

**PIMA HEALTH SYSTEM
STANDARDS AND PROCEDURES**

SUBJECT: Medical Claims Review Standards	MM-II-007
APPLICABLE TO: Ambulatory, LTC - Institutional, HCBS	
EFFECTIVE DATE: 7/09 APPROVED BY: Fred Miller, MD by signature	
SUPERSEDES: 5/94, 1/95, 12/96, 7/98, 9/98, 12/98, 5/02	

I. STATEMENT OF PURPOSE:

To establish guidelines for the medical review of claims both pre and post payment to ensure appropriate payment.

II. STANDARDS:

- A. This standard is applicable to all medical claims.
- B. Prospective prepayment medical claims review may be performed on the following claims including but not limited to:
 - 1. Outlier claims
 - 2. Out of area (OOA) claims
 - 3. Observation stay claims
 - 4. Inpatient hospital per diem discrepancy claims
 - 5. Prior period coverage claims
- C. Quarterly retrospective or post payment review may be conducted on selected claims according to the following process:
 - 1. Provider selection determined by consensus of the Medical Director, Utilization Management and Claims Division Managers.
 - 2. Determining criteria may include, but not be limited to:
 - a) high volume providers
 - b) costly procedures/services
 - c) problematic provider/services
 - d) repetitive incorrect billing practice.

III. PROCEDURE:

- A. Medical Claims are reviewed in the QNXT system.
- B. Medicare, AHCCCS and PHS guidelines are utilized in reviewing all claims.
- C. Claims will be reviewed in a timely fashion in order to ensure payment of the claim within thirty (30) days of receipt of claim.

- D. Prospective and retrospective payment review determinations will be documented.
- E. The Medical Claims Review Nurse will determine if a claim is clean by applying the following criteria:
1. Claims must be initially submitted within six (6) months from the date of service unless otherwise indicated by contract.
 2. Claims must be submitted on a proper form (i.e., UB92, HCFA 1500) or in a format that indicates the specific services and charges being billed.
 3. Claims for the balance after Medicare and other coordination of benefits (COB) require a copy of the Explanation of Benefits (EOB). If Medicare or other insurance carriers have denied the claim, a copy of the denial and all other documentation must accompany the submitted claim.
 4. All inpatient claims must include a UB-92, itemized statement and a discharge summary (regardless of total charges).
 - Surgical inpatient claims require, in addition to above, an operative report, operating room record, and an anesthesia report.
- F. Vendors must resubmit previously denied corrected claims within twelve (12) months from the date of service.
- G. Ambulance medical claims review will occur when Medicare (primary payor) has denied payment or when an inappropriate charge has been identified by the claims processors.
- H. Emergency room medical claims review will occur on out-of-area ER visits, and when inappropriate charges are identified by claims processors.
 - Payment determinations will be based on medical necessity and on the AHCCCS rules and regulations defining emergency services.
- I. Inpatient and outpatient medical claims review will occur on out-of-area claims, per diem discrepancy claims, on claims submitted without timely notification to the Plan, and on claims identified for inappropriate charges.
 1. Pima Health System will use AHCCCS, Medicare and PHS (when applicable) guidelines for review.
 2. In-area hospital reimbursement will be based on the facility per contracted rates.
 3. Inpatient claims must include the following:
 - a) UB - 92
 - b) Itemized Bill
 - c) History, Physical, Discharge Summary and Operative/Procedure Report, when applicable if information is not accessible on line
- J. In-area and out-of-area HCFA 1500 medical claims review will follow AHCCCS and Medicare guidelines and will be performed when:
 1. inappropriate charges are identified
 2. claims pended by the QNXT system for CPT/HCPCS codes
 3. claims with “by report” CPT codes

4. claims with multiple procedure codes or modifiers and
 5. claims where medical judgment is required for appropriate payment purposes.
- K. Observation stay medical claims review will follow AHCCCS, Medicare and PHS guidelines.
- Observation stay claims must include a UB-92, itemized bill discharge summary, operative or procedure reports, physician orders and physician notes.
- L. Outlier claims must include a UB-92, itemized bill, a discharge summary, operative or procedure reports, physician orders and physician progress notes to ascertain medical necessity.
1. PHS will follow the facility contracted rate reimbursement methodology.
 2. Medicare and AHCCCS guidelines will be followed for claims review.
- M. Prior period coverage claims review will follow the guidelines established for all types of claims review using “medical necessity” to establish appropriateness for the services rendered.
- N. Inpatient hospital per diem discrepancy claims will be reviewed based on AHCCCS rules.
- Reimbursement will follow the contracted facility rates.
- O. The PHS Medical Director is consulted by the Medical Claims Review Nurse whenever needed.
- P. The Medical Claims Review Nurse may participate in the Medical Grievance Process by:
1. Reviewing the grieved claim.
 2. Rendering a determination based on the medical record documentation or by referring the grieved claims to the Medical Director.
 3. Participating as an active member in the medical claims grievance and appeals process.
- Q. The following references are used by the Medical Claim Review Nurse when reviewing claims and issuing payment determinations:
1. CPT - 4 Coding Book
 2. ICD - 9 Coding Book
 3. HCPCS Coding Book
 4. Web base Medical and/or CMS publications/website
 5. Pharmaceutical sources
 6. AHCCCS manuals, website