CLINICAL CLAIM REVIEW

Provider Insight: Place of Service Review

When HMS has been contracted by a health plan to conduct Place of Service (POS) clinical claim reviews, we review certain identified claims and medical records associated with those claims to verify that billing of an inpatient POS is consistent with CMS policy, regulations, health plan payment policy and other industry standards.

POS Review is complementary to prior authorization and pre-certification programs.

HMS uses data-driven algorithms to identify hospital inpatient claims with characteristics indicating potential incorrect billing. The POS Review is complementary to prior authorization and pre-certification programs that payers may use.

We do not make a medical necessity determination of services. The POS review does verify that the place of service billed was consistent with the patient's condition and the care and services actually provided, as documented in the complete medical record.

The audit results ensure payments are consistent with the services provided. If HMS finds an inpatient stay billed in error, in most cases the provider can rebill the claim for the level of care and services associated with the appropriate setting.

Our expert team of reviewers includes nurses, certified coders, therapists, and social workers, along with a panel of contracted physician reviewers who represent all American Board of Medical Specialties areas of medicine. The team operates under the direction of the HMS chief medical officer and medical directors.

What to Expect if You've been Notified of a POS Review

Claim audits are an important tool health plans use to control cost and ensure compliance with regulations and policies. When submitted claims are selected for POS review, you will receive a medical record request letter regarding medical records relevant to the claims in question.

The medical record request will include:

- Additional information on the audit being performed
- List of medical record documentation needed in order to complete the audit
- A time frame explaining when the medical record must be received and
- Instructions on the best way to submit medical record documentation to HMS

The medical record request letter you receive will also include contact information for our Provider Relations team, who are ready to answer any questions and help with the audit process.

After the requested medical records are received, an experienced team of nurses or physicians will perform an in-depth review of the submitted documentation. The type of audit HMS conducts on any group of claims can vary and will be determined by the criteria set by the health plan.

A determination will be made based on our findings, and a notice will be mailed to you with the results. If the notice is for an overpayment, we'll provide the claim information and the rationale for the determination. It's possible you may disagree with the audit findings and rationale. Detailed instructions for appealing the determination are included.

Contact HMS today for additional questions regarding our clinical claims review process or if you have questions regarding a request for medical records you have received.

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