**Payment Policy |** Post Payment Audits

**EFFECTIVE DATE:** 06|27|2022
**POLICY LAST UPDATED:** 08|03|2022

## OVERVIEW

This policy documents post-payment audit recovery and other adjustments due to under or overpayments in non-federal products (Commercial) in accordance with RI General Laws (RIGL) § 27-19-56 and § 27-20-51 and is applicable to healthcare providers. "Healthcare provider" means an individual clinician, either in practice independently or in a group, who provides healthcare services, and any healthcare facility, as defined in § 27-20-1 including any mental health and/or substance abuse treatment facility, physician, or other licensed practitioner identified to the review agent as having primary responsibility for the care, treatment, and services rendered to a patient.

This policy does not apply to Medicare Advantage Plans, Federal Employees Program, or other federal programs. For these programs, post-payment recovery would follow the guidelines set forward by these agencies.

## MEDICAL CRITERIA

Not applicable

## PRIOR AUTHORIZATION

Not applicable

## POLICY STATEMENT

**Commercial Products**

The provider shall upon request and at no cost to BCBSRI, provide BCBSRI and/or its audit designee with provider's billing, financial, and medical records relating to covered health services provided to subscribers. BCBSRI and/or its audit designee will be provided with an electronic copy of the complete medical record or granted access to obtain records via remote access for each audited claim within 30 calendar days following a request for such. Failure to provide access to medical records will result in a recovery of the full claim amount.

Any request for recovery made by Blue Cross & Blue Shield of Rhode Island (BCBSRI) or any request related to underpayment received from a healthcare provider will be adjudicated in a manner consistent with RIGL § 27-19-56 and § 27-20-51 as detailed below for non-federal programs. BCBSRI may voluntarily, and at its sole discretion, correct underpayment outside of these time frames. Providers may voluntarily correct overpayment outside of these time frames.

If a claim is denied or no payment is made on a claim for any other reason, contractual obligations regarding timely filing apply. Any request for an adjustment to a claim on which no payment was made must occur within the contractual timely filing deadline that applied to the original filing. Any appeal of a denied claim must be made within the contractual time frames.

These policies do not apply to fraud or intentional misrepresentation of services.

If Blue Cross elects to employ extrapolation methodology the audit sample shall be derived using generally accepted statistical sampling principles, rules and techniques recognized in the field of statistical probability.

Extrapolation of audit results to the defined audit population will be done at the election of BCBSRI. Defined audit population means a specific area within a specific BCBSRI product (e.g. emergency dept. claims for the BCBSRI commercial product, etc.). Extrapolation of audit results of one claim area for one BCBSRI product may not be carried over to other areas or BCBSRI products.

## COVERAGE

Not applicable

## BACKGROUND

**Blue Cross & Blue Shield of Rhode Island's Right to Recovery**

**From Providers** (individual clinician, either in practice independently or in a group, who provides healthcare services, and otherwise referred to as a non-institutional provider):

Blue Cross & Blue Shield of Rhode Island's right to recovery of payments shall be in accordance with RIGL § 27-19-56 (a) and § 27-20-51 (a), unless the contract with the provider was negotiated and includes different time frames for the right to recover payments. BCBSRI is both a Nonprofit Hospital Service Corporation and a Nonprofit Medical Service Corporation and therefore, both sections of the law are applicable.

***§ 27-19-56 Post-payment audits. –*** *(a) Except as otherwise provided herein, any review, audit or investigation by a nonprofit hospital service corporation of a health care provider's claims that results in the recoupment or set-off of funds previously paid to the health care provider in respect to such claims shall be completed no later than eighteen (18) months after the completed claims were initially paid, except that the period for recoupment or set-off for claims submitted by a mental health and/or substance use disorder provider, for those services, licensed by this state, and participating with the health insurer or health plan, shall be no later than twelve (12) months.-This section shall not restrict any review, audit or investigation regarding claims that are submitted fraudulently; are known, or should have been known, by the health-care provider to be a pattern of inappropriate billing according to the standards for provider billing of their respective medical or dental specialties; are related to coordination of benefits, are duplicate claims, or are subject to any federal law or regulation that permits claims review beyond the period provided herein.*

- ***§ 27-20-51 Post-payment audits.***
  *(a) Except as otherwise provided herein, any review, audit, or investigation by a nonprofit medical service corporation of a health-care provider's claims that results in the recoupment or set-off of funds previously paid to the health-care provider in respect to such claims shall be completed no later than eighteen (18) months after the completed claims were initially paid, except that the period for recoupment or set-off for claims submitted by a mental health and/or substance use disorder provider, for those services, licensed by this state, and participating with the health insurer or health plan, shall be no later than twelve (12) months. This section shall not restrict any review, audit, or investigation regarding claims that are submitted fraudulently; are known, or should have been known, by the health-care provider to be a pattern of inappropriate billing according to the standards for provider billing of their respective medical or dental specialties; are related to coordination of benefits; are duplicate claims; or are subject to any federal law or regulation that permits claims review beyond the period provided herein.*

**From Institutions/Hospitals**:
Effective after January 1, 2015:
Any review or audit by Blue Cross & Blue Shield of Rhode Island of an institution or hospital that results in the recoupment of funds previously paid to the institution or hospital with respect to the institution's or hospital's claims shall be completed in accordance with the time set forth in such provider's contract, or if no time is set forth in the contract, the time frames in this statute.

**Provider's Right to Recovery from Blue Cross & Blue Shield of Rhode Island:**

**From Providers** (individual clinician, either in practice independently or in a group, who provides healthcare services, and otherwise referred to as a non-institutional provider):

The provider's right to recovery shall be in accordance with RIGL § 27-19-56 (b) and § 27-20-51 (b):

***Post-payment audits. –*** *(b) No health care provider shall seek reimbursement from a payer for underpayment of a claim later than eighteen (18) months from the date the first payment on the claim was made, except if the claim is the subject of an appeal properly submitted pursuant to the payer's claims appeal policies or the claim is subject to continual claims submission.*

No provider shall seek reimbursement from Blue Cross & Blue Shield of Rhode Island for underpayment of a claim later than the timeline set forth above, except if the claim is the subject of an appeal properly submitted pursuant to the Blue Cross & Blue Shield of Rhode Island's claims appeal policies or a different time period is set forth in a negotiated provider contract. Appeal submittal must be within appeal time frames.

**Institution's/Hospital's Right to Recovery from Blue Cross & Blue Shield of Rhode Island:**

Effective after January 1, 2015:
Any review or audit by an institution and/or hospital which results in the request for a higher payment of funds previously paid to the institution or hospital shall be completed in accordance with the time set forth in such provider's contract, or if no time is set forth in the contract, the time frames in this statute.

***This policy shall not restrict any review, audit or investigation regarding claims that are suspected as being submitted fraudulently.***

***§ 27-20-51 (d) and § 27-19-56 (d):***
*Except for those contracts where the health insurer or plan has the right to unilaterally amend the terms of the contract, the parties shall be able to negotiate contract terms which allow for different time frames than is prescribed herein.*

**The above policy has the following limitations:**

- Timely filing requirements are not affected. The above policy and statute refer to time frames after the initial payment.
- Time frames for appeals of denied claims are not affected. Appeals of denied claims must be made within the time frames set forth in the provider's contract.
- Underpayment reimbursement requests must be received (18) months of the date first payment was made.

## CODING
Not applicable

## RELATED POLICIES
Not applicable

## PUBLISHED
Provider Update, October 2022
Provider Update, Dec 2021
Provider Update, May 2020
Provider Update, June 2019
Provider Update, April 2018
Provider Update, Dec 2017

## REFERENCES

1. Rhode Island General Law, § 27-20-1 Nonprofit Medical Service Corporations, Definitions
2. Rhode Island General Law, § 27-19-56 Post-payment audits
3. Rhode Island General Law, § 27-20-51 Post-payment audits
4. Rhode Island General Law, § 27-18-65. Post-payment audits.

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