



# **COMMUNITY FIRST**

## **HEALTH PLANS**

*Keeping Our Commitment to You*

### **CFHP 2012 Claims Audit Plan**

12238 Silicon Dr., Ste. 100  
San Antonio, Texas 78249  
Phone: (210) 358-6000  
Fax: (210) 358-6014

**Visit us online at [www.cfhp.com](http://www.cfhp.com)**

# CFHP 2012 CLAIMS AUDIT PLAN

## AUDIT PROGRAM STATEMENT

Community First Health Plans Inc. (CFHP) has developed an audit program designed to concurrently and retrospectively review claim submissions with medical record documentation to determine appropriate reimbursement.

CFHP reserves the right to conduct claim audits and reviews to ensure compliance with standard coding, billing, medical record documentation guidelines and appropriate reimbursement.

If such a review determines that an overpayment occurred, CHFP will notify providers in writing, identifying the claim(s) which generated the overpayment. Initiation of a recoupment may take place at CFHP's sole discretion should the provider fail to respond to or cooperate with CFHP. 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. Claims payment is subject to member eligibility and benefit coverage on the date of service, coordination of benefits, claims editing logic, authorization and utilization management guidelines when applicable, medical record documentation, appropriate coding and adherence to plan policies and procedures.

The Audit Plan may be revised as necessary to reflect changes in CFHP policies or procedures and or directives from local, state and federal regulatory policies and/or procedures

## MEDICAL RECORD REQUESTS

Claim review activity will require the submission of medical records either retrospectively (post payment) or concurrently (pre-payment). Providing medical records for the purpose of an audit when requested by CFHP is not a HIPAA violation. Claims may still be sent electronically. For paper or electronic claim submission, medical records will be required at the time of submission. Medical records may be faxed or mailed to the attention of the CFHP Coding Department.

- For claims reviewed concurrently or on a pre-payment basis the request for medical records will be reflected on an Explanation of Payment (EOP) designated by the EOP message "T0": Fax Medical Records to CODING DEPARTMENT with claim number or EOP. No payment will have been made by CFHP at this time.
- For claims reviewed retrospectively or on a post payment basis the request for records will be noted in bold on the CFHP envelope sent with the letter requesting medical records. The message stamped on the envelope will state: "Medical Records Request".
- It is important to respond to a medical record request timely and complete manner. Not responding to the request for medical records may initiate recoupment by CFHP. If you have questions regarding the request, please contact CFHP within the time frame specified in the letter.

## MEDICAL RECORD DOCUMENTATION REQUIREMENTS

CFHP has established the following guidelines for medical record documentation in accordance with guidance from Texas Medicaid, HHSC and CMS:

Required:

- All medical documentation must be written in English only.
- All entries must be legible to individuals other than the author, dated (month, day, and year), and signed by the performing provider.
- Each page of the medical record must document the patient's name and Texas Medicaid Number.
- A copy of the actual authorization from HHSC or its designee (e.g., TMHP) must be maintained in the medical record for any item or service that requires prior authorization.
- Allergies and adverse reactions (including immunization reactions) must be prominently noted in the record.
- The selection of evaluation and management codes (levels of service) must be supported by the client's clinical record documentation. The AMA CPT descriptors of key/contributory components with level of service descriptions are used to evaluate the selection of levels of service.
- The history and physical must document the presenting complaint with appropriate subjective and objective information.
- The services provided must be clearly documented in the medical record with all pertinent information regarding the patient's condition to substantiate the need and medical necessity for the services.
- Medically necessary diagnostic lab and X-ray results must be included in the medical record and abnormal findings must have an explicit notation of follow-up plans.
- Necessary follow-up visits specify time of return by at least the week or month.
- Unresolved problems are noted in the record

Preferred:

- Immunizations are noted in the record as complete or up-to-date. (Required for Texas Health Steps visits)
- Personal data includes address, employer, home/work telephone numbers, sex, marital status, and emergency contacts.

## REIMBURSEMENT INFORMATION

Providers are reimbursed according to the Community First Health Plans 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 Texas Medicaid Provider Manual
- Current Centers for Medicare & Medicaid Services (CMS) guidelines
- National Correct Coding Initiative (NCCI)
- Current Procedural Terminology (CPT)
- Current Healthcare Common Procedure Coding System Level II (HCPCS)
- Current International Classification of Diseases (ICD-9-CM)
- Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)
- Current Uniform Billing Editor (UB 04)
- Diagnosis Related Groups (DRG)
- CFHP Claims editing logic
- Specialty Society Guidelines and
- FDA guidelines, and Drug manufacturers' package label inserts as appropriate

## **AUDIT PLANNING PROCESS**

Similar to the OIG Work Plan, CFHP will publish an annual Audit Plan to be implemented in January of each specific year which describes specific areas of claim reviews and evaluations that will be initiated at the beginning of each year. The audit plan will be published and available for Providers ninety (90) calendar days in advance of its implementation and available for review of the CFHP website ([www.cfhp.com](http://www.cfhp.com)). The Audit Plan is in addition to statutory mandated compliance activities and/or specific Benefit Program requirements. Notification of the Audit Plan will be provided each September/October prior to the initiation on January 1st of every year. Audit planning is an ongoing and active process. In evaluating specific Audit Plan proposals, CFHP considers a number of factors, including but not limited to the following:

- requirements for OIG reviews, as set forth in laws, regulations, or other directives
- requests made or concerns raised by CMS, Medicaid, HHSC, Trailblazer Health Enterprises, LLC and OIG Work Plan,
- requirements and guidelines for CPT, HCPCS and ICD-9, UB-04 and DRG assignments
- management's actions to implement recommendations from previous reviews
- internal and external referrals

## **PROVIDER EDUCATION**

While Providers are ultimately responsible for the appropriate coding of services, billing of claims and maintaining supporting documentation, CFHP will provide ongoing Provider education information and resources throughout the year. This shall include but is not limited to, Provider Orientation sessions, ongoing visits by CFHP staff (Network Management, Quality Management, CFHP Medical Directors and Coding and Documentation Department) and specific Benefit Program Provider Manuals.

Information will be shared throughout the year in the following manner:

- CFHP's web site
- Provider Newsletters
- Updates to specific Benefit Program
- Provider Manuals Provider Orientations Network Management Representative site-visits

## **ORGANIZATION**

The Claims Audit Plan will describe specific areas of claim reviews and evaluation assignments. The assignments will describe the category, subject, scope of the review, criteria related to the assignment and the anticipated time of when the reviews and evaluations will begin (i.e., Issue date). Claim reviews and evaluation assignments may be from the following categories but not limited to:

- Ancillary Services
- Claims Logic and System Configuration Edits
- Contractual Agreements
- Emergency Room Services
- Evaluation and Management Services (E/M)
- Inpatient Hospital Services
- Modifier Use
- Multiple Surgery Procedures
- Observation Services
- Office Services
- Outpatient Hospital Services
- Services not requiring authorization
- Surgical Procedures

# 2012 CLAIMS AUDIT PLAN: SCOPE

## PROVIDER EDUCATION CAMPAIGN:

**The 2011 Audit Plan identified several areas within coding, billing and documentation where improvement is required to meet compliance standards.** CFHP will be notifying providers who will require additional pre-payment claim reviews during 2012 and work to assist Providers and their staff with training and education to meet compliance standards. (Work In Progress)

**ICD-10 training will also begin during 2012.** The Coding and Documentation Department will be providing several basic training sessions throughout the year to prepare Providers and their staff for the changes that will occur with the implementation of ICD -10. Please see the CFHP website for details and to schedule your training dates. (New Start FY 2012)

**MODIFIER 25: CFHP will continue to monitor with pre-payment reviews and provide training and education to physicians who have not met the compliance standards of coding and documentation for modifier 25.**

In prior reviews, CFHP found that a significant portion of these services were billed with this modifier inappropriately, resulting in overpayments. CFHP will evaluate provider claims on a **pre-payment** review basis for modifier 25 to determine if services are billed appropriately. Guidelines from CMS and CPT in general state a provider should not bill evaluation and management codes on the same day as a procedure or other service unless the evaluation and management service is a significant, separately identifiable service from such procedure or service. This claim review will correspond to E/M services billed on the same day as a "surgical procedure" (CPT Codes 10000-69999, excluding routine injections or immunizations or venipunctures. (Work in Progress)

**MODIFIER 59: Multiple surgical procedures (5 or more) performed on the same day billed with modifier 59 will require complete medical record documentation to support reimbursement.**

CFHP will evaluate provider claims on a **post-payment** review basis for modifier 59 to determine if services are billed appropriately. Guidelines from CMS and CPT state that under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier -59 is used to identify procedure(s) or service(s) that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury not ordinarily encountered or performed on the same day by the same physician. In prior reviews, CFHP found that a significant portion of these services were billed with these modifiers and were documented, resulting in large overpayments. CFHP will also identify physicians with aberrant coding patterns for modifier 59. (Work in Progress)

**Highest Level E/M Services: CFHP will continue to monitor with pre-payment reviews and provide training and education to physicians who have not met the compliance standards of coding and documentation for high E/M services. Claims billed with CPT codes 99205, 99215 and 99245 will require complete medical record documentation with claim to support reimbursement.**

In prior reviews, CFHP found that a significant portion of these services were billed with and inappropriately high E/M level, resulting in overpayments. CFHP will examine provider claims on a **pre-payment review basis** for CPT codes 99205, 99215 and 99245 to determine if services were coded accurately. (Work in Progress)

**THSteps:** THSteps visits will be reviewed on a **retrospective review basis** for providers with excessive utilization billing patterns. Documentation will be reviewed for completeness of the components of the Periodicity Schedule, acute care visits billed on the same day of THSteps visits and billing of Exception-to Periodicity Checkups. (Work in Progress)

## **SURGICAL PROCEDURES**

### **Laparoscopic Approach versus Open Approach: Fallopian Tube/Ovarian Procedures**

CFHP will review claims and medical records on post payment review bases to determine if documentation supports appropriate CPT billing of an Open procedure rather than a Laparoscopic approach. In prior reviews, CFHP found that a significant portion of these services were billed inappropriately, resulting in overpayments. CFHP will also identify physicians with aberrant coding patterns for these CPT codes. (Work in Progress)

### **Lysis of Adhesions Procedure:**

CFHP will review claims and medical records on a post payment review basis for CPT codes 58660 (Lysis of Adhesions – separate procedure) to determine if documentation supported appropriate reimbursement. In prior reviews, CFHP found that a significant portion of these services were billed inappropriately, resulting in overpayments. CFHP will also identify physicians with aberrant coding patterns for this CPT code. (Work in Progress)

### **Transforaminal Epidural Injections:**

CFHP will review appropriateness of coding and documentation retrospectively for claims paid for transforaminal epidural injections CPT codes 64479-64480 and 64483-688484. (Work in Progress)

### **Removal of Impacted Cerumen:**

CFHP will continue to monitor with pre-payment reviews and provide training and education to physicians who have not met the compliance standards of coding and documentation for CPT code 69210.

In prior reviews, CFHP found that a significant portion of these services were billed inappropriately, resulting in overpayments. Claims billed with CPT codes 69210 will require complete medical record documentation with claim to support reimbursement on a pre-payment basis. (Work in Progress)

## CLAIMS LOGIC AND SYSTEM CONFIGURATION EDITS

### **Medically Unlikely Edits (MUE's) and National Correct Coding Initiative (NCCI):**

CFHP will implement claims system configuration edits for DME and Outpatient Facility (updated quarterly). CFHP will also identify physicians with aberrant coding patterns related to improper billing. (New Start FY 2012)

### **Medicaid Manual/ TMHP Guidelines:**

CFHP will implement claims system configuration edits based on Texas Medicaid Provider Manual and Texas Medicaid Healthcare Partnership (TMHP) guidelines as needed to standardize claims processing procedures. (New Start FY 2012)

## CFHP CODING AND DOCUMENTATION REFERENCES AND EDUCATIONAL RESOURCES

CFHP Fraud Prevention Plan  
CFHP Provider Newsletters  
CFHP Education Links  
[www.chp.com](http://www.chp.com)

Medicaid Provider Procedures Manual  
Bulletins and Banner Messages  
Fee Schedules  
[www.tmhp.com](http://www.tmhp.com)

National Correct Coding Initiative (NCCI)  
Use of Modifiers  
<http://www.cms.gov>  
<http://www.trailblazerhealth.com/Publications/Training%20Manual/NCCI.pdf>

Medically Unlikely Edits (MUE's) (Units of service)  
<http://www.cms.gov>  
[http://www.cms.hhs.gov/NationalCorrectCodInitEd/08\\_MUE.asp#TopOfPage](http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage)

Evaluation and Management Services Documentation Guidelines  
<http://www.cms.gov/MLNProducts/Downloads/MASTER1.pdf>  
[https://www.cms.gov/MLNProducts/downloads/eval\\_mgmt\\_serv\\_guide-ICN006764.pdf](https://www.cms.gov/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf)

Physician Signature Guidelines  
<http://www.trailblazerhealth.com/Medicare.aspx>  
<http://www.trailblazerhealth.com/Tools/Notices.aspx?DomainID=1&ID=13648>

Educational Manuals and Web Guides  
<http://www.trailblazerhealth.com/Medicare.aspx>  
<http://www.trailblazerhealth.com/Publications/Default.aspx?DomainID=1>  
[https://www.cms.gov/MLNEdWebGuide/25\\_EMDOC.asp#TopOfPage](https://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp#TopOfPage)

Medicare Physician Fee Schedule Database (Global Days)  
<http://www.cms.gov>

Medicaid Integrity Program – General Information  
<http://www.cms.gov/MedicaidIntegrityProgram/>