Purpose

To identify, prevent, and correct fraud, waste and abuse, and to facilitate accurate claim payments through prepayment and post-payment audit review processes that include medical review.

Community Health Options will analyze claims to determine provider compliance with Centers for Medicare & Medicaid Services (CMS) coding and billing rules, Community Health Options' policies, any in-place contractual agreement(s), and federal/state regulations, and take appropriate corrective action when healthcare providers are non-compliant. The goal is to "correct the behavior in need of change and prevent future inappropriate billing" (Medicare Program Integrity).

Definitions

Audit: a qualitative or quantitative review of claims, itemized bills, and medical documentation provided by healthcare providers for the purpose of ensuring such healthcare services are billed and reimbursed appropriately under the terms of the contractual agreement after all appropriate claim edits.

Healthcare providers: healthcare providers of service, suppliers, or facilities that have submitted claims to Community Health Options.

Post-payment: a claim determination made after the claim has been paid.

Prepayment: a claim determination made before claim payment.

Unsupported or undocumented charges: services billed on a claim that are not supported by the healthcare provider's medical documentation (also known as over-charge).

Related Policies

Community Health Options has the authority to review any claim at any time. Community Health Options will target error prevention efforts toward services and items that pose the greatest financial risk and that represent the best investment of resources.

Community Health Options or its designee may request medical documentation and/or full bill itemization to substantiate the treatment items, services, and supplies provided and billed by Health Core providers, in the course of conducting reviews and audits. Resources utilized include, but are not limited to, the following:

- American Medical Association Current Procedure Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) rules
- Centers for Medicare & Medicaid Services (CMS) guidelines as stated in manuals, transmittals, etc.
- CMS National Coverage Determinations (NCD) and Local Coverage Determinations (LCD)
- Food and Drug Administration
- Community Health Options policies
- Industry-standard utilization management criteria and/or care guidelines, such as MCG guidelines
- International Classification of Diseases (ICD) codes
- National Uniform Billing Committee (NUBC) and National Uniform Claim Committee (NUCC) guidelines
- Statues and regulations

Additional Documentation Request

Healthcare providers are required to submit additional documentation for claims identified for prepayment or post-payment audit within 30 days from the dated Community Health Options request notice. If additional documentation is not received, Community Health Options will complete the payment recoupment process for post-payment audit(s) or claim denials for pre-payment audit(s).

Community Health Options is not liable for interest or penalties when healthcare providers fail to submit required/requested documentation for claims prepayment or post-payment audit.

Claim Edits

Claim edits focus on service dates, revenue codes, procedure codes (CPT® and HCPCS), modifiers, Type of Bill (TOB), units of service, diagnosis, member eligibility, historical claims data, etc. Edits shall include, but are not limited to:

- Non-Covered Services
    - The service(s) is a non-covered service according to plan/policy terms and provisions.
- Authorization (Days, Level of Care, etc.)
    - Services billed without prior authorization or inconsistent with the approved authorization on file will be denied or paid at the authorized level of care. Services billed should match the medical documentation equivalent to the medically necessary care provided.
- Procedures/Charges unlisted, undocumented, or incorrectly coded
    - Unlisted, undocumented, or incorrectly coded procedures/charges must be adequately described, documented, and coded to the highest specificity to complete a diligent bill review.
- Duplicative Procedures/Charges
    - A charge that duplicates another service or supply in the billing on the same date of service.
- Coordination of Benefits
- Insurance Liability and Recovery (Subrogation)
- CMS National Coding Correct Initiative (NCCI)
    - "The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment" (CMS).
    - Source Documents: https://www.cms.gov/medicare/coding-billing/ncci-medicare
- CMS Medically Unlikely Edits (MUE)
    - "The CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate...An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. All HCPCS/CPT codes do not have an MUE" (CMS).
    - Source Documents: https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-medically-unlikely-edits
- Medicare Procedure-to-Procedure (PTP)
    - "Each edit table contains edits which are pairs of HCPCS/CPT® codes that in general should not be reported together. Each edit has a column one and column two HCPCS/CPT® code. If a provider reports the two codes of an edit pair, the column two code is denied, and the column one code is eligible for payment. However, if it is clinically appropriate to utilize an NCCI-associated modifier, both column one and column two codes are eligible for payment" (CMS).
    - Source Document: https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-procedure-procedure-ptp-edits
- Medicare Add-on Code Edits
- "An add-on code is a HCPCS/CPT code that describes a service that, with one exception (see CR7501 for details), is always performed in conjunction with another primary service. An add-on code with one exception is eligible for payment only if it is reported with an appropriate primary procedure performed by the same practitioner. An add-on code with one exception is never eligible for payment if it is the only procedure reported by a practitioner" (CMS).

- Source Document: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits
- CMS Professional Component/Technical Component (PC/TC)
    - CMS Notional Physician Fee Schedule (NPFS) Relative Value File, Professional Component (PC)/Technical Component (TC) Indicators are used to determine if a CPT® or HCPCS procedure code is eligible for separate reimbursement.
    - Source Documents: https://www.cms.gov/medicare/payment/fee-schedules/physician and https://www.cms.gov/files/document/physician-fee-schedule-guide.pdf
- CMS Global Surgery
    - CMS Global Surgery status indicators are used to determine if reimbursement is appropriate as identified in field 16 of the Addendum B. "This field provides the postoperative time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service" (CMS).
    - Source Document: https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient-pps/quarterly-addenda-updates
- CMS Ambulatory Surgical Center (ASC)
    - ASC Covered Surgical Procedures list as required by Federal Regulation (Source:47 FR 34094, Aug. 5, 1982) and maintained by CMS. Social Security Low: Title 42 Section 416.1 (2) Section 1833(i)(7)(A) of the Act requires the Secretary to specify the surgical procedures that can be performed safely on an ambulatory basis in an ambulatory surgical center. https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-payment-rates-addenda

Bill Audit Review Denial Coding

Bill Audit Review Summary Reports will be sent to the healthcare provider that identifies the billing and coding errors not eligible for reimbursement. Line-item denial codes include, but are not limited to the following:

Edit Code	Short Description
1500	Provider-Based Billing
10a	Service included in the overall management of the patient
15a3	Unbundled from the global surgery procedure charge
16F	Med dispensed outside of paradigm or clinical guide.
16g	Diluent solution unbundled
16h	Basic IV support supplies and solutions
1a1	Drug admin unbundled from nursing incremental
1a2	Unbundled from the nursing incremental charges.
1b	Routine floor stock item unbundled
1c	Routine equipment unbundled from room charge
1c3	Component equipment unbundled
25a	Charge not adequately coded or described
25b	Charge excluded from contracted arrangement
26c	Charge not supported by medical record
2a	Unbundled from specialty core room charge.
2a1	Oxygen and/or administration of oxygen should not be billed.
2b1	Oxygen and/or administration of oxygen should not be billed in specialty care beds (ICU, CCU, NICU, etc.).
4a1	Routine supplies unbundled from the global OR charge
4b1	Routine supplies unbundled from the global OR charge
4b3	Routine supplies, unbundled from OR Charge
4c1	Portable and Stat charges not covered in OR
4cs	Unbundled from global OR services
4r1	Routine equipment, unbundled

5a1	Unbundled from nursing incremental
5b	Routine supplies unbundled from recovery charge
5c	Unbundled from recovery charge
8b	Unbundled from global anesthesia charge
9b1	LOCM is unbundled from the diagnostic test performed.
AOCP	Add on code -pair missing
ASC	Procedure not supported in ASC setting
DD	Care day denied on prior authorization
doc	Medical records required
dup	Duplicate charge
HAC	Hospital Acquired Condition / Preventable Adverse Event
HCPCS	Procedure code invalid or missing
LOC	Level of Care adjustment
MedNec	Not clinically appropriate
MM_El	Service denied experimental/investigational
MM_MND	Medical necessity not supported by documentation
MMdoc	Medical records required
MUE	Frequency procedure
NCS	Non-Covered Benefit
Obs	Service lacks info or has submission/billing error
O	Not paid separately when the patient is an inpatient.
PA	Service not authorized
PAEx	Prior authorization exceeded
pc0	Code should be billed on a professional claim form for payment consideration
pc5	Code is deemed incident to another service
PD1	Determination based on the provisions of the insurance policy
PL1	Drug qualitative day limit reached
PL2	Drug quantitative day limit reached
PTP	Unbundle Pairs - Mutually Exclusive
UDT	Not reimbursed when billed as individual tests
unbl	Unbundled from primary code per NCCI

Bill Review Summary

Community Health Options notifies the healthcare provider of bill audit review findings and makes appropriate referrals for provider outreach and education, in a collaborative effort to reduce improper billing. Healthcare provider notification comes in the form of a claim remittance advice and in many cases a Bill Audit Review Summary. "Direct communication between Community Health Options and the provider is an essential part of solving problems. This process is carried out through written communication or by telephone because of specific claims or a group of reviewed claims. The overall goal of providing notification and feedback is to ensure proper billing practices and appropriate consideration of coverage criteria so claims will be submitted and paid correctly" (Medicare Program Integrity).

Conclusion

Healthcare providers (facilities, physicians, and other healthcare professionals) are responsible for accurately and timely: documenting, billing, and coding by following industry standard guidelines, including but not limited to AMA, CPT, HCPCS, CPT Assistant, NUBC, Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Policy Manual, NCCI table edits and other CMS guidelines for appropriate claims review processing by Community Health Options.

References/Resources

Medicare Program Integrity Manual, Chapter 3: https://www.cms.gov/Regulations-andGuidance/Guidance/ Manuals/downloads/pim83c03.pdf

Related Policies

Coordination of Benefits
Facility Revenue Code Requirements
Hospital Outpatient Observation
Itemized Bill Submission
Modifier Reference Guide
National Drug Code (NDC) Billing Requirements
Professional Services
Routine Supplies, Services, & Equipment
Unlisted / Unspecified / Miscellaneous Codes

Document Publication History

- 6/23/2023 Annual review; added to related policies section and updated source links as needed
- 7/1/2022 Annual review; updated denial coding list
- 4/26/2021 Added ASC to the Claim Edit list, expanded conclusion, expanded Related Policies section, removed CARC/RARC from Denial Coding section due to upcoming changes, and updated Denial Codes.
- 9/9/2019 Initial publication