EFFECTIVE DATE: 05|15|2012
POLICY LAST UPDATED: 05|15|2012

OVERVIEW
All Providers shall, upon request and at no cost to BCBSRI, provide BCBSRI access at reasonable times to billing, financial, and medical records relating to Covered Health Services provided to Members.

MEDICAL CRITERIA
Not applicable.

PRIOR AUTHORIZATION
Not applicable.

POLICY STATEMENT
BCBSRI shall have the right to review medical and billing records ("audit") to verify compliance with contracts, including but not limited to review of, payment and medical policy, claim payment system configuration, benefit coverage and/or industry standard diagnosis and procedure coding rules. The diagnostic and procedural information reported by the provider on the claim form must conform to AHA Coding Clinic ICD-9-CM and/or ICD-10 - CM coding rules and conventions and the American Medical Association CPT coding rules and conventions.

Inspection of Records Process:

1. Except where fraud is being investigated, Provider shall be given thirty (30) days advance notice before the start of an audit.
    a. Scheduling of audits, pre-audit conferences, correspondence and any audit appeals will be coordinated through a representative to be determined by Provider. Upon receipt of the audit notice, Provider shall designate such representative.
    b. Provider may change the representative at any time by giving written notice to BCBSRI.
2. Where the collection of patient records will be a material task, prior to the commencement of an audit a complete list of patient names and other distinguishing information whose records will be required shall be sent to the contact designated.
    a. If the audit sample is a random sample it shall be derived using generally accepted statistical sampling principles, rules and techniques recognized in the field of statistical probability.
    b. BCBSRI reserves the right to expand the scope of the audit should additional areas be identified.
3. 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.
4. Extrapolation of audit results to the defined audit population will be done at the election of BCBSRI.
    a. Defined audit population means a specific area within a specific BCBSRI product (e.g. emergency dept. E&M claims for the BCBSRI commercial product, etc.). Extrapolation of audit results of one claim area for one BCBSRI product may not be carried over to other areas or BCBSRI products.
    b. If so elected, extrapolation is to be done in accordance with generally accepted statistical sampling principles, rules and techniques recognized in the field of statistical probability.
5. Within thirty (30) days from the audit completion the BCBSRI auditors will send a letter (the "Audit Completion Letter") summarizing the audit findings, provide itemized detail of the adjustments and explain the results of their findings.
    a. The Audit Completion Letter is to be sent by Certified Mail to the attention of the Provider designee.

6. Any amounts found due and owing may, after notice, be recovered by setoff against future remittances.
7. The Provider can appeal the audit findings by sending an audit appeal as well as relevant substantiating documentation (the "Provider Audit Appeal Request") within thirty (30) days of receipt of the Audit Completion Letter.
    a. The Provider Audit Appeal Request is to be sent by Certified Mail to the attention of the Audit and Recovery Services Department designee.
8. Upon receipt of the Provider Audit Appeal Request the audit findings and any additional information submitted by the Provider will be reviewed by Audit and Recovery Services Department management and selected staff. BCBSRI will respond with the results of the review ("Provider Audit Appeal Request Response") in writing by Certified Mail within twenty (20) days of receipt of the Provider Audit Appeal Request.

Dispute Resolution:
If the Provider is not in agreement with the review findings, a review of the audit findings and supporting documentation shall be conducted by objective third parties.

1. In such case, the Provider shall send a request to the Audit and Recovery Services Department designee via certified mail within ten (10) days of receiving the Provider Audit Appeal Request Response.
2. The costs of the third party objective review will be borne equally between the Provider and BCBSRI.
3. The third party review will be done by three professionals with expertise in the primary area of dispute, with the exception of Diagnosis Related Groups (DRG) validation (see V.).
    a. In the event that the primary issue in dispute is coding related, three (3) 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 will review all documentation and make a determination.
        i. 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.
        ii. The three Reviewers shall review the audit findings and supporting documentation and submit their findings within thirty (30) days of receiving the assignment.
        iii. The Reviewer's findings shall be sent simultaneously to both parties by certified mail upon completion of such review.
    b. In the event the primary 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 Reviewers in lieu of the Certified Professional Coders.
    c. In the event that the primary 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.
4. If the three reviewers do not arrive at a consensus the majority opinion shall prevail
5. In the event that the issue in dispute is related to Diagnostic Related Grouping (DRG) inpatient claims, an independent DRG validation service, to be agreed upon by both parties, will be utilized to validate the diagnosis and procedures that were used to establish the DRG for the claim.
6. All dispute resolution processes are determinative between the parties.
7. Any further funds found due and owing as a result of the decision, by either party, shall be remediated thru the Provider settlement.

COVERAGE
Not applicable.

BACKGROUND
Not applicable.

CODING
Not applicable.

RELATED POLICIES
None.

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Provider Update, July 2012

REFERENCES
None

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