Failure to adhere to proper coding and documentation guidelines could result in, including but not limited to, enrollment in a pre-pay review program, referral to the Special Investigations Unit or loss of in-network status.

Revision history

DATE	REVISION
01/2020	• New Policy