Reimbursement/Billing Policy

PARAMOUNT

HMO AND PPO
ELITE (MEDICARE ADVANTAGE)
MARKETPLACE

Claims Payment Recovery/Recoupment

Policy Number: RM014
Last Review: 02/01/2024

GUIDELINES:

- Paramount Reimbursement Policies have been developed to assist in administering proper payment under benefit contracts.
- Reimbursement policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements.
- Paramount utilizes industry standard coding methodology and claims editing in the development of reimbursement policies. Industry standard resources include, but are not limited to, CMS National Correct Coding Initiative (NCCI), Medically Unlikely Edits (MUEs), Integrated Outpatient Code Editor (I/OCE) Clinical edits, Medical Policies, Reimbursement Policies, and Administrative/Provider Manuals. Paramount will not reimburse services determined to be Incidental, Mutually Exclusive, or Unbundled.
- All health care services, devices, and pharmaceuticals must be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes and modifiers, which most accurately represent the services rendered, unless otherwise directed by the Paramount. All billed codes must be fully supported in the member's legal medical record.
- Paramount utilizes CMS pricing algorithms where appropriate based on, National Physician Fee Schedule Relative Value File (NPFSRVF) pricing rules, Inpatient Prospective Payment Systems (MS-DRG, LTC, IPF, IRF & IPSNF) and Outpatient Prospective Payment Systems (OPPS, HHA, ASC, ESRD & OPSNF).
- Paramount liability will be determined after coordination of benefits (COB) and third-party liability (TPL) is applied to the claim. Member liability may include, but is not limited to, co-payments, deductibles, and coinsurance. Members' costs depend on member benefits.
- Paramount routinely reviews reimbursement policies. Updates are published on Paramount's website https://www.paramounthealthcare.com. The information presented in this reimbursement policy is accurate and current as of the date of publication. Paramount communicates policy updates to providers via Paramount's monthly bulletin.

SCOPE:

X Professional
X Facility

DESCRIPTION:

Claims payment recovery is the process where Paramount obtains reimbursement from a provider/facility/member for any portion of a claim which is determined to be ineligible for reimbursement. The purpose of this policy is to establish controls and protocols for retrospective reviews of claim payments and consistent administration to recover overpayment of claims.

POLICY:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

Paramount will seek overpayment recovery from both participating and non-participating providers when Paramount has determined an error in reimbursement related to, but not limited to, the following reasons:

- Retroactive member termination of coverage;
- Incorrect coding/billing based on national standards in effect on date of service;
- Incorrect payment based on benefit plan provisions;
- Fraud;
- Overpayment and duplicate payment;

- COB validation; and
- Retro/backdated fee schedules.

Paramount Commercial Insurance Plans:
Paramount will notify providers, via letter, when an overpayment has been identified

Overpayment Letters will include the following information:

(1) The full name of the beneficiary who received the health care services for which overpayment was made;
(2) The date or dates the services were provided;
(3) The amount of the overpayment;
(4) The claim number or other pertinent numbers;
(5) A detailed explanation of basis for the third-party payer's determination of overpayment;
(6) The method in which payment was made, including, for tracking purposes, the date of payment and, if applicable, the check number;
(7) That the provider may appeal the determination of overpayment, if the provider responds to the notice within thirty (30) days; and
(8) The method by which recovery of the overpayment will be made.

Overpayment review/appeal requests will be accepted when received by Paramount within thirty (30) days of the initial date on the Provider's overpayment letter.

If provider responds to the notice of determination of overpayment within thirty (30) days but elects not to appeal the determination or appeals the determination and the appeal is upheld or if provider does not respond to the notice of determination of overpayment within thirty (30) days, Paramount will initiate the auto-recovery process. Paramount will auto-offset funds from a current or future payment cycle whenever sufficient funds are expected to be available. In instances where sufficient funds are not available for offset, Paramount will issue a recovery notice (refund request) to the provider at the address on file. Recovery notices are expected to be satisfied in full, by the provider, within thirty (30) days of the date on the recovery notice. Providers who do not remit funds to Paramount on a timely basis will be subject to collection actions.

Elite (Medicare Advantage) Plans:
Paramount will initiate the auto-recovery process. Paramount will auto-offset funds from a current or future payment cycle whenever sufficient funds are expected to be available. In instances where sufficient funds are not available for offset, Paramount will issue a recovery notice (refund request) to the provider at the address on file. Recovery notices are expected to be satisfied in full, by the provider, within thirty (30) days of the date on the recovery notice. Providers who do not remit funds to Paramount on a timely basis will be subject to collection actions.

Overpayment review/appeal requests will be accepted by Paramount when applicable.

Paramount Advantage Medicaid: Dates of service prior to 2/1/2023
Paramount will seek overpayment recovery from both participating and non-participating providers in accordance with OAC 5160-1-19(G).

Claim adjustment requests to overpaid claims must be submitted, and overpayments refunded within sixty (60) days of discovery by either Paramount or the provider. When an overpayment is identified by Paramount, Paramount will notify providers, via letter, of the overpayment.

Paramount will initiate the recovery process sixty (60) days after discovery.

Paramount will auto-offset funds from a current or future payment cycle whenever sufficient funds are expected to be available.

In instances where sufficient funds are not expected to be available for offset, Paramount will issue a recovery notice (refund request) to the provider at the address on file. Recovery notices are expected to be satisfied in full, by the provider, within sixty (60) days. Providers who do not remit funds to Paramount on a timely basis will be subject to collection actions.

Overpayment Letters will include the following information:

(1) The full name of the beneficiary who received the health care services for which overpayment was made;
(2) The date or dates the services were provided;
(3) The amount of the overpayment;
(4) The claim number or other pertinent numbers;
(5) A detailed explanation of basis for the third-party payer's determination of overpayment;
(6) The method in which payment was made, including, for tracking purposes, the date of payment and, if applicable, the check number; and
(7) The provider has sixty (60) days from the date of the invoice to seek reconsideration or remit payment to Paramount.

Exceptions:
Member recovery (for claims that were paid to members) – it is the intent to recover from members using a reasonable timeframe. All cases resulting in an overpayment to a member must be reviewed with either the AVP Provider Experience or the AVP Member Services prior to any overpayment recovery action.

REVISION HISTORY EXPLANATION: 08/07/2020

Date	Explanation & Changes
08/07/2020	• Reimbursement Policy created
07/01/2021	• Administrative updates
11/01/2023	• Reimbursement/Billing Policy update to reflect current reimbursement/billing criteria
02/01/2024	• Reimbursement/Billing Policy updated to new policy template

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs

National Physician Fee Schedule Relative Value File Calendar Year XXXX, Centers for Medicare & Medicaid Services (CMS) https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

NCCI Policy Manual for Medicare Services, current version, Chapter 1, General Correct Coding Policies https://www.cms.gov/files/document/medicare-ncci-policy-manual-2023-chapter-1.pdf

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services https://www.ama-assn.org/amaone/cpt-current-procedural-terminology

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update

Centers for Medicare & Medicaid Services (CMS), ICD-10-CM Official Guidelines for Coding and Reporting https://www.cms.gov/medicare/coding/icd10

Centers of Medicare & Medicaid Services (CMS), Medicare Claims Processing Manual, Chapter 23-Fee Schedule administration and coding Requirements https://www.cms.gov/Regulations-and-

Guidance/Guidance/Manuals/downloads/clm104c23.pdf

Centers for Medicare & Medicaid Services (CMS), National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare

Center for Medicare and Medicaid Services, Medicare NCCI Medically Unlikely Edits (MUEs) https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medically-unlikely-edits

Industry Standard Review

Ohio/Michigan * Michigan does not have regulation regarding recovery timeframes; therefore, Paramount will apply Ohio ruled to Michigan claims.

Ohio Revised Code (“ORC”) 3901.388

Ohio Administrative Code (“OAC”) 5160-1-19

Indiana Code (“IC) 27-13-36.2-8

Indiana Code 27-13.36.2-9