SHARP HEALTH PLAN POLICY AND PROCEDURE	
Title: Internal Claims Audit Policy	**Product Line** (check all that apply)**:** ☒ Group HMO ☒ Individual HMO ☐ PPO ☒ POS N/A
Division(s): Administration, Finance and Operations	
Department(s): Claims Research, Customer Care, Network Development, Provider Contracts and Regulatory Affairs	
Owner (Title): Claims Research Supervisor	
Relevant Regulatory/Accrediting Agencies/Citations (specify): ☐ CMS: _____ ☒ DMHC: DMHC Financial Survey – 2009, Title 28, California Code of Regulations (CCR), Sections 1300.71 and 1300.71.38 ☐ NCQA-HP: _____ ☐ NCQA-WHP: _____ ☐ OTHER: _____	
Approved by: (Signature of VP, Compliance Officer, or CEO) Signature on File	**Approval date:**

I. PURPOSE: This Policy and Procedure establishes Sharp Health Plan's (Plan) guidelines for internal claims audits.

II. POLICY: It is the policy of Sharp Health Plan (Plan) on an annual or as needed basis, to systematically review and audit claims processed by Sharp Health Plan for compliance with all Regulatory requirements.

III. DEFINITIONS

A. DMHC: Department of Managed Healthcare

B. SHP: Sharp Health Plan

C. Paid Claims: Claims paid by Sharp Health Plan within the regulatory specified timeframes.

D. Late Claims: Claims paid by Sharp Health Plan outside of regulatory outlined timeframes

E. Denied Claims: Claims denied for payment by Sharp Health Plan

F. PDR Claims: Claims that were reviewed and adjudicated based on the DMHC outlined Provider Dispute Resolution (PDR) mechanism.

G. Answers Plus: The Sharp Health Plan data warehouse system.

H. Date of Receipt (DOR): The working day when a claim, by physical or electronic means, is first delivered to Sharp Health Plan.

I. Date of Payment (DOP): The date on which the payment was issued for to a provider for services rendered.

J. Date of Service: For Outpatient and Emergency Services, the date upon which the Provider delivered separately billable health care services. For Inpatient Services, the date upon which the enrollee was discharged from the inpatient facility. For Inpatient extended lengths of stay Sharp Health Plan will accept separately billable claims for inpatient services on a bi-weekly basis.

K. Provider: Physicians, hospitals, skilled nursing facilities, home health agencies, pharmacies, medical transportation companies, laboratories, radiology facilities, durable medical equipment supplies and other licensed health care entities or professionals which or who provide Covered Benefits to Members. A Provider of health care services may or may not be contracted with Sharp Health Plan.

IV. PROCEDURE

A. Using an Answers Plus query, a report generates a listing of all claims processed by SHP during the current audit period.

B. The claim report should include all elements listed in Attachment A.

C. The claims selected are done for the four specific areas of claims for audit. These areas include:

1. Paid Claims
2. Late Claims
3. Denied Claims
4. PDR Claims
5. 50 claims are selected at random for each of the specified areas.

D. An audit is then conducted on the selected claims.

1. 25 of the 50 claims are selected in each category.

a) In the event that the first 25 claims are 95% compliant with all audit criteria, the audit can be ended.

2. Audit criteria for all claims categories:

    a) Date of Receipt: Confirm the DOR is entered into system correctly.

    b) Number of days to enter into claim system: Confirm the claim is compliant with regulatory requirement for claims acknowledgement.

3. Audit criteria for all Paid and Late Claims

    a) Payment: Confirm the claim was paid in accordance with provider contract

    b) Timeliness: Confirm the days between DOR and DOP are less than forty-five (45) business days for HMO claims and thirty (30) business days for POS claims,.

        i) In the event that claims are not reimbursed forty-five (45) business days for HMO claims and thirty (30) business days for POS claims, interest and penalties will be paid to the provider in accordance with Title 28, California Code of Regulations (CCR), Section 1300.71 (AB 1455).

    c) Interest Calculation: Confirm that the appropriate interest and penalties were paid when applicable.

    d) Medical Records Request: Confirm compliance with Rule 1300.71(a)(8)(H) and (I) regarding medical record requests.

    e) Rescinded or Change Authorized Service: Confirm compliance with Rule 1300.71(a)(8)(T) regarding rescinding or changing an authorized service.

4. Audit criteria for all Denied Claims

    a) Appropriateness: Ensure the claim was denied appropriately based on the denied disposition code.

    b) Filing Deadline: Confirm compliance with all timely contracted and regulatory filing guidelines.

    c) Claim Forwarding: Confirm compliance with timeliness guidelines for all redirect Emergency service and care claims.

    d) Written Explanation: Confirm the appropriate written explanation for any denied, adjusted, contested claim was sent to the provider.

    e) Rescinded or Change Authorized Service: Confirm compliance with Rule 1300.71(a)(8)(T) regarding rescinding or changing an authorized service.

5. Audit criteria for all PDR Claims

    a) PDR Date of Receipt: Confirm the DOR is entered into system correctly per Rule 1300.71.38 (a) (3).

b) PDR Acknowledgement: Confirm the PDR is compliant with for acknowledgement per Rule 1300.71.38 (e).

c) PDR Turnaround Time: Confirm the PDR process time is compliant with Rule 1300.71.38 (f)

d) Claim Payment: Confirm the claim payment and written determination letter are in compliance with Rule 1300.71.38 (g).

e) Interest Calculation: Confirm that the appropriate interest and penalties were paid when applicable.

V. ATTACHMENTS:

A. Claims Data Report Field Requirements

VI. REFERENCES:

A. Title 28, CCR, Section 1300.71: Claims Settlement Practices

B. Title 28, CCR, Section 1300.71.38: Fast, Fair and Cost-Effective Dispute Resolution Mechanism

VII. TAGS: Claims, Audits, Internal Claims Audit, AB 1455

VIII. REVISION HISTORY:

Date	Modification (Reviewed and/or Revised)
11/02/2018	Revised Document
10/18/13	Revised Document
11/12/2012	Reviewed Document
12/23/2011	Reviewed Document
10/01/2010	Original Document

Sharp Health Plan Claims Data Audit Report Requirements

Field Name/ Description	Description
Claim Number	The unique applicable claim/form/document number to identify a claim.
Date of Service	First date of service identified on claim. (Per Rule 1300.71(a)(7), "Date of Service," for the purposes of evaluating claims submission and payment requirements under these regulations, means: (A) For outpatient services and all emergency services and care: the date upon which the provider delivered separately billable health care services to the enrollee. (B) For inpatient services: the date upon which the enrollee was discharged from the inpatient facility. However, a plan and a plan's capitated provider, at a minimum, shall accept separately billable claims for inpatient services on at least a bi-weekly basis.)
Date Received	Date claim received by MSO, IPA or Hospital. (Per Rule 1300.71(a)(6), "Date of receipt" means the working day when a claim, by physical or electronic means, is first delivered to either the plan's specified claims payment office, post office box, or designated claims processor or to the plan's capitated provider for that claim. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code section 641. In the situation where a claim is sent to the incorrect party, the "date of receipt" shall be the working day when the claim, by physical or electronic means, is first delivered to the correct party responsible for adjudicating the claim.)
Amount Billed	The amount billed by the provider of service.
Check Number	Check number issued for claim payment.
Check Date	Date check generated.
Payment Date	Date check mailed or ACH/EFT payment is initiated to the financial institution. If the claim was totally denied, please input denial date in this field. (Per Rule 1300.71(a)(5), "Date of payment" means the date of postmark or electronic mark accurately setting forth the date when the payment was electronically transmitted or deposited in the U.S. Mail or another mail or delivery service, correctly addressed to the claimant's office or other address of record. To the extent that a postmark or electronic mark is unavailable to confirm the date of payment, the Department may consider, when auditing claims payment compliance, the date the check is printed and the date the check is presented for payment. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code Section 641.)
Amount Paid.	Amount paid for claim, NOT the check amount which may include multiple claims.
Withhold Amount	Amount withheld under a risk-sharing agreement.
Amount of Interest Paid	Amount of interest paid.
Date Interest Paid	If interest is paid separately. (Definition to be consistent with payment date)
Check Number for Interest Paid	Check number for interest payment, if paid separately
Claim Status	Paid, pended, denied, adjusted, processed but waiting for the check to be mailed, and etc.
Denied Code	Denial Code/Indicator representing denial reason, including denials based on claims filing deadline.
Line of Business	Such as Commercial, Medicare, Medicaid, Healthy families, etc. or Code/Indicator to reflect the line of business that the claim belongs to.
ER or non-ER	Indicator for emergency (ER) or non-ER claims.
Provider Name	Name of provider rendering service.
Provider Status	Contracted provider or non-contracted provider.
Provider Type	Identify facility claim or professional claim and whether medical or dental, vision, pharmacy, mental health, or surgical center.
Service Type	Inpatient, outpatient, etc.