



EFFECTIVE DATE: 11 | 15 | 2011
POLICY LAST UPDATED: 10 | 16 | 2012

OVERVIEW

The purpose of this policy is to document the audit process and procedures for all providers.

MEDICAL CRITERIA

Not applicable.

PRIOR AUTHORIZATION

Not applicable.

POLICY STATEMENT

1. The provider shall maintain such records for the periods required under applicable laws and regulations, and shall provide such further medical, financial and administrative information to BCBSRI as necessary for billing verification. The provider shall further, upon request and at no cost, provide BCBSRI with access at reasonable times to the provider's billing, financial, and medical records relating to covered health services provided to subscribers. The results of such inspections shall be confidential unless otherwise provided by law. Upon request, the provider shall provide BCBSRI copies or extracts of such records at no cost.
2. The diagnostic and procedural information reported by the provider on the claim form must conform to AHA Coding Clinic ICD-9-CM coding rules and conventions and the American Medical Association CPT coding rules and conventions. All definitions for principal diagnosis, other diagnoses and complication will be consistent with the Uniform provider Discharge Dataset data element definitions.
3. Audit Timetable: BCBSRI shall have the right to audit medical and billing records of any covered health services rendered to verify compliance. The provider shall be given thirty (30) days advance notice before the start of an audit. Scheduling of audits, pre-audit conferences, correspondence, and any audit appeals will be coordinated through the provider's designee. The provider may change the coordinator at any time by giving written notice via certified mail to the management of the Audit and Recovery Services department at BCBSRI.
 - a. Within ten (10) days prior to the commencement of an audit, BCBSRI auditors will conduct a pre-audit telephone conference explaining the nature of the audit, timetable, and other requirements. Ten (10) days prior to the commencement of an audit a complete list of patient names, medical record numbers, and patient account numbers whose records will be required shall be sent to the contact designated by the provider. Throughout the audit, BCBSRI auditors will keep provider designee informed of issues and questions as they arise and will make every effort to resolve these matters before the completion of the audit. BCBSRI reserves the right to expand the scope of the audit should additional areas be identified.
 - b. If BCBSRI chooses to employ extrapolation methodology, the audit sample shall be derived using generally accepted statistical sampling principles, rules, and techniques recognized in

the field of statistical probability which will be forwarded to the provider ten (10) days prior to the commencement of the audit. Defined audit population means a specific area within a specific BCBSRI product (e.g., emergency department claims for the BCBSRI commercial products, etc.). Extrapolation of audit results of one claim area for one BCBSRI product may not be carried over to other areas or BCBSRI products.

- c. Within thirty (30) days from the audit completion, the BCBSRI auditors will send a letter (“Audit Completion letter”) summarizing the audit findings, provide copies of the adjustments and explain in detail, the results of their findings.
 - d. The provider can dispute the audit findings by sending an audit appeal (the “provider Audit Appeal Request”) within thirty (30) days of receipt of the Audit Completion letter, along with any/all additional documentation/information to support the provider position. The provider Audit Appeal Request is to be sent by certified mail to the attention of the management of the Audit and Recovery Services Department. Upon receipt of a provider Audit Appeal Request, the disputed claims, audit findings, and any additional information submitted by the provider will be reviewed by the Audit and Recovery Services Department management and selected staff. BCBSRI will respond with the results of the review in writing by certified mail within thirty (30) days of receipt of the provider Audit Appeal Request. At that time, any amounts found due and owing to either party may be credited or recovered by BCBSRI via offset against future remittances.
4. **Audit Dispute Resolution:** If the provider and BCBSRI cannot reach agreement within the audit appeal process, a review of the audit findings and supporting documentation shall be conducted by objective third parties (“Dispute Resolution”). In such case, either party may send a request to the other party requesting this review. The provider shall send a request to the management of the Audit and Recovery Services Department via certified mail within forty (40) days of the mailing of the "provider Audit Appeal Request" requesting this review. BCBSRI shall send the request to the provider designee via certified mail within forty (40) days of the receipt of the "provider Audit Appeal Request," requesting this review.
 5. **Non-DRG Hospital Dispute Resolution:** The third party review will be done by three certified professional coders (the “Reviewers”) with expertise in the specific area subject to the dispute (e.g., E&M) and who are members of the American Association of Professional Coders and/or the American Health Information Management Association. One reviewer shall be selected by the provider and one reviewer shall be selected by BCBSRI with the third reviewer selected by the two reviewers chosen by the parties. The three reviewers shall review the audit findings and supporting documentation and submit their findings within thirty (30) days of receiving the assignment. The reviewers’ findings shall be sent simultaneously to both parties by certified mail upon completion of such review. The costs of the third party objective review will be borne equally between the provider and BCBSRI. In the event the issue in dispute requires physician review, the same process as outlined above shall be followed, with three physicians Board Certified in the specialty area in dispute acting as third party reviewers in lieu of the Certified Professional Coders. In the event that the issue in dispute involves the validity of a random sampling to be used as a basis for extrapolated results, the same process as outlined above shall be followed, with three mathematical statisticians who are members of the American Statistical Association acting as third party reviewers. If the three reviewers do not arrive at a consensus determination, the majority opinion shall prevail. This process is determinative between the parties. Once an amount owed to BCBSRI or the provider has been determined, BCBSRI shall have the right to recover by offset against future remittances or credit the provider within thirty (30) days of the receipt of the reviewers’ decision.
 - a. **DRG Hospital Dispute Resolution:** Should the provider disagree with BCBSRI on the final DRG determination notice, the claim in question shall be referred to an impartial third party (for example 3M™ DRG Validation or Ingenix DRG Validation) for review. The decision

of the impartial third party shall be binding on BCBSRI and the provider. Any costs associated with an appeal to the impartial third party shall be shared equally between the parties.

6. Facility Providers: BCBSRI will initiate billing validation audits for any given calendar year (twelve (12) month period) no later than twelve (12) months after the close of the calendar year. The right to initiate the auditing of records rendered during the term of the Participation Agreement shall survive any termination of the Participation Agreement by twelve (12) months. The provider will be audited pursuant to BCBSRI reimbursement policies and where no promulgated policy exists the AHA Coding Clinic ICD-0-CM coding rules and conventions, the National Correct Coding Initiative policies and the American Medical Association CPT coding rules and conventions will be the audit standard.
7. Professional Providers: please refer to the Post Payment Recovery and Reimbursement Mandate Policy

This policy shall not restrict any review, audit or investigation regarding claims that are suspected as being submitted fraudulently.

COVERAGE

Not applicable.

BACKGROUND

Not applicable.

CODING

Not applicable.

RELATED POLICIES

None

PUBLISHED

Provider Update, December 2012

REFERENCES

None

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