Payment Policy | Hospital Audit Process

EFFECTIVE DATE: 01|01|2017
POLICY LAST UPDATED: 09|20|2016

OVERVIEW

This is an administrative policy to document the audit process and procedures for all local participating facilities.

MEDICAL CRITERIA

Not applicable

PRIOR AUTHORIZATION

Not applicable

POLICY STATEMENT

The following process is followed for local participating facilities:

A. All providers shall maintain such records for the periods required under applicable laws and regulations, and shall provide such further medical, financial, and administrative information to Blue Cross & Blue Shield of Rhode Island (BCBSRI) as necessary for billing verification. The provider shall further, upon request and at no cost, provide BCBSRI and/or its audit designee 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 of such records at no cost.

B. The diagnostic and procedural codes and associated information reported by the provider on the claim form must conform to American Hospital Association (AHA) *Coding Clinics* and the *Official ICD-9-CM/ICD-10-CM Guidelines for Coding and Reporting*, which include official coding rules and conventions for ICD-9/ICD-10 code assignment. All definitions for diagnosis and procedural codes will be consistent with the Uniform Hospital Discharge Data Set (UHDDS) and the American Medical Association CPT coding rules and conventions, which will be utilized for assigning and reporting of CPT codes.

C. **Conditions of the Audit**

Every medical record must be complete with all documentation to include, but not be limited to physician orders, diagnoses, evaluations, consultations, medications, treatments, test reports and results, history and physical, emergency room records, all surgical, medical and other professional consults and interventions, care plans, discharge plans, consents, interventions, discharge summary, and documentation of care provided along with the patient's response to those treatments, interventions, and care. The record must be completed promptly after discharge in accordance with State law and/or hospital policy, but no later than thirty (30) days after discharge.

BCBSRI and/or its audit designee will be provided with an electronic copy of the complete medical record, or granted access to obtain records via remote access for each audited claim within 30 calendar days following a request for such. On-site audits may not be required by providers in order to conduct review. Auditors shall group audits to increase efficiency whenever possible. All relevant documentation must be submitted during the audit, which includes the initial review and the first level appeal. Post-audit documentation will not be recognized to support code assignment as the second level appeal is a review of the audit findings and supporting documentation provided during the audit.

There shall be a fifteen (15) day prior notice requirement for cancellation by either party of an audit, unless cancellation is due to unforeseen circumstances such as weather or illness. If a provider believes that an auditor will have problems accessing medical records, the provider shall notify the auditor well in advance of the date the audit is scheduled to commence. Providers shall supply BCBSRI and/or its audit designee with any information that could affect the audit efficiency.

Network providers will make every effort to enhance efficiency with the review process by supporting remote audits. Auditors will group audits to increase their efficiency whenever possible.

BCBSRI reserves the right to expand the scope of the audit should additional areas be identified.

BCBSRI or its audit designee must submit audit notification to the provider no later than eighteen (18) months after the completed claims were initially paid. Specific contractual language supersedes the timeframe noted above.

Scope of the Audit Programs

i. DRG Validation Audits will include but is not limited to validation that:

   a. A physician order for inpatient service is present in the record;

   b. ICD-9/10-CM diagnostic and procedure code assignment(s) are accurately reported and sequenced on the claim;

   c. Discharge disposition status code assignment is accurate;

   d. Present-on-Admission (POA) indicator assignments are accurate;

   e. Hospital-Acquired Conditions and/or Never Events are identified;

   f. DRG grouping is accurate;

   g. Claim payment is accurate;

   h. And, any other factor that impacts the DRG assignment and/or claim payment.

ii. Provider Bill Audits will include but are not limited to validation of line-item charges that:

   a. A physician order and/or approved hospital policy support the line-item charge(s) for test/service/supply on the claim;

   b. Services/tests/supplies are documented in the medical record and/or other appropriate department records as having been provided to the patient. Departmental records and/or treatment logs presented to the auditor in support of the line-item charge(s) will reflect the patient name, date/time of service, signature of hospital staff providing the service. Patient response to treatment will also be documented on treatment log and/or in the medical record by hospital staff providing the service.

   c. Charges are recorded on the bill accurately and in accordance with applicable coding guidelines and conventions.

d. Charges reflected on the bill are in conjunction with the hospital's charge master in place at the time the services were rendered. The charge master should include all billable codes and shall demonstrate a consistent and accurate application of charge assignment formulas.

iii. DRG Outlier Claims

a. Certain DRG Outlier claims may benefit from line item charge review to incorporate the components detailed above in Section D ii, regarding Scope of Provider Bill Audit.

D. **DRG Validation and Provider Bill Audit Program Timetable and Workflow**

The provider and BCBSRI's audit designee should make every effort to resolve billing and/or coding inquiries directly. If required for the audit, the provider will submit to BCBSRI's audit designee a final, itemized bill within 30 calendar days of request. If a satisfactory resolution of the questions surrounding the bill is not achieved by the audit designee, then a full audit process may be initiated by BCBSRI or its audit designee.

BCBSRI shall have the right to audit medical and billing records of any covered health services billed to verify validity and accuracy of the charge/coding. The provider shall be given thirty (30) days advance notice before the start of an audit. Scheduling of audits, correspondence, and any audit appeals will be coordinated through the provider's audit coordinator. The provider may change its audit coordinator at any time by giving written notice via certified mail to BCBSRI and/or its audit designee.

No later than ten (10) days prior to the commencement of an audit a complete list of patient names, medical record numbers, and patient account numbers associated with the medical records required for review shall be sent to the provider's audit coordinator.

Initial Review

Within thirty (30) days from completion of the initial record review, BCBSRI's audit designee will issue an initial report ("Preliminary Audit Report") that summarizes the audit findings and provides detail of the audit determination from comprehensive medical record review.

Provider Appeal Opportunities

The provider can appeal the initial audit determination by sending an audit First Level Appeal request (the Hospital Audit Appeal Notice) to the audit designee within thirty (30) calendar days from the date of the Preliminary Audit Report, along with all additional documentation to support the provider's position. The provider will include a copy of the complete medical record for the auditor to thoroughly evaluate with respect to the provider's First Level Appeal before a final determination is made. The provider's First Level Audit Appeal request is to be sent by certified mail directly to BCBSRI's audit designee as outlined in the Preliminary Audit Report. The provider can opt to electronically submit its First Level Appeal directly to the audit designee, accompanied by a complete medical record and supporting documentation, via a secure portal.

BCBSRI's audit designee will respond directly to the provider with the results of its final review. In the event that the provider fails to submit a First Level Appeal request to the audit designee within thirty (30) calendar days from the date of the Preliminary Audit Report, the original audit determination will stand and overpayment will be recovered by BCBSRI via offset against future remittances. If the provider and the audit designee cannot reach agreement with audit findings, the provider shall be afforded an opportunity to file a Second Level Appeal directly to the management of the BCBSRI Audit and Recovery Services Department via certified mail within thirty (30) calendar days from the date of the final audit report. Upon receipt of provider's Second Level Appeal BCBSRI will arrange for *a review of the audit findings and supporting documentation*

provided during the audit by an independent third party with the qualifications and experience in the area of coding required for the audit.

The decision of the 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.

RELATED POLICIES
None

PUBLISHED
Provider Update, November 2016
Provider Update, December 2012

REFERENCES
None

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