

TITLE:	Evaluation of Outlier Billing Patterns
DEPARTMENT:	PAYMENT POLICY
ORIGINAL EFF. DATE:	10/05/2026
REVISION DATE:	N/A

1. PURPOSE

This policy establishes Curative's approach to identifying and reviewing aberrant or outlier provider billing patterns and to requesting medical records or other supporting documentation when there is a reasonable, documented basis to evaluate potential waste, abuse, coding error, or other inappropriate billing. The policy is intended to promote accurate claim payment, consistent coding validation, and fair provider review while protecting members from inappropriate financial liability.

Curative and any delegated entity performing payment integrity functions on Curative's behalf will apply this policy consistently with applicable provider agreements, benefit plan documents, federal and state law, and other Curative payment or medical policies.

2. SCOPE

This policy applies to professional, facility, ancillary, and other provider claims submitted to Curative when a provider, provider group, service, code set, or billing pattern has been identified for targeted prepayment or postpayment review. It applies to participating and nonparticipating providers to the extent permitted by contract and applicable law.

This policy does not replace medical necessity review, prior authorization requirements, fraud investigations, benefit determinations, or provider appeal rights. Those processes may apply independently or concurrently when appropriate.

3. DEFINITIONS

- 3.1. **Correct Coding:** A claim payment adjustment in which the code, level of service, units, modifier, or other reimbursement element used for payment differs from that submitted based on information available to Curative, subject to applicable contract and law.
- 3.2. **Medical Documentation:** Contemporaneous clinical, billing, or other records reasonably necessary to validate the services billed, including medical records, orders, reports, itemized bills, operative notes, treatment plans, time documentation, medication administration records, or other supporting records.
- 3.3. **Prepayment Review:** Review of a claim and, when required, supporting documentation before final payment is issued.
- 3.4. **Postpayment Review:** Review of a paid claim and supporting documentation to determine whether payment was accurate and supported.
- 3.5. **Substantiated Billing Concern:** An aberrant or recurring billing pattern for which Curative has documented information establishing a reasonable basis for provider-specific payment integrity review or payment adjustment. Evidence may include claims analytics, peer comparisons, coding or utilization trends, prior review results, referrals, audits, record review, or other relevant information.
- 3.6. **Medical Necessity:** A service, supply, device, procedure, treatment, or item is considered medically necessary when a prudent physician or other qualified health care professional would provide or order it, in accordance with generally accepted standards of medical practice, and when it is clinically appropriate in terms of type, frequency,

extent, site, and duration of service or treatment

4. POLICY

Disclaimer: These Payment Policies serve as a comprehensive guide for all providers, assisting in submitting accurate claims and outlining the essential framework for reimbursement. The determination that a service, procedure, or item is covered under a Curative member's benefit plan does not constitute a guarantee of payment. Services must meet medical necessity and authorization guidelines appropriate to the procedure and diagnosis and, where mandated, the members state of residence. Services rendered must be within the legal scope of practice for the specific type of provider and align with the professional credentials and training in the state where the care is furnished.

To ensure proper processing, providers are required to adhere to industry-standard, compliant codes and follow proper coding, billing, and submission guidelines. Current Procedure Terminology (CPT®*) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or relevant revenue codes must be used for billing. Codes submitted must be fully supported by corresponding documentation in the medical record. Unless noted otherwise within a policy, these payment policies apply to both participating and non-participating providers and facilities.

Curative reserves the right to take corrective action, which may include the rejection or denial of the claim, or the recovery and/or recoupment of any previous claim payment if proper coding, billing guidelines, or these established payment policies are not followed. Providers may refer to the Provider Manual for guidance on addressing such actions, including the formal claim reconsideration, appeals, and dispute resolution processes.

These policies may be superseded by mandates within provider contracts and/or state or federal laws. Curative retains the right to revise these policies as deemed necessary and will publish the most current version on the Curative website.

Curative reserves the right to request and review comprehensive medical records to support claims submitted under this policy. Discrepancies, incomplete documentation, or coding misalignments may result in claim adjustments, denials, or post-payment recoveries.

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Reimbursement Guidelines

4.1. Provider Specific Billing Review

Curative may use claims analytics, coding edits, peer comparisons, utilization trends, prior review results, referrals, audits, or other payment integrity methods to identify aberrant or recurring provider billing patterns that warrant additional review.

A substantiated provider-specific pattern of aberrant coding or billing may result in targeted prepayment or postpayment review. The scope and duration of the review will be reasonably related to the identified billing concern and may include defined services, codes, modifiers, units, levels of service, or other claim characteristics.

When placing a provider on provider-specific billing review, Curative will document a reasonable basis for the action. The basis may include one or more of the following:

- A recurring pattern that materially differs from appropriate peers and is not adequately explained by known differences in patient population or practice characteristics;
- Claim-level analysis or medical record review that identifies unsupported or

inconsistent coding, units, modifiers, diagnoses, place of service, or level of service;

- Prior education, inquiry, audit, or review identifying repeated billing or documentation deficiencies;
- Information from a regulatory, law enforcement, network, credentialing, clinical, compliance, or payment integrity source that reasonably supports further review;
- Other documented facts establishing a reasonable concern regarding billing accuracy or appropriateness.

4.2. Medical Documentation and Claim Determination

Curative may require medical records and other supporting documentation necessary to validate the services billed, including the reported code, units, modifiers, diagnoses, place of service, medical necessity, and level of service.

Curative may reduce payment of a submitted code or level of service based on a provider statistical outlier pattern and require documentation for higher level of service, except where prohibited by federal or state laws or regulations. When documentation is received and reviewed, claims will be reimbursed based on the level of service and other claim elements supported by the medical record, applicable coding standards, Curative reimbursement policies, the Provider Agreement, the member benefit plan, and applicable law.

Claims for which requested documentation is not provided, is incomplete, or does not substantiate the billed service may be denied or otherwise adjusted as permitted by the Provider Agreement, applicable reimbursement policies, the member benefit plan, and law. Where the documentation supports a different payable code, level of service, units, modifier, or other claim element, Curative may reimburse the claim at the level supported by the documentation when permitted.

4.3. Prepayment, Post-payment, and Reconsideration

Curative may place a provider or a defined subset of claims on targeted prepayment or postpayment review when a substantiated billing concern indicates an elevated risk of inaccurate payment, waste, abuse, or recurring coding or documentation error. Prepayment or postpayment review is a payment integrity measure and does not, by itself, constitute a finding of fraud or an adverse credentialing action.

Providers may submit medical records and other supporting information through the applicable reconsideration, appeal, or dispute process. Curative will consider timely submitted documentation relevant to the billed service and will reprocess or otherwise adjust a claim when the documentation demonstrates that a different payment determination is appropriate.

Curative may periodically reassess provider-specific review and may discontinue, modify, or expand the review based on subsequent claim experience, medical record results, provider education or corrective action, and whether the identified billing concern has been sufficiently corrected.

4.4. State-Specific and Contractual Requirements

This policy will be administered subject to applicable federal and state law and the terms of the controlling provider agreement and benefit plan. If a law, regulation, provider agreement, or benefit plan imposes a more restrictive requirement than this policy, the more restrictive requirement will govern to the extent applicable.

Nothing in this policy authorizes automatic or uniform coding adjustments where prohibited by law. Curative may implement state-specific procedures, exclusions, or notices as necessary.

5. REFERENCE DOCUMENTS AND MATERIALS

- Curative Provider Manual - Claims Processing and Payment; provider dispute and appeal provisions.
- Applicable Curative Payment Policies and Medical Policies.
- Applicable provider agreements and member benefit plan documents.
- American Medical Association Current Procedural Terminology (CPT®) and CPT coding guidance.
- Centers for Medicare & Medicaid Services National Correct Coding Initiative (NCCI), when applicable.
- ICD-10-CM and ICD-10-PCS Official Guidelines for Coding and Reporting, when applicable.
- Applicable federal and state laws and regulations governing claims payment, medical record requests, coding adjustments, prompt payment, recoupment, and provider appeals.

6. COLLABORATING DEPARTMENTS

- 6.1. Claims
- 6.2. Compliance
- 6.3. Medical Management
- 6.4. Network
- 6.5. Clinical Services

7. POLICY & PROCEDURE CONTROL

This Policy will be reviewed at least annually and as necessary.

REVISION HISTORY			
Date	Author	Version	Comments
10-05-2026	Payment Integrity	001	Initial Version