Introduction to Provider Audit

Introduction

The Provider Audit Department provides oversight to ensure that the delegated provider network remains within compliance standards for their claims processing operations.

The delegated network affiliates are audited at least once a year according to regulatory requirements. These results are reported Regulatory Compliance, Network Management and the Department of Managed Healthcare (DMHC) and the Center for Medicare and Medicaid Services (CMS) as appropriate for the product line.

Delegation Process

As a network model Health Maintenance Organization (HMO), the health plan contracts with outside physician networks to provide services to its members. Those contracts determine who is responsible for claims payment based on the type of service provided as agreed to in the Division of Financial Responsibility (DOFR).

Members select their physician network when they enroll in the health plan and claims are generated when they receive services. The physician networks receive a set fee per patient assigned to them called capitation and this amount is negotiated into their contract. It can be a set rate or a percentage of the member's premium. The delegated provider network then makes payment from this fund.

Division of Financial Responsibility and Risk Determination

Claims for certain types of services may be paid by the health plan or by the delegated payer. These claims are divided between institutional services, also known as hospital services, and physician services, also known as professional services. These are known as Part A and Part B under Medicare.

Institutional services are the facility portion of inpatient services, emergency services, outpatient surgery and some outpatient procedures. Physician services cover professional fees that result from any of the above services as well as office visits with physicians, the physician component of laboratory and radiology services, physical or occupational therapy and other physician services.

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Introduction to Provider Audit, Continued

Audit Cycle

Every delegated payer must be audited at a minimum of once a year.

An annual audit should be performed within 9 to 15 months of the prior annual or compliant audit. If the payer remains compliant, they will remain on an annual audit cycle.

To achieve overall compliance on an audit, they must achieve 95% compliance for all required processing timeframes and pass all pass/fail elements. A non-compliant score in any area will cause the whole audit to be non-compliant.

When an audit is non-compliant, the payer is placed into the sanction process until compliance is achieved or Undelegation occurs.

The Audit Cycle and audit types are as follows:

1. Annual Audit
2. 90-day Extension
3. 2nd 90-day Extension
4. Oversight with Corrective Action Plan
5. Partial Undelegation
6. Full Undelegation

At most points in the Audit Cycle, if compliance is achieved, the delegated payer will revert to an Annual Audit Cycle. Circumstances may warrant additional oversight when recommended.

Compliance Oversight

Compliance requirements are determined by regulatory agencies as well as state and federal laws.

The agencies that set compliance requirements are as follows:

- Center for Medicare and Medicaid Services (CMS)
- Department of Managed Health Care (DMHC)

The state and federal laws that set compliance requirements are as follows:

- Health Insurance Portability and Accountability Act (HIPAA)
- Employment Retirement Income Security Act (ERISA)
- AB1455 – Provider Dispute Resolution

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Compliance Oversight, continued

The health plan has filed their audit process and any additional requirements and standards they have in place with the regulatory agencies and are expected to enforce and remain compliant with the standards and processes they have submitted.

CMS

The Center for Medicare and Medicaid Services is a federal agency that oversees health plans that operate under federal funding.

Medicare is an insurance program available to certain individuals when they turn 65 years of age or earlier if they are receiving disability through the Social Security program. Not all individuals qualify for Medicare if they have paid into another retirement benefit agency such as the California Public Employee Retirement System.

The program has 2 components: Part A, Part B and Part D.

Part A covers hospital services such as the facility portion of an in-patient hospitalization or the facility portion of an out-patient service. Part A is the primary portion of Medicare insurance and is available as a stand alone component or jointly with Part B and Part D.

Part B covers physician services, such as an office visit with a physician, as well as outpatient services such as lab work or diagnostic services. Part B is a supplemental benefit that is optional and available at an additional cost.

Part D covers pharmaceutical services and is generally not included in capitation or claims payment from the provider network. Some injectable medications will fall under Part B services but most pharmaceutical services are part of their prescription management program.

DMHC

The Department of Managed Health Care is a regulatory agency that oversees managed health care plans that operate in the state of California. Managed health care plans fall under 3 types: Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO) and Point of Service Plans (POS).

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Introduction to Provider Audit, Continued

HIPAA	The Health Insurance Portability and Accountability Act was enacted in 1996 and in addition to other requirements, calls for a health plan and any delegated entities to put safeguards in place to protect the privacy of identifying information and health information.
ERISA	ERISA is a Federal law that provides oversight for retirement and employee benefit plans, including health benefits, offered by private enterprises. ERISA regulations apply to any health benefit plan offered by a private employer. Health benefits offered by governmental agencies and religious institutions are exempt from ERISA mandates. Updates to ERISA law requires health plans and delegated payers to process clean claims for ERISA members within 30 calendar days.
AB1455	AB1455 was enacted by the State of California requiring each health plan or delegated payer to initiate a policy and procedure to manage disputes initiated by a provider. This regulation stipulates certain requirements regarding the timeframe for acknowledging the receipt of a dispute, the timeframe for sending a determination of the dispute as well as specific requirements for the language used in the determination letter.

Sanctions

Introduction

When a delegated entity is found to be less than 95% compliant on an annual audit, there is a set progression of audits where they are given time to become compliant. If they fail to become compliant within a specified time, additional sanctions may become necessary.

The progression of sanctions are as follows:

- 1st 90-day extension
- 2nd 90-eay extension
- Oversight with Corrective Action Plan
- Partial Undelegation
- Full Undelegation

1st 90-Day Extension

If a delegated entity is found to be non-compliant during their annual audit, a 90-day extension is automatically granted to allow the entity a set additional time to achieve compliance.

The payer is given 90-days from the date of the non-compliant audit to achieve compliance and an audit is scheduled for no more than 120 days from the date of the non-compliant audit.

A corrective action plan will be drafted by the payer and approved by the auditor.

The audit will cover the last 30 days of the 90-day period or the last full month of the 90-day period as determined between the auditor and the payer.

If compliance is achieved during the extension period, the payer will return to an annual audit cycle.

2nd 90-Day Extension

If a delegated payer continues to be non-compliant on their 1st 90-day extension, a 2nd 90-day extension may be granted provided the payer meets certain criteria. The criteria are as follows:

- Improvement in the non-compliant area but less than 95% compliance
- Compliance in original area but non-compliant in a new area

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Sanctions, Continued

2nd 90-Day Extension, continued

The payer is given 90-days from the date of the non-compliant audit to achieve compliance and an audit is scheduled for no more than 120 days from the date of the non-compliant audit.

If the area of non-compliance is a new area, a new corrective action plan will be drafted by the payer and approved by the auditor.

The audit will cover the last 30 days of the 90-day period or the last full month of the 90-day period as determined between the auditor and the payer.

If compliance is achieved during the extension period, the payer will return to an annual audit cycle.

Oversight with Corrective Action Plan

If the payer fails to achieve full compliance within their eligible extension periods, they will be placed on Oversight with Corrective Action Plan. In this situation, they will be referred to the Claims Undelegation Resolution Team (CURT Team).

The CURT Team will assign a representative to meet with the payer. The CURT Team will review their claims processing operations to determine areas of inefficiencies and a corrective action plan will be developed. The CURT Team will meet with the payer during the Oversight period to continue to evaluate the claims processing operation with a goal of continued improvement.

Once a payer goes on Oversight, all product lines will fall under the Oversight sanction regardless of whether they were compliant on the annual audit or 90-day extension.

The auditor will audit the payer on a monthly basis to monitor compliance during the oversight period. The oversight period is no less than 3 months or until the payer achieves 3 consecutive months of compliant audits. If the payer fails to achieve compliance with 12 months of oversight, the next level of sanction will be initiated.

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Sanctions, Continued

Oversight with Corrective Action Plan, continued	During the oversight period, a portion of capitation will be withheld to cover the cost of providing oversight. If compliance is achieved during the oversight period, the payer will return to an annual audit cycle.
Partial Undelegation	If a payer fails to achieve compliance during a year of oversight, they will be placed on a partial Undelegation. During a partial Undelegation, capitation will be withheld by the health plan. The CURT Team representative will work with the payer to contract with a consultant to provide oversight of the claims operation. The consultant will work with the payer to determine the root cause of the non-compliance and develop an action plan to correct it. Claims will be processed by the payer however payment will be made by the health plan from the withheld capitation. During a partial Undelegation, an audit is not performed until the root cause of non-compliance is addressed and corrected. At the end of a 12-month period, an assessment is conducted to determine if compliance is achieved in all areas of the operation and all product lines, and that the payer has the financial ability to make payment within the required timeframes. If compliance is achieved within a 12-month period, the payer will return to oversight until 3 consecutive audits demonstrate compliance. If compliance is achieved within the oversight period, the payer will return to an annual audit cycle.
Full Undelegation	On Full Undelegation status, the health plan pays all claims on behalf of the delegated payer and retains a portion of the capitation payments in reserve to off-set those costs.

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Sanctions, Continued

Full Undelegation, continued	Once a payer is Undelegated, their compliance is no longer monitored by the Provider Audit Department until they are re-delegated for claims payment as determined by a joint decision of the CURT Team, Network Management Representative and Regulatory Compliance. The payer may fall under oversight of the DMHC or CMS if they are non-compliant or on sanction with multiple health plans. If the provider network has not been re-delegated within a year, they may be subject to termination of their contract.
Off-Cycle Audit	Although most payers are placed on an annual audit cycle after achieving compliance, an off-cycle audit may be triggered under certain circumstances: Self-Reported timeliness indicates a non-compliance with processing timelines for more than 2 months in a row Self-Reported timeliness is not submitted DMHC or CMS inquiry Network Management or Regulatory Compliance request Increase in appeals and grievance activity Change in management company, location or a significant change to the claims operation If an off-cycle audit is non-compliant, the delegated payer would be subject to sanction.

Compliance Requirements

Introduction	Specific standards are in place based on regulatory timeframes. Generally, the requirements are based on processing timeframes but they also cover areas that are to be included in the payers Policies & Procedures and compliance with audit requirements as detailed in their Audit Confirmation letter.
Audit Compliance	During an on-site audit, some elements are a pass or fail while other elements are required to be within a certain percentage. In order to remain compliant, all pass/fail elements must pass and other elements must be at least within 95% compliance. A questionnaire regarding Policies and Procedures and an Attestation form must be completed annually and provided at the time of the annual audit or if any changes are made to the management company, location or significant changes in the claims operation processes. Failure to provide this information at the annual audit can result in a non-compliant audit and placement into the sanction process. Discretion may be used if the payer provides the information within 2 business days of the audit.
Monthly Self-Reported Timeliness	Self-reported timeliness reports must be submitted by the 10th of the month for the previous month. These reports must provide the total number of claims processed and the percentage that meet the required timelines. If self-reported timeliness shows less than 95% compliance for 3 months in a row or more than 3 months in a 6-month timeframe, reports are not submitted on-time or at all, an off-cycle audit may be initiated.
Compliance with Audit Deadlines	The delegated payer must provide reports to the auditor by a specific date in order to complete the random selection for the audit. Failure to provide these reports can result in a non-compliant audit.

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Compliance Requirements, Continued

Questionnaire	On an annual basis, each delegated payer must submit a questionnaire that addresses their claims processing operation. This includes the policies and procedures they have in place that address specific compliance requirements, and along with a walk-through and on-site observation, are used to determine compliance with certain pass/fail elements.
Attestation	An attestation regarding the check-run processing time must be submitted at the time of their annual audit, or one time per year for a payer on the sanction cycle. The attestation will state the processing time between check run and check mailing. It generally varies between the same day to 2 business days. The timeliness requirements are based on the period of time from when the claim is received and when the check is mailed. This form may be required more frequently depending on their overall compliance as well as if any changes are made to the processing such as when the check printing is moved from onsite to an offsite location.

The Audit Process

Introduction

The Audit Process starts approximately 3 months before the annual audit and involves the following steps:

- Pre-Audit Preparation
- Conducting the Audit
- Post-Audit Follow-Up

Pre-Audit Preparation

Audits must be conducted annually at a minimum, depending on multiple factors. Preparing for an audit begins approximately 90 days prior to their anniversary of the most recent compliant audit. Prior to the audit, the auditor must perform the following tasks:

- Establish the audit date with the contact at the delegated payer
- Send a letter of confirmation including the audit date, audit period and deadline for the audit sample
- Create a random sample and return the selection to the payer
- Review file to verify the self-reported timeliness
- Prepare the audit spreadsheet

Conducting the Audit

When conducting the audit, the auditor will perform the following tasks:

- Walkthrough
- Review of Policies & Procedures
- Review of Attestation and Questionnaire
- Review of claims and documentation
- Preliminary Audit Results

Post-Audit Follow-Up

The following tasks will need to be performed in the office following the audit:

- Notification of Preliminary Results
- Audit Report
- Audit Results Letter

Each of these tasks has a specific timeframe for completion.

Preparing For The Audit

Introduction

A report is generated monthly with the payers that are due for an annual audit. The payer will appear on the report 3 months prior to their annual audit.

Payers on sanction will have their audits scheduled at the review of the preliminary results based on what stage of the cycle they are on.

Pre-Audit Tasks

The following tasks must be completed prior to the audit:

- Set up an audit date with the contact at the group/hospital
- Send a letter of confirmation that confirms the parameters of the audit, the deadline for the audit sample and the date of the audit
- Create a random selection for the audit sample and return that selection to the contact
- Review the file to verify the self-reported timeliness as well as the questionnaire and attestation from previous years
- Prepare the audit spreadsheet

Scheduling the Audit

Audits must be conducted annually at a minimum and may be performed more frequently based on performance in specific areas. Audits must be conducted within 9-15 months from a compliant annual audit.

A delegated payer may have all their product lines on the same audit schedule or they may be on different schedules if compliance in all areas was not achieved at the same annual audit. When this occurs, the payer may choose to perform some audits early in order to have all product lines on the same schedule. Some payers prefer not to audit all product lines on the same day, depending on their staffing.

Approximately 90 days prior to the anniversary date, an audit date must be scheduled based on availability. During that scheduling, an audit date will be verbally confirmed, the audit period selected and a the product line confirmed.

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Preparing For The Audit, Continued

Confirming the Audit	Within 2 days of scheduling the audit, an audit confirmation letter will be sent to confirm the audit date, time, product line, type of audit, audit period and the due date for the audit selection. A copy of this letter must be emailed to the Network Management Representative as well as the Claims Compliance Database Administrator.
Reviewing the Audit File	When the selection is received, the file needs to be reviewed to compare the audit sample reports to the self-reported timeliness. The numbers should approximately match. There may be minor discrepancies, and these are not a concern. If there is a large discrepancy between the number of claims processed on the timeliness report and the number of claims that have been sent in the selection sample, this must be discussed with the contact at the delegated payer to make sure that non-compliant claims haven't been purposely eliminated from the report.
Audit Selection	The delegated payer will send a report of all claims processed, based on compliance areas by product line, for the audit period that was selected. A random sample must be made for the actual audit. The number of claims needed will vary based on whether or not it is an annual audit or a sanction audit as well as the product line. Some small payers may not have enough claims to meet the sample requirements, in which case, the sample will consist of the entire number of claims processed during the audit period. If the report is sent via electronic excel file, a random sample can be generated by utilizing a macro. When transferring electronic files via email, procedures must be followed to ensure the data is encrypted and the PHI is protected. If the report is sent hard copy, the selection will need to be done manually.

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Preparing For The Audit, Continued

Audit Selection, continued

In both situations, the total claims for the audit period would be divided by the audit sample size and the resulting number will determine which claims to select. For example, a report showing 800 claims, with an audit sample size of 20 would mean that every 40th claim would be selected.

Preparing the Spreadsheet

To save time during the actual audit, the spreadsheet can be preloaded in advance from the audit selection report.

It is helpful to fill in any of the spreadsheet information that is contained on the report. Based on the claims processing system used by the delegated payer, the amount of information will vary.

During the audit, each claim will need to be verified to ensure that the information matches what was reported and to provide data that was not available on the selection report.

Conducting The Audit

Introduction

When conducting the audit, there are several tasks that must be performed:

- Walkthrough
- Review of Attestation and Questionnaire
- Review of Policies & Procedures
- Review of Claims and Documentation
- Review of 3 randomly selected provider contracts
- Preliminary Audit Results

Walk Through

The walkthrough should show the path of the claim as it travels through the organization and gives the auditor the opportunity to ensure that best practices are followed in all areas of the operation, including the following:

- Mail room and date stamping
- Data entry
- Claims processing
- Medical review
- Account and payment

Potential issues to look for are:

- Claims are unaccounted for
- Claims do not have date stamps
- Unopened mail prior to the daily mail delivery

Mail should be opened the day it is delivered or if opened the next day, it must be stamped with the date that it was received and procedures must be in place to ensure the correct date is used.

Although the auditor's primary job is to assess the operation to ensure compliance, there is a training component that goes along with the job to assist where problems are evident. The health plan is ultimately responsible for the compliance of all delegated payers in the network and the organization's goal is for all of the delegated payers to achieve and maintain 95% compliance in all areas.

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Conducting The Audit, Continued

Review of Attestation and Questionnaire

After the walkthrough has been performed, the audit questionnaire must be reviewed to verify that the information in the questionnaire matches what was observed in the walkthrough.

If there are areas of discrepancy, the delegated payer must provide a corrected questionnaire with during the audit or they will be non-compliant.

The attestation verified the processing time from the check run to the check mailing. Generally, checks are mailed within 2 business days of the check run. Smaller operations may mail them the same day.

The information is entered into the spreadsheet and the timeline is calculated based on the mailing date.

Review of Policies and Procedures

Policies & Procedures will need to be reviewed for the following areas:

Policy & Procedure	Review to Include
ERISA Claims Processing Time	Verification that a procedure is in place to ensure ERISA claims are flagged and expedited to meet a 30-day turnaround time or that all commercial claims are processed within the 30-day timeframe.
Mail Forwarding	Verification that claims received that are not the payer's responsibility are recorded with the date they are received and the date they are forwarded to the correct payer.
HIPAA Policy	Verification that policies are in place to protect the privacy of identifying information and medical information.

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Conducting The Audit, Continued

Review of Policies and Procedures, continued

Policy & Procedure	Review to Include
Timely Filing Timeframes and Requirements	The timeframe where a claim must be submitted for payment should be documented and within required guidelines for in provider contracts, state limits or benefit plan limits.
Payment Methodology for Payment of Non-Contracted Provider Claims	The payer must have a policy on how they determine payment amount for non-contracted providers, notification method and the procedure for appealing the payment rate. Best practices pay non-contracted providers in full to prevent balance billing to the health plan members.

Claims Review

The delegated payer is required to provide documentation for all areas that are covered in the audit. This information will vary by product line and will be covered in more detail in that section.

If adequate documentation is not provided, that claim will be considered non-compliant

Review of Provider Contracts

Prior to the audit, the auditor will randomly select 3 provider contracts to review from the list of contracted provider claims. This is done to ensure that providers listed as contracted have valid contracts in place for the date of service.

The auditor will verify the contract status as well as the effective date. The auditor is not responsible for verifying if the claims is paid at the correct contract rate, only that a contract is in place for the date of service.

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Conducting The Audit, Continued

Preliminary Audit Results

During the audit, the claim information and documentation of compliance areas will be entered in the spreadsheet which will generate the preliminary audit results.

The auditor will meet with the delegated payer to go over the results and the payer's representative will sign the preliminary audit results. Generally, the delegated payer has reviewed the selection prior to the audit and are aware of the expected results.

If the audit results are non-compliant, the timeframe for the 90-day extension audit is discussed and the audit date is scheduled.

At the auditor's discretion, some pass/fail elements may be appealed by providing the required information or documentation within 2 business days of the audit.

The results are referred to as preliminary as the final report is issued after returning to the office. During this time, the delegated payer may submit documentation that disputes non-compliant findings.

Post-Audit Follow-Up

Introduction

Upon returning to the office, several tasks that must be completed before the audit is considered complete and final results can be sent to the provider. These tasks have specific timelines that are reported to the DMHC. Those tasks are as follows:

- Notification of Preliminary Results to required inter-departmental contacts
- Completion of Audit Report and distribution to required inter-departmental contacts
- Filing of audit paperwork in the correct file
- Notification of the official audit results to the payer

Notification of Preliminary Results

The preliminary results that is signed by the payer's representative must be forwarded to the Network Management Representative and the Claims Compliance Database Administrator within 2 business days of the completion of the audit. If the audit was non-compliant, a copy must also be sent to the Claims Undelegation Team.

The preliminary results are scanned and then emailed to the appropriate contacts. The original is filed with the Audit Report in the electronic Audit File which will be discussed later in the document.

Audit Report

The Final Audit Report must be completed within 15 calendar days of the Audit date. The audit report will cover all areas that are observed in the walkthrough and all areas with specific compliance requirements.

A copy of the final Audit Report is sent to the Network Management Representative, the Claims Compliance Database Administrator and the Claims Compliance Manager. If the audit was non-compliant, a copy of the report must also be sent to the Claims Undelegation Team.

Electronic copies of the Audit Report, Audit Results Letter and the spreadsheet used during the audit must also be forwarded and filed in the electronic Audit File based on type of audit, product line and date of the audit.

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Post-Audit Follow-Up, Continued

Audit Results Letter

A letter must be sent to the delegated payer advising them of the final results of the audit and include the following information:

- Compliance status
- Compliance percentage for all areas
- Status of the delegated payer

This letter must be sent within 15 calendar days of the Audit date.

A copy of this letter must be sent to the Network Management Representative, the Claims Compliance Database Administrator and the Claims Compliance Manager. If the audit was non-compliant, a copy of the letter must also be sent to the Claims Undelegation Team.

A electronic copy will also be filed in the electronic Audit File based on type of audit, product line and date of the audit.

Product Lines

Introduction

The Claims Compliance Auditor will conduct an audit over several components and product lines. They are as follows:

- Medicare claims
- Commercial claims
- Provider Dispute Resolution
- Medicare Denial Letters
- Commercial Denial Letters

Medicare

Medicare claims are regulated by CMS and follow specific guidelines for processing timelines. They also must meet HIPAA requirements. An audit of Medicare claims covers paid claims only and the audit covers examines 3 components:

Claims from non-contracted providers
Claims from contracted providers
Interest payment on non-compliant claims

Commercial

Commercial claims are primarily regulated by the DMHC but also must meet ERISA and HIPAA requirements. An audit of commercial claims covers the following components:

- Claims Acknowledgement
- Paid claims
- Contested claims
- Claims forwarding
- Interest payment

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Product Lines, Continued

Provider Dispute	Provider Disputes are regulated by the DMHC based on requirements set forth in AB1455. An audit of provider disputes covers the following components: • Acknowledgment Letter • Resolution Letter • Uphold Reason
Medicare Denial Letter	Commercial denial letters are regulated by CMS. The audit covers denial letters sent to members for which the member will have a financial responsibility. Denials to providers without a member financial responsibility are not covered in the audit. An audit of Medicare denial letters covers 3 separate components: • Letter template • Timeliness • Denial Reason • Member Liability • Appeals Process
Commercial Denial Letter	Commercial denial letters are regulated by the DMHC. The audit covers denial letters sent to members for which the member will have a financial responsibility. Denials to providers without a member financial responsibility are not covered in the audit. An audit of Commercial denial letters covers the following components: • Letter template • Timeliness • Denial Reason • Member Liability • Appeals Process

Medicare Claims Audit

Introduction

Medicare claims are regulated by CMS and covered paid claims only. Claims are audited for payment timeliness as well as interest payment on non-compliant claims. The audit covers the following elements:

- 30-day claims
- 60-day claims
- Interest payment

Delegated entities must demonstrate 95% compliance with all audit timeframes and 100% compliance for interest payment on non-compliant claims.

Determining Received Date and Calculating Turn-Around Time

For Medicare-risk claims, the claims received date and turn-around time are determined as follows:

- Received date is based on the **first date stamp** on the claim and not the date stamp of the responsible entity.
- Turn-around time is based on **calendar** days.
- A claim is considered paid when the **check is mailed** and not when the check is approved or printed. The attestation will indicate the check mailing turn-around time.

Non-Contracted Provider Claims

Claims from non-contracted providers must be processed within 30 calendar days from the first date stamp on the claim. Due to this, they are often referred to as 30-day claims.

The auditor must locate the earliest date stamp on the claim as well as the date stamp for the entity responsible for payment. This information is gathered to monitor claims forwarding to ensure that it is taking place within a reasonable time-frame.

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Medicare Claims Audit, Continued

Non-Contracted Provider Claims, continued

If the length of time between the first date stamp and the date stamp of the responsible entity seems excessive or there are multiple date stamps which indicate that the claim has been forwarded to more than 2 entities, the auditor should notify the appropriate Network Management Coordinator for the forwarding entity.

Professional claims from non-contracted providers will be paid according to the Medicare fee schedule for the region. Institutional claims will be paid according to Diagnosis Related Groupings (DRG).

Non-contracted provider claims must be 95% compliant with the required timeframes.

Contracted Provider Claims

Claims from contracted providers must be processed within 60 calendar days from the first date stamp on the claim. Due to this, they are often referred to as 60-day claims.

Claims are from contracted providers generally do not have multiple date stamps or issue with claims forwarding. However, it can occur and the auditor should notify Network Management if there appear to be issues.

The auditor will review 3 randomly selected contracts from the list of contracted provider claims to ensure that contracts are in place for the date of service.

Contracted provider claims are paid based on the contract rate.

Contracted provider claims must be 95% compliant with the required timeframes.

Interest Payment

Interest must be paid on every non-contracted provider claim that is paid after 30 calendar days. Interest must be paid at the correct annual percentage set by CMS and must be paid for each day past the 30-day timeframe.

Payment of interest is a pass/fail component.

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Medicare Claims Audit, Continued

Conducting a Medicare Audit

The Medicare Audit will cover the following:

- Walk through and Policy & Procedure Review
- Claims Review
- Preliminary Results

Walk Through and Policy & Procedure Review

During the audit, the auditor must review the following:

Walkthrough	During the walkthrough, the following procedures should be observed: • Mailroom and date stamping • Claims forwarding process • Entry in to processing system • Check processing • Record storage
Policy & Procedure Review	The following Policy & Procedures should be reviewed: • HIPAA Privacy Policy • Claims Forwarding Policy

Claims Documentation

The payer should provide the following information for each claim:

- Copy of claim form or screen print of claim information for electronic claims
- Any medical records that were provided with the claim
- Documentation showing the dates of processing including:
  - Received date
  - Date entered in system
  - Date sent for review if applicable
  - Date sent for payment
  - Date of check run
- Copy of bank statement or cancelled check

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Medicare Claims Audit, Continued

Claims Review

Most claim information is entered in to the spreadsheet from the audit sample. The auditor will review the following information:

- Provider name
- Date of service
- Amount of claim
- Contract status
- First received date
- Payer's received date
- System entry date
- Date paid
- Date check mailed
- Check number
- Date check cleared
- Interest payment and rate if applicable

If the required information is not provided, the auditor has discretion to allow time to gather the information or for some items, such as the questionnaire or attestation, they may allow 2 business days to provide it. However, without the attestation, the default of 2 business days will be used to calculate mailing time.

Preliminary Results

After the claim review and entry, the auditor will prepare the following information:

- Percentage of claims paid with the required timeframes
- Payment of interest pass/fail if applicable
- Preliminary Audit Results

The representative at the payer will then be required to sign the preliminary results and if the audit is non-compliant, the dates for the 90-day audit, the audit review period and the deadline for the Corrective Action Plan will be determined and noted on the form.

Commercial Claims Audit

Introduction

Commercial claims are regulated by the DMHC. The audit covers the following elements:

- Claims acknowledgment
- Paid claims
- Contested claims
- Claims forwarding
- Interest payment
- ERISA claims

Delegated entities must demonstrate 95% compliance with all audit timeframes and 100% compliance for interest payment on non-compliant claims.

Determining Received Date and Calculating Turnaround Time

For Commercial claims, the claims received date and turn-around time are determined as follows:

- Received date is based on the **first date stamp from the correct payer** on the claim and not the first date stamp from any other entity.
- Turn-around time is based on **45 working** days. The spreadsheet will calculate this information based on the date the claim is received and the date the check is mailed however in the case of holidays or for claims that are marginal, a manual count should be conducted.
- A claim is considered paid when the **check is mailed** and not when the check is approved or printed. The attestation will indicate the check mailing turn-around time.

Claims Acknowledgement

The delegated payer is not required to send an acknowledgment for each claim received. They are required to be able to acknowledge that a claim has been received if that information is requested by the provider. They must be able to provide that acknowledgement within 2 days of the receipt of the claim.

This information is calculated based on the timeframe from the received date to the date that the claim is entered in the system.

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Commercial Claims Audit, Continued

Claims Acknowledgement, continued

Some claims processing system utilize the data entry date as part of the claim number but for other systems, it is a data entry field.

Claims acknowledgment must be 95% compliant with required timeframes

Conducting a Commercial Audit

The Commercial Audit will cover the following:

- Walk through and Policy & Procedure Review
- Claims Review
- Preliminary Results

Walkthrough and Policy & Procedure Review

During the audit, the auditor must review the following:

Walkthrough	During the walkthrough, the following procedures should be observed: • Mailroom and date stamping • Claims forwarding process • Entry in to processing system • Check processing • Record storage
Policy & Procedure Review	The following Policy & Procedures should be reviewed: • HIPAA Privacy Policy • Claims Forwarding Policy

Continued on next page

Commercial Claims Audit, Continued

Claims Documentation

The payer should provide the following information for each claim:

- Copy of claim form or screen print of claim information for electronic claims
- Any medical records that were provided with the claim
- Documentation showing the dates of processing including:
  - Received date
  - Date entered in system
  - Date sent for review if applicable
  - Date sent for payment
  - Date of check run
  - Copy of bank statement or cancelled check

Paid Claims Review

Most claim information is entered in to the spreadsheet from the audit sample. The auditor will review the following information:

- Provider name
- Date of service
- Amount of claim
- Contract status
- First received date
- Payer's received date
- System entry date
- Date paid
- Date check mailed
- Check number
- Date check cleared
- Interest payment and rate if applicable

Paid claims must be 95% compliant with required timeframes.

Continued on next page

Commercial Claims Audit, Continued

Contested Claims

Contested claims are claims that are received without all the necessary supporting information. This information can include the following:

- Authorization
- Medical records
- Verification of timely filing

When a claim is received that does not contain all the necessary documentation to support payment, the claim is pended and a letter is sent to the provider requesting the additional information. If the provider does not submit the necessary information within 45 days, the claim will be denied.

Contested claims may also be referred to as unclean claims.

Claims must be paid or contested within 45 working days from the date the claim is received.

10 Contested claims are reviewed for each month of the audit period; however most payers do not have that amount.

Information on contested claims is entered in the spreadsheet to verify that required timeframes have been met but additionally, when claims are not forwarded for payment, the denial must indicate there is no member liability for the outstanding balance.

Claims Forwarding

Payers must be able to demonstrate that all claims received that are the responsibility of a different payer are forwarded within 10 days from the date the claim is received.

A claim that is received that is the responsibility of another entity, whether the health plan, hospital or medical group/IPA is referred to as a forwarded claim or a misdirected claim. These occur for a variety of reasons including incorrect eligibility information or incorrect billing on the part of the provider of service.

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Commercial Claims Audit, Continued

Claims Forwarding, continued	Payers can track this information in a variety of ways. Some providers track their claims forwarding date in a database and run reports. Other payers log the misdirected claims and indicate the date received as well as forwarded. The volume for the claims processing operation will often determine the tracking method. Mail forwarding must be 95% compliant with the 10 day timeframe.
Interest Payment	Interest must be paid at the correct annual percentage set by the DMHC and must be paid for each day past the 45 working day timeframe. Interest payment is a pass/fail component.
Payment Methodology for Non-Contracted Providers	Payers must have a policy in place to determine the payment methodology for non-contracted providers. Methodology can include the following: • Payment in full • Payment at Medicare Fee schedule • Payment at Usual Customary and Reasonable (UCR) The payer must have a set policy in place and the EOP must include language either explaining the methodology or providing information on where to view the methodology, language advising that the member is not liable for the balance and information on how to file a Provider Dispute. The methodology for payment of non-contracted providers is a pass/fail component.
ERISA	Claims for ERISA members must be paid or denied within 30 days of the date received. A payer must either have a policy in place to pay or deny all claims within 30 days of the date received or have a process in place to identify ERISA members and process those claims within the required timeframes.

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Commercial Claims Audit, Continued

Preliminary Results

After the claim review and entry, the auditor will prepare the following information:

- Percentage of claims paid with the required timeframes
- Notification of the results for all pass/fail elements
- Preliminary Audit Results

The representative at the payer will then be required to sign the preliminary results and if the audit is non-compliant, the dates for the 90-day audit, the audit review period and the deadline for the Corrective Action Plan will be determined and noted on the form.

Provider Dispute Audit

Introduction

Assembly Bill 1455 (AB1455) was approved as law in September 2000. This bill requires all claims payment entities to institute a process for a provider to file a dispute on a claim denial or payment rate. AB1455 also sets certain requirements regarding the process and timeframes.

A provider dispute is a written notice challenging, appealing or requesting reconsideration of a claim that has been denied, adjusted or contested or seeking the resolution of a billing, payment or contract dispute.

AB1455 stipulates that certain requirements be met:

- Notification of the provider dispute resolution
- Acknowledgment of the provider
- Resolution of the provider dispute

Notification of Provider Dispute Resolution Process

Notification of the provider dispute resolution process must be included on all payments and denials with either the specific process or the location where the provider can view that information.

The notification of the provider dispute process is a pass/fail component.

Acknowledgement Letter

Provider disputes must be acknowledged by the payer within 2 working days for an electronic submission and 15 working days for a written submission. This notification must be done in writing.

The acknowledgment letter must be 95% compliant within the required timeframe.

Resolution Letter

A provider dispute must be resolved within 45 working days from the day it is received. The acknowledgment must be done in writing and if denied it must contain clear language regarding the reason for the denial.

The resolution letter must be 95% compliant within the required timeframe.

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Provider Dispute Audit, Continued

Payment	If a provider dispute is approved for payment, the payment must be made within 2 days of the determination, this includes the time from the check run to the check mailing date. Payers will need a process in place for special check runs in order to remain compliant with the required payment timeframe. The payment must be 95% compliant within the required timeframe.
Uphold Reason	If the original claims determination is upheld, the provider dispute is considered a denial however, they language used is “upheld” indicating that the decision on the original claim is upheld. The reason must be clear and appropriate. The uphold reason is a pass/fail component.
Conducting the Provider Dispute Audit	For the Provider Dispute Audit, a full walk through and policy review is generally not necessary. Compliance with the requirements of the law are evident during the review of the individual disputes. The auditor will perform the following tasks: • Review the dispute paperwork and verify the information in the spreadsheet is correct and that all timeframes have been met • Review the letter on any upheld disputes to determine that the uphold reason is appropriate • Review any paid disputes to determine if it is compliant with payment timeframes and that interest has been paid back to the original claims receive date

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Provider Dispute Audit, Continued

Preliminary Results

After the claim review, the auditor will prepare the following information:

- Percentage of claims paid with the required timeframes
- Notification of the results for all pass/fail elements
- Preliminary Audit Results

The representative at the payer will then be required to sign the preliminary results and if the audit is non-compliant, the dates for the 90-day audit, the audit review period and the deadline for the Corrective Action Plan will be determined and noted on the form.

Medicare Member Denial Letters

Introduction

When a denial results in a member liability, the denial must be made within a specific timeframe and included specific denial language.

The denial letter audit is generally conducted in the office rather than on-site at the payer. The payer will mail all necessary information and documentation or email electronic versions of the documentation prior to the date of the audit.

The Medicare-risk member denial letter audit will cover the following areas:

- Letter template
- Timeliness
- Claim information
- Denial reason
- Member liability

Letter Template

Each delegated payer must submit a letter template that will be used for all denial letters. The template must adhere to CMS requirements with specifics regarding the format, denial reason, font size and information on how to appeal the decision.

The auditor will review the denial letter to verify that the payer is using the template that they have previously submitted for approval.

The letter template is a pass/fail component.

Timeliness

Member denial letters must be issued within 30 days of the received date of the claim.

Timeliness must be 95% compliant with required timeframes.

Continued on next page

Medicare Member Denial Letters, Continued

Claim Information	The letter must include information regarding the specific service that has been denied including the following: • Provider name • Date of service • Type of service • Amount of the claim Claim information is a pass/fail element.
Denial Reason	The denial reason must be appropriate and in compliance with required guidelines specific to medical necessity, prior authorization and prudent laypersons understanding in emergency situations. The denial reason is a pass/fail component.
Member Liability	The denial letter must include language that specifically advises the member of their financial responsibility for the services incurred. The member liability language is a pass/fail component.
Conducting the Medicare Denial Letter Audit	The auditor will perform the following tasks when conducting a denial letter audit: • Review the letter to determine if it adheres to the letter template on file • Review policies and procedures, questionnaire and attestation • Review the claim and enter the received date into the spreadsheet • Review the denial letter and enter the date into the spreadsheet • Review the letter to determine if the denial reason and member liability language is included and appropriate • Review the denial to determine if the denial is appropriate to the claim submitted

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Medicare Member Denial Letters, Continued

Conducting the Medicare Denial Letter Audit, continued

- Verify that all information is correctly entered in to the spreadsheet including the following information:
    - Provider name
    - Date of service
    - Amount of claim
    - Received date of the claim
    - Date of the denial letter
- Calculate the percentage of compliance within the required timeframes
- Prepare the Audit Results
- Update data base

    Mail results letter to payer

Commercial Member Denial Letter

Introduction

When a denial results in a member liability, the denial must be made within a specific timeframe and included specific denial language.

The denial letter audit is generally conducted in the office rather than on-site at the payer. The payer will mail all necessary information and documentation or email electronic versions of the documentation prior to the date of the audit.

The Commercial Member Denial Letter audit will cover the following areas:

- Letter template
- Timeliness
- Claim information
- Denial Reason
- Member Liability

Letter Template

Each delegated payer must submit a letter template that will be used for all denial letters. The template must adhere to DMHC requirements with specifics regarding the format, denial reason, font size and information on how to file an appeal.

The auditor will review the denial letter to verify that the payer is using the template that they have previously submitted for approval.

The letter template is a pass/fail component.

Timeliness

Member denial letters must be issued within 30 days of the received date of the claim.

Timeliness must be 95% compliant with required timeframes.

Denial Reason

The denial reason must be appropriate and in compliance with required guidelines specific to medical necessity, prior authorization and prudent laypersons understanding in emergency situations.

The denial reason is a pass/fail component.

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Commercial Member Denial Letter, Continued

Member Liability

The denial letter must include language that specifically advises the member of their financial responsibility for the services incurred.

The member liability language is a pass/fail component.

Conducting the Commercial Denial Letter Audit

The auditor will perform the following tasks when conducting a denial letter audit:

- Review the letter to determine if it adheres to the letter template on file
- Review policies and procedures, questionnaire and attestation
- Review the claim and enter the received date into the spreadsheet
- Review the denial letter and enter the date into the spreadsheet
- Review the letter to determine if the denial reason and member liability language is included and appropriate
- Review the denial to determine if the denial is appropriate to the claim submitted
- Verify that all information is correctly entered in to the spreadsheet including the following information:
    - Provider name
    - Date of service
    - Amount of claim
    - Received date of the claim
    - Date of the denial letter
- Calculate the percentage of compliance within the required timeframes
- Prepare the Audit Results
- Update data base
- Mail results letter to payer

Audit Sample Size

Introduction

The audit sample size will vary based on several factors. Those factors are:

Audit type:
- Annual audit
- 1st & 2nd 90-day extension
- Oversight with Corrective Action Plan
- Partial Undelegation
- Off-cycle

Product line:
- Medicare
- Commercial
- Provider Dispute
- Member Denial Letter

Annual Audit

For an annual audit, the audit samples are as follows:

Medicare-Risk	
Audit Element	**Sample Size**
Non-contracted Provider Claims	20 claims per month 3 months audit period
Contracted Provider Claims	20 claims per month 3 months audit period

Commercial Claims	
Audit Element	**Sample Size**
Paid Claims	20 claims per month 3 months audit period
Contested Claims	10 claims per month 3 months audit period

Continued on next page

Audit Sample Size, Continued

Annual Audit, continued

Provider Dispute	
Audit Element	**Sample Size**
Acknowledgment Letter	10 letters per month 3 months audit period
Resolution Letter	10 letters per month 3 months audit period

Member Denial Letters	
Audit Element	**Sample Size**
Denial Letter	20 letters per month 3 months audit period

1st and 2nd 90-Day Extension

For a 90-day extension audit, whether the 1st or 2nd extension, the audit samples are as follows:

Medicare-Risk	
Audit Element	**Sample Size**
Non-contracted Provider Claims	20 claims per month 1 month audit period
Contracted Provider Claims	20 claims per month 1 month audit period

Commercial Claims	
Audit Element	**Sample Size**
Paid Claims	20 claims per month 1 month audit period
Contested Claims	10 claims per month 1 month audit period

Continued on next page

Audit Sample Size, Continued

1st and 2nd 90-Day Extension, continued

Provider Dispute	
Audit Element	**Sample Size**
Acknowledgment Letter	10 letters per month 1 month audit period
Resolution Letter	10 letters per month 1 month audit period

Member Denial Letters	
Audit Element	**Sample Size**
Denial Letter	20 letters per month 1 month audit period

Oversight with Corrective Action Plan & Partial Undelegation

For a partial or full undelegation audit, the audit samples based on product line are as follows:

Medicare-Risk	
Audit Element	**Sample Size**
Non-contracted Provider Claims	20 claims per month 1 month audit period
Contracted Provider Claims	20 claims per month 1 month audit period

Commercial Claims	
Audit Element	**Sample Size**
Paid Claims	20 claims per month 1 month audit period
Contested Claims	10 claims per month 1 month audit period

Continued on next page

Audit Sample Size, Continued

Oversight with Corrective Action Plan & Partial Undelegation, continued

Provider Dispute	
Audit Element	**Sample Size**
Acknowledgment Letter	10 letters per month 1 month audit period
Resolution Letter	10 letters per month 1 month audit period

Member Denial Letters	
Audit Element	**Sample Size**
Denial Letter	20 letters per month 1 month audit period

Off-Cycle Audit

For an off-cycle audit, the audit samples based on product line are as follows:

Medicare-Risk	
Audit Element	**Sample Size**
Non-contracted Provider Claims	20 claims per month 1-3 month audit period based on degree and timeframe of non-compliance
Contracted Provider Claims	20 claims per month 1-3 month audit period based on degree and timeframe of non-compliance

Continued on next page

Audit Sample Size, Continued

Off-Cycle Audit, continued

Commercial Claims	
Audit Element	**Sample Size**
Paid Claims	20 claims per month 1-3 month audit period based on degree and timeframe of non-compliance
Contested Claims	10 claims per month 1-3 month audit period based on degree and timeframe of non-compliance

Provider Dispute	
Audit Element	**Sample Size**
Acknowledgment Letter	10 letters per month 1-3 month audit period based on degree and timeframe of non-compliance
Resolution Letter	10 letters per month 1-3 month audit period based on degree and timeframe of non-compliance

Member Denial Letters	
Audit Element	**Sample Size**
Denial Letter	20 letters per month 1-3 month audit period based on degree and timeframe of non-compliance