Provider Audit Policy

Policy

This policy establishes the basic framework for Fallon Health to analyze claim data and confirm that claim submissions accurately represent the services provided to members, and to ensure that billing is conducted in accordance with Official Guidelines for Coding and Reporting and Coding Clinic or when applicable Current Procedural Terminology (CPT) guidelines, verifying and other applicable standards, rules, laws, regulations, contract provisions, and payment policies.

The Plan will audit claim payments and medical records to determine if claims have been submitted accurately and are being reimbursed correctly by verifying that charges billed are documented, ordered, and accurate verifying that codes assigned and charges billed are documented. Audits reconcile charge data on a provider's claim with the provider's medical and clinical documentation. Claim payments that are found to be inconsistent with Plan policies will be retracted.

In alignment with CMS standards, medical records must contain information to justify treatment, admission or continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. Medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided. All records must document relevant medical history, updated examination of the patient, admitting diagnosis, consultative evaluations, complications, informed consent, discharge summary, final diagnosis with completion of medical records within 30 days following consultation or discharge. All corrections of medical records must be made within 30 days following consultation or discharge. When an error is made in a medical record entry, proper error correction procedures must be followed for both paper and electronic records. For example, for paper records, a thin pen line should be drawn through the incorrect entry to make sure that that the inaccurate information is still legible. The provider must state the reason for the error, document the correct information, and sign and date the correction. The original entry must not be obliterated or otherwise altered by blacking out with marker, using white out, writing over an entry, or by other means. For electronic records, use an addendum to identify corrections due to errors. Documentation should include only acceptable standard abbreviations from Jablonski's or Dorland's Dictionary of Medical Acronyms & Abbreviations. Documentation inserted or altered beyond 30 days of discharge or audit notification is issued to the provider will not be considered.

Signed Business Associate Agreements are obtained for any vendor conducting audits on the Plan's behalf.

This policy applies to all parties that submit medical claims to the Plan for reimbursement.

In general, audits are conducted with final paid dates in the current or previous calendar year.

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(s) of Coverage. If this 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.

All personnel involved in the audit shall maintain a professional, courteous manner and shall resolve all misunderstandings amicably and directly with each other if at all possible.

Parties to an audit shall strive to eliminate ongoing problems or questions whenever possible as part of the audit process.

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

Providers will not be paid audit or copy fees associated with any of the audit reviews.

Providers may not bill the member for any reimbursement differences that result from the audit.

For Primary Care Provider (PCP) referral audits:

- When a PCP refers a member to a specialist, the PCP contacts the specialist by telephone, mail, or prescription and provides the PCP's name, NPI number, the reason for the referral, and the number of visits authorized.
- This referral must be documented in both the PCP's and the specialist's medical record for the member.
- The Plan will periodically audit medical records to ensure that PCP referral for specialty care was obtained. The lack of proof of PCP referral will result in the retraction of claim payment.

For Hospital/Facility audits:

- The Plan will request an itemized bill for claims meeting the audit criteria. Itemization will be sent within 10 days of the request.
- If selected for audit, 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 45 days of the initial request at a mutually agreed date and time. There is a 15 days prior notice requirement for cancellation by either party.
- Hospitals/Facilities will designate an individual(s) to coordinate all billing audit activities. Duties of an audit coordinator include, but are not limited to, the following areas:
    A. Scheduling audits;
    B. Advising other provider personnel/departments of pending audits;
    C. Verifying that the auditor is an authorized representative of the Plan;
    D. Gathering the necessary documents for the audit and ensuring that the health record is complete and in order;
    E. Coordinating the auditor's requests for information;
    F. Coordinating the space in which the audit will be conducted; and,
    G. Coordinating the access to records and provider personnel;
    H. Orienting auditors to record documentation, provider specific conventions, and provider billing practices and policies;
    I. Acting as a liaison between the auditor and other provider personnel;
    J. Making available any and all charge master data for reference by the Plan's audit designee;
    K. Conducting an exit interview with the auditor to answer questions and review audit findings;
    L. Reviewing the auditor's final written report and following up on any charges still in question or dispute;
    M. Arranging for any required adjustment(s) to bills and/or issuing refunds to the Plan.
- The Plan expects that the medical record will be complete and in order. The Hospital/Facility Representative should insure that medical records are complete and in order before the audit commences. Any additional documentation (i.e. ancillary records and/or logs) that supports billed charges will be available at the commencement of the audit. Source documents will serve to provide further detail but should be supported by the clinical picture and will not conflict with specific documentation in the medical record.
- If the Hospital/Facility Representative identifies that an auditor may have problems accessing records, the Hospital Representative shall notify the auditor prior to the scheduled date of audit to reschedule such audit date. Providers shall supply the auditor and the Plan with any and all information that could affect the efficiency of the audit Documented policies and procedures should be available for review upon request. The

Hospital/Facility Representative will be available to the auditor(s) during the audit clarify charge descriptions, answer questions, and research issues. Requests for additional information and supporting documentation will be provided within a reasonable amount of time not to exceed 30 days. Information and documentation that is not received within 30 days of receipt of audit findings will not be reviewed.

- Undercharges are documented services that were billed on the original audited claim but not billed to the full extent of the services provided. The net adjustment on the audit report will reflect unsupported and undercharges. A corrected claim form will not be required. The Hospital/Facility is expected to present any and all under billing to the Plan's audit designee for review before the audit commences. All unsupported or unbilled charges identified and verified by both audit parties will be recognized, evaluated, recorded, or presented in a final report. Under billing that is not submitted for review before the audit commences will not be recognized, evaluated, or recorded in the final audit report.
- Late charges are charges that were not submitted on the original claim. Late charges will be considered for payment only if they are presented before the audit commences so that charges can be fully evaluated at the time of the review. A corrected claim form will be required for any late charges that have been verified. The audit process is not intended to present an opportunity for providers to submit late charges. All late charges need to be formally submitted to the Plan through the claim submission process. Late billing that is not submitted within six months of discharge and prior to an audit commencing will not be recognized, evaluated, or recorded in the final audit report. Such late charges will not be paid by the Plan.
- A written preliminary report of audit findings should be a part of each audit. An exit interview will be offered to the provider and, if the provider waives the exit conference, the auditor will note that decision in the written report. The Hospital is expected to present supporting documentation before adjustments to the preliminary audit findings are made. Resolution of any discrepancies, questions, or errors that have been identified in the audit shall occur within 30 days of the audit. Both parties will agree to respond to calls and emails in a timely manner and work toward closure of audits within 30 calendar days of the audit or receipt of the preliminary findings. All audit findings will stand if provider fails to provide supporting documentation or to communicate agreement with audit findings within 30 days of the audit. Audit results are final once the parties agree to the audit findings or after thirty (30) days elapses post audit
- Any finding that cannot be resolved between the Provider's representative and the Plan's audit representative will be submitted to the payer as a disputed charge.
- Audit results are final once the parties agree to the audit findings or after thirty (30) days elapses post audit and audits will not be re-opened for any reason.
- Disputed charges will be documented in the audit report with supporting documentation for the dispute. The Plan or its designee upon request shall have access to records, including but not limited to securing copies of the record, to support the audit findings. Disputed charges will be addressed through the Plan Provider Appeal Process. An initial notification letter will be sent to the facility advising that the Plan has received the dispute and request that any pertinent medical documentation supporting their claim is sent to the Provider Appeals Department within 45 business days of receipt of the notification. All cases will be held until requested documentation is received or for 50 business days from the date of the notification letter, whichever is sooner. At which time, the disputed audit finding is forwarded to a qualified Appeal Reviewer for consideration. Upon review of the available information, the Appeal Reviewer may determine that the audit findings are valid, in which monies will be recouped from the facility, or ***not-valid,*** in which no further action will be taken and the claim will not be adjusted further for those disputed charges. The facility and the Plan's audit designee will be notified in writing of the Plan determination and rationale for the determination. The determination is final and binding

and in keeping with the provisions of your contract with the Plan. This review process is considered your right to appeal. No additional appeal will be considered.

For other Provider audits:

- The Plan will request medical records for claims meeting the audit criteria. Requests for medical records will indicate an expected response date of three weeks following the request date.
- The Provider Representative should respond to the audit request within the specified time frame unless otherwise agreed upon by both parties.
- Providers will designate an individual(s) to coordinate all billing audit activities. Duties of an audit coordinator include, but are not limited to, the following areas:
    A. Responding to requests for medical records and ensuring that the health record is complete and in order; any additional documentation (i.e. ancillary records and/or logs) that supports billed charges should be included;
    B. Scheduling audits when indicated;
    C. Advising other provider personnel/departments of pending audits;
    D. Verifying when an auditor is an authorized representative of the Plan;
    E. Coordinating the auditor's requests for information;
    F. Coordinating the access to records and provider personnel;
    G. Orienting auditors to record documentation, provider specific conventions, and provider billing practices and policies;
    H. Acting as a liaison between the auditor and other provider personnel;
    I. Confencing with the auditor to answer questions and review audit findings;
    J. Reviewing the auditor's final written report and following up on any charges still in question or dispute;
    K. Arranging for any required adjustment(s) to bills and/or issuing refunds to the Plan.
- Providers shall supply the Plan with any and all information that could affect the efficiency of the audit.
- Documented policies and procedures should be available for review upon request or at the time of an audit. Requests for additional information and supporting documentation will be provided within a reasonable amount of time not to exceed 30 days. Information and documentation that is not received within 30 days of receipt of the report of audit findings will not be reviewed.
- A written preliminary report of audit findings will result from each audit. A review meeting will be offered to each provider and, if the provider waives the opportunity to meet, the auditor will note that decision in the written report. The review meeting will also be a forum to clarify charge descriptions, answer questions, and research issues. The Provider is expected to present supporting documentation before adjustments to the preliminary audit findings are made. Resolution of any discrepancies, questions, or errors that have been identified in the audit shall occur within 30 days of the audit. Both parties will agree to respond to calls and emails in a timely manner and work toward closure of audits within 30 calendar days of the date of the preliminary findings. All audit findings will stand if provider fails to provide supporting documentation or to communicate agreement with audit findings within 30 days of the audit. Audit results are final once the parties agree to the audit findings or after 30 days elapses post audit.
- Audit results are final once the parties agree to the audit findings or after thirty (30) days elapses post audit and audits will not be re-opened for any reason.
- Disputed audit findings can be addressed through the Plan Provider Appeal Process.

Reimbursement

The Plan requires accurate and appropriate documentation to support charges billed.

Billing/coding guidelines

Providers are expected to have the necessary documentation to support billed charges as required by the Plan and consistent with industry standards.

This policy applies to all services rendered to Plan members.

Place of service

This policy applies to services rendered in all settings.

Policy history

Origination date:	03/01/09
Previous revision date(s):	05/01/2010 - added provider (non-hospital) language and changed name from Facility Bill/Charge Audit Policy to Provider Audit Policy. 11/01/2015 - Annual review and moved to new Plan template. 05/01/2016 - Updated policy section.
Connection date & details:	January 2017 –Updated policy section. January 2018 – Updated the policy section. July 2019 - Annual review, no updates.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.