ConnectiCare

Payment Integrity Administrative Policy:

Claim Review Program

REVIEW DATE:	APPROVED BY
11/14/2025	**HCCI (Health Care Cost Initiative Committee)**

Overview:

ConnectiCare continues their 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. The plan 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.

The plan 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.

Examples of claim review programs are:

- Ambulatory Payment Classification (APC) claim review
- Diagnosis Related Group (DRG) claim review
- Itemized bill reviews (outlier and stoploss payments)
- Fraud, waste and abuse reviews
- E&M and procedural correct coding reviews
- Modifier usage including modifier 59 and modifier 25

Required Documentation:

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

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Laboratory and Pathology reports must include:

- Referring provider
- Rendering provider
- Specimen numbers/labels
- Clinical history and orders
- 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. This applies to group contracts as well.

Evaluation and Management Claim Post Pay Review Program:

ConnectiCare 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, the plan will initiate 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, the plan will audit the records received and review the sample against billed services to determine appropriateness of level billed.

What is upcoding?

Upcoding is the practice of using billing or revenue codes that describe more extensive services than those performed or documented, as defined by the Centers for Medicare & Medicaid Services (CMS).

Example: CPT code 99205 (new patient, outpatient visit - highest level) is billed

Scenario: A patient who came in for a sore throat, had a throat culture, and was put on penicillin. No other conditions were assessed, treated, or coded on the claim for this encounter.

The 99205 code would require that the medical decision-making level was determined to be high or the total time for the evaluation and management service performed on the date of the encounter was 60-74 minutes in length because of medical necessity.

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A sore throat evaluation and management visit, as described above, would be more appropriately coded as 99202 (new outpatient visit lowest level) based on documentation guidelines from the CMS Evaluation and Management Services Guide. The 99202 code would require that the medical decision-making level was determined to be straightforward or the total time for the evaluation and management service performed on the date of the encounter was 15-29 minutes in length because of medical necessity.

Healthcare professionals should, consistent with standard industry practice, select the CPT code that best represents the level of service performed when submitting claims for payment.

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 andnecessary 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 Note: All modifier use must follow CMS and AMA guidelines for appropriate designation and will be reviewed.

If the review 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.

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Pre-pay E&M Review Program:

We review the use of evaluation and management (E&M) coding practices on claims submitted by participating health care providers to monitor for potential upcoding. This program is part of our ongoing efforts to help improve health care quality and affordability.

E&M upcoding evaluation process

We have developed a process for reviewing claims specific to E&M coding. As part of this process, claims are evaluated, and billing practices are compared to those of a health care provider's peers within the same primary specialty and in the same community. Statistical analysis is conducted and health care providers whose billing practices on submitted claims differ from their peer group are evaluated further.

Outreach

We may contact health care providers who differ from their peer group for further evaluation. We generally send those providers a letter and report based on our findings.
In some cases, including those when audit results demonstrate consistently high outlier utilization, a prepayment review process may be utilized.

Questions and Answers

What is the purpose of the E&M coding initiative?
As part of our process, we routinely review claims to help ensure coding and payment accuracy. This initiative was implemented to increase awareness about submitting accurate coding and appropriate charges for the services performed and documented.

How are outliers determined?
Benchmarks and outliers are determined at the market level and by the same specialty and subspecialties of the provider. Claim data is reviewed against E&M coding parameters and reports are run to identify health care providers whose claims are different than those of their peers. Providers may also be enrolled in this program after a post-pay audit.

Why did you down-code my claim without reviewing my records?
Using data collected by millions of claims the prepayment review process allows for payment of the claim at a level consistent with how the claims are coded. Utilizing all diagnosis codes on the claim a potentially more appropriate level of services is selected. If you disagree with this level of service, you may file an appeal or dispute with medical records to support the level of service billed.

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Additional information

- For additional information about CPT coding, visit the American Medical Association website
- CMS Evaluation and Management Services Guide

Revision History

Company(ies)	DATE	REVISION
ConnectiCare	11/14/2025	• Policy criteria will only apply to ConnectiCare Commercial (SM GRP/LRGE GRP/ASO) Plans for dates **on or after January 1, 2026.**
ConnectiCare	11/14/2025	• Transferred policy content to individual company-branded template. No changes to policy title or policy number.
EmblemHealth ConnectiCare	10/2021	• Added Q&A section • Reformatted and reorganized policy, transferred content to new template
ConnectiCare	1/2020	• New Policy