POLICY AND PROCEDURE

DEPARTMENT: Internal Audit	DOCUMENT NAME: Post Claim Payment Audit
PAGE: 1 of 6	REPLACES DOCUMENT: LA.IA.05
APPROVED DATE: 08/2020	RETIRED:
EFFECTIVE DATE: 08/2020	REVIEWED/REVISED: 08/2020
PRODUCT TYPE: All	REFERENCE NUMBER: LA.IA.11

SCOPE:

Post Claim Payment Audit for claims processed on Amisys.

PURPOSE:

To describe the requirements and process for auditing post claim payment accuracy, processing accuracy and financial accuracy.

POLICY:

Internal Audit – Claims Audit (IA), independent of the Claims department, perform statistically valid quality audits of processed claims (post-payment), which assess claims for processing, payment and financial accuracy, as well as compliance with contract obligations. Random and/or financially stratified samples are selected from each check run on a weekly basis, which includes all paid, denied, appealed and adjusted claims. Generally, we use a sample size calculator from the OIG website. The assumptions are based on a 99% confidence level, plus or minus 2.5% to 3%, assuming a 3% error rate, which may be adjusted based on risk or to comply with regulatory or other contract requirements. Unless otherwise specified, this sample size is then evenly distributed over each week within the measurement period, which is quarterly. The quarterly measurement period is consistent with quarterly financial reporting cycle.

We automate where possible to randomly select the sample of claims. Selections are chosen from all processed claims including paid, denied, appealed and adjusted claims.

Based on emerging error trends or management requests, additional audits to address other process and/or configuration issues may be performed.

Post claim payment audit criteria includes, but is not limited to:

- Recalculate claim dollars allowed and paid to the specific underlying source documents (e.g. provider contracts, fee schedules, benefit grid)
- Accuracy of claim data entry (paper submissions)
- Claims paid to the appropriate provider record (may vary based on Tax ID, NPI, location combinations)
- Proper authorization was obtained for service
- Member eligibility accurately applied
- Allowed payment agrees with contracted rate or non-contracted provider requirements
- Ensure duplicate claim submissions were identified and denied

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- Claims processed in accordance with UM/care management decisions regarding services and whether the reason for payment was accurately applied
- Other insurance investigated for coordination of benefits
- Modifier codes correctly applied
- Proper coding was consistent with provider credentials
- Denial reasons were applied appropriately
- Prompt payment regulations are appropriately applied
- Non-covered services were appropriately identified and denied
- Review for outliers/unusual practices

Audit forms, error status, auditor notes, etc. are documented in a web based program ClaimAuditor (CM). While daily notifications of errors are sent, a comprehensive file of errors, including those with outstanding corrective actions, is shared on the Internal Audit Intranet site so management may timely perform root-cause analysis and submit corrective actions as necessary. The monthly sampling provides an in-depth view on the accuracy of claims processing, feedback for internal continuous process improvement and staff training needs.

On a monthly basis, IA produces a consolidated summary of results, including commentary on primary drivers along with outstanding corrective actions. With the facilitation and insights from Internal Audit, Claims leadership reviews the audit results with health plan leadership to ensure systems are adjusted as needed for continuous improvement. If necessary, recommendations are made regarding monitoring, management structure and staffing requirements. In addition, Health plan and/or Claims department designees are responsible for training and/or coaching each analyst/department representative on how to address the manual errors identified.

PROCEDURE:

1. On a weekly basis, we generate a sample containing a random number of claims using one of two options:
    a. We manually prompt and execute a pre-defined SQL script which grabs a specified number of random claims or entire universe from the appropriate EDW table.
    b. We also utilize a prepopulated SQL script which auto runs and generates a sample report every week on Monday mornings, pulling the previous seven (7) calendar days of paid claims.

2. The weekly sample size is based on taking the total quarter sample and distributing it ratably throughout the quarter.

3. The file containing the audit selections is then imported into CM, which acts as a repository of audit selections and audit forms as well as a communication and tracking software.

4. Audit criteria includes, but is not limited to, standard industry operating procedures, state requirements, state specific Medicaid/Medicare fee schedules, provider and facility contractual agreements and corporate policies and procedures.

5. Performance is measured utilizing the following standards:

   A. Processing Accuracy = (Claims without non-financial errors / Total number of audited claims

   B. Financial Accuracy = 1 - {(Absolute Value of over and under payments) / (Total paid $'s of claims audited)}

   C. Payment Accuracy = (Claims without financial errors / Total number of claims audited

6. The audit form includes basic demographic and audit information such as business unit, paid date, audit date, claim number, error type, total number of errors issued, error description, billed dollars, paid dollars, and over/under dollar value, etc. In addition, auditors are required to maintain source documentation, such as claims system screen prints, provider contracts, fee schedules, etc. on the IA network drive for all errors.

7. Errors are classified into 3 buckets – classification, groups and types. The categories under each bucket are based on a predefined list which is routinely reviewed and updated by management.

   a. Claim error is first classified as to whether it was caused by the auto-adjudication software set-up (system) or manual claims (manually paid by an analyst).
   b. The next step is to determine the first point in the adjudication process that failed (benefits, auth, provider, member, pricing, etc).

c. Finally, a final qualifier is assigned, which further describes the error in terms of services received (physician v ambulance) or further describes the software set-up gap.

Only one error group is designated to each claim for quality measurement purposes regardless of the number of errors found per claim. However, all errors noted during the audit are recorded in the CM software and communicated to the designated business unit "error responder" for review and/or correction.

8. System errors may be assigned to the designated Configuration department manager for resolution (depending on the type of error) while manual errors are typically assigned to the Claims department designee.

    a. If there is more than one payment error attributed to a claim audit, IA classifies the error to the first step in adjudication process which failed. Further, in situations where there is a system and manual error, IA classifies as a system error, to aide in the tracking and reporting of system corrections. In both situations, the other errors are documented and management is informed. IA will request a management response to any additional errors noted.

9. Louisiana Healthcare Connections and Claims department (i.e. error responders) are automatically notified via email of system and manual errors immediately following the issuance of an error through the CM software.

10. Validated or rebutted errors are to be returned to IA within 5 business days, with all responses received by the 10th calendar day. All rebuttals must contain appropriate supporting documentation to support the finalized claim results.

11. Rebuttals are reviewed as received by Claims Audit. If after review and discussion with the applicable functional area resolution/agreement cannot be made, a rebuttal committee meeting will be scheduled. The rebuttal committee consists of Claims department leadership and IA leadership who determine final decisions.

12. IA summarizes major error type trends routinely. Training topics are also communicated routinely with the Claims Training department and/or responsible functional area.

13. The following reports are prepared monthly or as needed. Notifications of readiness are emailed to designated leadership and the reports are posted on the

intranet, with appropriate and applicable security levels, to ensure accessibility of monthly and historical reports.

a. Claims Quality Accuracy Dashboards/Trend Reports: Consolidated and business unit accuracy results are shared entity wide on a monthly basis, along with comments on trends and drivers. Additional information in these reports include: a summary of top payment errors for the current quarter, top outstanding issues and other fluctuation analysis. On a weekly basis, additional interim reports may be distributed as needed.
b. Value Add Audits: When necessary, these reports summarize the results of additional claim audits above and beyond the statistical-based random sample. The report formats vary based on the nature of these audits.
c. Corrective Action Plan (CAP) Tracking: Claim correction validation is performed at least quarterly, and for system errors. IA assigns a task using CM to track un-remediated system corrective action plans (i.e. CR ticket #, Jira ticket #, CRM #).
d. Miscellaneous: Other reports and communications are distributed as needed and/or requested; such as regulatory report requirements or line of business reports.
e. Internal Quality Standard: Our department adheres auditor, as measured monthly, to internal quality standards whereby by an auditor independent of the process selects random claims from each auditor for re-audit. Additionally, other production standards are measured and monitored at least on a weekly basis. Further specifics are outlined in separate policies and procedures.

REFERENCES: N/A

ATTACHMENTS: N/A

DEFINITIONS: N/A

REVISION LOG

REVISION	DATE
Converted corporate to local policy.	08/15/2020

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The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to an actual signature on paper.

Senior Director of Network Accounts: _____Electronic Signature on File_____