



Let us help you manage your benefits cost and risk.

Medical Claim Audits

Each year employers pay thousands of healthcare claims for employees and family members enrolled in their health and welfare Plans. Most of these employers rely on third party administrators to ensure that valid claims are paid accurately and according to the terms of the company's plan document. Additionally, the third party administrators are expected to ensure that the employer receives appropriate credits for employee deductibles and co-payments, provider discounts, and coordinated benefits between spouses. With the cost of these benefits increasing by double digits each year, employers are focusing more attention on whether the claims are being paid accurately and that the company is receiving all of the appropriate credits based on their governing plan documents and contracts with their service providers.

In this age of downsizing and restructuring, companies do not have the internal resources to audit the work that is being done by their third party administrator. Consequently, employers do not know whether their administrators are paying the claims correctly or not. For every claim that is not paid accurately, the employer's profits are reduced. In addition, if a very large claim is not paid accurately by the administrator the employer's reinsurance will not reimburse the company for the invalid claim. All of this means that a company can be losing substantial dollars each year that would otherwise increase the company's profits.

Our Medical Claim Audit Services

Bartlett O'Neill Consulting's medical claim audit is a comprehensive approach to ensure that your company's healthcare claims are paid properly by your third party administrator. The review is an outsourced solution. Therefore, the company has to participate to obtain cooperation from its third party administrator to provide the necessary data and to obtain financial recovery for overpayments that are identified. The audit is also a process improvement solution whereby the errors identified in our audit trigger corrective action by your administrator, which reduces future payment errors.

We analyze a sample of payments to ensure that your administrator has processed and paid the claims correctly. We can select the sample based on areas where you have the greatest concern regarding correct processing and payment or we can select a random sample. Some of our general tests include:

- ❖ Duplicate payments
- ❖ Subrogation
- ❖ Eligibility
- ❖ Plan limitations
- ❖ Coordination of benefits
- ❖ Coinsurance/deductibles
- ❖ Provider of service discounts
- ❖ Consistent interpretation of the Plan's benefit parameters
- ❖ Reasonableness of payment turnaround time

For the claims contained in our sample which are found to be in error, we will provide you with the amount of the error and the reason we believe the claim is in error to aid you in determining how you and the administrator are going to correct the claim.



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How does the Medical Claim Audit work?

The Medical Claim Audit is a five-step process.

- ❖ **Step 1.** Data gathering – With the company’s assistance we obtain a “paid claims history” computer file from your third party administrator. We also obtain information regarding the provisions of the plan including but not limited to plan documents, summary plan descriptions, summaries of material modification, etc.
- ❖ **Step 2.** Data reconciliation and sample selection – We review the information from the administrator to ensure that it is complete and accurate. Once we are comfortable that the information is complete and accurate, we select the sample to be audited based on your criteria that was established at the beginning of the engagement, e.g., judgmental or statistical sampling.
- ❖ **Step 3.** Medical claim audit – We review each claim selected in Step 2 for accuracy and completeness at the administrator’s office.
- ❖ **Step 4.** Incorrect payment confirmation – Once we have identified errors, they are presented to the third party administrator for confirmation or explanation. If the administrator is unable to provide documentation to support that the claim payment was accurate, we will include the error in our report and notify the administrator that the error will be included in the report.
- ❖ **Step 5.** Final report – The errors that we identified in Step 4 are included in our final report. The report will also contain recommendations regarding process improvements and additional audit work if warranted.