HEALTH CARRIER CLAIM AUDIT GUIDELINES MODEL ACT

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emergency services, organized administrative structure and administrative, statistical and medical records.

B. "Claim audit" means a process to determine whether data in a claimant's medical record for health care documents health care services listed on a claim for payment submitted to a carrier. Claim audit does not mean a review of the medical necessity of the services provided, or the reasonableness of charges for the services.

C. "Claimant" means an insured or enrollee under a health benefit plan who receives surgical or inpatient care, the costs of which are submitted to a carrier for payment, either by the claimant or by another on the claimant's behalf.

D. "Final claim" means the final itemized bill from an institutional provider detailing all the charges for which the institutional provider is seeking payment.

E. "Health benefit plan" means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

F. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

G. "Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a provider-sponsored organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

H. "Institutional provider" means an institution providing health care services in a health care setting, including but not limited to hospitals, other licensed inpatient centers, ambulatory surgical centers, skilled nursing centers and residential treatment centers.

I. "Medical record" means a compilation of charts, records, reports, documents, and other memoranda maintained by an institutional provider wherever located, to record or indicate the past or present condition, sickness or disease, and treatment rendered, physical or mental, of a patient.

J. "Qualified claim auditor" means a person employed by a corporation or firm that is recognized as competent to perform or coordinate claim audits and that has explicit policies and procedures protecting the confidentiality and disposal of all patient information in its possession.

K. "Underbilled charges" means the volume of services indicated on a claim is less than the volume identified in the institutional provider's medical documentation; also known as undercharges.

L. "Unbilled charges" means charges or services provided for and not billed.

M. "Unsupported charges" or "undocumented charges" means the volume of services indicated on a claim exceeds the total volume identified in the institutional provider's medical documentation; also known as overcharges.

Section 4. Applicability and Scope

This Act shall apply to all health carriers. The institutional provider accepting assignment of benefits of an insured shall be responsible for the conduct and results of the claim audit whether conducted by an employee or by contract with another firm. The institutional provider and carrier shall:

(6) Whom to contact to discuss the request and scheduled audit.

G. Institutional providers that cannot accommodate an audit request that conforms to these guidelines shall explain why the request cannot be met in a reasonable period of time and shall be provided with a reasonable period to reschedule the audit. Auditors shall group audits to increase efficiency whenever possible.

H. It shall be the responsibility of the institutional provider seeking payment of a claim or reimbursement under a managed care contract to notify the auditor prior to the scheduled date of audit, if the auditor will have problems accessing records. As a condition for payment, the institutional provider shall be responsible for supplying the auditor with any information that could affect the efficiency of the audit once the auditor is on-site.

Section 7. Institutional Provider Audit Coordinators

A. Institutional providers shall designate an individual to coordinate all claim audit activities. An audit coordinator shall have the same qualifications as required for an auditor pursuant to Section 5 of this Act. The duties of an audit coordinator include, but are not limited to, the coordination of the following areas:

(1) Scheduling an audit;

(2) Advising other institutional provider personnel and departments of a pending audit;

(3) Ensuring that the condition of admission statement is part of the medical record;

(4) Verifying that the auditor is an authorized representative of the carrier;

(5) Gathering the necessary documents for the audit;

(6) Coordinating auditor requests for information, space in which to conduct an audit, and access to records and institutional provider personnel;

(7) Orienting auditors to hospital/surgery center audit proceduresy s340 Tc 0 Tw 32.728 0 Td( )TjEM

Section 8. Conditions and Scheduling of Audits

A. In order to have a fair, efficient, and effective audit process, institutional providers and carrier auditors shall adhere to the following requirements:

(1) Whatever the original intended purpose of the claim audit, all parties shall agree to recognize, record or present any identified unsupported, unbilled or underbilled charges discovered by the audit parties;

(2) The scheduling of an audit shall not preclude late billing;

(3) The parties involved in the audit shall mutually agree to set and adhere to a predetermined time frame for the resolution of any discrepancies, questions or errors that surface in the audit;

(4) An exit conference and a written report shall be part of each audit; if the institutional provider waives the exit conference, the auditor shall note that action in the written report. The specific content of the final report shall be restricted to those parties involved in the audit;

(5) The institutional provider shall be afforded sixty (60) days to contest all findings, after which the audit shall be considered final;

(6) Once both parties agree to the audit findings, audit results are final;

(7) All personnel involved shall maintain a professional, courteous manner and resolve all misunderstandings amicably; and

(8) At times, the audit will note ongoing problems either with the billing or documentation process. When this situation occurs, and it cannot be corrected as part of the exit process, the management of the institutional provider and carrier shall be contacted to apprise them of the situation. The institutional providers and carriers shall take appropriate steps to resolve the identified problem. Parties to an audit shall eliminate ongoing problems or questions whenever possible as part of the audit process.

Section 9. Confidentiality and Authorizations

A. All parties to a claim audit shall comply with all federal and state laws and any contractual agreements regarding the confidentiality of patieee2 (t)-3 (ialit)78-stop5.1 (in)2.2 (s)-y (y)-8.y-1 (nt)-4.9 (i)-8

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the institutional provider's ancillary departments in the form of department treatment logs, daily records, individual service or order tickets, and other documents.

C. Auditors may have to review a number of other documents to determine valid charges. Auditors