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Anthem Increases Claims Auditing Activities

In recent months, APS has seen an increase in pre-payment and post-payment reviews on claims by Anthem Blue Cross Blue Shield. These reviews come via paper mail, follow the carrier's standing policy of auditing claims for appropriate payment and can put your revenue at risk. It is imperative that letters received at the practice location are forwarded on for timely processing. According to the policy, letters may be received electronically also and follow this timeline:

1. Letter mailed by Anthem or its designee after confirmation of physical or electronic address.
2. When a response is not received within 30 days of the date of initial request, a second letter is sent.
3. When a response is not received within 15 days of the second request, a final request letter is sent.
4. When a response is not received within 15 days of the date of the final request:
    a. Anthem or its designee will initiate claim denial for claims identified as pre-payment review or post-payment audit as a Provider or Facility failed to submit required documentation. The member must be held harmless.

The letter lists all of the required documentation they are asking the Provider to supply. For the majority of the reviews, the APS insurance department can upload all of the requested documentation through the Availity portal. It's important to be sure our clients are documenting all services provided within their reports and following advice provided during their regular coding and documentation audits. Pre and Post-payment reviews are becoming more frequent for other payers as well.

This policy can be found in the carrier's Provider Manual. Click here to see Ohio's Provider Manual, as an example, and refer to page 98.

APS will continue to monitor this policy and all others that affect your revenue cycle. Please contact your Practice Manager if you have any questions.

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