# Review of Provider Claims Payment Policy

## Applicability

This Policy applies to the following Fallon Health products:

☒ Fallon Medicare Plus, Fallon Medicare Plus Central (Medicare Advantage)
☒ MassHealth ACO
☒ NaviCare HMO SNP
☒ NaviCare SCO (Medicaid-only)
☒ Summit Eldercare PACE
☒ Fallon Health Weinberg PACE
☒ Community Care (Commercial/Exchange)

## Policy

This policy establishes the basic framework for Fallon Health or it's designee to analyze claim data and confirm that claim submissions accurately represent the services provided to members, and to ensure that billing is conducted in accordance with Official Guidelines for Coding and Reporting and Coding Clinic or when applicable Current Procedural Terminology (CPT) guidelines, verifying and other applicable standards, rules, laws, regulations, contract provisions, and payment policies.

The Plan or via its designee will conduct a post payment review of claim payments and medical records to determine if claims have been submitted accurately and are being reimbursed correctly by verifying that charges billed are documented, ordered, and accurate verifying that codes assigned and charges billed are documented. The reviews will reconcile charge data on a provider's claim with the provider's medical and clinical documentation. Claim payments that are found to be inconsistent with Plan policies will be retracted.

In alignment with CMS standards, medical records must contain information to justify treatment, admission or continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. Medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided. All records must document relevant medical history, updated examination of the patient, admitting diagnosis, consultative evaluations, complications, informed consent, discharge summary, final diagnosis with completion of medical records within 30 days following consultation or discharge. All corrections of medical records must be made within 30 days following consultation or discharge. When an error is made in a medical record entry, proper error correction procedures must be followed for both paper and electronic records. For example, for paper records, a thin pen line should be drawn through the incorrect entry to make sure that that the inaccurate information is still legible. The provider must state the reason for the error, document the correct information, and sign and date the correction. The original entry must not be obliterated or otherwise altered by blacking out with marker, using white out, writing over an entry, or by other means. For electronic records, use an addendum to identify corrections due to errors. Documentation should include only acceptable standard abbreviations from Jablonski's or Dorland's Dictionary of Medical Acronyms & Abbreviations. Documentation inserted or altered beyond 30 days of discharge or review notification is issued to the provider will not be considered.

Signed Business Associate Agreements are obtained for any vendor conducting post payment review(s) on the Plan's behalf.

This policy applies to all parties that submit medical claims to the Plan for reimbursement.

In general, post payment reviews are conducted with final paid dates in the current or previous calendar year.

Plan members have agreed to give the Plan the right to obtain from any source all medical records or other information that is needed, in accordance with the Plan Evidence(s) of Coverage. If this Plan member release is in conflict with any other law or regulation governing release of medical information, the Provider will identify the conflict and work with the Plan to resolve the conflict.

All personnel involved in the post payment reviews shall maintain a professional, courteous manner and shall resolve all misunderstandings amicably and directly with each other if at all possible.

Parties to an post payment review shall strive to eliminate ongoing problems or questions whenever possible as part of the process.

Any overpayment identified will be expected to bebe settled by the Plan and the provider within a reasonable period of time not to exceed 30 days after the conclusion of the review unless the Plan and the provider agree otherwise.

Providers will not be reimbursed for any fees associated with any of the reviews.

Providers may not bill the member for any reimbursement differences that result from the review.

For primary care provider (PCP) referral reviews :

- When a PCP refers a member to a specialist, the PCP contacts the specialist by telephone, mail, or prescription and provides the PCP's name, NPI number, the reason for the referral, and the number of visits authorized.
- This referral must be documented in both the PCP's and the specialist's medical record for the member.
- The Plan will periodically review medical records to ensure that PCP referral for specialty care was obtained. The lack of proof of PCP referral will result in the retraction of claim payment.

For hospital/facility post payment reviews:

- The Plan or via its designee will request an itemized bill for claims meeting the review criteria. Itemization will be sent within 10 days of the request.
- If selected forreview , the Hospital/Facility Representative should respond to the review request within 14 days and, unless otherwise agreed upon by both parties, schedule the review within 45 days of the initial request at a mutually agreed date and time. There is a 15 days prior notice requirement for cancellation by either party.
- Hospitals/Facilities will designate an individual(s) to coordinate all billing review activities. Duties of an coordinator include, but are not limited to, the following areas:
  A. Scheduling of the post payment review;
  B. Advising other provider personnel/departments of pending review;
  C. Verifying that the reviewer is an authorized representative of the Plan;
  D. Gathering the necessary documents for the review and ensuring that the health record is complete and in order;
  E. Coordinating the reviewer's requests for information;
  F. Coordinating the space in which the review will be conducted; and,
  G. Coordinating the access to records and provider personnel;
  H. Orienting reviewers to record documentation, provider specific conventions, and provider billing practices and policies;
  I. Acting as a liaison between the reviewer and other provider personnel;
  J. Making available any and all charge master data for reference by the Plan's designee;
  K. Conducting an exit interview with the reviewer to answer questions and review findings;
  L. Reviewing the reviewer's final written report and following up on any charges still in question or dispute;
  M. Arranging for any required adjustment(s) to bills and/or issuing refunds to the Plan.

- The Plan expects that the medical record will be complete and in order. The Hospital/Facility Representative should insure that medical records are complete and in order before the reviewcommences. Any additional documentation (i.e. ancillary records and/or logs) that supports billed charges will be available at the commencement of the review. Source documents will serve to provide further detail but should be supported by the clinical picture and will not conflict with specific documentation in the medical record.
- If the Hospital/Facility Representative identifies that an reviewer may have problems accessing records, the Hospital Representative shall notify the reviewer prior to the scheduled date of review to reschedule the date. Providers shall supply the reviewer and the Plan with any and all information that could affect the efficiency of the review Documented policies and procedures should be available for review upon request. The Hospital/Facility Representative will be available to the reviewer(s) during the review clarify charge descriptions, answer questions, and research issues. Requests for additional information and supporting documentation will be provided within a reasonable amount of time not to exceed 30 days. Information and documentation that is not received within 30 days of receipt of review findings will not be reviewed.
- Undercharges are documented services that were billed on the original reviewed claim but not billed to the full extent of the services provided. The net adjustment on the review report will reflect unsupported and undercharges. A corrected claim form will not be required. The Hospital/Facility is expected to present any and all under billing to the Plan's reviewer designee for review before the review commences. All unsupported or unbilled charges identified and verified by both review parties will be recognized, evaluated, recorded, or presented in a final report. Under billing that is not submitted for review before the review commences will not be recognized, evaluated, or recorded in the final report.
- Late charges are charges that were not submitted on the original claim. Late charges will be considered for payment only if they are presented before the review commences so that charges can be fully evaluated at the time of the review. A corrected claim form will be required for any late charges that have been verified. The process is not intended to present an opportunity for providers to submit late charges. All late charges need to be formally submitted to the Plan through the claim submission process. Late billing that is not submitted within six months of discharge and prior to an review commencing will not be recognized, evaluated, or recorded in the final report. Such late charges will not be paid by the Plan.
- A written preliminary report of the findings should be a part of each review. An exit interview will be offered to the provider and, if the provider waives the exit conference, the reviewer will note that decision in the written report. The Hospital is expected to present supporting documentation before adjustments to the preliminary review findings are made. Resolution of any discrepancies, questions, or errors that have been identified in the review shall occur within 30 days of the review. Both parties will agree to respond to calls and emails in a timely manner and work toward closure of review within 30 calendar days of the review or receipt of the preliminary findings. All review findings will stand if provider fails to provide supporting documentation or to communicate agreement with review findings within 30 days of the review. Results are final once the parties agree to the review findings or after thirty (30) days elapses post review.
- Any finding that cannot be resolved between the Provider's representative and the Plan's review representative will be submitted to the payer as a disputed charge.
- Results are final once the parties agree to the findings or after thirty (30) days elapses post reviews will not be re-opened for any reason.
- Disputed charges will be documented in the report with supporting documentation for the dispute. The Plan or via its designee designee upon request shall have access to records, including but not limited to securing copies of the record, to support the findings. Disputed charges will be addressed through the Plan Provider Appeal Process. An initial notification letter will be sent to the facility advising that the Plan has received the dispute and request that any pertinent medical documentation supporting their claim is sent to the Provider Appeals Department within 45 business days of receipt of the notification. All cases will be

held until requested documentation is received or for 50 business days from the date of the notification letter, whichever is sooner. At which time, the disputed finding is forwarded to a qualified Reviewer for consideration. Upon review of the available information, the Appeal Reviewer may determine that the findings are valid, in which monies will be recouped from the facility, or ***not-valid,*** in which no further action will be taken and the claim will not be adjusted further for those disputed charges. The facility and the Plan's designee will be notified in writing of the Plan determination and rationale for the determination. The determination is final and binding and in keeping with the provisions of your contract with the Plan. This review process is considered your right to appeal. No additional appeal will be considered.

For other provider claim reviews:

- The Plan or via it's designee will request medical records for claims meeting the post payment criteria. Requests for medical records will indicate an expected response date of three weeks following the request date.
- The provider representative should respond to the request within the specified time frame unless otherwise agreed upon by both parties.
- Providers will designate an individual(s) to coordinate all billing activities. Duties of an coordinator include, but are not limited to, the following areas:
  A. Responding to requests for medical records and ensuring that the health record is complete and in order; any additional documentation (i.e. ancillary records and/or logs) that supports billed charges should be included;
  B. Scheduling when when indicated;
  C. Advising other provider personnel/departments of pending reviews;
  D. Verifying when an reviewer is an authorized representative of the Plan;
  E. Coordinating the reviewer's requests for information;
  F. Coordinating the access to records and provider personnel;
  G. Orienting reviewers to record documentation, provider specific conventions, and provider billing practices and policies;
  H. Acting as a liaison between the reviewer and other provider personnel;
  I. Confencing with the reviewer to answer questions and review audit findings;
  J. Reviewing the reviewer's final written report and following up on any charges still in question or dispute;
  K. Arranging for any required adjustment(s) to bills and/or issuing refunds to the Plan.
- Providers shall supply the Plan with any and all information that could affect the efficiency of the review.
- Documented policies and procedures should be available for review upon request or at the time of an review. Requests for additional information and supporting documentation will be provided within a reasonable amount of time not to exceed 30 days. Information and documentation that is not received within 30 days of receipt of the report of findings will not be reviewed.
- A written preliminary report of findings will result from each review and an Reviewer Worksheet and Findings Letter will be provided.
- Results are final once the parties agree to the audit findings or after thirty (30) days elapses post review and will not be re-opened for any reason.
- Disputed findings can be addressed through the plan provider appeal process.

## Reimbursement

The Plan requires accurate and appropriate documentation to support charges billed.

## Billing/coding guidelines

Providers are expected to have the necessary documentation to support billed charges as required by the Plan and consistent with industry standards.

This policy applies to all services rendered to Plan members.

## Place of service

This policy applies to services rendered in all settings.

## Policy history

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| Origination date: | 03/01/09 |
| Previous revision date(s): | 05/01/2010 – Added provider (non-hospital) language and changed name from Facility Bill/Charge Audit Policy to Provider Audit Policy.<br>11/01/2015 – Annual review and moved to new template.<br>05/01/2016 – Updated policy section. |
| Connection date & details: | January 2017 – Updated policy section.<br>January 2018 – Updated the policy section.<br>July 2019 – Annual review, no updates.<br>June 2024 – Replaced the term “audit” with “review” throughout and renamed Review of Provider Claims (formerly Provider Audit). |

*The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.*