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Origination: Legal & Fraud, Waste, Abuse & Recovery (existing policy effective 2009 has been revised and restated in 2018)
Last Review: November 2024
Next Review: March 2026
Effective Date: March 1, 2025

Description

This policy defines Blue Cross VT provider audit process including the use of sampling methodologies and extrapolation. Within the context of this policy, the term "provider" refers to all types of facilities, suppliers, practices, and individual providers that bill the Plan for services.

Policy & Guidelines

I. General Guidelines

Plan conducts provider audits to help ensure the proper administration of healthcare benefits for its customers consistent with federal and state law, as well as Plan policies.

The audit process may be used to validate a variety of data, depending on the objectives of the specific audit. Typically, an audit will verify the following types of information:

- Services have been coded in accordance with the American Medical Association's Current Procedural Terminology (CPT) and the Health Care Procedure Coding System (HCPCS).
- Documentation supports that the level of service(s) performed were consistent with the codes submitted.
- Services billed for meet Plan's definition of medical necessity or otherwise are proper for payment under specific policies.
- Compliance with Plan's Provider Handbook, Corporate Medical Policies and Corporate Payment Policies.
- Compliance with provider contracts; and
- Compliance with other applicable laws and regulations, as appropriate.

This policy focuses on audits initiated by Plan's internal auditing team. Plan does, however, partner with third-party vendors to provide auditing services including, but not limited to: (1) reviews on coordination of benefit claims; (2) reviews for duplicate services; (3) reviews for claims suspected to have administrative billing and payment errors; (4) reviews for compliance with

certain payment policies; and (5) quality assurance review of claim processing for facility billing, high-cost injectable drugs, home infusion, and renal dialysis. Plan also partners with a third-party vendor for retrospective provider credit balance reviews of all active Plan accounts. These vendors may outreach to provider offices directly to obtain more information, and Plan expects providers to respond in a timely manner to these requests. For more information about Plan's third-party auditing vendor partnerships, please see Plan's Provider Handbook.

II. Identifying Providers for Initial Audit

Plan reserves the right in its sole discretion to audit all providers at any time to ensure compliance with the guidelines stated in Plan policies, provider contracts, and/or Provider Handbook. However, typically an audit occurs based on a review of utilization and billing patterns relative to peers or information received via the Plan's Fraud, Waste, and Abuse hotline, customer complaints, and internal or external referrals.

After a provider has been selected for an audit, typically the Plan will request medical records for the services being audited. The records will be reviewed by an individual with the requisite level of clinical and coding experience. Such reviewer may be a Plan employee or an external resource. While most audits are conducted post-payment, the Plan may request medical records and review a Provider's claims for services on a pre-payment basis.

If an audit identifies instances of non-compliance with a policy, coding conventions, or medical necessity guidelines, Plan reserves the right to recoup all non-compliant payments.

III. Record Requests

When a provider has been identified for an initial audit, the Plan will notify the selected entity of the audit and request the documentation needed to conduct the audit. The provider shall submit the documentation to the Plan within thirty (30) calendar days of the date of the request. Claims for which documentation is not submitted or made available by the end of thirty (30) calendar days may be recouped due to lack of documentation.

Providers may request an extension, which will be granted in the Plan's sole discretion, but providers shall not exceed 45 days to provide requested documentation without approval from the Plan.

As necessary based on the circumstances (e.g., concern of fraud or harm to members, potential for alteration of medical records), Plan may require the provider to provide documentation in a shorter time, including with no notice. In cases where no advance notice is given, the provider will be provided with Plan's written notification of intent to audit when the auditor arrives on site.

If no response is received within forty-five (45) calendar days after the date of the request, Plan may: (1) require pre-payment review and submission of medical records, and Plan will deny or

recode claims based on the sufficiency of the documentation; (2) deny the services completely as not medically necessary based on lack of documentation to support services were rendered; (3) temporarily suspend provider from the network; and/or (4) take other action as may be necessary.

Medical records will be requested from the provider in writing, as directed by the Plan with appropriate tracking method. Medical records will be provided to Plan as they exist on the date of the request; it is strictly prohibited to modify medical records or any other information upon receipt of an audit request. The submitted claims and requested medical records will be audited remotely, at the Plan's offices, unless Plan elects to do an on-site review.

Provider site reviews are performed at the provider's location(s). Considerations in determining whether to conduct the review at the location of the provider include, but are not limited to, the following:

- The extent of aberrant coding, billing, or utilization patterns that have been identified.
- The presence of multiple program integrity issues.
- Evidence or likelihood of fraud, waste, or abuse.
- Number of providers subject to the audit.
- Whether the review is initial or follow-up.
- Past failure(s) of the provider to submit requested medical records in a timely manner or as requested; or
- Other factors as determined by the Plan which support the need for an on-site record review.

IV. Medical Record Documentation Guidelines

Medical records are to be created and maintained at the time, or shortly after, services are performed and before claims are submitted. For the purposes of an audit, the contemporaneous records will be the basis for the Plan's audit findings. If the provider modifies the medical record later, it will not affect the audit results. Audit findings are based on documentation available at the time of the audit. Audit findings will not be modified by entry of additional information after initiation of the audit, for example, to support a higher level of coding.

Guidelines for documentation and coverage may be found in Plan's Provider Handbook and policies. These resources are available online at our website, www.bluecrossvt.org, under the "Providers" section.

V. Use of Sampling

Plan typically will use a form of sampling to audit a provider. Plan reserves the right to review additional records as warranted by the nature of the audit, preliminary findings, or other relevant factors.

a. Probe Sampling

Plan's provider audit process typically begins with a "probe" sample of claims submitted to test a hypothesis that claims submitted may be coded or reimbursed by Plan in error or are otherwise problematic. A probe audit is intended to contain a sample that will be large enough to provide confidence that a problem does or does not exist but small enough to limit administrative burden. Typically, depending on the nature of the audit, a probe sample will involve a review of claims for twenty to forty members which exhibit characteristics aligned with the potential problem. A probe sample may also include specific medical records if Plan has received information indicating a potential issue with a specific claim or series of claims. Typically, with a probe sample, medical records will be audited remotely.

Based on the extent and severity of the results of the probe sample, Plan may take additional or other actions as warranted, such as:

- Advise provider there were no negative audit findings and no action is needed.
- Educate the provider,and establish expectations for corrective action going forward.
- Recover monies associated with the submitted claims contained with the probe sample.
- Pursue settlement with the provider; or
- Expand the scope of the audit, including taking a statistical sample or possible conducting a full audit.

b. Statistical Sampling

Although a probe audit may be statistically valid, in some situations, additional auditing will be required. In the context of this policy, this is referred to as "statistical sampling." Typically, statistical sampling may be used when:

- The provider requests a statistical sampling, typically as means to resolve findings identified via probe sampling; or
- Plan determines additional sampling is required.

When the Plan determines statistical sampling must occur, the Plan will notify the provider in writing. The provider shall respond to the notice within thirty (30) days. A statistical sampling audit may occur on-site at the provider's office or Plan may request records to view remotely. See the "Record Requests" section, above, for more information about this process. The Plan notification will include:

- An explanation of why the audit is being conducted (i.e., why the provider was selected).
- The time period under review.
- A list of submitted claims that require medical records or other supporting documentation.

- A statement of where the review will take place (provider office or remote site).
- An explanation of how results will be calculated if claims are determined to have problems, such as they should not have paid or were overpaid; and
- An explanation of the possible methods of monetary recovery if an overpayment is determined to exist.

Plan's statistical sampling process is as follows:

(1) A statistically valid sample will be selected from the sampling universe of records to be audited. The sample size shall be selected using accepted sample size estimation methods. The confidence level of the sample size calculation shall not be less than ninety-five percent (95%).

(2) Following the sample audit or review, the statistical margin of error of the sample will be computed for a ninety-five percent confidence level. The lower limit error rate will be extrapolated to the universe from which the sample was drawn.

(3) The statistical analysis program used by the Department of Health & Human Services, OIG-Office of Audit Service (RAT-STATS) will be used to estimate the sample size and margin of error, consistent with the sampling parameters.

(4) The audit or review findings generated through statistical sampling procedures shall be used in determining the amount of overpayment or underpayments received by the provider. If the statistical sampling process is undertaken, the results of the original probe audit will not be used to determine overpayments/underpayments.

Based on the extent and severity of the results of the statistical sample, Plan may take additional or other actions as warranted, such as:

- Advise provider there were no negative audit findings and no action is needed.
- Educate the provider and establish expectations for corrective action going forward.
- Recover monies associated with the submitted claims contained within the sample.
- Pursue settlement with the provider; or
- Expand the scope of the audit.

VI. Post-Audit Activity with Providers

The manner in which a provider is notified of audit results will vary, depending on various factors, including the nature of the findings and whether corrective action is required.

a. No Corrective Action Required by Provider

At the conclusion of a review, if no corrective action is required by the provider, the results are

shared with the designated provider in writing and no additional action will be taken by Plan or required by the provider.

b. Corrective Action Required by Provider

i. Plan Communication of Audit Results & Corrective Action

If corrective action is required by the provider, audit findings and the Plan's expectations will be communicated to the provider (1) at a face-to-face meeting with the Plan at a location to be determined by the Plan and (2) a follow-up in writing. A face-to-face meeting is required to:

- Ensure the provider understands the audit process and results.
- Answer any questions regarding correct coding/billing or documentation standards.
- Afford the provider an opportunity to furnish additional clinical information that was not originally sent with medical records[1]; and
- Discuss a corrective action plan and repayment arrangements, if applicable.

Plan may, in its sole discretion, communicate audit findings and expectations in advance of the face-to-face meeting to facilitate discussion, but this should not be expected nor is it required.

Corrective action typically involves repayment of incorrectly billed claims, as well as required actions to ensure that billing errors uncovered in the audit do not re-occur.

A provider may formally dispute Plan's audit findings by submitting documentation, with thirty (30) days of receiving the written summary of the audit findings, in writing for Plan's Legal Department and Medical Director to review. The Legal Department and Medical Director will review the written documentation and issue a written recommendation within thirty (30) days of receipt of the provider's dispute letter. To the extent the provider's claims are being suspended for pre-payment review during Plan's review period, Plan will decline to deny claims based on coding or documentation requirements for the issue under review by Plan. Play may continue to deny claims that are investigational or not medically necessary, but the provider may appeal such denials through the normal appeal process.

ii. Repayment Arrangements & Settlement Process

In the event an audit finds overpayment, the provider shall be required to repay the overpaid amounts as described below.

After the face-to-face meeting, Plan will issue a letter summarizing the audit findings, including any overpayment amount required based on the audit findings. Unless facts indicate an offer of

[1] It is expressly prohibited to modify the medical records provided in response to audit notice. However, if additional information is available, a provider may bring such information to the face to face meeting for consideration.

settlement would be unfruitful, the Plan will include with the letter a settlement offer using the results of the audit as the basis for extrapolation to determine the repayment amount and any required corrective action.

Typically, as part of the settlement, the provider will be required to reimburse the Plan for the projected total overpayment (minus any underpayments), which will be calculated as described below:

- The total dollar overpayment in the audit sample is calculated.
- This total overpayment is divided by the total paid dollars of audited services to determine the error rate.
- The error rate is multiplied by the total paid dollars for applicable services for which the provider received payment during an audit period. This amount is the total extrapolated overpayment.

If underpayments are found in an audit, they are subtracted from any overpayments, and factored into the calculated error rate.

The notice of overpayment and settlement offer will include information and documentation to support the calculations described above.

After receipt of the notice of overpayment, and settlement offer, the provider may, within thirty (30) calendar days:

- Request a follow-up meeting to discuss the letter and settlement offer, including a possible repayment plan; or
- Accept and sign the settlement agreement and remit overpayment.

Any provider accepting a settlement offer waives any appeal rights with respect to the services covered by the extrapolated overpayment, and Plan will not audit additional claims for the service(s) under review within the audit period.

If the provider does not wish to pursue a settlement or does not respond within thirty (30) calendar days to the Plan's letter and offer of settlement, or if Plan and provider are unable to reach agreement on the terms of a settlement within sixty (60) calendar days of the Plan's written offer of settlement, at Plan's discretion, Plan will take one or more of the following actions:

- Recoup overpayments from provider for the full extrapolated amount.
- Require the provider to submit future claims on paper along with all clinical records related to each claim, until corrective action has been demonstrated to Plan's satisfaction (sometimes referred to as the "educational period"). These claims will be reviewed prior to adjudication to assure that the documentation supports the services coded and billed,

as well as medical necessity. To the extent Plan denies a claim during this educational period, the provider must appeal that denial following Plan's policies and procedures. Nothing in this policy impacts a member's ability to appeal a denied claim or a member's other rights.

- Pursue additional auditing, including a more intense audit; or
- Terminate the provider with cause, following notice; the provider would have the right to appeal the termination provided such right to appeal has not otherwise been waived through a previous settlement agreement.

The dollars to be recovered pursuant to a settlement may be reduced below the total projected overpayment, at Plan's sole discretion.

The time period for resolving the terms of a settlement may be extended at Plan's discretion.

iii. Re-Audit

Plan reserves the right to re-audit the provider when corrective action is required. Re-audits will be performed within six (6) to twenty-four (24) months of the original audit. Providers who fail to meet the required expectations from the prior audit may be subject to provider contract termination.

Re-audits performed after twenty-four (24) months from the initial audit will be subject to the Plan's standard audit process and policies as stated above.

c. Termination with Cause

In the case of egregious behavior or repeated noncompliance with Plan's requirements, Plan may determine that termination of the provider's contract, with cause, is appropriate. Termination will occur in accordance with the terms of the provider's contract and Plan's Provider Contract Termination Policy.

Benefit Determination Guidance

Payment for services is determined by the member's benefits. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Eligible services are subject to applicable member cost sharing such as co-payments, co-insurance, and deductible.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information, please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Inter Plan Programs (IPP): In accordance with the Blue Cross and Blue Shield Association's Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (Blue Cross VT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices, payment policy and pricing are a local Plan responsibility that a member's Blue Plan must honor. A member's Blue Plan cannot dictate the type of claim form upon which services must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A member's Blue Plan cannot apply its local billing practices on claims rendered in another Plan's service area. A member's Blue Plan can only determine whether services rendered to their members are eligible for benefits. To understand if a service is eligible for payment, it is important to verify the member's benefits **prior** to providing services. In certain circumstances, the member may be financially responsible for services beyond the benefit provided for eligible services.

Claims are subject to payment edits that are updated at regular intervals and generally based on Current Procedural Terminology (CPT®), Health Care Procedural Coding System (HCPCS), Internal Classification of Diseases, CMS National Correct Coding Initiative Edits, Specialty Society guidelines, etc.

Eligible Providers

This policy applies to all providers/facilities contracted with the Plan's Network (participating/in- network) and any non-participating/out-of-network providers/facilities.

Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure adherence with the guidelines stated in the payment policy. If an audit identifies instances of non-adherence with this payment policy, Blue Cross VT reserves the right to recover all non-adherence payments.

Related Policies

Provider Contract Termination Policy
Claims Appeal Policy
Provider Appeals from Adverse Contract Actions & Denials of Participation in BCBSVT Networks (Including Related Reporting)
Site Visit and Medical Record Keeping Policy

Document Precedence

The Blue Cross VT Payment Policy Manual was developed to provide guidance for providers regarding Blue Cross VT payment practices and facilitates the systematic application of Blue Cross VT member contracts and employer benefit documents, provider contracts, Blue Cross VT corporate medical policies, and Plan's claim editing logic. Document precedence is as follows:

1) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the member contracts or employer benefit documents, the member contract or employer benefit document language takes precedence.
2) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and provider contract language, the provider contract language takes precedence.
3) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and corporate medical policy, the corporate medical policy takes precedence.
4) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the Plan's claim editing solutions, the Plan's claim editing solution takes precedence.

Policy Implementation/Update Information

This policy was originally implemented on August 2009.

Date of Change	Effective Date	Overview of Change
February 2015	February 2015	
November 21, 2024	March 1, 2025	No substantial changes to the Policy. Performed some editing and punctuation. TVHP deleted.

Approved by **Update Approved: 11/21/2024**

Tom Weigel, MD, Chief Medical Officer