# Audit Policy

## Purpose

The goal of Minuteman Health (MHI) Provider Audit program is to proactively analyze claims data and confirm that submissions accurately represent the services provided to Plan members, and to ensure that billing is conducted in accordance with Current Procedural Terminology (CPT) guidelines, HCPCS, ICD-9/ICD-10 coding definitions and standards, applicable Official Guidelines for Coding and Reporting for ICD-9-CM or Official Guidelines for Coding and Reporting for ICD-10-CM, Coding Clinics, National Correct Coding Initiative (NCCI) and AAPC guidelines, CMS guidelines, industry standards, laws, regulations, contract provisions, policies and procedures. MHI will audit claims payments, medical records and clinical documentation to reconcile charge data on a provider's claim to determine if claims have been submitted accurately, are reimbursed correctly and if charges billed are documented, ordered and meet medical necessity. Claim payments that are found to be inconsistent with these guidelines or MHI's payment policies will generally be retracted. This process also supports MHI's Fraud, Waste, and Abuse (FWA) comprehensive plan to prevent, detect and correct FWA as outlined in MHI's Fraud, Waste, and Abuse Prevention Policy.

## Applicable Plans

☒ MHI MA Plans
☒ MHI NH Plans

## Definitions

Provider Audit: The objective of the provider audit program is to ensure that MHI fulfills its responsibility to its risk-sharing partners, members and Plan sponsors by identifying and recovering inaccurate payments which are the result of inadvertent or intentional provider actions or misrepresentations, including incorrect coding and billing.

## Requirements

I. Areas reviewed under MHI's Provider Audit Program includes but are not limited to the following:

- ✓ Vendor audits for Provider Patient Accounts and Credit Balance
- ✓ DRG validation audits
- ✓ Line-item provider bill audits

- ✓ Duplicate billing/services
- ✓ Intentional misrepresentation
- ✓ Billing services at a higher level than which was rendered
- ✓ Professional Code Reviews (CPT code and modifier review)
- ✓ Claim audits to validate compliance with the Contract, Plan policies and procedures, relevant guidelines, laws and regulations
- ✓ Performance of unwarranted or medically unnecessary services for the purpose of financial gain

II. MHI reserves the right to audit any claims either prospectively or retrospectively, depending on the circumstances and regardless of the dollar amount billed. MHI may:

- ✓ Audit providers
- ✓ Outreach to a provider to discuss the issue
- ✓ Send a provider notice to inform the provider about improper billing practices identified and direct the provider to immediately work on a corrective action to end the improper billing.
- ✓ Recover funds from providers who engage in improper and/or inappropriate billing practices. Although audits are usually based on claim submissions for a 12 month period, audits and subsequent recoupment may extend back up to a four year period from audit completion date if it is determined that following receipt of a notice, a corrective action has not been executed by the provider or improper billing practices are being performed, resulting in unnecessary costs.
- ✓ Impose penalties and/or interest charges in the settlement of audits
- ✓ Suspend future claim payments once improper billing practices are suspected
- ✓ Access medical records of past and present MHI Plan members.

III. MHI may utilize any of the following processes:

- ✓ Auditing software designed to evaluate billing and coding accuracy as established by various industry sources including CMS and CPT guidelines
- ✓ Sample chart review
- ✓ Focused reviews
- ✓ Full chart review
- ✓ Collaboration by external vendors for the purpose of claims audit

Other techniques where appropriate

**IV. General Guidelines**:

- MHI or MHI's audit representative may request from the provider information and/or documentation related to a particular audit, including in some cases, the medical records. The provider will have up to 30 days following the request date to submit the requested information. The provider's representative should respond to the request for information within the specified time frame unless otherwise agreed upon by both parties. Request for additional information and supporting documentation will be responded to by the provider within a reasonable amount of time, not to exceed 30 days. Providers should supply MHI with any and all information that could affect the efficiency of the audit. If

requested documentation is not received, the claims will be denied to reflect audit findings.

- Documentation changes to medical record or physician queries occurring 30 days or more after the date of service will not be accepted as part of the record or considered for a final audit determination.

- Neither MHI nor MHI's audit representative will pay a hospital audit fee, copy fees, or be required to produce a separate signed patient authorization for the audit.

- Confidentiality and Authorizations:
    - All parties to an audit must comply with federal and state laws and contractual agreements regarding the confidentiality of patient information.
    - The provider will inform the MHI representative in a timely manner which federal or state laws prohibit or restrict review of the medical record.
        - Plan members have agreed to give the Plan the right to obtain from any source all medical records or other information that is needed, in accordance with the Plan Evidence of Coverage. If the Plan member release is in conflict with any other law or regulation governing release of medical information, the Provider will identify the conflict and work with the Plan to resolve the conflict.
        - Signed Business Associate Agreements are obtained for any vendor conducting audits on MHI's behalf.

- Providers must submit medical records when MHI is asked by regulators to furnish documentation.

- If a review identifies a persistent outlier pattern or egregious billing practice, MHI may take further action including, but not limited to, closing panels, pending provider claims for prepayment review, recovery of prior payment and termination of a provider contract, and legal and/or regulatory action.

- Any overpayment identified in the audit results that is owed to MHI shall be settled by MHI and the provider within a reasonable period of time not to exceed 30 days after the final audit report is submitted to the provider unless MHI and the provider agree otherwise.

- Providers do have the right to appeal. However, for professional code reviews (CPT), any appeal filed as a result of an audit must be submitted to MHI within 30 calendar days of the retraction/reprocessing.

Retractions resulting from failure to respond to a written request for medical records or other documentation are not subject to provider appeal unless otherwise agreed to by MHI or the provider can prove extenuating circumstances.

**V. Scheduling and Coordination:**

- The Provider's Representative should respond to the audit request within the specified time frame unless otherwise agreed upon by both parties. The Provider's Representative will also ensure that the health record is complete. Any additional documentation (i.e., ancillary records and/or logs) that supports the billed charges should be included.

- Providers who cannot accommodate an audit date within 30 calendar days of the request should explain why the request cannot be met by the provider in a reasonable period of time, and obtain approval for a time-limited extension from MHI. Audits will be grouped to increase efficiency whenever possible.

- Providers should designate an individual to coordinate all billing audit activities. Duties of the Provider's audit coordinator include, but are not limited, the following areas:

    - ✓ Scheduling an audit
    - ✓ Advising other provider personnel/departments of a pending audit
    - ✓ Verifying that the auditor is an authorized representative of MHI
    - ✓ Gathering the necessary documents for the audit
    - ✓ Coordinating auditor requests for information
    - ✓ Providing access to records and provider personnel
    - ✓ Orienting auditors to record documentation conventions, provider policies, and billing practices
    - ✓ Acting as a liaison between the auditor and other personnel
    - ✓ Participating in the exit interview with the auditor to answer questions and review audit findings
    - ✓ Reviewing the auditor's final written report and following up on any charges/coding still in dispute;
    - ✓ Arranging for any required adjustment to bills or refunds

**VI. Hospital/Facility Audits:**

- MHI or MHI's audit representative may request detailed information for claims selected for audit consideration. This includes, but is not limited to itemized bills, medical records, and invoice detail. The provider will submit requested information within 30 calendar days of the request.

- If the claim is selected for detailed review, the Hospital/Facility Representative should respond to the audit request within 14 days and, unless otherwise agreed upon by both parties, schedule the audit within 30 calendar days of the initial request at a mutually agreed date and time. There is a 15 day prior notice requirement for cancellation by either party. An exception will be made for unforeseen circumstances such as weather or illness.

- Hospitals/Facilities will designate an individual(s) to coordinate all billing audit activities.

- Requests for audits should include the following information:

    - Patient Name
    - Patient's date of birth
    - Patient account number or medical record number
    - Date of admission and discharge, or first and last dates of service
    - Final total billing amount
    - Name of the audit firm

- MHI or its audit representative may choose to conduct audits remotely; however, remote audits should conform to the guidelines for billing audits set forth in this document. MHI expects that the medical record submitted by the hospital for review will be complete and that any and all additional under-billing/late billing/under-coding will have already been presented on the claim prior to commencement of the audit.

- If a provider believes an auditor will have problems accessing records remotely or otherwise, the provider should notify the auditor within 15 days of the scheduled date of audit. Providers should supply the auditor and/or MHI with any information that could affect the efficiency of the audit.

- All personnel involved should maintain a professional courteous manner and resolve all misunderstandings amicably.

- At times, the audit will note ongoing problems either with the coding or documentation process. When this situation occurs and it cannot be corrected as part of the exit process, the management of the provider or MHI should be contacted to identify the situation and take appropriate steps to resolve the identified problem. Parties to an audit should eliminate on-going problems or questions whenever possible as part of the audit process.

- In order to have a fair, efficient, and effective audit process, providers and MHI's auditors should adhere to the following:

    - Whatever the original intended purpose of the audit, all parties should agree to address unbilled and undercoded charges presented prior to the commencement of the medical record review. Under-billing, late billing, and under coding that is not submitted *before* the record review commences will not be considered for additional payment.

    - An exit conference will be offered and a written report should be part of each audit. If the provider waives the exit conference, the auditor should note that in the audit form. The specific content of the final report should be restricted to those parties involved in the audit.

**A. DRG Validation Audit Program**

- DRG validation audits will include the validation of:

  - ✓ Diagnostic and/or procedural code assignment(s)
  - ✓ Present on Admission (POA) Indicators assignment(s)
  - ✓ Sequencing of the diagnostic and procedural codes
  - ✓ DRG grouping assignment and associated payment
  - ✓ Discharge status code assignment
  - ✓ Physician-ordered inpatient services
  - ✓ Other factors that impact the DRG or DRG payment

- Documentation changes to medical records occurring thirty days or more after the date of service will not be accepted for audit purposes. Changes to the record or additional physician queries made after audit notification date will not be considered for audit purposes.

- Any payment identified in the audit results that is owed to either party by the other should be settled by the audit parties within a reasonable period of time, not to exceed 30 days after the audit, unless the two parties agree otherwise.

- Audit fees and copy fees should not be assessed to or its audit representative by the provider in connection with a DRG validation audit, nor shall MHI or audit representative be required to produce a separate signed patient authorization.

**B. Provider Bill Audit Program**

- Provider bill audits of line-item charges will include the investigation of whether or not:

  - ✓ Services, tests, and supplies were delivered by the institution in compliance with the physician's plan of treatment. In appropriate situations, professional staff may provide supplies or follow procedures that are in accordance with established signed institutional policies, procedures, or professional licensure standards. All such policies should be reviewed, approved, and documented as required by the Joint Commission on Accreditation of Healthcare Organizations or other accreditation agencies. Policies should be available for review by the auditor.
  - ✓ Services were documented in medical record or other appropriate records as having been rendered to the patient.
  - ✓ Charges were reported on the bill accurately.

- The health record documents clinical data on diagnoses, treatments, and outcomes. The health record may not back up each individual charge on the patient bill. Other signed documentation for services provided to the patient may exist within the provider's ancillary departments in the form of department signed treatment logs, individual service, and other documents. Auditors may have to review a number of other documents to determine the validity of charges.

Auditors must evaluate these sources of information. Providers must ensure that proper policies and procedures exist to specify what documentation and authorization must be in the health record and in the ancillary records and/or logs. The ancillary logs must document that services have been delivered to patient and include the patient's response to treatment if not already documented within the medical record. When sources other than the health record are providing such documentation, the provider should make those sources available to the auditor during time of audit.

- Changes to the record made after audit notification date will not be considered.

- All findings identified during the course of an audit will be reviewed and addressed by both the provider and MHI's audit representative. Providers are responsible for identifying under billing, known overbilling issues, or coding error issues. MHI's audit representatives will evaluate the validity of under billed, unbilled, and/or under coded items/test/services presented *prior to the start of the medical record review*. Payment of late billing is made at the discretion of MHI.

- Any payment identified in the audit results that is owed to either party by the other should be settled by the audit parties within a reasonable period of time not to exceed 30 days after the audit unless the two parties agree otherwise.

- Audit fees and copy fees should not be assessed to MHI or its audit representative by the provider in connection with an audit, nor shall MHI or audit vendor be required to produce a separate signed patient authorization.

**VII. Audit Findings Submission of Initial Results and Provider Rebuttal/Appeal Process:**

A written report of any preliminary audit findings will result from each initial review. An exit conference will be offered to the provider and, if the provider waives the opportunity, the auditor will note that decision in the written report. The exit conference will be a forum to clarify audit findings, charge descriptions, and research questions and issues. The provider is expected to respond to questions and/or present supporting documentation to MHI's audit representative before adjustments to the preliminary audit findings are made; this shall occur within 30 calendar days of the audit. Audit results are final and will not be reopened if the parties agree to the audit determinations or after the 30 day period elapses with no provider Rebuttal letter and accompanying supporting documentation/complete medical record. Finalized audits will not be re-opened for any reason.

- **DRG Validation Audit Program Rebuttal and Appeal Process**:

  **Rebuttal:** If the provider disagrees with MHI's audit representative's initial audit findings, the provider may rebut the audit finding by submitting additional supporting documentation directly to MHI's audit representative via certified mail within 30 calendar days of the exit conference and submission of the audit report. DRG rebuttals must include a copy of the entire medical record, if not already submitted to MHI or MHI's audit representative, to allow for a thorough review. Post-audit documentation by the attending physician will not be considered for rebuttal and/or appeal review. Audit findings will be upheld if provider fails to submit supporting documentation or communicates agreement with audit findings within 30 days of the audit.

**Appeals**: Any audit finding in disagreement between MHI's audit representative and the provider representative may be appealed by the provider within 30 calendar days of the final audit report date. Provider appeals should be sent certified mail directly to MHI and a copy of the entire medical record should be included for review, if not already submitted to MHI's audit representative. Appeals must be received by MHI within 30 calendar days of the final audit report date. Provider appeals that are filed within 30 calendar days of the final audit report will be reviewed by MHI, via its dispute resolution process, and a final audit determination will be made. The provider and MHI's audit representative will be notified of the final determination before any related overpayment is retracted.

- **Provider Bill Audit Program Rebuttal and Appeal Process**:

**Rebuttal**: If the provider disagrees with any of MHI's audit representative's initial audit findings, the provider may rebut the audit finding(s) by submitting additional supporting documentation directly to MHI's audit representative via certified mail within 30 calendar days of the exit conference and submission of the audit report. Audit findings will stand if the provider agrees with the audit determination or fails to submit supporting documentation to MHI's audit representative within 30 calendar days of the audit report date. Audit results are final and will not be reopened once the parties agree to the audit findings or after 30 calendar days elapses post audit. Finalized audits will not be re-opened for any reason.

**Appeals**: Any audit finding in disagreement between MHI's audit representative and the provider representative may be appealed by the provider within 30 calendar days of the final audit report date. Provider appeals should be sent certified mail directly to MHI and include a copy of the entire medical record for review if it has not already been provided to 's audit representative. Those appeals that are filed within 30 calendar days of the final audit report will be reviewed by MHI and a final determination as to the audit findings made. The provider and MHI's audit representative will be notified of the final determination before any related overpayment is retracted.

**Member Responsibility:**

Provider may not bill the member for any reimbursement differences that result from the audit. Provider is responsible for settlement of changes in member liability resulting from the audit.

## Authorization Requirements

None

## References

Fraund, Waste, and Abuse Prevention Policy

## Important Note About This Reimbursement Policy

Providers are responsible for submission of accurate claims. All EDI claims must be submitted in accordance with HIPAA 5010 Standards and Paper claims must be submitted on either CMS1500 or CMS1450 (UB04) claim forms. MHI's reimbursement policy includes the use of Current Procedural Terminology (CPT®[1]), guidelines from the Centers for Medicare and Medicaid Services (CMS), *Official Guidelines for Coding and Reporting*, Coding Clinic, Faye Browne, and other coding guidelines. Providers will be reimbursed based on the codes(s) that correctly describe the health care services provided.

MHI uses a customized version of the McKesson Claims Editing System known as ClaimsX-ten to process claims in accordance with MHI reimbursement policies.

MHI may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to MHI enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to, legislative mandates, the type of provider agreement and the terms of that agreement, the MHI Provider Manual, and/or the enrollee's benefit coverage documents.

MHI reserves the right to audit any provider and/or facility to ensure compliance with the guidelines stated in this payment policy in accordance with our provider review policy.

## Resources

American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services

MHI Provider Manual

## History

Updated 11/1/2014, 11/1/2015, 4/29/2016,11/01/2016
Replaces Audit Policy 4/29/2016

1 CPT® is a registered trademark of the American Medical Association.