

# **Provider Audit**

especially prepared for

State Bar of Michigan, Health Care Law Section Blue Cross Blue Shield of Michigan May 21, 2019

### **Purpose of audits**



- Ensure that the most appropriate and cost-effective services and supplies are provided to our members
- Medical records and/or documentation are compliant with BCBSM and CMS guidelines for benefit, medical and payment policies
- Oversee payment accuracy

Providers are required make available and retain all medical records of services or supplies furnished to Blue Cross members for audit



## **Working together**



### Multiple disciplines needed for successful audits

Nationally known Auditors (registered nurses, certified coders, pharmacy technicians and DME billing specialists) vendors **Developers and analysts** Medical Consultants

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Compliance: coding and documentation

### > Medical Necessity: appropriateness of care



## **Areas of focus-overutilization**



- Audit for overutilization of services:
  - Lack of sufficient documentation in the medical record to support services or supplies billed (e.g., order, signatures & dates, units, etc...)
  - Lack of medical necessity or clinical information to support services or supplies billed (e.g., InterQual, CPT/HCPCS coding, NCD and LCD's)
  - Non or not covered services or supplies billed to the member's benefit plan (e.g., experimental or investigational services)

- Unbundling of services

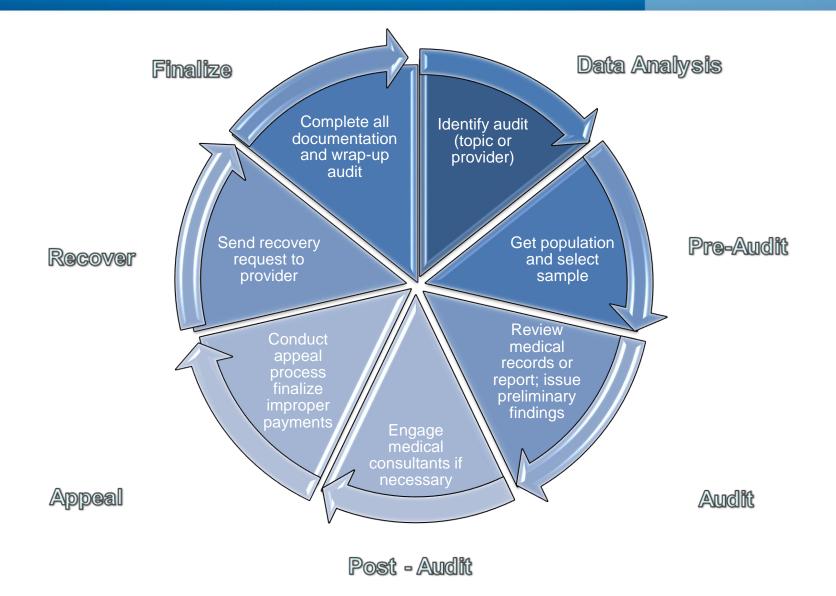
## **Areas of focus-overpayment**



- Audit for overpayment of services:
  - Improper payment for services (e.g., prior authorization not met)
  - Payment for services that do not meet professionally recognized standards or levels of care (e.g., lack of documentation for timed or psychiatric codes)
  - Excessive billed charges or selection of the wrong code(s) for services or supplies
  - Services or supplies that should not have been or were not provided

### How we conduct audits





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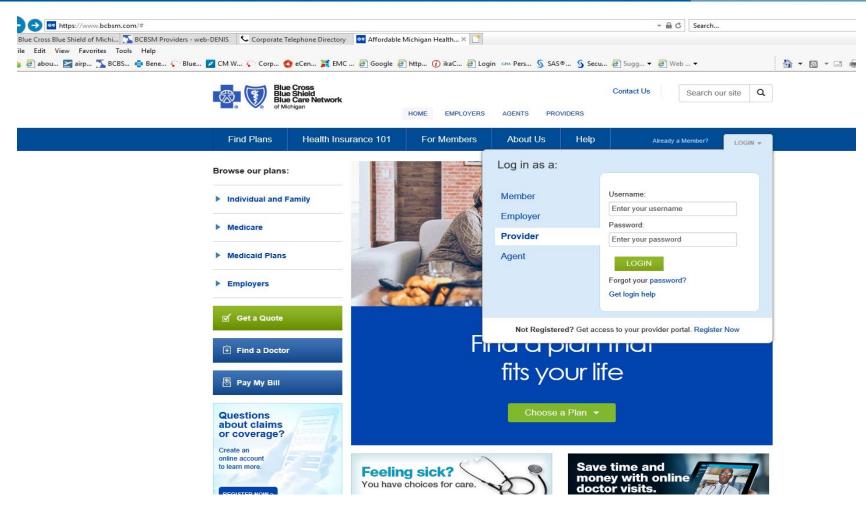


### Internal Review

- Provider requests in 30 calendar days of receiving initial reporting letter
- Within 30 days of request a determination letter will be sent
- External Peer Review (medical necessity)
  - Provider requests in 30 calendar days from receipt of internal review
  - Within 30 days of request a determination letter will be sent.
- May 2018 Record article
- https://www.bcbsm.com/newsletter/therecord/2018/record\_0518/Record\_0518h.shtml

## Login to BCBSM resources





### https://www.bcbsm.com/



- WebDenis
  - Participation Agreement
  - Provider Publications
    - WebDenis alerts
    - Record articles
    - Verify patient eligibility
    - Other newsletters and resources
    - Non-facility benefit information

#### To HIPAA View Option

Back to Provider Secured Home

Broadcast Messages

Subscriber Info.

Provider Enrollment

BCBSM Provider Publications and Resources

BCN Provider Publications and Resources

Provider Manuals

Claim Submission

Facility Claims

Professional Claims

BCBSM Contact Us.

BCN Contact Us.

Web-DENIS Documentation

Logout



Blue Cross Blue Shield Blue Care Network of Michigan



### Benefit Explainer

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- Benefit/coverage information
- Benefit policy for a procedure code
- Medical/payment policy report

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	<ul> <li><u>BPR Search</u> View and print BCBSM benefit information, payment rules and member cost sharing. Search by contract number, group keywords an identifiers, topics, codes or unique "Benefit Package ID." Link to additional resources.</li> </ul>	<ul> <li>Medical/Payment Policy Report</li> <li>View and print BCBSM's general (not group-specific) medical and payment policy rules for a specific time frame. Search by topics, codes or keywords to determine whether and how BCBSM covers a service. Link to additional resources.</li> </ul>			
	<ul> <li>BCBSM Provider Manuals Search View and print content from BCBSMs online health care provider manuals. Easily search by provider for participation requirements and agreements, provider billing instructions and eligibility rules. Link to additional resources, such as <i>Record</i> articles.</li> </ul>	<ul> <li>Jobs Manage your research with this tool. Virtual documents you request get filed here for viewing and printing at your convenience. Delete files when you are done.</li> </ul>			
	<ul> <li><u>Switch Roles</u></li> <li>Change your view so you can see exactly what your caller is viewing.</li> </ul>	Manage Favorites     View and manage your list of favorite topics.			
	<ul> <li><u>Communications*</u> View communications and news. An asterisk will display when there are unread communications.</li> </ul>				



### Internal Review

- Provider requests in 50 calendar days of receiving initial reporting letter
- Within 50 days of request a determination letter will be sent
- External Peer Review (medical necessity)
  - Provider requests in 20 calendar days from receipt of internal review.
  - Within 50 days of request a determination letter will be sent. This is binding for provider and BCBSM

### Medicare Plus Blue provider manual

<u>https://www.bcbsm.com/content/dam/public/Providers/Documents/help/medicare-plus-blue-ppo-manual.pdf</u>

## Login to Medicare Advantage resources



https://misource.bcbsm.com/home/default.aspx

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#### Blue Cross Blue Shield Blue Care Network

### MISource frequently accessed documents

- Authorization
- Benefits
- Claims
- Enrollment
- MPSERS
- Part D Drugs
- Premium Billing/Finance
- URMBT
- Care Management
- Grievance and Appeals



https://misource.bcbsm.com/Documents/misourcealertlinkmenu.aspx

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ANCC RNs	ISMG			
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Call-In Pricing (SCIP)	Michigan Recoveries			
CBSS	Pricing Operations			
	G			
FlexLink	Provider			
Group Administration	Quality (Claims-BlueCard-Price	ng Ops)		
Group Customer Inquiry & Billing	RCO Claims			
Group Customer Membership	SASC			
	Statewide Walk-In Center			~
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- Pre-work
  - Review coding, documentation and billing processes within the practice
  - Re-train staff if necessary
  - Implement a tracking system to monitor the audit results
- When an audit begins
  - Respond promptly
  - If you can't respond promptly, request an **extension** for a medical record submission or appeal
  - Provide the entire medical record or itemized bill unless otherwise specified in the letter
  - Follow the steps in the audit letters you receive from Blue Cross or the vendor
  - Verify audit findings, overpayments and claim adjustment
  - Do not balance bill patient for claim adjustment due to the audit



