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

Blue Cross Blue Shield Blue Care Network of Michigan

Multiple disciplines needed for successful audits

Nationally known vendors

Auditors (registered nurses, certified coders, pharmacy technicians and DME billing specialists)

Developers and analysts

Medical Consultants

Types of audits

- Compliance: coding and documentation
- Medical Necessity: appropriateness of care

Areas of focus-overutilization

Blue Cross Blue Shield Blue Care Network of Michigan

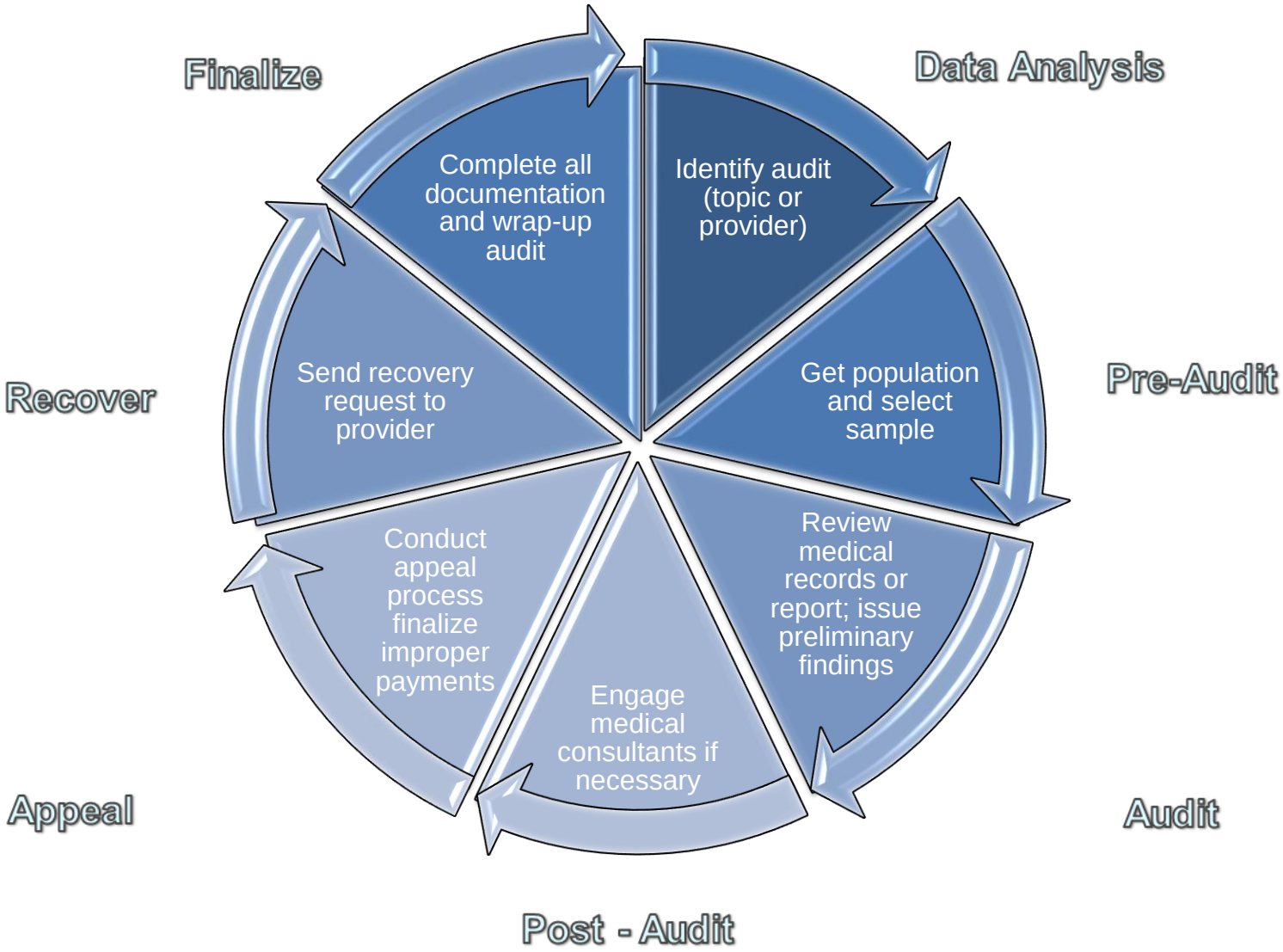
- Audit for overutilization of services:
  - Lack of sufficient documentation in the medical record to support services or supplies billed (e.g., order, signatures & dates, units, etc...)
  - Lack of medical necessity or clinical information to support services or supplies billed (e.g., InterQual, CPT/HCPCS 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

Blue Cross Blue Shield Blue Care Network of Michigan

- 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



Appeal levels – Commercial

Blue Cross Blue Shield Blue Care Network of Michigan

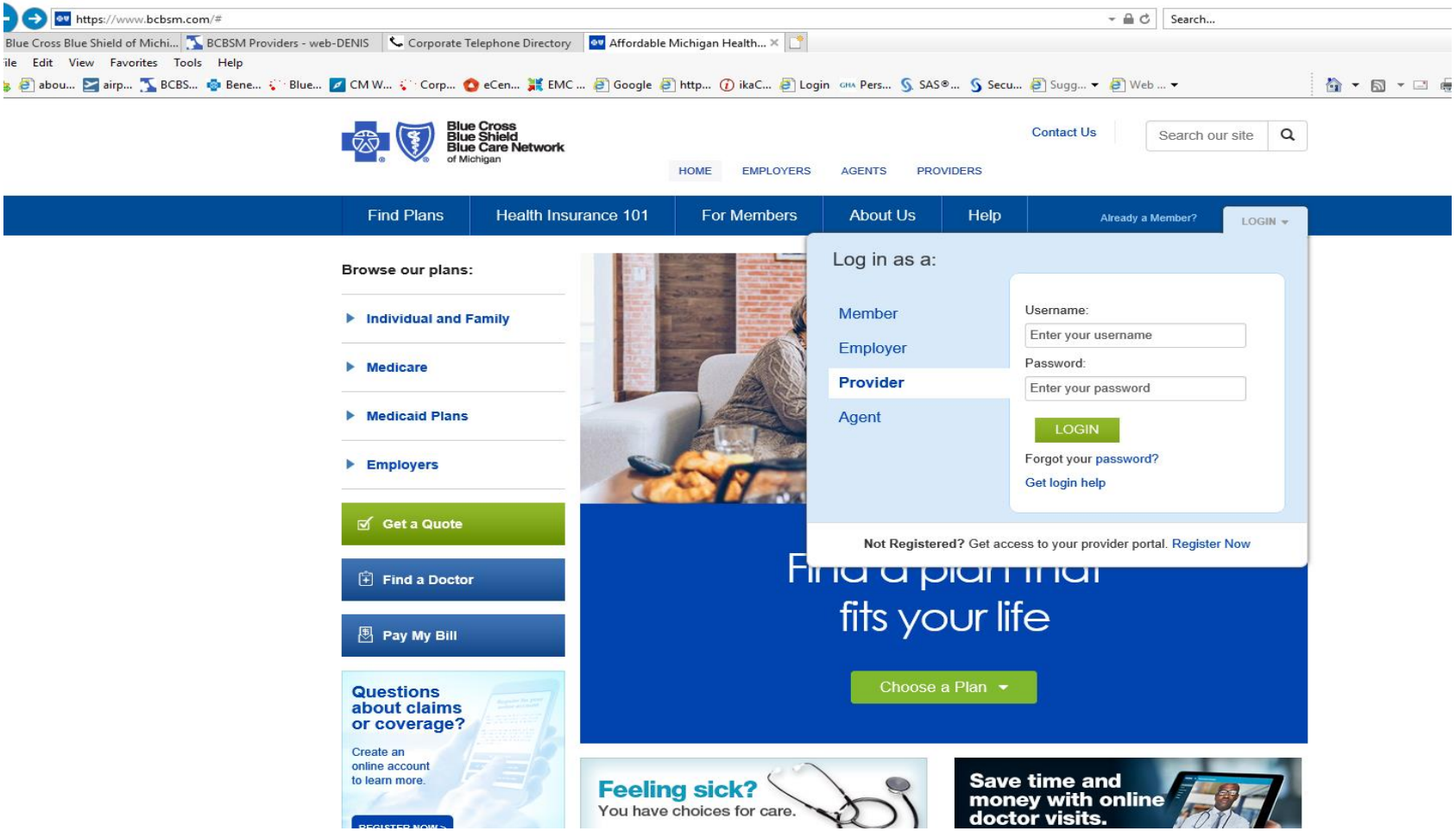
- Internal Review
  - Provider requests in 30 calendar days of receiving initial reporting letter
  - Within 30 days of request a determination letter will be sent

- 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



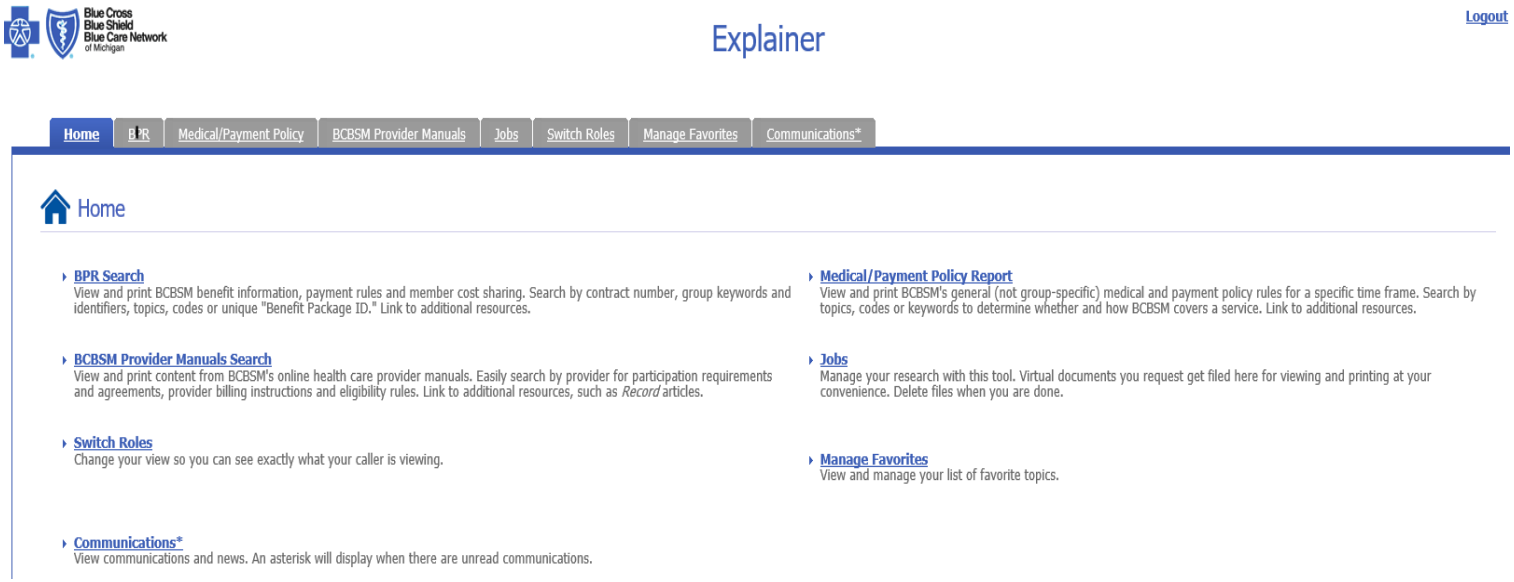
https://www.bcbsm.com/

Provider on-line resources

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

Provider on-line resources

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



Appeal levels – Medicare Advantage

- Internal Review
  - Provider requests in 50 calendar days of receiving initial reporting letter
  - Within 50 days of request a determination letter will be sent

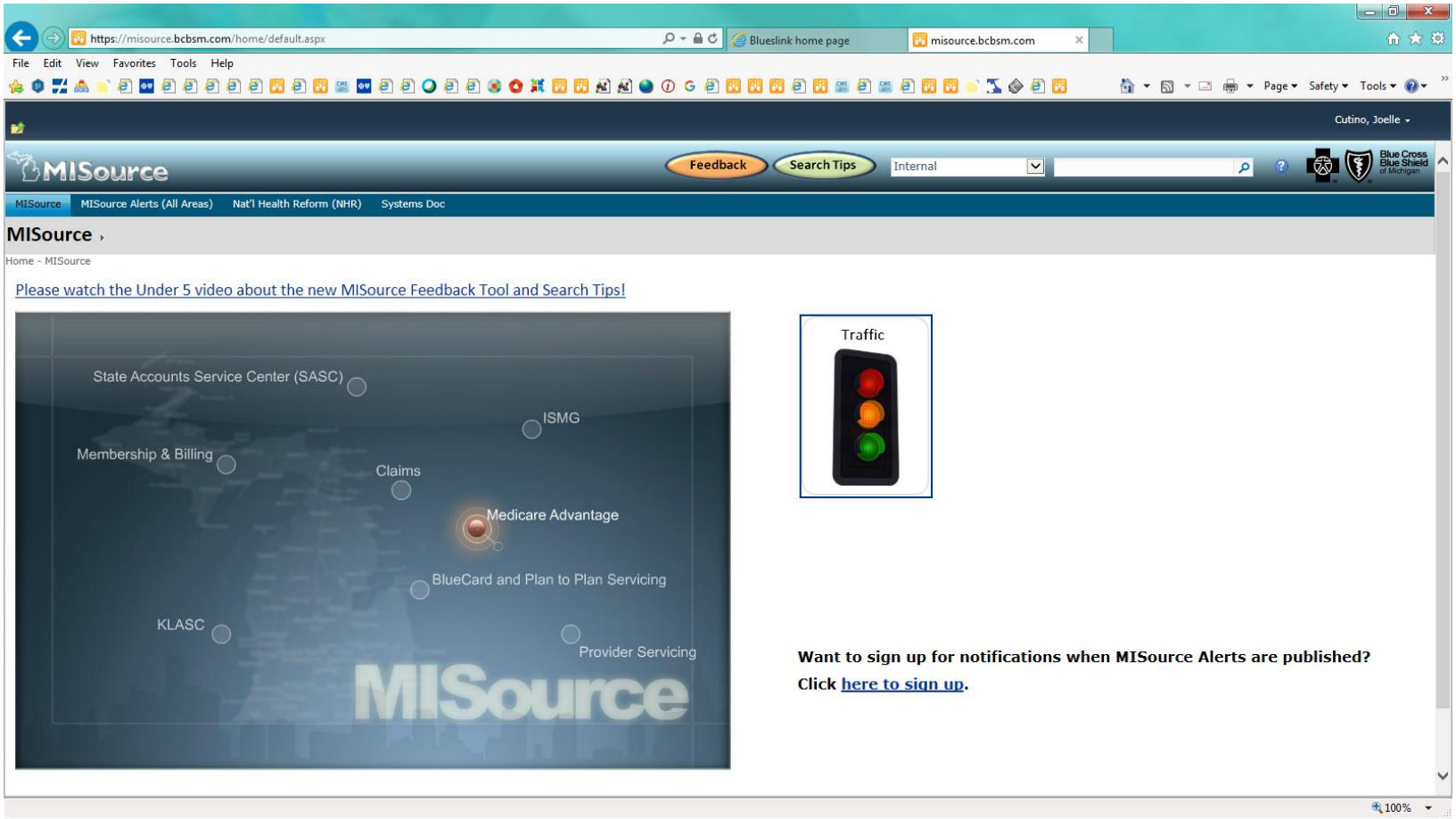
- External Peer Review (medical necessity)
  - Provider requests in 20 calendar days from receipt of internal review.
  - Within 50 days of request a determination letter will be sent. This is binding for provider and BCBSM

- Medicare Plus Blue provider manual

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

Login to Medicare Advantage resources

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



Provider on-line resources

MISource frequently accessed documents

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

Provider on-line resources

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

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

Blueslink home page | misource.bcbsm.com | misourcealertlinkmenu

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- Auto National Claims (ANCC)
- ANCC RNs
- BlueCard Home
- BlueCard Host
- Call-In Pricing (SCIP)
- CBSS
- FlexLink
- Group Administration
- Group Customer Inquiry & Billing
- Group Customer Membership
- IMB
- ISMG
- KLASC
- Medicare Advantage
- Michigan Recoveries
- Pricing Operations
- Provider
- Quality (Claims-BlueCard-Pricing Ops)
- RCO Claims
- SASC
- Statewide Walk-In Center

100%

Best practices when responding to audits

Blue Cross Blue Shield Blue Care Network of Michigan

- 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

Questions