Coding Policy Policy and Procedure		
SUBJECT: Coding Policy 59.0 Claims Coding Audits	DEPARTMENT: **Special Investigations Unit**	
ORIGINAL EFFECTIVE DATE: 03/2004	DATE(S) REVIEWED / REVISED: 1/05, 1/06, 1/07, 1/08, 01/09, 01/11, 01/12, 01/13, 01/14, 06/14, 01/15, 01/16, 01/17, 01/18, 01/19, 01/20, 01/21	
APPROVED BY: Coding Policy Review Committee	NUMBER: **MC 59.0**	PAGE: **1 of 3**

SCOPE:
Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:
Health Plan Providers
All Lines of Business

POLICY:
Incomplete or illegible records may result in denial of payment for services billed to Company. Claim payment decisions that result from a coding audit and/or medical review of a practitioner's records are not a reflection on the practitioner's competence as a health care professional or the quality of care provided to patients. Specifically, the results are based on review of the documentation that Company received. To support a valid claim, there must be sufficient documentation in the provider's or hospital's records to verify the services were performed, were "reasonable and necessary," and required the level of care that was delivered. In addition, the documentation must reflect the ICD-10 diagnosis codes submitted on the claim. (See also Coding Policy 58.0.)

PROCEDURE:
Company has developed audit programs designed to concurrently (prepayment) and retrospectively (post-payment) review claim submissions with medical record documentation to determine appropriate reimbursement and to ensure compliance with standard procedure (CPT and HCPCS codes) and diagnosis (ICD-10) coding, billing, and documentation guidelines. If such a review determines that an overpayment has occurred, Company will notify providers in writing, identifying the claim(s) which generated the overpayment. A recoupment process may be initiated at Company's sole discretion should the provider fail to respond or cooperate.

When records are requested, providers are required to send all documents that support the billed services within the time frame designated in the written request. Documentation substantiating the medical necessity for treatment must be in the medical record. Documentation of all services rendered is absolutely necessary for a claim to be properly evaluated. If there is no documentation, then there is no justification for the services billed. Additionally, if there is insufficient *or* illegible documentation submitted to support claims that have already been adjudicated by Company, reimbursement may be considered an overpayment and the funds may be partially or fully recovered.

AUDIT PROCESS:
Medical Records Requests
When Company conducts a claims review or audit, providers are required to submit medical records upon request, either retrospectively or concurrently. Providing medical records to Company for an audit is not a Health Insurance Portability and Accountability Act (HIPAA) violation. It is important to

respond to a medical record request in a timely manner and to send all records to support the services billed in compliance with Company policy. Company may initiate a recoupment process against providers who do not respond to a request from Company for medical records. Providers who have questions are advised to contact Company at the number specified on the request and within the time frame specified in the letter.

Medical records may be downloaded to a password encrypted CD (preferred). For claims reviewed concurrently or on a prepayment basis, the request for medical records will be reflected on an Explanation of Payment (EOP) designated by the EOP message. For claims reviewed retrospectively or on a post-payment basis, a letter will be sent to the provider requesting the required records.

Determining Which Claims to Audit

Health Plan Auditing is a statutory mandated compliance activity and/or specific Benefit Program requirement. When choosing to audit, Company considers a number of factors, including, but not limited to, the following:

- Requirements for Office of the Inspector General (OIG) reviews, as set forth in laws, regulations, or other directives
- Requests made or concerns raised by CMS, Medicaid, Noridian Medicare and OIG Work Plan
- Requirements and guidelines for CPT, HCPCS, /ICD-10, UB-04 and APR-DRG assignments
- Management's actions to implement recommendations from previous reviews
- Internal and external referrals

Reimbursement Information

Providers are reimbursed according to the Company contractual agreement and are subject to payment edits that are updated at regular intervals. Payment edits are generally based on the following source documents: Current Centers for Medicare & Medicaid Services (CMS) guidelines

- National Correct Coding Initiative (NCCI) (MUE)
- Current Procedural Terminology (CPT)
- Current Healthcare Common Procedure Coding System Level II (HCPCS)
- Current International Classification of Diseases (ICD-10-CM)
- Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSMIV)
- Current Uniform Billing Editor (UB 04)
- All Patient Refined Diagnosis Related Groups (APR-DRG)
- Company Claims editing logic
- Specialty Society Guidelines and
- FDA guidelines and Drug manufacturers' package label inserts as appropriate

Reimbursement is subject to member eligibility and benefits on the date of service, benefit limitations, coordination of benefits, claim edits logic authorization and utilization management guidelines when applicable, medical record documentation, appropriate coding, and adherence to plan policies and procedures.

Provider Education

Although providers are responsible for coding services and billing claims appropriately and maintaining supporting documentation, Company offers ongoing provider education, information, and resources throughout the year. This includes, but is not limited to:

- Orientation sessions
- Visits by Company staff (Network Management, Quality Management, Risk Adjustment Management)
- Correspondence from Company Medical Directors, External Audit, and Medical Coding Compliance Department
- Provider Manuals
- Information shared throughout the year via:
  - Providence Health Plan’s web site (ProvLink)
  - Provider Newsletters (Connections, Medical Policy Alerts)
  - Payment Policies
  - Edit Reviews
  - Provider Manuals
  - Quality Medical Management/ Credentialing Management Representative site visits

REFERENCE:

CMS/Medicare Rules and Regulations
Current Procedural Terminology (CPT)
Providence Health Plan Coding Edits
Providence Health Plan Coding Policy MC 58.0 Documentation Guidelines for Medical Services
Providence Health Plan Coding Policy MC 61.0 Documentation Guidelines E&M Codes Based on Time
Providence Health Plan Coding Policy MC 60.0 Documentation Guidelines Amended Notes