# THE COMMONWEALTH OF MASSACHUSETTS

## Report to the
## Massachusetts Division of Insurance

*Report of the Targeted Market Conduct Examination of
the Readiness of*

# Harvard Pilgrim Health Care, Inc.
# and
# HPHC Insurance Company, Inc.

**Quincy, Massachusetts**

*for Compliance with M.G.L. c. 176O §5A*

*For the Period September 1, 2011 through December 31, 2011*

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June 24, 2012

Joseph G. Murphy
Commissioner of Insurance
Massachusetts Division of Insurance
1000 Washington Street, Suite 810
Boston, Massachusetts 02118-6200

Dear Commissioner Murphy:

Pursuant to your instructions and in accordance with Massachusetts General Laws, Chapter 175, Section 4 and Chapter 176G, Section 10, a targeted examination has been made of the market conduct affairs of

**Harvard Pilgrim Health Care, Inc.**
**and**
**HPHC Insurance Company, Inc.**

at its office located at:

**1600 Crown Colony**
**Quincy, Massachusetts 02169**

The following report herein is respectfully submitted.

# PURPOSE AND SCOPE OF THE EXAMINATION

Under authorization of the Division of Insurance ("Division"), pursuant to M.G.L. c. 175, § 4 and M.G.L. c. 176O, § 10 a targeted market conduct examination of Harvard Pilgrim Health Care, Inc. and HPHC Insurance Company, Inc. (collectively known as the "Company" or "Harvard") was performed by Examination Resources, LLC. The scope period of this examination was September 1, 2011 through December 31, 2011 ("Examination Period"). The onsite examination began March 12, 2012 and ended March 22, 2012.

The purpose of the examination was to determine the status of the Company's compliance with M.G.L. c. 176O, § 5A, which requires insurance carriers to accept and recognize patient diagnostic information and patient care service and procedure information submitted pursuant to, and consistent with, the current Health Insurance Portability and Accountability Act ("HIPAA") compliant code sets; the International Classification of Diseases ("ICD"); the American Medical Association's Current Procedural Terminology ("CPT") codes, reporting guidelines and conventions; and the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System ("HCPCS"). Section 5 further requires insurance carriers to adopt the aforementioned coding standards and guidelines, and all changes thereto, in their entirety, which shall be effective on the same date as the national implementation date established by the entity implementing the coding standards. The examination also included review of the claims forms in use by the Company to determine if the Company uses the standardized claim formats for processing health care claims as adopted by the National Uniform Claim Committee and the National Uniform Billing Committee and implemented pursuant to the HIPAA.

In addition, the examination included a review of the Company's response to the required status reports pursuant to M.G.L. c. 176O, § 5A, which requires insurance carriers to submit quarterly detailed status reports of their compliance with certain identified coding issues. The coding issues are those issues for which compliance is required by M.G.L. c. 176O, § 5A, and as agreed upon by the Advisory Committee created by Chapter 305 of the Acts of 2008. For purposes of this examination, the status report submitted by the Company on November, 15, 2011 was reviewed by the examiners. In addition, the Company provided for review the most recent version of its compliance report, as of February 15, 2012.

In reviewing materials for this examination report, the examiners relied on records provided by the Company and personal observation by the examiners of processes and controls during the onsite examination. Testing was performed on both a sample basis and total population review on certain codes and/or modifiers, when feasible.

The National Association of Insurance Commissioners ("NAIC") Market Analysis Handbook allows the utilization of Audit Command Language ("ACL") for determining sample sizes and sampling. The 2011 version of the handbook was used. Samples sizes for this examination were calculated by entering a Confidence Level of 95%, an Upper Error Limit of 5% and an Expected Error Rate of 2%. ACL returned a sample size of 184 for the claims review.

# EXECUTIVE SUMMARY

This summary of the targeted market conduct examination of the Company is intended to provide a high-level overview of the examination results. The body of the report provides details of the scope of the examination, tests conducted, findings, observations, recommendations and, if applicable, subsequent Company actions.

The examination included three areas of review: Processes and Controls, Review of Chapter 305 – Payer-Provider Coding Status Report and a Claims Sample Review.

The following is a summary of all substantive issues found, along with related recommendations and, if applicable, subsequent Company actions made, as part of the examination.

## I.    Processes and Controls

The review of the processes and controls along with the claims sample review and total population review of certain codes indicates that system edits are working as expected and processes and controls are appropriate for compliance with the uniform coding requirements by July 1, 2012..

## II.    Chapter 305 – Payer-Provider Coding Status Report

Review of the Company's responses to each listed issue along with the claims sample review and/or review of the total population for a given code within the data file (1,600,945 claim records) showed that the Company's responses were accurate.

## III.    Claims Sample Review

There were 184 claim files reviewed included a total of 436 CPT/HCPCS codes, 93 Modifiers and 359 ICD codes. There were no exceptions noted.

# EXAMINATION RESULTS

## I.      Processes and Controls

Claims processing is similar for both Electronic and Paper claims, the only difference is that paper claims are scanned and entered into the system by data entry personnel. From that point forward the process is the same. Electronic claims are submitted to the Company by providers through different submission channels.

After submissions are received they process through the Company's Electronic Data Interchange ("EDI") engine and through the different system edits. The EDI Team is responsible for all phases of testing and the implementation of new claims submitters and also provides support for existing submitters. In the event of claim rejections, this team also provides support for providers to make corrections. The EDI engine system is a pre-processor to ensure that valid CPT, ICD and Modifiers were used. Once the claim passes the edit process, they are moved into the system. About 84% of the claims are automatically adjudicated. Any claims that are pended go through a manual review.

The Company audits the process on a daily basis. Data entry is done by two vendors and they are audited daily. Claims processors are also audited individually and on a daily basis. Every claim that is over $10,000 is reviewed for payment accuracy.

Effective September 2011, the Company implemented the use of a new EDI claim processing engine for commercial (non-Medicare) business. This processing engine, the Edifecs application, manages the use of standard clinical (*e.g.,* procedure and diagnosis) codes through two components.

The first component of code submission is the identification of the code type being submitted, and validation that the code is a component of the applicable code type. The Edifecs transaction application utilizes code type qualifiers as defined in the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 Health Care Claim: Institutional (837) and Health Care Claim: Professional (837).

The second component is the list of valid codes that may be submitted. The application vendor, Edifecs, acquires all national standard code set updates monthly from applicable code set owners. These updated code sets are distributed to Harvard each month. Harvard Pilgrim in turn, installs the most recent code sets provided within 5 days of receipt of the updated code sets. To date, Harvard has not edited, deleted or added any codes to the national standard code sets.

The examiners requested additional information regarding the process of updating codes. The Company provided numerous reports for new or deleted codes effective January 1, 2012, showing the entire process which includes procedures, testing and implementation. The testing process produces very comprehensive reports including an indication of the expected outcome, actual outcome and documentation about whether the tested codes

pass or fail. If any of the tested codes fails the test, the codes are reinstalled and retested. If retest fails, then Edifecs is contacted for resolution.

The Company provided a description of each system edit. From a review of these edits along with the review of the selected sample and total population of given codes oit appears that the edits are working as expected and the processes and controls are appropriate.

## II. Chapter 305 – Payer-Provider Coding Status Report

The quarterly detailed status report of the Company's compliance with certain identified coding issues, submitted as of November 15, 2011, was reviewed. The Company also provided the latest version of that report, as of February, 15, 2012, to the examiners.

The responses to each issue listed were reviewed and testing was performed either on a sample basis (claims sample review), review of the total population of a given code within the data files provided by the Company, or both. The examiners were able to confirm all responses, therefore, participation of an Information Technology ("IT") Specialist in the examination was not deemed necessary.

### *Issue 1*

Bilateral procedures (Modifier 50) - There are concerns that certain payers will not accept the Bilateral Modifier 50 and require that the CPT Code be listed twice.

**Company Response:** The Company stated "it applies standard coding requirements and that the Company's system configuration was updated to accept billing bilateral services with a modifier 50, on either one or two lines. Implementation was completed effective 11/01/2008."

**Testing:** The selected sample did not contain any claims with Modifier 50; however, review of the total population for this code within the data file shows that Modifier 50 is accepted by the Company. In those instances where it appeared twice in the same claim, it was for a different CPT code.

**Results:** No exceptions were noted.

### *Issue 2*

Multiple Procedures (Modifier 51) (Physician Practice vs. Facility) - Per CPT coding conventions, this modifier should only be used for physician practices. There are concerns that certain payers have medical policies that do not distinguish this and may instruct hospitals to report Modifier 51 which is not for use in the hospital setting.

**Company Response:** The Company stated "it applies standard coding requirements and accepts Modifier 51 on CMS-1500 claims, and does not require 51 on UB claims."

**Testing:** The selected sample did not contain any claims with Modifier 51, however a review of the total population for this code within the data file, showed 171 facilities claims records containing Modifier 51. The examiners randomly selected 3 claims to determine if Modifier 51 was used in processing the claim. The Company stated that it does have some general editing in place that would deny a code if Modifier 51 is appended to an inappropriate CPT/HCPCS code. For example, Modifier 51 can not be appended to an E&M service, but it can be appended to surgical codes. When a facility appends Modifier 51 on a claim for a surgical procedure, the system accepts the incorrect modifier but the system just stores the modifier and does not include it when it processes the claim for payment. Review of the files confirmed that the 3 claims were for surgical procedures and that the modifier was not used to process the claim.

**Results:** The system accepts the incorrect modifier, but it is not being used to process the claim. The issue with this approach is that any required reporting would not be fully accurate as it would report the modifier that has been stored in the system.

### Issue 3

Reduced Services (Modifier 52) - There are concerns that certain payers require use of Modifier 73/74, and vice versa, for incomplete or reduced colonoscopy procedures (Physicians).

**Company Response**: The Company stated "it applies standard coding requirements and accepts and recognizes Modifiers 52, 73, 74."

**Testing:** The selected sample did not contain any claims with Modifiers 73/74, however, review of the data files shows that there were no Physician claims using Modifiers 73/74 for reduced colonoscopy procedures.

**Results:** No exceptions were noted.

### Issue 4

Distinct Procedures (Modifier 59) - There are concerns that payers vary in their instruction/recognition of Modifier 59 and do not clearly communicate any pertinent payment reduction/considerations to the providers.

**Company Response**: The Company stated "it applies standard coding requirements and accepts and recognizes Modifier 59 for facility and professional claims."

**Testing:**  Review of the total population for this code within the data file showed that Modifier 59 is allowed by the Company. The selected sample showed that the Company clearly communicates any pertinent payment reduction/considerations to the providers.

**Results:**  No exceptions were noted.


### Issue 5

Repeat Clinical Diagnostic Lab Test (Modifier 91) - There are concerns regarding confusion associated with criteria to be used in the application of Modifier 91 and that certain  payers do not recognize that Modifier 91 is to be used only for repeat lab tests and not other diagnostic test CPT code ranges.

**Company Response:**  The Company stated "it applies standard coding requirements and recognizes Modifier 91 submitted on both facility and professional claims."

**Testing:** The selected sample did not contain any claim with Modifier 91; however, review of the total population for this code within the data file showed that Modifier 91 is accepted by the Company.  A further review showed that when used, it was for repeat lab tests.

**Results:**  No exceptions were noted.


### Issue 6

Accepting multiple modifiers on the same line - There are concerns that payers vary in accepting the number of modifiers on the same line - some allow 2, 3 or 4.  There are concerns that despite allowing more than one modifier on a line, certain payers only recognize the first modifier.

**Company Response:**  The Company stated "it applies standard coding requirements and accepts up to 4 submitted modifiers on the same line for both facility and professional claims and recognizes two for the purposes of reimbursement."

**Testing:**  The selected sample showed the use of two modifiers in the same line and both were recognized when processing the claim.

**Results:** No exceptions were noted.


### Issue 7

V76.0-V76.9 - Screening for Malignant Neoplasm - There are concerns that for certain payers multiple claims are rejected because the V code is sequenced first, and that

Information Systems ("IS") issues exist for certain payers that are unable to screen secondary diagnostic codes.

**Company Response:** The Company stated "it applies standard coding requirements and accepts up to 4 submitted modifiers on the same line for both facility and professional claims and recognizes two for the purposes of reimbursement."

**Testing:** The selected sample showed claims with V76.x diagnostic codes and all were handled properly.

**Results:** No exceptions were noted

### *Issue 8*

V57.0-V57.9 - Encounter for Rehabilitation. Services - There are concerns that certain payers will not accept the correct V Code sequencing (1st Listed) for Rehabilitation encounters and instruct providers to incorrectly sequence a medical condition first for Rehabilitation Therapy or Services.

**Company Response:** The Company stated "it applies standard coding requirements and accepts up to four submitted modifiers on the same line for both facility and professional claims and recognizes two for the purposes of reimbursement."

**Testing:** There were no claims with ICD code V57.x in the selected sample. However, review of the total population for these codes within the data file shows claims with V57.x codes in different positions.

**Results:** No exceptions were noted.

### *Issue 9*

V67.0-V67.9 - Follow-up Examinations - There are concerns that certain payers instruct providers to omit the V code and list the code for the original condition or injury – even if resolved.

**Company Response:** The Company stated "it applies standard coding requirements and accepts up to four submitted modifiers on the same line for both facility and professional claims and recognizes two for the purposes of reimbursement. The Company also stated that it does not change the sequence of submitted diagnoses."

**Testing:** There were no claims with ICD code V67.x in the selected sample. However, review of the total population for these codes within the data file shows many claims with V67.x codes; therefore, there is no indication that V67 codes are being omitted.

**Results:**  No exceptions were noted.


*Issue 10*

V51-V58.9 - Encounter for Aftercare - There are concerns that certain payers will not process claims with this range of codes and instruct providers to submit the code for the initial injury or illness in the first position in order to process the claim.  Some Specific Aftercare V Codes within this range that trigger edits: V51-Plastic Surgery – Aftercare; V54.81-V54.9 – Orthopedic Aftercare; V58.0-Encounter for Radiation Therapy; V58.1-Encounter for Chemotherapy; V58.61-V58.61 – Long-term current use of medications (i.e. coumadin); V55.3 –Attention to Colostomy- (i.e. Closure).

**Company Response:**  The Company stated "it applies standard coding requirements and recognizes all current ICD-9 diagnosis codes and does not reject claims based on diagnostic or re-sequence the order of submitted diagnoses."

**Testing:**  The selected sample showed proper use of V5x codes.  Review of the total population for these codes within the data files shows these codes being accepted and recognized in different positions.

**Results:**  No exceptions were noted.


*Issue 11*

V30.00-V39.20 - Liveborn Infants - There are concerns that certain payers instruct providers to omit the V code as the first listed code on claims forms.

**Company Response:**  The Company stated "it applies standard coding requirements and recognizes all current ICD-9 diagnosis codes and does not reject claims based on diagnostic or re-sequence the order of submitted diagnoses."

**Testing:**  There were no V3x codes in the selected sample. However, review of the total population for these codes within the data file showed no evidence that V codes are being omitted.

**Results:**  No exceptions were noted.


*Issue 12*

V04.8 –Flu; V05.9 – Viral; V06.5-Tetanus Vaccinations - There are concerns that certain payers reject claims for these codes with error message:  Diagnosis incorrect for reimbursement.

**Company Response:** The Company stated "it applies standard coding requirements and recognizes all current ICD-9 diagnosis codes and does not reject claims based on diagnostic or re-sequence the order of submitted diagnoses."

**Testing:** The selected sample showed that these codes were handled properly.

**Results:** No exceptions were noted

### *Issue 13*

Contraceptive V25.09-Mgt; V25.41-BCP Surveillance; V25.49-Surveillance - There are concerns that certain payers reject claims with the error message: Diagnosis incorrect for reimbursement.

**Company Response:** The Company stated "it applies standard coding requirements and recognizes all current ICD-9 diagnosis codes and does not reject claims based on diagnostic or re-sequence the order of submitted diagnoses."

**Testing:** The selected sample did not have any claims with ICD codes V25x. However, review of the total population for these codes within the data file showed these codes accepted and recognized in multiple positions.

**Results:** No exceptions were noted.

### *Issue 14*

V72.8x –Other Specified Exams - There are concerns that certain payers reject claims with first listed diagnosis of V Code for the Examination. Instructions are given to submit a medical condition (acute or chronic) rather than the V Code.

**Company Response:** The Company stated "it applies standard coding requirements and recognizes all current ICD-9 diagnosis codes and does not reject claims based on diagnostic or re-sequence the order of submitted diagnoses."

**Testing:** The selected sample did not include any claims with ICD Code 72.8x. However, the IT specialist reviewed the total population for these codes within the data file and determined that these codes were accepted and recognized in different positions.

**Results:** No exceptions were noted.

### *Issue 15*

Timely ICD-9, CPT-4, HCPCS updates in system - There are concerns that providers are looking for the actual dates that the codes are adopted and the actual dates they are implemented/used for claims processing.

**Company Response:**  The Company stated "it applies standard coding requirements and implements updates to CPT effective in January and HCPCS codes are updated on a quarterly basis. ICD-9 codes are effective in October and April.  New codes are accepted for processing on the compliance dates set forth by the Federal Government and mandated by HIPAA."

**Testing:**  The Company provided numerous reports for new or deleted codes effective January 1, 2012, showing the entire process which includes procedures, testing and implementation.  The testing process produces very comprehensive reports including an indication of the expected outcome, actual outcome and if the tested codes pass or fail. Review of the documentation showed that updates are made timely.

Results:  No exceptions were noted.


### *Issue 16*

Physical Therapy ("PT")/Occupational Therapy ("OT") evaluation versus initial evaluation - PT and OT share many of the same CPT codes.  Standard coding guidelines requires modifiers, but there are concerns that certain payers do not allow them  and are also requiring inappropriate use of CPT codes by requiring OT to be billed using Evaluation or Re-Evaluation CPT codes, instead of the actual modalities that were performed.

**Company Response:**  The Company stated "it applies standard coding requirements and does not restrict CPT evaluation, re-evaluation, or modality by revenue code."

**Testing:**   The review of the selected sample and total population of the data file showed proper use of modifiers.

**Results:**  No exceptions were noted.


### *Issue 17*

Canceled Procedures – V Code and Modifiers - Institutional Claims: Modifiers and ICD-9 codes exist to reflect cancellation of planned procedures.  There are concerns that certain payers do not have clear-cut payer policies and recognition of modifiers to promote consistent capture and claims processing.

**Company Response:** The Company stated "it applies standard coding requirements and recognizes all current ICD-9 diagnosis, CPT procedure codes and modifiers."

**Testing:** The selected sample showed that the Company allows and recognizes codes and modifiers for Institutional cancelled procedures.

**Results:** No exceptions were noted.


### *Issue 18*

Canceled Procedures – V Code and modifier – Physician - Modifiers and ICD-9 codes exist to reflect cancellation of planned procedures. There are concerns that certain payers do not have clear-cut payer policies and recognition of modifiers is needed in order to promote consistent capture and claims processing.

**Company Response:** The Company stated "it applies standard coding requirements and recognizes all current ICD-9 diagnosis, CPT procedure codes and modifiers."

**Testing:** The selected sample showed that the Company allows and recognizes codes and modifiers for Physician cancelled procedures.

**Results:** No exceptions were noted.


### *Issue 19*

Total Number of diagnosis accepted and/or recognized - Institutional Claims – there are concerns that there was variation in the number of outpatient diagnostic codes accepted and recognized by payers.

**Company Response:** The Company stated "it applies standard coding requirements and recognizes up to four submitted ICD-9 diagnosis codes and does not re-sequence the order of submitted diagnoses."

**Testing:** Review of the total population of the data file and the selected sample showed up to four ICD codes accepted and recognized by the Company for Institutional claims.

**Results:** No exceptions were noted.


### *Issue 20*

Total Number of diagnosis accepted and/or recognized - physician level claims - There are concerns that that there was variation in the number of outpatient diagnostic codes accepted and recognized by payers.

**Company Response:** The Company stated "it applies standard coding requirements and recognizes up to four submitted ICD-9 diagnosis codes and does not re-sequence the order of submitted diagnoses."

**Testing:** Review of the total population of the data file and the selected sample showed up to four ICD codes accepted and recognized by the Company for Physician claims.

**Results:** No exceptions were noted.

### *Issue 21*

Medical Necessity Denials and Rejections - Code Recognition: Claims Denials and Rejections There are concerns that certain payers are not consistently reading or recognizing additional 2nd, 3rd, 4th listed diagnoses codes pre-determined and documented medical necessity for the plan(s).

**Company Response:** The Company stated "it applies standard coding requirements and recognizes up to four submitted ICD-9 diagnosis codes and does not re-sequence the order of submitted diagnoses."

**Testing:** Review of the total population of the data file and the selected sample showed up to four ICD codes accepted and recognized.

**Results:** No exceptions were noted.

### *Issue 22*

Medical Necessity Denials and Rejections: Policy Coverage Logic - There are concerns that for certain payers 1. Payer Guidelines fail to recognize official coding guidelines by requiring 1st listed/primary codes that are vague and/or should never be used as 1st listed diagnostic codes (examples: Late effect 900 codes) 2. Incorrect ICD-9-CM diagnostic codes are listed by the payer for coverage. Failure of the payer to recognize the correct diagnoses codes (example: authorizing coverage for 996.52 complications for skin grafts vs. amputation flap complication code category range). 3. Policy Coverage Language that ensures coverage for high risk/family history conditions but fails to recognize Official Sequencing Guidelines for codes submitted. In other words, recognizes 1st listed code only.

**Company Response:** The Company stated "it applies standard coding requirements and is compliant and recognizes UB04 & HIPAA code sets, as well as ICD 9 diagnosis code set."

**Testing:**  Review of the total population of the data file and the selected sample showed up to four ICD codes accepted and recognized.

**Results:**  No exceptions were noted

### *Issue 23*

Medical Necessity Claims and Rejections: Outpatient Claims and Rejections - There are concerns that for certain payers 1.  Medical Policy Language Fails to Address Official Outpatient Coding Guidelines (example:  Fetal Ultrasounds - Coverage Policy lists "coverage for suspected condition listing").

**Company Response:**  The Company stated "it applies standard coding requirements and is compliant and recognizes official coding guidelines for outpatient services."

**Testing:**   The selected sample showed that outpatient claims were handled properly.

**Results:**  No exceptions were noted.

### *Issue 24*

Unlisted CPT Procedure Codes - There are concerns that for certain payers 1.  Payer Rejections and Mandates for Hospital to "Change" the Unlisted Code to closest/similar CPT Code due to Payer IS/ Processing Constraints and/or lack of Medical Review Policies pertaining to unlisted CPT Codes.

**Company Response:**  The Company stated "it applies standard coding requirements and reviews unlisted service for coverage determination and medical policy. The Company also stated that it accepts unlisted CPT procedures when no valid CPT is available."

**Testing:**  There were no unlisted codes in the selected sample.  The examiners reviewed the Company's procedures for claims with unlisted codes.  Because unlisted and unspecified procedure codes do not describe a specific procedure or service, the Company requires the provider to submit supporting documentation when filing the claim. Pertinent information should include:

*   A clear description of the nature, extent, and need for the procedure or service.
*   Whether the procedure was performed independent from other services provided, or if it was performed at the same surgical site or through the same surgical opening.
*   Any extenuating circumstances which may have complicated the service or procedure.
*   Time, effort, and equipment necessary to provide the service.
*   The number of times the service was provided.

When submitting supporting documentation, the provider is required to *underline* the portion of the report that identifies the test or procedure associated with the unlisted procedure code. Required information must be legible and clearly marked.

The review of the provided documentation showed that the Company's procedures for processing claims with unlisted codes are appropriate.

**Results:** No exceptions were noted.

### Issue 25

Unlisted CPT Procedure Codes - Errors in Assignment (Payer and Provider) - Payer/Provider Audit Discrepancies. There are concerns about discrepancies in certain payers' provider audits with Multiple Payer Rejections of Unlisted CPT Procedure Codes leading to manual re-review, manual appeal, manual re-submission of supporting documentation.

**Company Response:** The Company stated "it applies standard coding requirements and reviews unlisted service for coverage determination and medical policy. The Company also stated that it accepts unlisted CPT procedures when no valid CPT is available."

**Testing**: See above issue 24.

**Results**: No exceptions were noted.

### Issue 26

Retrospective Diagnosis Related Groups (DRG) and CPT Audits (Inpatient and Outpatient Provider) – There were the following concerns for certain payers –

1. Payer/Provider Discrepancies. Multiple Rejections of Initial DRG Assignment leading to manual re-review, manual appeal, manual re-submission of supporting documentation.
2. Auditors fail to quote and/or ignore Official ICD-9-CM and CPT Code Set Guidelines.
3. High Appeal/Over-turn Rates Upon Re-Review (35-40%).
4. Escalating Administrative Costs Associated with Payer's Failure to Recognize Official Code Set Guidelines.

**Company Response:** The Company stated "it applies standard coding requirements and works to ensure that the contracted DRG Validation vendor findings cite only the official code set guidelines."

**Testing:**   The selected sample showed that DRG Claims were handled properly.

**Results:**  No exceptions were noted.

**III.** **Claims Review**

The Company provided a data file containing 1,600,945 claim records. A total of 184 claims were randomly selected for review. The sample was reviewed to determine the Company's acceptance and recognition of information submitted pursuant to current coding standards and guidelines required as well as use of standardized claim formats.

The Company uses standardized claim formats for processing health care claims as adopted by the National Uniform Claim Committee and the National Uniform Billing Committee and implemented pursuant to the HIPAA.

The claim files reviewed included a total of 436 CPT/HCPCS codes, 93 Modifiers and 359 ICD codes.

**Results:**

No exceptions were noted.

# ACKNOWLEDGMENTS

The courtesy and cooperation of the officers and employees of the Company during the examination are acknowledged and appreciated.

Victor M. Negron, AIE, FLMI, and Timothy Nutt, CIE, participated in this examination.

Respectfully submitted,


Examination Resources, LLC