

Visit **Benefits and Pensions Monitor** magazine online at: <http://www.bpmmagazine.com>

Claims Payment Audits - Good Plan Governance

By: Susan Bowyer

When are two **benefit** programs with equal coverage not equal? It's at the time of claim payment. Plan coverage descriptions may be the same but the actual handling of claims can differ from **administrator** to **administrator**. A move from one to another could uncover significant changes affecting payment experience and overall plan costs.

Most sponsors place a considerable amount of importance on the selection of an **administrator** to meet the design and service needs of their **benefit plan** at a competitive cost. The decision to move the plan to a new **administrator** is not made without thoughtful consideration – the advantages must exceed the disadvantages of switching. But, once all of the plan design, underwriting, services, and costs are finalized, what have you actually purchased? The most important service that your plan **administrator** provides is the payment of claims.

Greater Emphasis On Claims Needed

Aggregate claims experience data and financial statements are audited and analyzed on a regular basis. Even with a greater emphasis on plan governance and accountability, however, how often are plan sponsors auditing the main cost driver, the underlying claim payments? Thorough, accurate claims adjudication requires:

- All information necessary to assess eligibility of payment
- Payments that are accurate and in accordance with the contract
- Policies and practices to prevent, detect, and protect the plan from abuse and fraud, including recovery of money when necessary

Audits of claim payment practices have found that some administrators make coverage decisions that are outside the terms of the contract – and often without plan sponsor approval. Often described as the administrator's 'standard handling' practices, they may include:

- Coverage of preventative drugs and services
- Elimination of contractual requirements for medical referrals for certain practitioners
- Payment of services before they are actually incurred
- Coverage of services not in the contract

Claims are paid not only by your administrator, but also by organizations to which they sub-contract services (pharmacy benefit managers, data entry providers, out-of-country claim adjudicators). Most plans with a drug card are sub-contracted to a pharmacy benefit manager, but some plan sponsors will be surprised to learn that claims for services such as ambulance, vision, equipment, and paramedical practitioners may also be sub-contracted. When an administrator conducts its own internal audits and gives assurances of accuracy standards and quality controls, does it include these sub-contracted claims?

Third-party Audit

A third-party audit of the administrator will typically yield more discrepancies and inaccuracies than an administrator's self-audit. The administrator audits against its own standards and practices – which may not be in agreement with the contract. It is also important to note that an administrator's compliance with accounting guidelines does not ensure claim payment accuracy standards and quality controls.

Employer sponsored plans are often open to abuse and fraud. Claims may be submitted to your plan by employees and dependents, and by an array of providers (pharmacists, hospitals, paramedical practitioners, dentists). Misuse of plans can come in many forms:

- Rendering treatment and services not medically required
- Charging for treatment not performed
- Excessive billings
- Drug abuse
- Altering of service dates to avoid plan maximums

Transactions that take place between the provider and the administrator with little or no participation of the claimant are especially susceptible. Not all administrators provide an Explanation of Benefit (EOB) payment to claimants when payment is assigned to the provider, citing administrative cost as the reason. It is not uncommon for providers of service to have patients sign a blank claim form that the provider later completes or submits electronically with no patient review. The claimant should review an EOB at the time of the claim payment, or should, at a minimum, be provided with a periodic summary to review and advise the administrator of any items, services, or amounts that do not agree with what they received. With electronic claim submissions and direct-from-provider submissions, involving the claimants through receipt of an EOB should be a relatively easy – and a valuable – step in reducing abuse, fraud, and errors.

Appropriate Sampling

A thorough audit includes a review of the claim system, payment practices, and controls as well as a sampling of claims. A thorough sample includes not only a review of electronic claims payment data, but also an audit of an appropriate sampling of hard copy claims. Our audits of hard copy claim samples show that 95 per cent of errors could not have been detected through an electronic review alone. Findings from past audits have included:

- payment of predetermination submissions as incurred claims
- duplicate payments
- lack of adherence to reasonable and customary guidelines
- coding and payment of ineligible coverage
- payment beyond the age limitation of the plan
- system errors in the application of maximums
- services paid at an incorrect co-insurance level
- payment to the wrong plan member
- payment under the wrong service type affecting accumulation toward service maximums
- non-enforcement of co-ordination of benefit provisions
- a lack of investigation of 'red flags' or suspicious claims

Good plan governance includes knowing how and what is being paid under your benefit program. Plan sponsors, not their administrators, should be making plan design decisions and know that claims are being paid based on plan documentation and that sufficient controls are in place to protect the plan from abuse and fraud. If the day comes to move to a new administrator, sponsors should know how to specify claim payment requirements based on already established practices. This puts them in a position to assure employees that such a move will not significantly impact claim payments or the cost of the plan.

Susan Bowyer is a principal in the Toronto office of Mercer Health & Benefits.