Operations Bulletin 05-11

Date: June 15, 2011

To: Participating Providers

Re: **Payment Integrity Program**

The passage of health care reform legislation in early 2010 has generated increased scrutiny of medical claims processes among all industry stakeholders. In order to clarify Geisinger Health Plan's[1] claim review process for Participating Providers, we are sharing the following information on our Payment Integrity Program in this Operations Bulletin:

Payment Integrity Program
- Purpose
- Process
- Provider Responsibility & Dispute

Information communicated and included herein amends the Participating Provider Guide and is effective for all Health Plan product lines. The Participating Provider Guide is available online at www.thehealthplan.com. Questions related to this communication can be addressed by contacting our Customer Service Team at (800) 447-4000.

Payment Integrity Program

Purpose

In accordance with your contractual agreement, the Health Plan's Payment Integrity Program may monitor and manage payment integrity for all Health Plan product lines to ensure timely and accurate claim payments. Periodic claim audits, conducted through the Payment Integrity Program are meant to:

- Verify the financial accuracy of claims payment;
- Evaluate Health Plan and provider compliance with contractual rights and obligations related to claims, including reimbursement rates, and;
- Ensure the appropriateness and accuracy of provider billing practices.

The Payment Integrity Program utilizes third-party payer billing audit guidelines as outlined in the National Health Care Billing Audit Guidelines developed by the American Health Information Management Association, American Hospital Association, Association of Healthcare Internal Auditors, Blue Cross Blue Shield Association, Healthcare Financial Management Association, and Health Insurance Association of America, unless otherwise specified below or in a specific provider's contract.

Health Plan policies, including but not limited to medical, authorization, eligibility, claims administration and reimbursement, apply to all audits. In the event the Health Plan does not maintain a policy regarding a specific subject, we reserve the right to utilize policies promulgated by the Centers for Medicare and Medicaid Services (national or local), American Medical Association, and national health insurance carrier organizations.

[1] *Geisinger Health Plan, Geisinger Indemnity Insurance Company and Geisinger Quality Options, shall collectively be referred to herein as "Health Plan".*

Please note: The Health Plan will not reimburse a provider or a third party working on behalf of a provider for services expressly performed to facilitate an audit.

Process

- Periodic claim audits may be conducted on-site at a Participating Provider's location or by desk audit at the Health Plan.

- The Payment Integrity Program includes, but is not limited to, the following audit functions:
    - DRG Validation
    - Credit Balance Audit
    - Coordination of Benefits
    - Other Party Liability
    - Coding Compliance Audits

- Claims are selected for audit using criteria consistent with recognized statistical sampling and probability methodology. Only claims with a final bill-paid date that is not more than two (2) years prior to the proposed audit date (unless otherwise agreed upon) are eligible for review. In the case of suspected fraud and/or abuse there is no restriction on the look-back or recovery period. If additional areas of concern are identified during the course of an audit, the scope of the audit may be expanded.

- You will be notified in writing of our intent to audit not less than thirty (30) days prior to the proposed audit date. Sufficient information regarding the nature of the audit and the specific claims to be audited will be provided with the notification.

- Auditors with expertise, integrity and professionalism will conduct the audit, verifying service descriptions against appropriate charge description masters.

- All documentation containing sufficient information to identify the individual completing the documentation and his or her credentials will be accepted as evidence that specific services were provided.

- You will receive an Audit Summary Report detailing the findings for each claim reviewed upon conclusion of an audit.

- You will have thirty (30) days from the date of the Audit Summary Report (unless otherwise agreed upon) to respond to all claims with audit discrepancies and to submit late charge bills for any agreed upon previously unbilled or under-billed services/items identified at the beginning of an on-site audit or submitted with the documentation packet for a desk audit.

- At the conclusion of the thirty (30) day response period, you will receive a Final Audit Summary Report.

- Claim payments will be adjusted or retracted as indicated by the Final Audit Summary Report. Audit-related retractions and/or claim adjustments will be identified on our Remittance Advice. However, you will have the opportunity to dispute the findings of the Finial Audit Summary Report.

Provider Responsibility & Dispute

You are responsible for the following upon notification by the Health Plan of its intent to audit:

- Designate someone with relevant knowledge and experience to coordinate audit activities, attend an exit conference at the conclusion of an on-site audit, and/or receive audit results at the conclusion of a desk audit.

- Respond to audit notification and provide requested information and/or documentation within the designated time period.

- Notify the Health Plan at least ten (10) business days in advance if an on-site audit must be rescheduled or if you are unable to provide documentation for a desk audit within the designated time period.

- Provide clinical records and any additional documentation (e.g., signed and dated ancillary department records/logs, signed and dated charge tickets, descriptions and cost of services, supplies, or implants billed as "miscellaneous" items, policies developed, adopted, and periodically reviewed by clinical staff, as evidenced by dates of implementation and review and signatures of policy owner(s), etc) in support of the claims in question as well as charge description masters spanning the service dates of the claims in question, at a mutually agreed upon time and location for on-site audits or in the documentation packet for desk audits.

- Identify and present, at the beginning of an on-site audit or in the documentation packet of a desk audit, any charges omitted from the final bill or billed insufficient quantity on the final bill that you would like to have considered for payment.

- Provide a suitable work area for on-site audits and provide any additional information and/or documentation essential to the auditors' understanding of the exact nature of specific charges.

- Provide copies of medical records, if requested.

- Respond to audit findings and submit late charge claims for any agreed upon previously unbilled or under-billed charges to the auditor within thirty (30) days of the Audit Summary Report date (unless otherwise agreed upon).

If you dispute the audit findings on a Final Audit Summary Report you may submit a letter of dispute accompanied by all clinical documentation related to the charge in question, any relevant policies as previously described, and any other supporting information to the Health Plan's Manager of Audit, Payment Integrity Department within thirty (30) days of the date of the Final Audit Summary Report.

The Manager will review your dispute, research the issue(s), and consult Health Plan clinicians and other subject matter experts as necessary. The Health Plan will make a good faith effort to review the dispute and notify you in writing of the final determination within thirty (30) days of receipt of the dispute; provided, however that the Health Plan reserves the right to extend the review period if necessary to complete a full and final review. If the review period is extended, the Health Plan will notify you in writing of the extension.

The Health Plan is committed to conducting impartial audits and making fair and equitable determinations. We aim to foster an environment of respectful cooperation with providers during the audit process to ensure medical services rendered are paid for accurately.

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