Optum

Quick Reference Guide

# Provider Post-Pay Audits

Optum's Payment and Network Integrity (PNI) team works with providers to identify and correct claim billing, coding and payment issues related to potential Fraud, Waste, Abuse and Error.

Specifically, we conduct routine audits as part of this commitment to payment accuracy and integrity to determine whether:

- Billed services accurately represent the services provided
- Amounts billed are payable according to the terms, conditions and exclusions outlined in the member's plan benefits and according to our reimbursement policies.

This guide covers common questions about our audit process, including HIPAA considerations, how claims are selected for review (extrapolation) and provider responsibilities around corrected claims and overpayments.

## Audit overview

### How providers/facilities are selected for audit

Being selected for audit does not imply wrongdoing. Providers and facilities are selected for audit based on a variety of factors including:

- Unusual billing patterns or high service volumes
- Claims data inconsistencies
- Member complaints or concerns
- Referrals from regulatory or oversight entities
- Random sampling as part of routine compliance reviews

### Why and how are post-pay claims reviewed

Post-pay claim reviews and any associated overpayments are part of your Participation Agreement and detailed in the UnitedHealthcare Care Provider Administrative Guide – Chapter 11: Compensation that reads:

*We may review paid claims to help ensure payment integrity. If reviewing all medical records for a procedure would burden you, we may select a statistically valid random sample (SVRS) or smaller subset of the SVRS. This gives an estimate of the proportion of claims we paid in error. The estimated proportion, or error rate, can be projected across all claims to determine overpayment. You may appeal the initial findings. You must supply all requested medical records. Failure to do so may result in a failure of the entire SVRS and all claims submitted within the review.*

## Your Participation Agreement and HIPPA

HIPAA **does not** require authorization to release member-related information for an audit. Here's why.

1. Both providers and health plans are considered covered entities.
   - Under HIPAA, a provider must obtain authorization from a patient prior to disclosing protected health information except when dealing with a "covered entity" on payment, treatment or health care operations matters. See 45 CFR §§ 164.501 and 164.506 for more information.
2. Audits are considered part of health care operations. See 45 CFR § 164.501 for more information.

In addition, Article 6 of your Participation Agreement states providers shall provide access to records upon request.

# Audit process

## What to submit during an audit

As part of the audit, you may be asked to provide additional documentation that supports the services billed. HIPPA-compliant Progress Notes related to Treatment, Payment and Operations may be required. Progress notes should include, but are not limited to:

- Medication prescription monitoring (if applicable)
- Functional status
- Symptoms
- Session start and stop times
- Modalities and frequency of treatment furnished
- Clinical testing results (if applicable)
- Summary of diagnosis, treatment plan/goals, prognosis and progress to date

## How to submit a corrected claim

If your claim was submitted with incorrect/inaccurate information or processed incorrectly you may follow the appropriate steps to submit a corrected claim. Before submitting, carefully check the following:

- ICD-10 diagnosis codes and CPT/HCPCS procedure codes: Ensure they are based on the patient's medical record and the services rendered
- Reimbursement polices and clinical criteria

You may also find these Claim Tips helpful.

## Claim overpayments from the audit explained

If an audit determines you were overpaid on a claim(s), we will send a letter that:

- Identifies the amount overpaid.
- Asks to recoup the overpayment through:
  - Submitting a check

- Having offset payment(s) taken out of future **total** (not individual member) claim payments. These recoupment letters include instructions and are sent through Payment Recovery Services.

You may also choose to submit a corrected claim or dispute the claim. See the overpayment letter for additional details.

# Extrapolation

## What is extrapolation?

Extrapolation means we take the findings from the audit process, which uses a smaller sample size, and extend those findings on the same percentage basis to a larger sample of claims to determine the overpayment amount.

Extrapolation is a separate process from the audit. Only some states, markets and situations require extrapolation.

## Claim sample selection and methodology

**Sample summary:** The sample summary provides more details about the Optum's claim sample selection/methodology. Specifically, it:

- Describes the Reason for Sampling that group of claims. See the Provider Behavior section titled *Creation & Parameters of the Universe of Claims, & Sampling Methodology*. This information speaks to questions surrounding summary statistics and representativeness checks to ensure the sample reflects the broader claims universe when determining payment amounts.
- Validates the methodology used
- Reflects a statistically appropriate, valid and random sample as part of a partial or, if necessary, full SVRS

## Statistical sampling/extrapolation

**Which claims are extrapolated:** Codes that are originally selected or included in a random sample and determined to have a Financial Error Rate are subject to extrapolation. Those that were ancillary claim lines or not included in a random sample, but included in the claim being reviewed, are not subject to extrapolation.

**Benefits of extrapolation:** Statistical sampling through extrapolation minimizes bias by ensuring every item in the total claim population has an equal or known chance of being selected. It eases provider administrative burden, while providing a more efficient and accurate way for auditors to assess both under and overpayments.

## Full statistically valid random sample (SVRS)

Either Optum or the provider may request a full SVRS.

If statistically appropriate, the sample may be used to determine the Financial Error Rate. If further analysis is needed, Optum may re-use the results and conduct a full SVRS.

Extrapolated letters only indicate the number of records required, not dates of service or member names.

- If the provider requests a full SVRS, we will send a letter that lists the additional, required Member Names & Dates of Service needed

If a provider requests information about the full universe(s) of claims used, Optum will provide more information

## Claim overpayments from extrapolation explained

**How the extrapolated overpayment amount was determined:** Overpayment amounts determined during extrapolation differ from the initial overpayment calculation.

The extrapolation findings result in a Financial Error Rate, which is then applied across the universe of claims from which the random sample was drawn. The result is the projected overpayment and the subsequent final overpayment amount.

The extrapolation and subsequent Financial Error Rate is a more accurate and conservative finding rather than number of claims in error. This benefits providers because we consider the difference in only supported and unsupported paid amounts, including lower level, bundled and  more appropriate code adjustments.

## Questions?

If you have questions about the post-pay audit and/or sampling (extrapolation) process, overpayments, please contact your Provider Relations Advocate.

- To find your Provider Relations Advocate, please call the Provider Services Line (PSL) at **877-614-0484**.