MASSACHUSETTS

# Blue Claim Payment Integrity

## Get the Most from Your Claims with These Cost-Containing Policies and Procedures

At Blue Cross Blue Shield of Massachusetts, making quality health care affordable is our top priority. We're constantly looking for ways to reduce our claims costs, and those of our clients. That's why we've put in place a variety of cost-containment policies and procedures to help improve claim accuracy and turnaround times, and prevent duplicate payments, waste, billing abuse, and fraud.

## We Offer Best-in-Class Resources

**Here are examples of the teams, software, and systems we have in place to support every step of the claims process:**

### Advanced Claims Editing Solution

We've deployed a flexible, state-of-the-art claims editing platform to ensure professional and institutional claims are properly coded. Claims are automatically evaluated prior to payment to improve accuracy, consistency, and processing turnaround times. The platform incorporates guidelines from industry-standard clinical coding sources, including Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), International Classification of Diseases Clinical Modification (ICD-CM), American Medical Association (AMA), and Centers for Medicare and Medicaid Services (CMS) guidelines, specialty society guidelines, medical literature research and standards, and Blue Cross payment and medical policy.

### Pre-payment Forensic Review

We, in partnership with a nationally recognized payment integrity vendor, have developed a program to review targeted high-cost inpatient facility claims prior to payment. This program is intended to ensure processing in accordance with established medical, benefit, and reimbursement policies, industry standard inpatient clinical coding guidance and conventions. (This program is effective 4/1/2018 for FI only, ASC will be live on 1/1/2019.)

### Dedicated Claims Data Mining

We've developed rigorous audit procedures to meticulously evaluate paid claims against our provider network contracts, medical and payment policies, and reimbursement guidelines. A team of skilled auditors has been established with varied backgrounds in claims payment, clinical coding, pharmacy, accounting, IT, and data management and manipulation. Together with our contracted payment integrity vendor, we approach these reviews with a hybrid, double-layer model to ensure claim payment accuracy.

### Other Dedicated Claims Resources

- We have a separate Fraud Investigation and Prevention (FIP) unit to identify and investigate allegations of potential fraud and pursue recoveries for any overpayments. FIP maintains a confidential fraud hotline and proactively identifies potential cases using fraud detection software. Employees, including certified fraud examiners, certified professional coders, and nurses, investigate cases. The FIP unit works closely with law enforcement and the boards of registration to prevent billing abuse and make financial recoveries where appropriate.

- Pharmacy benefit managers (PBMs) administering pharmacy benefits are required to follow their own policies and procedures to detect fraud waste and abuse. Blue Cross audits PBMs on a quarterly basis, if not more frequently, to ensure compliance with this requirement.
- Using vendors and internal resources, the Claims Recovery Team identifies credit balances, duplicate claim payments, proper coordination of benefits, and claim overpayments and underpayments.
- Dedicated resources perform post-payment audits of diagnosis-related group (DRG), outpatient, and professional claims. Threshold limits are defined and, for DRG claims, a software program is used to identify claims that don't fall within the defined norm for DRG payment. In addition, our highly skilled clinical coders perform professional and facility documentation reviews.
- We conduct provider audits of paid, professional provider claims to verify the accuracy of claims reimbursement supported by medical record documentation and the National Healthcare Billing Audit guidelines. Our Provider Audit department reviews paid professional (CMS-1500) claims to validate the accuracy of provider billing. This includes review of assigned evaluation and management (E&M) codes, Current Procedural Terminology (CPT) codes, and modifiers. Please note that this policy only applies to audits performed by the plan's Physician Audit team.
- We use a case-identification vendor to identify workers' compensation and third-party cases where Blue Cross may be entitled to assert a lien or other subrogation rights to recover medical claims incurred as a result of a third party's negligent or intentional acts or omissions. We have dedicated resources to negotiate resolution of these cases.
- We coordinate benefits with other health insurers, including automobile, Medicare, and commercial insurance, to prevent duplication of payments. To identify subscribers who may have other insurance, we match our members' eligibility against a national database of other health insurances' eligibility on a regular basis, and we also participate in a data exchange with CMS to identify members who have Medicare coverage.
- Other activities to prevent waste and abuse include, but are not limited to: a payment policy to ensure claims are paid or denied appropriately, cost-containment initiatives, and utilization review.

### Here's What You Can Do

In addition to our best-in-class resources, here are a few things you can do to help ensure accurate payments:

- If you're a self-funded account, you may be eligible to have your coordination of benefits calculations performed through the maintenance of benefits provision. This approach may reduce your liability as a secondary payer. Please ask your account representative for more details.
- If you're a fully insured account, you can continue to use our standard benefit coordination of benefit calculations.
- Take advantage of opportunities to share Medicare and workers' compensation benefit data, so you can avoid any potential for duplication of benefits.
- Keep in mind the importance of sending timely updates to employees about benefits and eligibility to ensure accurate claim processing and minimize retroactive processing of claims.

**If you have any questions, please contact your account executive.**

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