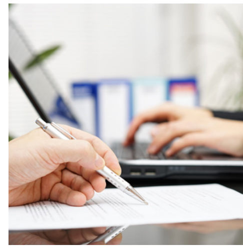

Claims Audits

An Important Tool for Medical Plan Sponsors

It's no secret that healthcare costs represent a major portion of a typical organization's employee benefit costs, and that such costs continue to rise.

And, recognizing that no single solution exists to address the underlying complexities contributing to this continuous uptrend in healthcare costs, it's imperative to employ every available strategy to modify or mitigate your healthcare spend, including:

- introduce employee wellness initiatives
- modify your plan design
- continuously re-evaluate your contribution strategies
- conduct a dependent eligibility audit

One additional strategy to supplement those listed above is the ongoing performance monitoring of your claims administrator, to verify that your medical plan is being properly managed and administered as it was designed and intended by you. Because a claims administrator will make claim payments on behalf of its clients using the client's own funds – typically in the millions of dollars – you must ensure, through routine claims audits, that appropriate financial controls are in place to ensure accurate claim payments. Conducting regular claim audits on your claims payer should be viewed as the normal course of business and a critical component of your oversight responsibility.

A comprehensive, objective claims audit will not only help satisfy your fiduciary responsibility to your employees and shareholders, it will also give a quantifiable return on investment. In fact, a claims audit can often pay for itself in that the cost for doing the audit can be covered by what the plan will save on overpayments averted in the future. For these reasons, you can't afford to ignore the benefits generated by a claims audit.

Why Conduct a Claims Audit?

Certainly, you contract with a claims administrator for its efficiency and cost-effectiveness in administering a benefit plan. It's likely you went through a comprehensive

EMPLOYEE BENEFITS AUDIT AND COMPLIANCE SOLUTIONS

> It is estimated that the overpayment error rate ranges from 2% to 5% of overall medical claim costs each year at even the best claims administrators.

selection process. However, once the claims administrator is chosen, it remains your obligation to verify that the claims administrator is performing at the appropriate level.

Why is such oversight necessary? Despite the best intentions of even the most competent claims administrator, errors are made among the thousands of claims that are received and processed every day. It is estimated that the overpayment error rate ranges from 2% to 5% of overall medical claim costs each year at even the best claims administrators.

Recognizing that errors can and do occur, the best practice for a plan sponsor includes periodically conducting a claims audit.

Although an audit can be conducted on a dental plan or a vision plan, the vast majority of audits are done on medical plans, since medical plans comprise the bulk of an employer's healthcare spend.

A medical claims audit of a self-funded plan is typically recommended every 2-3 years, *if prior results (and self-reported results, if available) have been satisfactory*. If prior results have been unsatisfactory, or serious service issues have arisen, a quicker re-audit would be appropriate. An audit might also be triggered by a specific change in administration, such as the installation of a new type of plan, a move to a new claims administrator, a move in the current claims administrator's claim processing site, or the installation of a new claims processing system.

Doesn't a Claims Administrator Audit Itself Internally?

All well-run claims administrators have internal audit programs to monitor claims processing quality. However, a claims administrator's internal audit program might never select a claim from your population, or might select just one or a few. There is no guarantee the individual nuances of your benefit plan are being incorporated into the claims administrator's internal review. Typically, a claims administrator's "book of business" rules are applied to claims processing during the internal audit process, even when a specific benefit plan might have a different design or intent.

Regardless of the claims administrator's internal audit programs, it will always be your responsibility to independently evaluate the claims administrator's handling of your plan's assets and its adherence to the nuances of your specific benefits program. Doing so will provide the necessary oversight to assure accurate claims handling on your own plan(s).

What Does a Claims Audit Actually Involve?

A medical claims audit typically includes an audit team's on-site review of a sample of claims – usually about 200 to 250 claims, going from zero-pay claims to the highest-paid claim in the audit period. The auditors check for financial and payment accuracy, proper administrative procedures, and satisfactory turnaround time.

Claims audits reveal discrepancies such as covering ineligible claimants, paying for ineligible services, and circumventing referral requirements. They discover duplicate payments and examine for the proper application of benefits maximums within an employer's plan – whether daily or annual. Such audits identify overpayments and underpayments, facilitate recovery of funds due from the recipients of overpayments, and make suggestions for improving claims processing.

Because claims administration is highly automated, errors uncovered may be "systemic" in nature, and thus may extrapolate to significant sums.

Even with automation, a portion of certain claims – usually complex, larger claims, such as facility claims – may be processed manually. Therefore, the preferred audit methodology will combine an audit of a stratified, random sample – to increase the likelihood that all key elements of claim payment logic are tested – with focused reviews in areas that often require manual intervention or have higher chance of error, such as high-dollar claims.

> A healthcare claims audit is a diagnostic tool, designed to assess whether claims are
> (1) being adjudicated correctly,
> (2) in accordance with the provisions of the benefits plan, and
> (3) paid only on behalf of eligible participants under the plan.

Once the claims have been reviewed on-site at the claims administrator and all outstanding audit issues resolved, preliminary findings are presented to the claims administrator for review. After the claims administrator reviews the draft report, the audit firm prepares the final report and delivers it to the client, and the claims administrator is asked to respond formally to the findings and recommendations. The final step is the in-person presentation of the final report to the plan sponsor and claims administrator.

What Types of Audits Exist?

The typical medical claims audit performed by major consulting/auditing firms involves a detailed review of a statistically valid, random sample of claims. Such an audit reviews a sample of claims selected from strata defined by dollars paid to ensure that both large and small dollar claims are represented in the sample.

Another type of paid-claim audit is the "focused sample" audit. In this audit, a particular type of claim is selected for review, such as high-dollar claims, or claims for specific services (e.g., gastric surgery claims).

A specialized type of audit not involving the review of paid claims is known as a "pre-implementation" or "installation" audit. In this type of audit, test claim scenarios for each plan option, benefit and limit are adjudicated in the claims administrator's claim system in the presence of the independent auditor, to make certain the claim processing outcomes correctly interpret plan provisions – and to avoid costly systemic errors before the plan goes live. A pre-implementation audit determines whether the claims administrator has accurately loaded the client's benefit plan design into the claims processing system. The pre-implementation audit is typically conducted shortly before or immediately after the effective date of a new plan or the installation of a new claims administrator.

Another specialized type of audit that does not involve the review of paid claims is an "operations review." This type of examination entails a detailed evaluation of the controls employed by the claims administrator to ensure quality claims administration and customer service. Areas reviewed include: internal audit, system capabilities, staffing, workflow, performance standards

and overall quality assurance. Findings are compared to industry best practices. The operations review is sometimes performed in conjunction with a random sample claims audit and can also be a key component in the evaluation of a potential new claims administrator.

What are the Typical Findings From a Medical Claims Audit?

Although unique issues often arise that are very specific to the particular nuances of the plan being audited, there are some claims audit findings that are seen over and over again.

These include:

- incorrect application of (or failure to apply) network rates – usually where manual claims payment processes are involved
- incorrect plan accumulators applied (e.g.; deductible, out-of-pocket maximum) – typically seen where claim adjustments have been made
- payment for ineligible charges (e.g.; bariatric surgery; assisted/artificial reproductive techniques)
- incorrect coordination of benefits calculations
- failure to apply office visit copayments correctly when multiple services are involved.

Important Note: There is no guarantee that an audit will lead to discovery and recovery of overpayments, although an audit that does not uncover some financial errors is extremely rare. The major consulting/auditing firms will not recommend that an audit be conducted specifically to discover and recover overpayments on past claims, unless there is evidence to suggest that the claims administrator has been mis-paying a specific type of claim (e.g., high dollar claims). Instead, an audit should be conducted primarily to make certain that the plan is being operated as the plan was designed and as you intend, as well as to prevent financial errors on future claims.

Although the financial significance to plans of recovering overpaid claims is important, it is equally important that plan participants not suffer the financial burden of underpaid claims. Thus, in an audit by an independent third party, overpayments and underpayments are given equal treatment.

AIM is a boutique employee benefits, audit and compliance advisory firm that works with employers, plan sponsors and benefit professionals to maximize the value of their employee benefits programs. AIM is an independent affiliate of Conner Strong & Buckelew, a leading insurance, risk management and employee benefits brokerage and consulting firm.

For more information, please contact us at 1-866-284-4995 or visit aim-benefits.com.

info

EMPLOYEE BENEFITS AUDIT AND COMPLIANCE SOLUTIONS