Audit Policy

Overview

This Anthem Audit Policy applies to Providers and Facilities. If there is conflict between this Policy and the terms of the applicable Provider or Facility Agreement, the terms of the Agreement will prevail. If there is a conflict in provisions between this Policy and applicable state law that is not addressed in the Provider or Facility Agreement the state law will apply. All capitalized terms used in this Policy shall have the meaning as set forth in the Provider or Facility Agreement between Anthem and Provider or Facility.

Coverage is subject to the terms, conditions, and limitations of a Covered Individual’s Health Benefit Plan and in accordance with this Policy.

There may be times when Anthem conducts claim reviews or audits either on a prepayment or post payment basis. Claim reviews and audits are conducted in order to confirm that healthcare services or supplies were delivered in compliance with the Covered Individual’s plan of treatment or to confirm that charges were accurately reported in compliance with Anthem’s policies and procedures as well as general industry standard guidelines and regulations.

In order to conduct such reviews and audits, Anthem or its designee may request documentation, most commonly in the form of patient medical records. Anthem may accept additional documentation from Provider or Facility that typically might not be included in medical records such as other documents substantiating the treatment or health service or delivery of supplies, Provider’s or Facility’s established internal policies, professional licensure standards that reference standards of care, or business practices justifying the healthcare service or supply. The Provider or Facility must review, approve and document all such internal policies and procedures as required by The Joint Commission (“TJC”) or other applicable accreditation bodies and such policies shall be made available for review by the auditor.

This policy documents Anthem’s guidelines for claims requiring additional documentation and the Provider’s or Facility’s compliance for the provision of requested documentation.

Definitions

The following definitions shall apply to this Audit section only:

- **Agreement** means the written contract between Anthem and Provider or Facility that describes the duties and obligations of Anthem and the Provider or Facility, and which contains the terms and conditions upon which Anthem will reimburse Provider or Facility for Health Services rendered by Provider or Facility to Covered Individual(s).

- **Appeal** means Anthem’s or its designee’s review of the disputed portions of the Audit Report, conducted at the written request of a Provider or Facility and pursuant to this Policy.

- **Appeal Response** means Anthem’s or its designee’s written response to the Appeal after reviewing all Supporting Documentation provided by Provider or Facility.
• **Audit** means a qualitative or quantitative review of Health Services or documents relating to such Health Services rendered by Provider or Facility, and conducted for the purpose of determining whether such Health Services have been appropriately reimbursed under the terms of the Agreement.

• **Audit Report and Notice of Overpayment** ("Audit Report") means a document that constitutes notice to the Provider or Facility that Anthem or its designee believes an overpayment has been made by Anthem and identified as the result of an Audit. The Audit Report shall contain administrative data relating to the Audit, including the amount of overpayment and findings of the Audit, that constitute the basis for Anthem’s or its designee’s belief that the overpayment exists. Unless otherwise stated in the Agreement between the Provider or Facility and Anthem, Audit Reports shall be sent to Provider or Facility in accordance with the Notice section of the Agreement.

• **Business Associate** or designee means a third party designated by Anthem to perform an Audit or any related Audit function on behalf of Anthem pursuant to a written agreement with Anthem.

• **Provider or Facility** means an entity with which Anthem has a written Agreement.

• **Provider Manual** means the proprietary Anthem document available to the Provider and Facility, which outlines certain Anthem Policies.

• **Recoupment** means the recovery of an amount paid to Provider or Facility which Anthem has determined constitutes an overpayment not supported by an Agreement between the Provider or Facility and Anthem. A Recoupment is generally performed against a separate payment Anthem makes to the Provider or Facility which is unrelated to the services which were the subject of the overpayment, unless an Agreement expressly states otherwise or is prohibited by law. Recoupments shall be conducted in accordance with applicable laws and regulations.

• **Supporting Documentation** means the written material contained in a Covered Individual’s medical records or other Provider or Facility documentation that supports the Provider’s or Facility’s claim or position that no overpayment has been made by Anthem.

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**Policy**

Upon request from Anthem or its designee, facilities are required to submit additional documentation for claims identified for pre-payment review or post payment audit. Applicable types of claims include, but are not limited to:

1. Claims being reviewed to validate the correct diagnosis related group (DRG) assignment/payment (DRG validation audits)
2. Claims being reviewed to validate items and services billed are documented in the medical record for hospital bill audits (also known as hospital charge audits)
3. Claims with unlisted or miscellaneous codes
4. Claims for services requiring clinical review
5. Claims for services found to possibly conflict with covered benefits for Covered Individuals after validity review of the Covered Individual’s medical records
6. Claims for services found to possibly conflict with Medical Necessity of covered benefits for Covered Individuals
7. Claims requesting an extension of benefits
8. Claims being reviewed for potential fraud, abuse or demonstrated patterns of billing/coding inconsistent with peer benchmarks
9. Claims for services that require an invoice
10. Claims for services that require an itemized bill
11. Claims for beneficiaries where other health insurance (OHI) is indicated with the claim submission
12. Claims requiring documentation of the receipt of an informed consent form
13. Claims requiring a certificate of Medical Necessity
14. Appealed claims where supporting documentation may be necessary for determination of payment
15. Other documentation required by other entities such as the Centers for Medicare and Medicaid Services (CMS), and state or federal regulation
16. Documentation for such services as the provision of durable medical equipment, prosthetics, orthotics, and supplies, rehabilitation services, and home health care
Anthem or its designee will use the following guidelines for records requests and the adjudication of claims identified for prepayment review or post payment audit:

1. Upon confirmation of Provider’s or Facility’s address, an original letter of request for supporting documentation will be sent.
2. When a response is not received within 30 days of the date of the initial request, a second request letter will be sent.
3. When a response is not received within 15 days of date of the second request, a final request letter will be sent.
4. When a response is not received within 15 days of the date of the final request (60 days total):
   a. Anthem or its designee will initiate claim denial for claims identified as pre-payment review claims as Provider or Facility failed to submit the required documentation. The Covered Individual shall be held harmless for such payment denials.
   or
   b. Anthem or its designee will initiate claim retractions for claims identified as post payment audit claims as Provider or Facility failed to submit the required documentation. The Covered Individual shall be held harmless for such payment retractions.

Anthem or its designee will not be liable for interest or penalties when payment is denied or recouped when Provider or Facility fails to submit required or requested documentation for claims identified for prepayment or post payment audit.

[This policy will not supersede any individual Provider or Facility contract provisions or state or federal guidelines.]

Procedure

1. **Review of Documents.** Anthem or its designee will request in writing or verbally, final and complete itemized bills and/or complete medical records for all Claims under review. The Provider or Facility will supply the requested documentation in the format requested by Anthem or its designee within the time frame outlined above.
2. **Scheduling of Audit.** After review of the documents submitted, if Anthem or its designee determines an Audit is required, Anthem or its designee will call the Provider or Facility to request a mutually satisfactory time for Anthem or its designee to conduct an Audit; however, the Audit must occur within forty-five (45) calendar days of the request.
3. **Rescheduling of Audit.** Should Provider or Facility desire to reschedule an Audit, Provider or Facility must submit its request with a suggested new date to Anthem or its designee in writing at least seven (7) calendar days in advance of the day of the Audit. Provider’s or Facility’s new date for the Audit must occur within thirty (30) calendar days of the date of the original Audit. Provider or Facility may be responsible for cancellation fees incurred by Anthem or its designee due to Provider’s or Facility’s rescheduling.
4. **Under-billed and Late-billed Claims.** During the scheduling of the Audit, Provider or Facility may identify Claims for which Provider or Facility under-billed or failed to bill for review by Anthem during the Audit. Under-billed or late-billed Claims not identified by Provider or Facility before the Audit commences will not be evaluated in the Audit. These Claims may, however, be submitted (or resubmitted for under-billed Claims) to Anthem for adjudication.
5. **Scheduling Conflicts.** Should the Provider or Facility fail to work with Anthem, or its designee in scheduling or rescheduling the Audit, Anthem or its designee retains the right to conduct the Audit with a seventy-two (72) hour advance written notice, which Anthem or its designee may invoke at any time.
While Anthem or its designee prefers to work with the Provider or Facility in finding a mutually convenient time, there may be instances when Anthem or its designee must respond quickly to requests by regulators or its clients. In those circumstances, Anthem or its designee will send a notice to the Provider or Facility to schedule an Audit within the seventy-two (72) hour timeframe.

6. **On-Site and Desk Audits.** Anthem or its designee may conduct Audits from its offices or on-site at the Provider’s or Facility’s location. If Anthem or its designee conducts an Audit at a Provider’s or Facility’s location, Provider or Facility will make available suitable work space for Anthem’s or its designee’s on-site Audit activities. During the Audit, Anthem or its designee will have complete access to the applicable health records including ancillary department records and/or invoice detail without producing a signed Covered Individual authorization. When conducting credit balance reviews, Provider or Facility will give Anthem or its designee a complete list of credit balances for primary, secondary and tertiary coverage, when applicable. In addition, Anthem or its designee will have access to Provider’s or Facility’s patient accounting system to review payment history, notes, Explanation of Benefits and insurance information to determine validity of credit balances. If the Provider or Facility refuses to allow Anthem or its designee access to the items requested to complete the Audit, Anthem or its designee may opt to complete the Audit based on the information available. All Audits (to include medical chart audits and diagnosis related group reviews) shall be conducted free of charge despite any Provider or Facility policy to the contrary.

7. **Completion of Audit.** Upon completion of the Audit, Anthem or its designee will generate and give to Provider or Facility a final Audit Report. This Audit Report may be provided on the day the Audit is completed or it may be generated after further research is performed. If further research is needed, the final Audit Report will be generated at any time after the completion of the Audit, but generally within ninety (90) days. Occasionally, the final audit report will be generated at the conclusion of the exit interview which is performed on the last day of the Audit. During the exit interview, Anthem or its designee will discuss with Provider or Facility its Audit findings found in the final Audit Report. This Audit Report may list items such as charges unsupported by adequate documentation, under-billed items, late billed items and charges requiring additional supporting documentation. If the Provider or Facility agrees with the Audit findings, and has no further information to provide to Anthem or its designee, then Provider or Facility may sign the final Audit Report acknowledging agreement with the findings. At that point, Provider or Facility has thirty (30) calendar days to reimburse Anthem the amount indicated in the final Audit Report. Should the Provider or Facility disagree with the final Audit Report generated during the exit interview, then Provider or Facility may either supply the requested documentation or Appeal the Audit findings.

8. **Provider or Facility Appeals.** See Audit Appeal Policy.

9. **No Appeal.** If the Provider or Facility does not formally Appeal the findings in the final Audit Report and submit supporting documentation within the (thirty) 30 calendar day timeframe, the initial determination will stand and Anthem or its designee will process adjustments to recover the amount identified in the final Audit Report.

### Documents Reviewed During an Audit

The following is a description of the documents that may be reviewed by the Anthem or its designee along with a short explanation of the importance of each of the documents in the Audit process. It is important to note that Providers and Facilities must comply with applicable state and federal record keeping requirements.
A. **Confirm that Health Services were delivered by the Provider or Facility in compliance with the plan of treatment.**

Auditors will verify that Provider’s or Facility’s plan of treatment reflected the Health Services delivered by the Provider or Facility. The services are generally documented in the Covered Individual’s health or medical records. In situations where such documentation is not found in the Covered Individual’s medical record, the Provider or Facility may present other documents substantiating the treatment or Health Service, such as established institutional policies, professional licensure standards that reference standards of care, or business practices justifying the Health Service or supply. The Provider or Facility must review, approve and document all such policies and procedures as required by The Joint Commission (“TJC”) or other applicable accreditation bodies. Policies shall be made available for review by the auditor.

B. **Confirm that charges were accurately reported on the Claim in compliance with Anthem’s Policies as well as general industry standard guidelines and regulations.**

The auditor will verify that the billing is free of keystroke errors. Auditors may also review the Covered Individual’s health record documents. The health record records the clinical data on diagnoses, treatments, and outcomes. A health record generally records pertinent information related to care and in some cases, the health record may lack the documented support for each charge on the Covered Individual’s Claim. Other appropriate documentation for Health Services provided to the Covered Individual may exist within the Provider’s or Facility’s ancillary departments in the form of department treatment logs, daily charge records, individual service/order tickets, and other documents. Anthem or its designee may have to review a number of documents in addition to the health record to determine if documentation exists to support the Charges on the Covered Individual’s Claim. The Provider or Facility should make these records available for review and must ensure that Policies exist to specify appropriate documentation for health records and ancillary department records and/or logs.

### Audit Appeal Policy

**Purpose:**

To establish a timeline for issuing Audits and responding to Provider or Facility Appeals of such Audits.

**Procedure:**

1. Unless otherwise expressly set forth in an Agreement, Provider or Facility shall have the right to Appeal the Audit Report. An Appeal of the Audit Report must be in writing and received by Anthem or its designee within thirty (30) calendar days of the date of the Audit Report unless State Statute expressly indicates otherwise. The request for Appeal must specifically detail the findings from the Audit Report that Provider or Facility disputes, as well as the basis for the Provider’s or Facility’s belief that such finding(s) are not accurate. All findings disputed by the Provider or Facility in the Appeal must be accompanied by relevant Supporting Documentation. Retraction will begin at the expiration of the thirty (30) calendar days unless expressly prohibited by contractual obligations or State Statute.
2. A Provider’s or Facility’s written request for an extension to submit an Appeal complete with Supporting Documentation or payment will be reviewed by Anthem or its designee on a case-by-case basis. If the Provider or Facility chooses to request an Appeal extension, the request should be submitted in writing within thirty (30) calendar days of receipt of the Audit Report. One Appeal extension may be granted during the Appeal process at Anthem’s or its designee’s sole discretion, for up to thirty (30) calendar days from the date the Appeal would otherwise have been due. Any extension of the Appeal timeframes contained in this Policy shall be expressly conditioned upon the Provider’s or Facility’s agreement to waive the requirements of any applicable state prompt pay statute and/or provision in an Agreement which limits the timeframe by which a Recoupment must be completed. It is recognized that governmental regulators are not obligated to the waiver.

3. Upon receipt of a timely Appeal, complete with Supporting Documentation as required under this Policy, Anthem or its designee shall issue an Appeal Response to the Provider or Facility. Anthem’s or its designee’s response shall address each matter contained in the Provider’s or Facility’s Appeal. If appropriate, Anthem’s or its designee’s Appeal Response will indicate what adjustments, if any, shall be made to the overpayment amounts outlined in the Audit Report. Anthem’s or its designee’s response shall be sent via certified mail to the Provider or Facility within thirty (30) calendar days of the date Anthem or its designee received the Provider’s or Facility’s Appeal and Supporting Documentation. Revisions to the Audit data will be included in this mailing if applicable.

4. The Provider or Facility shall have fifteen (15) calendar days from the date of Anthem’s or its designee’s Appeal Response to respond with additional documentation or, if appropriate in the State, a remittance check to Anthem or its designee. If no Provider or Facility response or remittance check (if applicable) is received within the fifteen (15) calendar day timeframe, Anthem or its designee shall begin recoupment of the amount contained in Anthem’s or its designee’s response, and a confirming recoupment notification will be sent to the Provider or Facility.

5. Upon receipt of a timely Provider or Facility response, complete with Supporting Documentation as required under this Policy, Anthem or its designee shall formulate a final Appeal Response. Anthem’s or its designee’s final Appeal Response shall address each matter contained in the Provider’s or Facility’s response. If appropriate, Anthem’s or its designee’s final Appeal Response will indicate what adjustments, if any, shall be made to the overpayment amounts outlined in the Audit Report or final Appeal Response. Anthem’s or its designee’s final Appeal Response shall be sent via certified mail to the Provider or Facility within fifteen (15) calendar days of the date Anthem or its designee received the Provider or Facility response and Supporting Documentation. Revisions to the Audit Report will be included in this mailing if applicable.

6. If applicable in the state, the Provider or Facility shall have fifteen (15) calendar days from the date of Anthem’s or its designee’s final Appeal Response to send a remittance check to Anthem or its designee. If no remittance check is received within the fifteen (15) calendar day timeframe, Anthem or its designee shall recoup the amount contained in Anthem’s or its designee’s final Appeal Response, and a confirming Recoupment notification will be sent to the Provider or Facility.

7. If Provider or Facility still disagrees with Anthem’s or its designee’s position after receipt of the final Appeal Response, Provider or Facility may invoke the dispute resolution mechanisms under the Agreement.