

Audit Policy

Policy¹

The purpose of the *Audit Policy* is to outline the process used to identify and recover inaccurate payments. Harvard Pilgrim Health Care analyzes claims data to ensure that billing is in accordance with Current Procedural Terminology (CPT) guidelines, Harvard Pilgrim Health Care Payment Policies, Benefit Policies, Medical Policies (including authorization requirements), Provider Contract terms, and Reimbursement methodologies.

Claim payments that are found to be inaccurate or inconsistent with Harvard Pilgrim Health Care's policies and contracts will be retracted. All claim audits performed by Harvard Pilgrim are limited to claims with dates of service that occurred in the current or previous year, except for those audits noted in the Retroactive Member Disenrollment Recovery; Northern New England Retroactive Health Insurance Denials; and Exception to Time Limit sections below.

Harvard Pilgrim Health Care audits can be Internal or External (also referred to as vendor audits). Harvard Pilgrim contracts with a number of vendors with expertise in areas related to coding, documentation and claim payment validation. Claim audits may be performed on a pre-payment or post-payment review. Claim audits involving review of claims data, claims payments and medical records, are performed on areas including, but are not limited to, the following:

- Billing for services that were not provided
- Billing with incorrect coding — CPT, ICD-10, modifiers, bundling/unbundling services
- DRG validation
- Hospital bill audit
- 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 and prepayment claims and medical record reviews
- Coordination of benefits
- Insurance liability and recovery

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

Note: Providers shall grant Harvard Pilgrim Health Care or its contracted agent access to review and copy member medical records within a reasonable period of time following such request. For purposes of this document, "reasonable" shall be defined as a maximum of two weeks from Harvard Pilgrim Health Care's initial request for access, unless a different time frame is mutually agreed upon by Harvard Pilgrim Health Care and the provider. Copies may be taken off-site by Harvard Pilgrim Health Care for additional review during the course of the audit.

DRG Audit Notification and Scheduling

Harvard Pilgrim Health Care or its contracted audit agent(s) and provider audit personnel should make every effort to directly resolve audit and coding inquires.

Harvard Pilgrim Health Care or its contracted agent may conduct audits off-site. Provider is required to submit a complete medical record for each claim to be audited directly to the contracted audit agent, upon request. Audits will be grouped to increase efficiency whenever possible. Harvard Pilgrim Health Care or contracted audit agent will pay no fees related to the audit itself, including copying fees for the medical record.

Providers shall submit a copy of the complete medical record to Harvard Pilgrim Health Care's contracted audit agent within 30 days of the request date. Providers who cannot accommodate an audit request that conforms to these guidelines must present the rationale as to why the request cannot be met and propose a reasonable period of time within which medical record copy will be furnished. Harvard Pilgrim Health Care will determine if the delayed time frame will be acceptable and, if not, will assist the contracted audit agent in negotiating a reasonable compromise.

Harvard Pilgrim Health Care expects that the requested health record information presented at the time for audit will be complete and legible. A separate, signed patient authorization will not be needed to conduct the audit.

The admitting physician is required to clearly indicate the patient's status in the physician's order (i.e. "admit to inpatient" or "admit to outpatient", etc.).

Harvard Pilgrim Health Care will not accept retrospectively amended medical records or physician queries beyond 30 calendar days from the service date. Harvard Pilgrim Health Care considers medical record documentation and/or physician queries present in the chart at the time the audit notification is made to the provider as the official record to support services provided for the basis of coverage or reimbursement determination.

Providers should always strive to group audits to increase efficiency whenever possible. If a provider is unable to accommodate the grouping of audits for any reason, the provider agrees to cooperate with auditors who may opt to conduct the audits off-site.

If a provider believes an auditor may have problems accessing records, the provider shall notify the auditor no less than two weeks prior to the scheduled date of audit to reschedule such audit date within a 30-day period. Providers shall supply the auditor and Harvard Pilgrim Health Care with any and all information that could affect the efficiency of the audit.

Resolution of any discrepancies, questions or errors that have been identified in the audit shall occur within 30 calendar days of the Submission Date. All audit determinations will stand and the audit results deemed final if the provider fails to submit to the contracted audit agent a rebuttal accompanied by supporting documentation to refute the initial audit findings or to communicate agreement with the audit findings within 30 calendar days of the Submission Date.

Retroactive Member Disenrollment Recovery

Retroactive member disenrollment adjustments will take place within a fixed period of time. Harvard Pilgrim will complete recovery of claim payments due to retroactive member disenrollment **no later than 225 days from the date of service**.

Because CMS has up to 36 months to notify Harvard Pilgrim of retroactive member disenrollment, the recovery of Medicare and GIC claim payments due to retroactive member disenrollment may be extended beyond the 225-day limit.

Northern New England Retroactive Health Insurance Denials

Retroactive denial and retraction of payment for Northern New England (NNE) is dependent on the claim payment date, which differs by state. As of 01/01/2019, New Hampshire retraction is not permitted if more than 12 months have elapsed from the original payment date. Maine retraction is not permitted if more than 12 months have elapsed from the original payment date. Compliance with NNE regulations require a written notice be sent to providers prior to reprocessing claims. There are exceptions to the 18/12-month 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
- Payment for services covered by Title XVIII, XIX or XXI of the Social Security Act

Exception to Time Limit

The following audits are not subject to the claims audit time limit:

- Administrative Service Only (ASO) audits
- Coordination of benefits (COB) and subrogation audits
- Investigations conducted by Harvard Pilgrim's Special Investigative Unit (SIU)
- Duplicate Payment of a Claim

Audit Appeals

All 1st Level Audit Appeals must be received within 90 days of the audit adjustment notification. 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 need to be followed.

Audit Appeals Address

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

Send to:

Harvard Pilgrim Health Care
P. O. Box 699183
Quincy, MA 02269-9183

PUBLICATION HISTORY

01/01/02	original documentation
07/15/02	deleted 180-day limit on audits from previous year; added On-Site Record Review
01/01/03	added NH retroactive denial information
01/01/04	added ME to retroactive denial
07/31/07	updated ME retroactive denial
04/30/08	clarified audit time limit and appeals related to Harvard Pilgrim SIU
11/15/09	annual review; clarified ME and NH retroactive denials
01/01/12	removed First Seniority Freedom information from header
06/15/12	annual review; minor edits for clarity
03/15/14	added CT retroactive denial information
01/02/19	updated NH retroactive denial as of 01/01/19
11/01/21	annual review
01/01/24	removed references to Connecticut

¹ This policy applies to the products of Harvard Pilgrim Health Care and its affiliates— Harvard Pilgrim Health Care of New England and HPHC Insurance Company—for services performed by contracted providers. Payment is based on member benefits and eligibility, medical necessity review, where applicable, and provider contractual agreement. Payment for covered services rendered by contracted providers will be reimbursed at the lesser of charges or the contracted rate. (Does not apply to inpatient per diem, DRG, or case rates.) HPHC reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated annually. Always use the most recent CPT and HCPCS coding guidelines.