n05695
Bill Audit Review

Values

Accountability ● Integrity ● Service Excellence ● Innovation ● Collaboration

Abstract Purpose:

Network Health Plan (NHP) conducts provider payment integrity audits to ensure accuracy of claim payments. The bill audit review identifies overutilization of services or other practices that directly or indirectly result in unnecessary costs to NHP and its members. Audits can be conducted on a pre or post payment basis. Network Health has the right to conduct audits of health care provider itemized bills and/or records related to services rendered to its members. The provider must allow access to the billing documents and medical records to conduct these audits. The bill audit review provides a detailed line-by-line analysis that identifies billing errors, unbundled services, incorrect, inconsistent, and unjustified coding errors, upcoding and erroneous charges. Network Health coordinates with the reviewing partner, Optum, for Medicare claims and American Health Holdings, Inc. (AHH), for all other lines of business to complete the bill audit review.

Policy Detail:

I. Network Health will identify Medicare claims with a billed amount of $150,000 or greater and $65,000 paid amount for all other lines of business for audit. Network Health reserves the right to change dollar thresholds at any time.

Procedure Detail:

I. For Medicare claims:
   - A. If a claim has an outlier and/or DRG 001-989, the claim is pended for bill audit review and an itemized bill is requested by Optum.
   - B. If the provider does not submit an itemized bill within 30 days, the claim will be denied.

II. For All other lines of business:
   - A. All claims that reach the dollar threshold are reviewed, claims are pended, and an itemized bill is requested by AHH.
   - B. If the provider does not submit an itemized bill within 30 days, the claim will be denied.

III. Optum or AHH will contact the provider to obtain the itemized bill.
   - A. If a response is not received within 14 days from the initial contact, Optum or AHH will send a written request.
   - B. If the itemized bill is not received within 30 days, the claim will be denied.

IV. The bill audit review will be completed within 5-7 business days of receipt of the itemized bill.
   A. If clinical findings are identified, a second review is completed by the NHP Medical Director.
   B. Optum or AHH will contact the provider to discuss the results of the audit and obtain written agreement to adjust the claim payment.

V. The claim will be processed based on audit results, and the claim remittance advice will be mailed to provider.

VI. Optum or AHH will mail the final provider notification letter to the provider.

VII. First level appeals must be submitted directly to NHP within 120 days from the date of the original provider remittance advice.

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