For billing and revenue code information, please refer to a current copy of the UB04 Manual, which lists the appropriate revenue codes for different Provider types.

Please note that all other sections of this Provider Policy and Procedure Manual also apply to hospital and ancillary Providers. Please see the definition of “Provider” in the Glossary section.

The remainder of this section applies to Providers that have signed the new Anthem Blue Cross and Blue Shield Facility Agreement executed after January 1, 2009. Please note the new hospital Agreement will be identified in the footer by stating “Facility Agreement ver. 8.1” or greater.

Provider Audit

Enterprise Audit Policy

This Provider Audit Policy applies to both professional and facility Providers. 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 Professional 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/Facility Agreement between Plan and Provider.

Coverage is subject to the terms, conditions, and limitations of an individual member’s certificate of coverage and in accordance with this Policy.

Procedure:

1. Review of Documents. Plan or its designee will request in writing or verbally, final and complete itemized bills for all claims under review. The Provider will supply the requested documentation in the format requested by Plan within thirty (30) calendar days of Plan’s request.

2. Scheduling of Audit. After review of the documents submitted, if Plan determines an Audit is required, Plan will call the Provider to request a mutually satisfactory time for Plan to conduct an Audit; however, the Audit must occur within forty-five (45) calendar days of the request.

3. Rescheduling of Audit. Should Provider desire to reschedule an audit, Provider must submit its request with a suggested new date, to the Plan in writing at least seven (7) calendar days in advance of the day of the Audit. Provider’s new date for the Audit must occur within ten (10) calendar days of the date of the original Audit. Provider may be responsible for cancellation fees incurred by Plan due to Provider’s rescheduling.

4. Under-billed and Late-billed Claims. During the scheduling of the Audit, Provider may identify claims for which Provider under-billed or failed to bill for review by Plan during the Audit. Under-billed or late-billed claims not identified by Provider before the Audit commences will not be evaluated in Audit. These claims may, however, be submitted (or resubmitted for under-billed claims) to Plan for adjudication.

5. Scheduling Conflicts. Should the Provider fail to work with Plan in scheduling or rescheduling the Audit, Plan retains the right to conduct the Audit with a 72 hour advance written notice, which Plan may invoke at any time. While Plan prefers to work with the Provider in finding a mutually convenient time, there may be instances when Plan must respond quickly to requests by regulators or its clients. In those circumstances, Plan will send a notice to the Provider to schedule an audit within the 72-hour timeframe.

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

7. **Completion of Audit.** Upon completion of the Audit, Plan will generate and give to Provider a Final Audit Report. This 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) calendar 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, Plan will discuss with Provider, its Audit findings found in the Final Audit Report. This 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 agrees with the Audit findings, and has no further information to provide to Plan, then Provider may sign the Final Audit Report acknowledging agreement with the findings. At that point, Provider has thirty (30) calendar days to reimburse Plan the amount indicated in the Final Audit Report. Should the Provider disagree with the Final Audit Report generated during the exit interview, then Provider may either supply the requested documentation, or Appeal the Audit findings.

8. **Provider Appeal’s.** See Provider Audit Appeal Policy

9. **No Appeal.** If the Provider 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 Plan will process adjustments to recover 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 Plan along with a short explanation of the importance of each of the documents in the Audit process. It is important to note that Providers must comply with applicable state and federal record keeping requirements.

**A. Confirm that services were delivered by the Provider in compliance with the physician’s plan of treatment.**

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

**B. Confirm that charges were accurately reported on the bill in compliance with Plan’s policies and procedures 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 patient’s bill. Other appropriate documentation for services provided to the patient may exist within the Provider’s ancillary departments in the form of department treatment logs, daily charge records, individual service/order tickets, and other documents. Plan 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 member’s bill. The Provider should make these records available for review and must ensure that policies and procedures exist to specify appropriate documentation for health records and ancillary department records and/or logs.
Provider Audit Appeals

Purpose:
To establish a timeline for issuing Audits and responding to Facility Appeals of such Audits.

Definition:
- **Agreement** – The written contract between Anthem and Facility that describes the duties and obligations of Anthem and the Facility, and which contains the terms and conditions upon which Anthem will reimburse Facility for health care services rendered by Facility to Anthem Covered Individual.
- **Appeal** – Anthem’s review, conducted at the request of a Facility and pursuant to this Policy, of the findings of an Audit made by Anthem or a Business Associate.
- **Audit** – A qualitative or quantitative review of services or documents relating to such services rendered to be rendered, by Facility, and conducted for the purpose of determining whether such services have been appropriately reimbursed under the terms of the Agreement for such services.
- **Audit Report and Notice of Overpayment (“Audit Report”)** – A document that constitutes notice to the Facility that Anthem believes an overpayment has been made by Anthem. 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 belief that the overpayment exists. Unless otherwise stated in the Agreement between the Facility and Anthem, Audit Reports shall be sent to Facility in accordance to the Notice section of the Agreement.
- **Business Associate** – 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.
- **Facility** – An entity with which Anthem has a written Agreement.
- **Recoupment** – The recovery of an amount paid to Facility which Anthem has determined constitutes an overpayment not supported by an Agreement between the Facility and Anthem. A Recoupment is generally performed against a separate payment Anthem makes to the Facility which payment is unrelated to the services which were the subject of the overpayment, unless an Agreement expressly states otherwise.
- **Supporting Documentation** – Written material contained in a member's medical records or other Facility documentation that supports the Facility's claim or position that no overpayment has been made by Anthem.

Procedure:
1. Unless otherwise expressly set forth in an Agreement, Facility shall have the right to appeal the findings of an Audit that was performed by Anthem and/or by a Business Associate. An Appeal of the findings in an Audit Report must be received by Anthem within sixty (60) calendar days of the date of the Audit Report. The request for Appeal must specifically detail the findings from the Audit Report that Facility disputes, as well as the basis for the Facility’s belief that such finding(s) are not accurate. All findings disputed by the Facility in the Appeal must be accompanied by relevant Supporting Documentation. If no Supporting Documentation is submitted to substantiate the basis for the Facility’s belief that a particular finding is not accurate the Facility will be notified of the denial and have thirty (30) calendar days to send a remittance check to Anthem. If no remittance check is received within the thirty (30) calendar day timeframe or if Facility does not respond to an Audit Report within sixty (60) calendar days of the date of such Report, Anthem will begin Recoupment proceedings within ten (10) calendar days, unless expressly prohibited by an Agreement.

2. A Facility’s written request for an extension to submit an Appeal complete with Supporting Documentation or payment will be reviewed by Anthem on a case-by-case basis. If the Facility chooses to request an Appeal extension, the request should be submitted in writing within sixty (60) calendar days of the receipt of the Audit Report or within thirty (30) calendar days of the receipt of Anthem’s appeal response and submitted to the Appeals Coordinator identified within the Audit Report. One Appeal extension may be granted during the appeal process at Anthem’s sole discretion, for up to thirty (30) calendar days from the date the Appeal would otherwise have been due. A written notification of approval or denial of an Appeal extension will be mailed to the Facility within seven (7) calendar days. Any extension of the Appeal timeframes contained in this policy shall be expressly conditioned upon the 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.
3. Upon receipt of a timely appeal, complete with Supporting Documentation as required under this Policy, Anthem shall formulate a response to the Facility (“Anthem’s Response”). Anthem’s Response shall be in writing, and shall address each matter contained in the Facility’s letter of Appeal. If appropriate, Anthem’s Response letter will indicate what adjustments, if any, shall be made to the overpayment amounts outlined in the Audit Report. Anthem’s Response shall be sent via certified mail to the Facility within sixty (60) calendar days of the date Anthem received the Facility Appeal and Supporting Documentation. Revisions to the Audit data will be included in this mailing if applicable.

4. The Facility shall have thirty (30) calendar days from the date of Anthem’s Response to send a response (“Facility Response”) or a remittance check to Anthem. If no Facility Response or remittance check is received within the thirty (30) calendar day timeframe, Anthem shall recoup the amount contained in Anthem’s Response, and a confirming Recoupment letter will be sent to the Facility.

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

The Facility shall have thirty (30) calendar days from the date of Anthem’s Final Response to send a remittance check to Anthem. If no remittance check is received within the thirty (30) calendar day timeframe, Anthem shall recoup the amount contained in Anthem’s Final Response, and a confirming Recoupment letter will be sent to the Facility.

Legal and Administrative Requirements Overview

Insurance Requirements

A. Facility shall, during the term of this Agreement, keep in force with insurers having an A.M. Best rating of A minus or better, with the following coverage.

1. Commercial General Liability insurance with limits of not less than $1,000,000 per occurrence and $2,000,000 in the aggregate for bodily injury and property damage, including personal injury and contractual liability coverage;
   a. Workers’ Compensation coverage with statutory limits and Employers Liability insurance
   b. Professional Liability/Medical Malpractice Liability Insurance with limits of not less than $1,000,000 per claim and $3,000,000 in the aggregate which shall pay for claims arising out of acts, errors or omissions in the rendering or failure to render the services to be obtained under this Agreement. If this insurance policy is written on a claims-made basis, and said policy terminates and is not replaced with a policy containing a prior acts endorsement, Facility agrees to furnish and maintain an extended period reporting endorsement (“tail policy”) for the term of not less than three years in the amount not less than the per claim and aggregate values indicated above. Professional Liability/Medical Malpractice limits may be satisfied with a combination of primary and excess coverage. Additionally, in states with patient compensation funds, a Facility may have less insurance coverage if the patient compensation fund, when considered with Facility’s insurance and any applicable limits on damage awards, provides equivalent coverage.

2. Self-Insurance can be in the form of a captive or self-management of a large retention through a Trust. A Self-insured Facility shall maintain and provide evidence of the following upon request:
   a. Actuarially validated reserve adequacy for incurred claims, incurred but not reported claims and future claims based on past experience;
   b. Designated claim Third Party Administrator or appropriately licensed and employed claims professional or attorney;
   c. Designated Professional Liability or Medical Malpractice Defense Firm(s);
   d. Excess Insurance/Re-insurance above self insured layer; self insured retention and insurance combined must meet minimum limit requirements; and
   e. Evidence of Surety Bond, Reserve or Line of Credit as collateral for the self-insured limit.
B. Facility shall notify Anthem of a reduction in, cancellation of, or lapse in coverage within ten (10) calendar days of such a change. A Certificate of Insurance shall be provided to Anthem upon request.

Dispute Resolution and Arbitration

The substantive rights and obligations of Anthem and Facility with respect to resolving disputes are set forth in the Anthem Facility Agreement (the “Agreement”). The following provisions set forth some of the procedures and processes that must be followed during the exercise of the Dispute Resolution and Arbitration Provisions in the Agreement.

A. Cost of Non-binding Mediation
   The cost of the non-binding mediation will be shared equally between the parties, except that each party shall bear the cost of its attorney’s fees.

B. Location of the Arbitration
   The arbitration hearing will be held in the city and state in which the Anthem office identified in the address block on the signature page to the Agreement is located except to the extent both parties agree in writing to hold the arbitration hearing in some other location.

C. Selection and Replacement of Arbitrator(s)
   For disputes equal to or greater than (exclusive of interests, costs or attorney’s fees) the dollar thresholds set forth in Article VII of the Agreement, then the panel shall be selected in the following manner. The arbitration panel shall consist of one (1) arbitrator selected by Facility, one (1) arbitrator selected by Anthem, and one (1) independent arbitrator to be selected and agreed upon by the first two (2) arbitrators. In the event that any arbitrator withdraws from or is unable to continue with the arbitration for any reason, a replacement arbitrator shall be selected in the same manner in which the arbitrator who is being replaced was selected.

D. Discovery
   The parties recognize that litigation in state and federal courts is costly and burdensome. One of the parties’ goals in providing for disputes to be arbitrated instead of litigated is to reduce the costs and burdens associated with resolving disputes. Accordingly, the parties expressly agree that discovery shall be conducted with strict adherence to the rules and procedures established by the mediation or arbitration administrator identified in Article VII of the Agreement, except that the parties will be entitled to serve requests for production of documents and data, which shall be governed by Federal Rules of Civil Procedure 26 and 34.

E. Decision of Arbitrator(s)
   The decision of the arbitrator, if a single arbitrator is used, or the majority decision of the arbitrators, if a panel is used, shall be binding. The arbitrator(s) may construe or interpret, but shall not vary or ignore, the provisions of the Agreement and shall be bound by and follow controlling law, including but not limited to any applicable statute of limitations, which shall not be tolled or modified by the Agreement. The arbitrator(s) may consider and decide the merits of the dispute or any issue in the dispute on a motion for summary disposition. In ruling on a motion for summary disposition, the arbitrator(s) shall apply the standards applicable to motions for summary judgment under Federal Rule of Civil Procedure 56. The cost of any arbitration proceeding under this section shall be shared equally by the parties to such dispute unless otherwise ordered by the arbitrator(s); provided, however, that the arbitrator(s) may not require one party to pay all or part of the other party’s attorneys’ fees. Judgment upon the award rendered by the arbitrator(s) may be confirmed and enforced in any court of competent jurisdiction. Without limiting the foregoing, the parties hereby consent to the jurisdiction of the courts in the State(s) in which Anthem is located and of the United States District Courts sitting in the State(s) in which Anthem is located for confirmation and injunctive, specific enforcement, or other relief in furtherance of the arbitration proceedings or to enforce judgment of the award in such arbitration proceeding.

F. Confidentiality
   All statements made, materials generated or exchanged, and conduct occurring during the arbitration process, including but not limited to materials produced during discovery, arbitration statements filed with the arbitrator(s), and the decision of the arbitrator(s), are confidential and shall not be disclosed in any manner to any person who is not a director, officer, or employee of a party or an arbitrator or used for any purpose outside the arbitration.
Medical Policies

All Anthem Medical Policies are posted on anthem.com:

- Go to anthem.com. Select Provider, Nevada and enter. From the Answers@Anthem tab, select Anthem Medical Policies.

- Or go directly to the following URL: