PROVIDER AUDIT POLICY

Policy

The purpose of the *Provider Audit Policy* is to convey how AllWays Health Partners identifies and recovers inaccurate payments. AllWays Health Partners analyzes claims data to ensure that billing is in accordance with Current Procedural Terminology (CPT) guidelines, AllWays Health Partners Payment Policies, Benefit Policies, Medical Policies (including authorization requirements), Provider Contract terms, reimbursement methodologies, and the National Healthcare Billing Audit guidelines.

Claim payments that are found to be inaccurate or inconsistent with AllWays Health Partners' policies and contracts will be retracted. All claim audits performed by AllWays Health Partners are limited to claims with paid dates that occurred in the current or previous 2 years, except for those audits related to Retroactive Member Disenrollment Recovery. AllWays Health Partners audits can be Internal or External (also referred to as vendor audits). AllWays Health Partners contracts with several vendors with expertise in areas related to coding, documentation and claim payment validation.

Claim audits may be performed on pre-payment or post-payment review. Claim audits involving review of claims data, claims payments, and medical records are performed on areas including, but not limited to, the following:

• Billing with incorrect coding (CPT, ICD10, modifiers, bundling/unbundling services)
• DRG validation
• Duplicate billing/services
• Prior authorizations not received/denied
• Multiple billings of services by more than one physician within a group
• On-site (vendor audits) for Provider Patient Accounts and Credit Balance Reporting
• Historical claims review
• Coordination of benefits
• Insurance liability and recovery

Audit findings may be disputed and appealed (see Audit Appeals section).

There are exceptions to the 2 years plus current retraction timeline. Exceptions include:

- Fraud
- Adjustment with another insurer/administrator/payer
- The claim payment was incorrect because the provider or the insured was already paid for the services identified in the claim
- The health care services identified in the claim were not delivered by the provider
- The claim payment is the subject of legal action
- Retroactive member disenrollment
- Payment for services covered by Title XVIII, XIX or XXI of the Social Security Act

- Administrative Service Only (ASO) audits
- Coordination of benefits (COB) and subrogation audits
- Investigations conducted by AllWays Health Partners' Special Investigative Unit (SIU)

Provider Audit Process

When an overpayment has been identified, AllWays Health Partners:

- generates a project ID and pulls all impacted claims
- sends an audit letter, notifying the provider that a retraction will take place 30-days from date of letter
    - Letter provides the # of claims affected and the recovery amount
    - Letter further notes that details must be requested via email to the Provider Audit email (audit@allwayshealth.org) or Provider Relations
- Provider may appeal within 30 days
- If a provider appeals before the scheduled retraction date, the following will take place:
    - If appeal is approved, claims will not be reprocessed
    - If appeal is denied, claim retractions will be processed and an appeal denial letter is sent to the provider
- Provider(s) have a 90-day limit from EOP date, to appeal any retractions

Audit Appeals

All audit appeals must be received within 90 days of the audit adjustment EOP date. Appeals received after the 90-day limit will not be considered. SIU investigation and determination are not subject to audit appeals. Standard appeal form guidelines must be followed.

Provider Audit Appeals Email Address

At the top of each claim, clearly print "Audit Appeals" in blue or black ink. Send to:

399 Revolution Drive, Suite 810
Somerville, MA 02145
allwayshealthpartners.org

References

Audit Appeal form link
https://resources.allwayshealthpartners.org/provider/forms/Provider_Audit_Appeal.pdf

Publication History

Topic: Provider Audit Policy	Owner: Network Management

January 1, 2019 *Original documentation*

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Payment policies are intended to assist providers in obtaining AllWays Health Partners ' payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers 'contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

AllWays Health Partners includes AllWays Health Partners, Inc. and AllWays Health Partners Insurance Company.