

Post-Payment Utilization Review

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The post-payment utilization review process

Post-payment utilization review is a key element of the overall utilization screening process Highmark Blue Shield uses to assure that its members receive health care services that are medically necessary and that the claims for these services are submitted properly.

Which providers are reviewed?

We are required to monitor all providers in our Participating, Preferred and Managed Care networks throughout Pennsylvania and the contiguous states.

There are three phases in Post-payment utilization review.

As part of our initial **claims review**, Highmark Blue Shield staff reviews each claim for easily identifiable errors and services claimed for payment that are not covered in a customer's benefit package. Frequently, Highmark Blue Shield pays for eligible services, even though a more extensive review of the provider's practice pattern may take place at a later time.

Pre-payment utilization review takes place before we pay the claim. Here, staff looks closely at selected claims to determine the medical necessity of the services reported. As in the initial claims review process, Highmark Blue Shield may conduct further review after the provider is paid.

Retrospective or post-payment utilization review takes place after we pay the claim. Frequently, post-payment utilization review cases involve long-term tracking and monitoring of many services rendered by providers.

History of post-payment utilization review

Highmark Blue Shield initiated post-payment utilization review in 1962 in cooperation with the Pennsylvania Insurance Department. Since that time, it has increased in importance, not only at Highmark Blue Shield, but in the entire health care industry.

Ultimate Goals of post-payment utilization review

- Enforce our contracts with all health care professionals.
- Ensure the payments are made consistent with medical policy.
- Educate our provider community on appropriate reporting and "Best Practice" guidelines.
- Identify and stop aberrant reporting.
- Be a deterrent to overutilization, underutilization and misutilization by providing a sentinel role.

In rare instances of suspected fraud, Highmark Blue Shield's Special Investigations unit tracks claim reporting, collecting information that may become evidence for law enforcement officials or the courts.

Professional consultants support and advise Highmark Blue Shield personnel in these post-payment utilization review activities.

When a problem is identified, what actions are taken to correct the provider's reporting?

- The provider is notified of our findings.
- No matter what the case... overutilization, underutilization or misutilization, through our education efforts, the provider is requested to correct their reporting pattern.
- If necessary, monies are requested to be refunded.

Defining the issue: overutilization, misutilization and underutilization

Overtutilization is the unnecessary or the repetitive performance of an eligible service, which either is not medically necessary, or is not in accordance with the accepted practice of medicine in the community.

Misutilization is the reporting of services not performed, the reporting of an ineligible service or the upgrading of a service to obtain a higher fee. This may involve fraudulent actions by either a member or provider.

Underutilization is the failure of the provider to furnish care and services when medically necessary in sufficient detail to ensure that members receive needed services to which they are entitled.

Identifying and investigating potential utilization problems

Along with identifying them on their own, Highmark Blue Shield receives leads on potential utilization problems from several sources. A provider may be identified through our normal statistical review process or by referrals from member complaints, customer groups, professional provider groups, other insurance agent plans, outside interested parties and other departments within the company. All complaints are pursued to resolution.

Several different techniques are used to investigate potential problems. They include:

Routine surveys of paid claims. Following generally accepted auditing principles, Highmark Blue Shield routinely surveys a percentage of all claims it receives. Our staff verifies the claims' accuracy by gathering information from hospital record rooms, providers' offices or members.

Special surveys. Surveys are performed as a result of discrepancies uncovered during our reviews. A number of representative claims are selected from all those submitted by a particular provider. Each claim is then verified through member interviews or on-site record reviews.

Statistical review of cumulative claims payment data. Highmark Blue Shield has developed a state-of-the-art utilization review system called ULTRA (Utilization Trends, Reporting and Analysis). ULTRA analyzes claims data and tracks the utilization of services to detect unusual patterns of utilization, charges or payments. ULTRA sorts services in many ways, such as by the number of services performed, the site of service, the region, the specialty, the diagnosis code and more, in many unique ways.

Pre-payment review of unusual claims. Conducted before final processing and payment of a claim, these provider-specific reviews are in addition to the usual pre-payment examination of all claims. The criteria for initiating pre-payment focused reviews vary as sophistication in processing claims increases.

Examples of the criteria used are:

- Reports of unusual combinations of multiple services;
- Multiple services by the same provider during one hospitalization;
- In-hospital medical care reported by several providers for the same case;
- Claims from providers whose practices are under review as a result of other utilization activities.

Special research studies. Highmark Blue Shield 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.

Our professional consultant program involves over 250 independent health care professionals who provide their perspective on issues of medical policy, clinical guidelines and unusual claims.

Quality of imaging films. Periodically reviews of imaging films will be conducted to ensure the quality of services provided to members. Films, selected at random, will be reviewed by an appropriate professional consultant.

Post-payment utilization review case procedures: what happens after a case is identified?

When a potential problem is identified, a review is initiated. A review can be closed at any time, if the information developed satisfactorily explains the initial problem detected. Routinely, we review information, including up to two (2) years of reportings. In certain circumstances, however, we may review up to four (4) years which is permitted under the Statute of Limitations in Pennsylvania.

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 utilization to his peers.

If irregularities are found (for example, the provider is performing more of a particular service than his or her peers), our first action will be to inform the provider of the irregularities through a letter or face to face meetings. In the letter, we will identify possible problems and include a statistical report to demonstrate where the provider may want to alter his, or her, pattern of practice.

On-site review: If warranted, on-site reviews may be conducted. This usually includes obtaining copies of clinical records.

Patients also may be interviewed by a staff representative to verify that services were performed as reported. Or, if the patient's age or condition precludes an interview, the representatives may interview the patient's relatives, as appropriate. These interviews usually are necessary only when office or home services are involved.

The interview seeks answers to four basic questions:

1. For what medical problems did you visit the provider?
2. When or approximately how often did you see the provider?
3. What services do you recall that the provider performed?
4. Were there any services for which you made payment yourself?

Our representatives are trained to avoid making any improper comments about the provider or to comment on the quality or appropriateness of treatment the member received. They always clearly identify themselves and present their contact with the member as a routine verification of services which have been paid by Highmark Blue Shield.

Discrepancies between information reported on the claim form and the member's recollection of the services performed are pursued carefully during any interview. Representatives make every effort to assess the reliability of persons interviewed and the accuracy of their statements.

Post-payment utilization review specialists

Post-payment utilization review specialists examine and summarize hospital and office records and reports of on-site record reviews. They also review statistical information on payments made, and prepare summaries of individual treatment patterns for a random selection of patients covering a period of at least one year.

Review by professional consultants

Although not required in every case, a professional consultant may be used to review documentation and provide a written opinion. Sometimes this is done at the request of the provider.

Professional consultants are contracted as Business Affiliates who are actively practicing health care professionals, representing every major professional specialty and discipline. These 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 services, and
- Provide written medical opinions regarding provider practice patterns and utilization.

Referrals to consultants involve two separate and distinct types of review, **pre-payment** and **post-payment**. **Pre-payment** reviews are performed on the medical necessity or appropriateness of service(s) or procedure code(s) prior to claims payment. **Post-payment** review involves utilizing professional consultants to review practice patterns and utilization. In these situations we are generally requiring their opinion as to the medical necessity of the services rendered, whether the documentation in the medical records supported the services billed and, if not, what services should have been reported?

In order to assure the credibility of these reviews, we always make every effort to use a consultant of the same specialty or subspecialty, similar practice (i.e., a provider in a small office practice would be reviewed by a consultant with a similar practice), and different geographic location to attempt to ensure that the provider being reviewed receives a completely unbiased review.

Provider contact and education

At this time, the provider is contacted by a Provider Relations representative to discuss the statistical data, the individual treatment patterns, the professional consultant's opinion, provide education on future reporting and, if necessary, obtain a refund of overpaid monies. If Highmark Blue Shield has determined a refund is due, the representative will inform the provider of the amount of the refund request and the provider's options for repayment.

What if the provider disagrees?

If the provider disagrees with our findings, a second review by a consultant may be requested. Or, since the initial review may have been based on a limited sampling, an extended statistically valid review involving a larger number of records, to be reviewed may be requested. In either case we would advise the provider that the overpayment may increase or decrease. Also, we inform network providers that they have the right to appeal their case to the Medical Review Committee.

The Medical Review Committee

Any UR case remaining unresolved between Highmark Blue Shield and the provider is referred to the Medical Review Committee (MRC) for consideration. The committee is made up of a variety of degree specialties and laymembers. The Review Committee Selection Committee is responsible for appointing MRC members.

This committee, under the Highmark, Inc. Bylaws, is charged with the following responsibilities:

- to consider of all 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 hearings 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

Determinations made by the committee are based on current medical practices and Highmark Blue Shield medical policy. The MRC is empowered to take a wide range of actions to resolve disputes. A provider has the right to be present throughout the proceedings and may be represented by legal counsel. MRC consideration is the provider's final level of appeal.

In considering any matter brought before it, the MRC may take any one or more of the following actions:

- refer the case for recommendation or action by any appropriate committee, board or division of the state professional society or local professional society of the provider involved;
- refer the matter to an appropriate law enforcement officer or agency of the Federal, State, or any Local Government if the Committee has probable cause to believe that the provider involved secured payment from the Corporation for services performed by the provider for a subscriber on the basis of material false information submitted to the Corporation with the intention of defrauding it;
- refer the matter to the state professional licensure board of the health care professional involved;
- render a finding that the Corporation is entitled to a refund of fees paid to the provider;
- render a finding that authorizes the Corporation to collect any refund by withholding future payments due from the Corporation to the provider involved and/or;
- render such a decision or take any other such action as may be necessary or appropriate to fully resolve any dispute presented to the Committee.

Resolution

Following a decision by the MRC, Highmark Blue Shield contacts the provider to resolve the problem. This may require a change in the providers reporting practices and a refund of overpayments.

Manipulation/Physical Therapy (MTPT) Services

Some groups require that MTPT services be reviewed. When required, you will need to submit therapy treatment plans (form 3861) for manipulation and or physical therapy services that exceed fifteen (15) medically necessary services per patient per calendar year. However, if a patient has both physical and manipulation therapies as covered benefits, there will be a fifteen (15) session threshold for physical therapy services (not performed as part of a manipulation service) and a separate fifteen (15) visit threshold for manipulation services.

Manipulation Therapy

For services provided prior to October 7, 2002, only one manipulation encounter will be eligible per day and should be reported utilizing the appropriate combination code S8901-S8910. However, for services provided after October 7, 2002, these codes are no longer valid for reporting services to Highmark Blue Shield. Do not report codes S8901-S8910 for manipulation therapy services. Instead, report the procedure code that is most appropriate for the individual services performed, for example, 98925-98929 or 98940-98943.

The manipulation codes include a pre-manipulation patient assessment. This means an evaluation and management (E/M) service should be reported separately only in these instances:

- the initial examination for a new patient or new condition,
- an acute exacerbation of symptoms or a significant change in the patient's condition, or,
- distinctly different indications unrelated to the manipulation.

You may report additional evaluation and management services if the patient's condition requires a significant, separately identifiable evaluation and management service, above and beyond the usual pre- and post-service work associated with the procedure. Report these evaluation and management services with a '25' modifier. Include documentation in the patient's medical record to support the necessity of the additional evaluation and management service.

Payment will not be made for procedures or modalities that are performed solely to prepare the patient for a manipulation procedure. This includes application of hot or cold packs (97010) and massage therapy (97124). Do not report these services separately when they are performed in conjunction with a manipulation procedure.

Manual therapy techniques (97140) are considered components of a manipulation. Separate payment will not be made for these services when performed in conjunction with a manipulation procedure.

When codes 97010, 97124 or 97140 are reported for a separate body region unrelated to the manipulation procedure, separate payment will be considered.

Codes reflect medical decisions

The typical manipulation service for a patient includes:

- a progress report from the patient and a brief physical examination which determines the method, location and intensity of the manipulation, if it is medically indicated.
- physical therapy, (e.g., heat, muscle stimulation, massage, trigger point stimulation, traction, etc.), which is often performed as an adjunct to manipulation, is also considered a component of a manipulation encounter.
- "active" rehabilitative procedures (procedure codes 97112-97116) are eligible in addition to the manipulation if medically indicated. A non-traumatic condition with no herniation does not require "active" rehabilitation in most patients.

We recognize that appropriate treatment may vary by patient and by condition. This threshold of fifteen (15) is designed to adequately cover the needs of most patients, without inundating providers' offices with paperwork. Unless there is a contractual limit to the contrary, all medically necessary manipulations will be reimbursed. Therefore, post-payment utilization review will continue its current practice of auditing claims and patient records to determine that care rendered is medically necessary. This will occur in all scenarios (including treatment plans of less than fifteen (15) sessions).

Physical therapy and rehabilitation services

Procedure codes W9715 and W9720 will no longer be valid for reporting services effective October 7, 2002. Do not report codes W9715 or W9720 for physical therapy and rehabilitation services performed on or after October 7, 2002. You should report the procedure code most appropriate for the individual service you perform, for example, 97010 - 97799.

Reimbursement may be made for physical therapy when it is performed with the expectation of restoring the patient's level of function that has been impacted by illness or injury. Maintain written treatment plans in the patient's medical records.

To maintain appropriate and reasonable payments for these therapy services, a review of the allowances associated with these procedure codes may occur and, as a result, minor adjustments may be made.

Note: These coding changes will not impact the current treatment plan review requirements.

The patient's records must include documentation to support the level of complexity represented by the code reported. The distinguishing criterion among the levels of codes is the complexity of medical decision-making. The total time spent with the patient or an extensive period of physical therapy does not necessarily indicate a presenting problem of greater severity warranting a higher level of reimbursement. Only a documented increase in the level of complexity in medical decision-making would result in a higher level of reimbursement. For our traditional indemnity products the therapy treatment plan review process is not a preauthorization/predetermination program. For this reason, it is extremely important that you submit the treatment plan as soon as it is determined that the patient will require more than fifteen (15) services. Do not wait until the fifteenth (15) service has occurred. Also, if you know that the patient will not require fifteen (15) services, a treatment plan will not need to be submitted.

Therapy Treatment Plan

To assist you with completing the treatment plan form, please refer to the following definitions of degrees of severity when indicating a mild, moderate, or severe condition:

Mild: neck/back extremity pain, stiffness or tenderness only, with minimal functional loss and minimal musculoskeletal signs.

Moderate: neck/back/extremity pain with moderate functional loss and significant musculoskeletal signs.

Severe: neck/back/extremity pain with marked to total functional loss, and major musculoskeletal and/or neurological signs.

- 1) Musculoskeletal signs may include:
 - a) point tenderness
 - b) decreased range of motion
 - c) significant palliative and/or provocative positions and movements
- 2) Neurological signs may include:
 - a) aberrant deep tendon reflexes and pathologic reflexes
 - b) weakness
 - c) sensory deficits
 - d) balance/coordination difficulties
 - e) cognitive deficits
- 3) Functional recovery:
 - a) *minimal function loss*: pain and/or injury and/or impairment which reduces the intensity of a person's usual activities.
 - b) *moderate functional loss*: pain and/or injury and/or impairment which significantly reduces the intensity, frequency and/or duration of a person's usual activities.
 - c) *total functional loss*: pain and/or injury and/or impairment which completely precludes a person's usual activities.
- 4) Treatment protocols based on injury/condition severity.
 - a) *Mild*:
 - Manipulation/mobilization and/or other physical medicine procedures.
 - Reassurance and education on proper body mechanics for performance of usual activities, and/or lifestyle modifications.
 - Rehabilitative (active) procedures generally not required.
 - b) *Moderate*:
 - Manipulation/mobilization and/or other physical medicine procedures
 - Reassurance and education on proper body mechanics for performance of usual activities, and/or lifestyle modifications.
 - Rehabilitative procedures (1-5 sessions) for demonstration and instruction of home based exercise programs.
 - c) *Severe*:
 - Manipulation/mobilization and/or physical medicine procedures.
 - Reassurance and education on proper body mechanics for performance of usual activities, and/or lifestyle modifications.
 - Patients may require more extensive and/or more intensive supervised rehabilitation with defined protocols.

Maintenance Programs

Therapy performed repetitively to maintain a level of function is not eligible for reimbursement. A maintenance program consists of activities that preserve the patient's present level of function and prevent regression of the function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved or when no additional functional progress is apparent or expected to occur.

Electronic billers

Treatment plans **cannot be submitted electronically**. Please send completed treatment plans to the address/fax number listed below.

Submission of claims/treatment plans

Please complete all applicable fields on the treatment plan form. You may list the physical examination findings and statement of goals on a separate printout and attach it to the treatment plan form if you choose. If you provide insufficient documentation or fail to complete vital fields on the form, we may either deny payment for the services described on your treatment plan, or, return it for corrections if:

- The wrong form is used, or the form is not included
- Any applicable section of the form is left blank
- The treatment plan information is illegible or incomplete

Therapy Treatment Plan Forms may be mailed or sent via facsimile (facsimile is preferable up to a maximum of ten (10) pages). Please do not fax any unrelated documents with the form, e.g., claims, etc.

When submitting treatment plans through the mail, please do not copy the forms. The distinctive green color is designed for easy recognition by our claims processors. Submitting copies of our form or submitting a form of your own creation will slow down processing and result in payment delays.

Treatment plans for our Traditional Indemnity and Central PPO lines of business (for professional/non-facility related only), should be mailed or faxed as follows:

Fax– 1-717-302-2101

Toll free fax – 1-866-286-8215

Highmark Blue Shield
PO Box 890140
Camp Hill, PA 17089-0140

* If you are mailing the form, you must use Form 3861 which is on green paper.

To order additional 3861 forms, complete form MA558 and send it to our Shipping Control department at:

Highmark Blue Shield
Shipping Control
P.O. Box 890089
Camp Hill, PA 17089

