26. Program Integrity (Section 36.0 Program Integrity)

a. Provide a detailed summary of Contractor's proposed Program Integrity plan, including a discussion of the following:

UnitedHealthcare Community Plan of Kentucky (UnitedHealthcare) is committed to the highest standards of quality and integrity and, in concert with the UnitedHealth Group Compliance & Ethics Office, has implemented the UnitedHealthcare Compliance Program (Compliance Program). Our Compliance Program promotes adherence with applicable legal requirements, fosters ethical conduct within the company and provides guidance to all those we do business with and for, including our employees, caregivers, providers, enrollees and contractors. Accordingly, the Program Integrity Plan (PI Plan) for the Commonwealth of Kentucky will be designed to outline internal controls and have documented policies and procedures (P&Ps) to address how we prevent, detect and correct fraud, waste and abuse (FWA). The foundation of the PI Plan is our Anti-Fraud, Waste and Abuse Program (Anti-FWA Program) which works to protect the ethical and fiscal integrity of UnitedHealthcare's Kentucky health care plan and the MCO program. We recognize the importance of combating FWA through effective and innovative prevention, detection, correction and reporting practices, both prospectively and retrospectively. Across the nation, we work to be good stewards of state and federal Medicaid dollars. We are steadfast in our commitment to preventing FWA through the implementation of multiple programs and processes that seek to identify problems arising from both intentional and unintentional practices. Our Anti-FWA Program and its P&Ps comply with all state and federal statutes and regulations, including 42 C.F.R. 438.608 and Section 6032 of the Federal Deficit Reduction Act of 2005, and, as described herein, will be customized as needed to ensure compliance with all relevant Kentucky statutes and regulations.

The Program Integrity (PI) Plan for the Kentucky MCO program will communicate how we proactively and retrospectively identify FWA. The PI Plan will include descriptions of our:

- Compliance and commitment to all DMS and federal requirements, standards and requests under the MCO contract
- Results of algorithms used for the analysis of claims data
- Reporting methods
- Program integrity unit's organization and lines of communication
- Disciplinary guidelines
- Operational system procedures and protocols

The components of this plan will be based upon all requirements listed in Attachment C – Draft Medicaid Managed Care Contract and Appendices, Section 36.1 Program Integrity Plan and the Appendix for PI Requirements, and UnitedHealthcare's Compliance Program.

Our designated interim Kentucky chief compliance officer (CCO) is Monique Beutel. We have extended a letter of intent for our Kentucky health plan chief compliance officer to an individual who has over 20 years in the industry and is currently working in the Kentucky market. They have accepted and are ready to begin post award. As interim CCO, Ms. Beutel has more than 20 years' experience in health care and is certified in health care compliance. She has experience administering requirements of Medicaid and Medicare compliance programs, has a background in health care finance and several years' experience as a compliance officer for Medicaid markets to include Maryland and Delaware. Our CCO will oversee our Anti-FWA Program, in collaboration with our special investigations unit (SIU), and will be responsible for overseeing all components of the Anti-FWA program, including identifying and instituting such changes as are necessary to ensure compliance with any unique Commonwealth FWA

requirements. The health plan's CCO's duties will include validating ongoing training takes place as appropriate, using available reports from the monitoring that occurs and referring (as appropriate) FWA cases to DMS. To meet and exceed DMS's defined minimum standards for our PI unit — which includes staff from our health plan, payment integrity, compliance, special investigation unit (SIU), legal and vendor/affiliate teams (e.g., pharmacy network audit team) — we will enhance our current investigatory capacity by hiring and maintaining two qualified, Kentucky-based full-time investigators who will be 100% dedicated to the Kentucky health plan and MCO program. These staff will minimally conduct three on-site visits to identified providers per quarter, upon approval by DMS at least 10 days in advance. We also will hire a dedicated, Kentucky-based, full-time PI coordinator with accountability to the CCO who will serve as DMS's single point of contact and facilitate timely responses to information requests, including claims data.

i. The Contractor's fraud and abuse detection/prevention program activities for employees, caregivers and providers, including reporting and follow-up, continuous monitoring of compliance, identification and reporting of issues to all required parties, and ongoing training.

Our Anti-FWA Program focuses on prevention, detection and correction activities undertaken to minimize or prevent overpayments due to FWA. Through our operational model, appropriately titled Prevention, Detection and Correction, we further increase the effectiveness of our local compliance program by drawing upon our national team that spans 31 states where we serve Medicaid enrollees. Through information sharing with programs in other states, our national and state teams can uncover potential schemes and bring in additional resources if needed to increase our ability to avoid or remediate fraud and abuse in Kentucky efficiently. Our Anti-FWA Program will be designed to fit the unique Kentucky landscape. The chief compliance officer, PI coordinator and full-time, Kentucky-based investigators will apply our industry expertise and vast FWA systems to meet the needs of the Commonwealth.

Figure 1. Key Features of UnitedHealthcare's Prevention, Detection and Correction Model

Our ***preventive*** FWA program has proven highly successful at protecting the integrity of health care dollars and generating savings. The program's tools, which focus on provider-centric and claims-centric analytics, create cost savings by preventing overpayments, and identifying and educating on aberrant provider billing practices. For example, our preventive Provider Awareness campaigns are targeted reviews aimed at engaging and collaborating with large groups of practitioners who are identified as needing education for a particular billing issue. Our engagement with the provider encourages billing behavior change in a less abrasive manner than a medical record review. Campaigns are customized based upon specific need. By addressing opportunities for provider education or investigating inappropriate provider billing practices before paying a claim, preventive FWA activities lead to cost avoidance

and reduce administrative costs. Refer to our response under *UnitedHealthcare's Proposed Approach to Prepayment Reviews* for more information on our preventive tools and capabilities.

The following table highlights the 2018 cost savings we achieved via our preventive program's avoidance and prospective activities and more.

Medicaid FWAE Program (2018)	Subprogram	Type	Total
Fraud & Abuse (FA)	System Edits	Avoidance	$141,273.07
		Prospective	$15,360,036.05
	Medical and Pharmacy	Prospective	$3,057,961.00
	Medical and Pharmacy	Retrospective	$2,972,962.34
FA Total			**$21,532,232.46**
Waste & Error (WE)	Medical	Prospective	$46,118,392.32
	Facility	Prospective	$40,822,319.88
	Medical and Pharmacy	Retrospective	$3,751,677.87
	Facility	Retrospective	$93,680,177.96
WE Total			**$184,372,568.03**
Grand Total			**$205,904,800.49**

Our retrospective FWA program includes ***detection***, audit, investigation and recovery activities where we have paid claims that we later associated with suspected FWA practices. Working with our vendors and contractors, we perform retrospective activities in compliance with contractual and regulatory requirements for reimbursement accuracy. These retrospective activities entail the same type of tasks used with prospective detection, investigations and recovery, and may occur in tandem with them. We review these investigations monthly with internal partners to determine strategy. We will review our case statuses with DMS as required quarterly.

Electronic data analysis or mining of claims data is generally regarded as the most effective method of ***detecting suspected FWA***. It uses algorithms and queries to electronically mine claims data from various sources to detect suspected FWA. A description of the categories of data analyses are in the following table:

Data Analysis to Detect Intentional and Unintentional Practices	
Post-payment Data Analytics	We apply multiple levels and types of electronic data analysis to paid claims to prevent future payments induced by FWA and to identify retrospective audit, investigation and recovery opportunities.
Payment Error Analysis	We analyze paid claims to identify various types of billing errors and irregularities. The analysis helps identify suspected instances of FWA.
Industry Trends (Sharing Awareness)	We review trends and information from multiple industry and professional associations. We assess their potential effect on our benefit programs and use the information to inform future FWA activities.
Aberrant Billing Patterns (ABPs)	We maintain libraries of ABPs that include queries and algorithms designed to identify suspected FWA based upon known or suspected schemes and practices. These ABPs include general queries and criteria applicable to all health plan claims and those tailored to common Medicaid FWA schemes. We use ABP criteria to analyze claims data and provider claim trends.
Provider/Enrollee Verification	We use electronic queries to verify the existence of providers billing for services and the existence and eligibility of enrollees.

UnitedHealthcare also has FWA correction mechanisms to provide prompt response to detected offenses and corrective action, including, but not limited to:

- Provider and/or pharmacy notification
- Education and recovery efforts
- Network termination
- Appropriate referral of suspected FWA matters to law enforcement, regulatory and administrative agencies, according to state and federal law and regulatory requirement

Retroactive affirmative recovery actions against paid claims are taken based upon prospective and retrospective activity where credible evidence exists to indicate the provider is engaged in FWA activity.

Using these described preventive, retrospective and corrective methods, specific FWA activities for employees, subcontractors, caregivers and providers include the following, with training as a critical component and benefit of our PI Plan for each entity type.

Entity	Fraud and Abuse Detection/Prevention Program Activities
Employees and Subcontractors	Every UnitedHealthcare employee is responsible for conducting business honestly and ethically, fostering a climate of ethical behavior that does not tolerate FWA. UnitedHealthcare employees do not engage in any activities that impede the investigation of suspected FWA and are required to report suspicions or observations of FWA or noncompliant activity. Employees reporting suspicions of FWA or noncompliant activity may remain anonymous and are protected from retaliation for reports made in good faith. Employees regularly receive training and education regarding these standards and responsibilities (e.g., FWA new hire and annual re-training, Code of Conduct new hire and yearly re-attestation) including required reporting methods. Specialized training and education in federal and state-specific regulatory and legal requirements may also be provided on compliance and FWA risks based upon the employee's job function and responsibilities. Subcontractors and vendors are required to provide similar training. They are required to attest annually that all new staff has been trained and that all existing staff has had annual training on FWA identification, reporting, standards of conduct and whistleblower protections.
Caregivers	Given that a large portion of complex care enrollees (e.g., LTSS, individuals with developmental disabilities and foster care) receive services outside of traditional facility settings, we see that area as one with an increased potential for FWA. We have extensive experience considering state-specific nuances when developing our algorithms for FWA programs and we will do so for the Kentucky MCO program's caregivers, whether they are the enrollee's family member hired/asked to be their attendant care worker or a direct care worker providing complex-care enrollee support via a home and community-based service (HCBS) agency. If the caregiver is a family member, we will have them become an employee of a participating provider or be hired through an HCBS agency with choice or self-directed programs. We have successfully used this solution in other markets, which helps us streamline FWA monitoring, education and reporting. While seeking cost avoidance and reduction of FWA, we educate caregivers on FWA, Code of Conduct and service delivery, and include anti-FWA-related materials in their UnitedHealthcare Welcome Kit. We offer education opportunities on an ongoing basis via such methods as provider advocates, mailers and bulletins. Examples of these trainings include reimbursement policy related to submission of claims and subcontracting of personal care services for independent caregivers. The delivery environment of care in the home makes accountability of visits and

Entity	Fraud and Abuse Detection/Prevention Program Activities
	services more challenging than in centralized, facility-based care models. Using electronic visit verification (EVV) system can cut down on fraudulently documented home visits by providing a means of electronically verifying that a caregiver is physically present with the enrollee. Therefore, during our Kentucky caregiver training sessions, we will mainly focus on the use of EVV in a managed care environment, subject to Commonwealth policy decisions about the new EVV federal regulations. Our provider advocates will offer educational assistance related to UnitedHealthcare's administrative processes and requirements around EVV and its relation to FWA — with a particular focus on claim submissions via the EVV system.
Providers	UnitedHealthcare checks the exclusion status of all applying providers against required exclusion lists and sites monthly, including (as appropriate): ▪ Health and Human Services Office of Inspector General's List of Excluded Individuals/Entities ▪ General Services Administration Excluded Parties List Service ▪ General Services Administration's System for Award Management ▪ CMS' Medicare Exclusion Databank ▪ State Board of Examiners ▪ National Practitioner Data Bank ▪ Health Integrity and Protection Databank ▪ Social Security Administration Death Master File ▪ National Plan and Provider Enumeration System ▪ U.S. Office of Foreign Assets Control ▪ State listings of excluded providers Following our monthly exclusion checks, we will report all exclusion information to DMS and immediately sever the relationship with a debarred or excluded individual. Once participating, we offer initial and ongoing integrity and compliance training to providers through our secure provider website, *UHCprovider.com* (available 24 hours a day, seven days a week). We also convey information about our Anti-FWA Program in our *Care Provider Manual*, our provider newsletter, *Practice Matters*, and through targeted provider education letters. Our provider advocates also conduct in-person training to providers and their staff as needed. As part of our continuing compliance monitoring of network providers and high-risk claims, we use predictive modeling, pre-pay analytic edits, libraries of ABPs algorithms, machine learning and data mining tools to identify aberrant and excessive billing practices and trends, inappropriate treatment, and fictitious and unqualified providers. For example, when we believe a provider has engaged in fraud or abuse, a prospective "flag" can be placed on provider payments. Flags are useful in preventing payments to providers until we validate their billing patterns. As an example of our provider FWA prevention success, in our Tennessee health plan, we determined through a medical record review that one of our in-network providers committed an ongoing health care fraud scheme primarily involving billing Medicare and TennCare for mobile allergy services, sublingual allergy drops and extended office visits. This provider tip was identified through our proactive algorithms. This specific algorithm was based upon a high number of patients per day. We sent the referral to the State and worked closely with federal law enforcement, including providing documentation of our case and claim data for the actual trial and sentencing. Our SIU prepared two witnesses who were ready to testify and coordinated efforts between state and federal law enforcement. They worked one-on-one with the Special Agent involved.

ii. An overview of the Regulatory Compliance Committee.

The Kentucky Regulatory Compliance Committee led by our health plan chief compliance officer and co-chaired by CEO Amy Johnston Little, will focus on engaging all members of the Kentucky leadership team to confirm that no area is missed in our review and implementation of the compliance program. Our compliance officer, who has direct accountability to the Board, will develop and manage the Kentucky Regulatory Compliance Committee meetings. The Regulatory Compliance Committee will interact with health plan leadership, shared service partners and compliance team staff to support shared accountability for Kentucky health plan compliance.

The membership will include, but will not be limited to our: chief operating officer, chief medical officer, chief finance officer, pharmacy director, quality director, behavioral health director, health services director, and marketing director. The Kentucky Regulatory Compliance Committee will meet at least quarterly or more frequently as needed and is co-chaired by the plan chief executive officer (CEO) and health plan chief compliance officer (CCO).

The Regulatory Compliance Committee assists the chief compliance officer with oversight and monitoring of the Kentucky operations, assessment of compliance risk areas and review of P&Ps. The committee also addresses regulatory changes and evaluates their effect on business processes, taking action when necessary. Ultimately, the Regulatory Compliance Committee facilitates the implementation of and adherence to the Compliance and Ethics Program, which is inclusive of Anti-Fraud and Program Integrity Plan activities, and reviews and assesses its overall effectiveness.

The CCO will ensure that the following components (at minimum) are included in the Regulatory Compliance Committee meeting process: maintain meeting documentation and educate the Regulatory Compliance Committee membership on the Compliance Program and its members' roles and responsibilities, with a focus on emerging risk.

iii. The proposed appeals process.

UnitedHealthcare National Appeals Performance
In 2018, we processed an average of 17,300 provider appeals per month, completing 98.8% within our standard contractual time frame. On average, we overturn about 28% of provider appeals because new information is presented during the appeal that was not available when the original claim was processed.

Each payment integrity inquiry and notice of overpayment provides information regarding the specific findings in addition to instructions on how providers can appeal the findings. We support and respond to every provider and enrollee reconsideration, dispute or appeal that directly or indirectly results from FWA or overpayment action. Our support and response will continue until the reconsideration, dispute or appeal is resolved based upon UnitedHealthcare's benefit coverage and claim coding standards.

Our process is structured to address the varying level of appeals (e.g., first level, second level). This structure will be updated to include any specific Commonwealth requirements, in addition to federal and contractual requirements including the use of an Independent Review Organization (IRO) when required. UnitedHealthcare records and retains information regarding the initial receipt, the ongoing correspondence, and the ultimate outcome of each appeal, dispute and grievance. In handling appeals, disputes and grievances, we respond within applicable turnaround time requirements for each Kentucky contracted product. We also consistently monitor our volume and turnaround times to meet requirements.

Our appeal and grievance process includes gathering facts about the reconsideration, dispute, or appeal and may include the following activities:

- Direct communication with the person who is filing the reconsideration, dispute or appeal, or the person's designated representative
- Interviewing other persons who may have information related to the reconsideration, dispute or appeal
- Analyzing relevant historic claims activity either at the enrollee or provider level
- Reviewing other reconsiderations, disputes or appeals that may be relevant or connected in some way
- Requesting and reviewing relevant medical records
- Interacting with United Clinical Services or UnitedHealthcare appeals and grievances teams for other considerations

Based upon the information received during the investigation of each reconsideration, dispute or appeal, we will take the appropriate resolution action(s) in a manner consistent with applicable UnitedHealthcare P&Ps, DMS contractual requirements and Commonwealth and federal law.

Our proven appeals process for managing FWA case finding disputes uses a two-tiered system of letters for disputes in the FWA arena:

1. The Engagement Letter is an opportunity to reach a mutually acceptable agreement.
2. If an acceptable agreement cannot be reached, we send a Demand Letter; UnitedHealthcare uses the term "dispute" instead of "appeal" in this situation.

Our *Care Provider Manual* explains the provider has 60 days to dispute (appeal) the demand. We have 30 days to respond to a provider dispute. We will review all documents received as a "dispute." If a dispute is not settled in 60 days, providers will be able to appeal final decisions in accordance with contractual requirements and Commonwealth regulations using the provider appeals process previously described and as appropriate.

iv. Proposed innovations for reporting data in the Program Integrity area. Provide examples of successful innovations implemented in Kentucky or other states.

UnitedHealthcare is a leader in the Program Integrity (PI) industry. We consistently collaborate with industry groups, government entities and law enforcement to combat fraud, maintain a high-quality program and identify opportunities for program enhancement via new, innovative solutions. UnitedHealthcare's investigations team maintains an active leadership role in the National Health Care Anti-Fraud Association; our current PI chief compliance officer and vice president of investigations is a former Board Chair (2017). This collaboration has led to the development of data reporting program innovations in our other Medicaid states. There are several innovative programs in place across UnitedHealthcare that provide further depth and breadth to our reporting capabilities. These programs meet the specific need of the particular state and/or local service areas to identify, quantify and address aberrant behaviors. We plan to implement and fully use the innovations described here to support the Kentucky MCO program.

Innovative Reporting

While we will use standard reporting criteria developed based upon our national experience, we will tailor reports to meet the specific needs of the Kentucky market. Our national best practice reporting capability is used as a baseline, and we will work with Kentucky regulators to determine if more focused reporting is needed based upon contractual requirements, specific populations and initiatives.

We have a dedicated centralized compliance regulatory reporting (CRR) team, which prepares and submits, periodic payment integrity reports concerning FWA detection and prevention efforts as required by state and federal statutes, regulations and contractual requirements. The CRR team staff is experienced reporting analysts. Regulators have sought our assistance in developing reporting templates in Florida and recently in North Carolina, noting that the dedicated nature of our team brings a depth of knowledge and experience in reporting and tracking outcomes. Our analysts collaborate with the health plan compliance officer and/or finance teams to develop standard periodic monitoring reports that are tailored to the individual market's contractual and regulatory reporting requirements. Our health plan chief compliance officer coordinates with the CRR team to ensure our compliance with timely report submissions. The compliance officer, PI coordinator, and PI team members supporting Kentucky will meet periodically with the Commonwealth regulatory agencies to review our reports, discuss providers under review, and share relevant case information.

Intelligence Center

INNOVATE

Our Intelligence Center identifies trends and behaviors based upon data, which in turn, is used to identify opportunities for cost containment and remediation whether that is fraud, waste, error or abuse. The Intelligence Center uses the latest detection tools and models to create dashboard visualizations that detail the areas where there is unusual outlier provider activity. It uses both adjudicated and 837 data sets, which allows historical analysis, but moves toward predictive provider behavior to detect issues before adjudication.

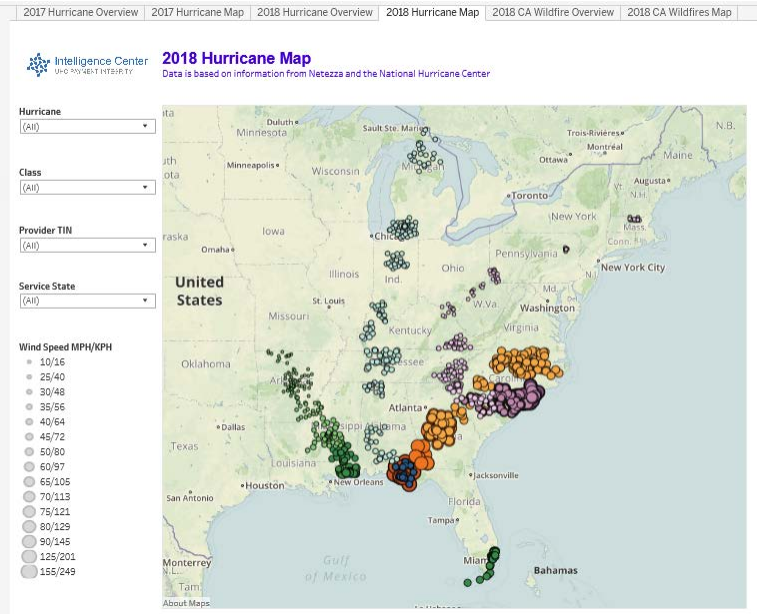

Figure 2. Example Intelligence Center Dashboard, showing the potential FWA, behavior and trend monitoring of providers who submitted claims for services performed during a hurricane.

Enhanced Provider Validation

Enhanced Provider Validation (EPV) is designed to target new out-of-network (OON) providers on first TIN/claim submission and to authenticate the new OON provider before adding them to our provider database. Stopping any fraudulent, new TINs before we pay them for the first time allows us to move from prepay and post-pay recoveries to avoidance. EPV applies analytics and an integrated end-to-end approach using multiple teams to review OON TINs before we pay their claims.

Premium Audit Services

Premium Audit Services
Our PAS Program CY 2018 results saved more than $134 million prospectively and retrospectively.

Premium Audit Services (PAS) develops and implements facility audits designed to identify billing and coding inaccuracy. All PAS audits include an in-depth review of critical claim elements such as medical record, itemized bill and manufacturer invoices. Audits are conducted retrospectively depending on federal and state regulations, national guidelines and contract terms. Facility audits are conducted across all

segments. All vendor audit concepts are vetted through the UnitedHealth Group compliance teams. Audits may include a review by registered/licensed nurses and/or certified coders working collaboratively with relevant facility representatives.

Drug Diversion Program

The Drug Diversion (DD) Program focuses on five controlled substance drug categories: 1) anti-anxiety medications; 2) muscle relaxants; 3) opioids/narcotics; 4) sedatives; and 5) stimulants. It is primarily used to identify parties, such as drug-seeking/addicted enrollees, medical professionals, pharmacists and others, who are involved in the diversion of controlled substances. The program targets medical professionals who prescribe controlled substances to UnitedHealthcare enrollees in the absence of i) a proper doctor-patient relationship and/or ii) a medical condition such as of cancer or a diagnosis of similar severity. It focuses on the following allegations: drug diversion; false medical claims (services up-coded, or not rendered to the enrollee receiving the controlled substance prescriptions); and patient harm (polydrug toxicity/death). The DD Program identifies leads at the provider and enrollee levels and takes the necessary actions (internal/external) to protect UnitedHealthcare and our enrollees (e.g., referring identified parties to required agencies and law enforcement, as required).

b. Describe the Contractor's proposed approach to prepayment reviews.

UnitedHealthcare's Proposed Approach to Prepayment Reviews

UnitedHealthcare recognizes that **the best time to address FWA is *before* a claim is paid**. Accordingly, we have P&Ps in place to administer prepayment reviews in accordance with all requirements noted in Attachment C – Draft Medicaid Managed Care Contract and Appendices, Section 36.2 Prepayment Review. We use aggressive and proven prevention techniques to inform our prepayment review strategy and continuously evaluate opportunities to expand and improve our program. These techniques include targeted programs, safeguards to prevent improper payments, provider education, employee education, provider facility reviews/audits and safeguards to prevent prohibited affiliations.

Comprehensive Payment Integrity Operations
Our Payment Integrity Program results include savings of more than $8 billion in 2018 using a dedicated workforce.

Our prospective FWA Program has proven highly successful at protecting the integrity of health care dollars and generating savings. The Program's tools, described in detail herein, create cost savings for managed care plans by preventing overpayments and identifying aberrant provider billing protocols. By addressing opportunities for provider education or investigating inappropriate provider billing practices before paying a claim, prospective FWA Program activities lead to reduced administrative costs.

Our comprehensive Payment Integrity Program uses the following customized tools and systems to analyze claims through prepayment clinical editing, screening and coding rules, and identify prospective payments for fraudulent or abusive charges to stop them prepayment.

- Unbundled codes
- Up-coded, invalid and duplicate codes
- Code fragmentation
- Enrollee age
- Patient gender
- Place of service
- Pre- and post-operative intervals
- Modifiers

When we identify either a provider or a type of service to flag for prepayment review, we have two distinct analytical methods that we employ. Claims that are "tagged" for a prospective review are denied and a medical record request is sent to the provider. The methods are:

- ***Prepayment Provider-Centric Flagging (P1):*** Flagging is an automated payment analytics approach that focuses on claims from specific providers identified by tips, previous suspect billing practices and historical claim data. Prospective provider flagging uses specific CPT code criteria to identify providers lacking necessary information, flags them in the system and stops claims missing required medical records. These flags prevent payments to these providers until we modify or remove the flags. Provider activity is continually monitored and reviewed to determine how long the flags should remain in place and whether they should be modified or removed. Processes are established for providers who wish to appeal or contest provider flag placements.
- ***Comprehensive Prepayment Claims-Centric Review (P2):*** P2 is an automated approach designed to identify and analyze billing patterns that represent a high risk of fraud and abuse before making payments. P2 review incorporates two complementary components that evaluate claims: challenger and predictive. Both analytics assume that most providers are billing correctly and look for claims that are outliers by creating data-driven peer groups. To achieve this, providers whose service mix is similar (based upon billed CPT codes) are grouped together.

When claims are identified via either P1 or P2, they are denied for review. We then send the identified provider a request for medical records to support a clinical review of the facility, conducted by a team comprising RNs, licensed practical nurses and certified coders. This cross-functional team conducts facility reviews aimed at determining whether the codes billed were indeed the services documented in the medical record. Outcome information from the reviewed claims is captured to allow for refinement and enhancement of this automated approach.