

Chapter 6

Policies and Procedures

Unit 3: Post-Payment Review

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6.3 Post-Payment Review Process

The Review Process

Post-payment practice pattern review is a key element of the 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.

Three Phases of Practice Pattern Review

1. Initial claims review - Highmark Blue Shield staff, or Blue Cross of Northeastern Pennsylvania staff if your main practice is located in the 13-county Northeastern Region, audits 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.

2. Pre-payment practice pattern review - staff looks closely at selected claims before the claim is paid in order 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.

3. Post-payment practice pattern review - staff looks closely at selected claims for multiple years after the claims have been paid in order to determine medical necessity and appropriateness of the services reported. These type cases involve long-term tracking and monitoring of many services rendered by providers.

History of Post-Payment Review

Highmark Blue Shield initiated post-payment practice pattern 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 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.
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6.3 Post-Payment Review Process, Continued

**Ultimate Goals
Of Post
Payment
Review,
(continued)**

In rare instances of suspected fraud, Highmark Blue Shield's Special Investigations unit, or Blue Cross of Northeastern Pennsylvania if your main practice is located in the 13-county Northeastern Region, 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 practice pattern review activities.

**When Problems
Are Identified**

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 educational efforts, the provider is requested to correct his or her reporting pattern.
 - If necessary, at the conclusion of the practice audit, monies may be requested to be refunded.
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6.3 Defining the Issues: Overutilization, Misutilization and Underutilization

Defining The Issues

Overutilization is the unnecessary or 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 includes 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.

6.3 Techniques Used for Investigation

Techniques Used For Investigation

1. 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 hospitals' medical records department, providers' offices or members.

2. 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.

3. Statistical review of cumulative claims payment data. Highmark Blue Shield has developed a state-of-the art practice pattern 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.

4. 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 post-payment practice pattern monitoring activities.

5. 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.

6. 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.

6.3 When A Case Is Identified

Process: When A Potential Problem Is Identified

When a potential problem is identified a case audit is initiated. This case 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 reporting. 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 post-payment practice patterns to his peers.

If during the audit 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, an on-site audit 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.

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6.3 When A Case Is Identified, Continued

Post-Payment Practice Pattern Review Specialists

It is the responsibility of the post-payment practice pattern review specialists to examine and summarize hospital and office records and reports of on-site audits. 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. 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.

Professional consultants are contracted as Business Affiliates who are actively practicing health care professionals, representing major professional specialties and disciplines. 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 audits, pre-payment and post-payment. Pre-payment practice pattern audits are performed on the medical necessity or appropriateness of service(s) or procedure code(s) prior to claims payment. Post-payment practice pattern audits involve utilizing professional consultants to review overall practice patterns. 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 the level of care. If they don't, we will ask the consultants what services, or level of care, 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), different geographic location to attempt to ensure that the provider being reviewed receives a completely unbiased review. Additionally, our consultants are currently in active practice to assure they are aware of the latest developments in their specialties.

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6.3 When A Case Is Identified, Continued

**Provider
Contact And
Education**

At this time, the provider is contacted by a Provider Relations representative to discuss several items: 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.

**When A
Provider
Disagrees With
The Findings**

If the provider disagrees with our audit findings, they have the opportunity to provide additional clinical documentation in support of their position and have this information considered. Or, since the initial review may have been based on a limited sampling, an expanded statistically valid review involving a larger number of records may be requested. Also, the providers are advised that they have the right to appeal their case to the Medical Review Committee (MRC). They are also advised that the determinations made by the MRC are binding on both the provider and Highmark Blue Shield.

6.3 Highmark's Medical Review Committee (MRC)

MRC Process

Any provider audit conducted by the post-payment practice pattern review or higher reimbursement area which remains unresolved can be referred to the Medical Review Committee (MRC) for consideration. The committee is made up of a variety of degree specialties and lay members. The Medical Review Committee, under the Highmark Inc. Bylaws, is charged with the following responsibilities:

- *to consider unresolved 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*

For more information on the Medical Review Committee, please visit the [Introduction of the Highmark Blue Shield Office Manual.](#)

6.3 Special Investigations Unit

Overview Of The SIU

In addition to conducting post-payment practice pattern reviews, Highmark also investigates potential member and provider fraud and abuse.

The Special Investigations Unit's mission is to maintain the integrity of member and provider claims submitted to Highmark, its subsidiaries, affiliates, and employees through proactive detection and investigation of potential fraud and abuse. When necessary, Special Investigations takes internal and/or external corrective action to assist Highmark in continuing to provide quality, affordable health care to all its clients.

For more information on the Special Investigations Unit, please visit www.highmark.com. Click the tab titled 'About Highmark,' then on the bottom of this page click '[We Fight Fraud](#)'.

Highmark established a Fraud and Abuse Hotline so that members and providers can notify Special Investigations of potential fraud/abuse. The fraud hotline is automated and allows anyone to leave a message 24 hours a day, seven days a week.

The Highmark Fraud and Abuse Hotline telephone number is: 1-800-438-2478.
