PROFESSIONAL HEALTH CARE **BENEFITS AUDITING**

Case Study – Claims Audit

Value Realized – Periodic Claims Audits Test Administrative Effectiveness

Business Situation

BMI is engaged to audit this client's medical plans every two years to ensure benefits are being paid appropriately by their third-party administrator and to test their overall administrative effectiveness.

Solution

Utilizing experienced staff and proprietary AUDiT iQ™ software, BMI customized an audit plan to meet the following objectives:

- ✓ Review 100% of all claims paid during the audit period chosen by the client.
- ✓ Test claims against Summary Plan Descriptions and enrollment records.
- ✓ Identify and analyze areas of possible fraud, waste, and abuse.
- ✓ Confirm appropriate coordination of benefits.
- ✓ Audit a sample of claims on-site at the third-party administrator's payment facility.
- ✓ Present detailed findings in addition to specific cost-savings recommendations based on the data and audit results.
- ✓ Provide post-audit guidance and assistance.

Audit Finding

- Failure to identify ineligible add-on codes, invalid CPT codes and inappropriate use of modifiers
- Lack of documentation to support medical necessity
- Payment for excluded services such as services related to dependent pregnancy
- Duplicate payments

Audit Outcome

A credit for the $77,000 in errors was issued to the client immediately along with their commitment to enhance system coding edits to prevent future errors. BMI assigned a Post-Audit Support Coordinator to walk the client through the audit findings and coordinate resolution to the identified errors.

In addition to errors identified and corrected directly through the audit, BMI's analysis of plan designs and claims data identified an additional $743,000 in potential future savings by making suggested plan language revisions. Areas in the analysis contained observations where the plan is silent, lacking limitations and or overly broad.

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