Auditing of Professional Services Claims

Questions and Answers for Health Care Providers

As of **October 29, 2012**, MVP Health Care has contracted with OrthoNet to assist with the ongoing review of professional services claims.

- The initiative entails pending two types of claims for additional review:
  - high-dollar procedure-based surgical claims (approximately 3 percent of surgical claims will be reviewed), and
  - professional services claims from practices that may benefit from additional consultation on coding accuracy.

Q. How will the initiative work?

A. Practices that are identified for this review will be individually notified by MVP that they are required to submit records for the claims that will be audited.

- These reviews will be conducted by specialty-appropriate physicians and will follow nationally accepted coding guidelines. It is important to note that these are NOT medical necessity reviews; only the accuracy of the coding of a particular set of services will be examined.
- For any claim that is pended for additional review, OrthoNet will contact your office to request additional information, such as patient medical records or operative/clinical notes. Requested information must be submitted within 60 days or the claim will be denied.

Q. Will the claim approval process take longer because of OrthoNet's audit?

A. Unless a health care provider submits records as part of the original claim submission, it is likely that claims that are reviewed by OrthoNet will take longer to process. This is because OrthoNet will request additional information from the submitting provider so that a determination can be made, so it depends on how quickly the provider office responds to the request.

Q. Will claims be identified for review by OrthoNet based on the billed or the allowed amount?

A. Claims will be identified for review based on the allowed amount.

Q. Will this impact members? If yes, how?

A. This initiative should not impact members. Members will be held harmless if a claim is denied due to OrthoNet's audit or a provider's lack of response to OrthoNet's request for additional information on a claim. Providers should not balance-bill members (If MVP pays less than what was billed by the provider, the member will not need to pay the difference).

Q. Will the member get an EOB if something is denied; if so, what will print on the EOB?

A. Yes, members will continue to be held harmless if a claim is denied as a result of OrthoNet's review. Yes, the member will get an EOB from MVP if a claim is denied with the reason: "denied pending medical records."

Q. What will happen if a health care provider does not provide the information requested by OrthoNet as part of its audit?

A. If the additional information requested by OrthoNet is not received, the claim will be denied.

Q. Will health care providers whose claims will be audited as part of this initiative be notified in advance?

A. Yes, MVP will notify the health care providers whose claims are audited, based on a listing generated by OrthoNet.

Q. As part of this program, codes originally used on claims may be changed to be more accurate or specific as a result of OrthoNet's review. Are there any legal issues if MVP change the coding on a claim?

A. No, there are no legal issues with code changes as a result of the audit by OrthoNet. Any changes will be made with the full knowledge of the provider who submitted the claim.

Q. Will members who see a non-participating provider end up having to pay the difference if the payment is reduced to that provider as a result of an audit?

A. No. If the review process reveals that a billed service was not performed, the service is not reimbursable. MVP will reimburse for the services rendered and the provider should not bill the member for anything additional.