| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-02022 (03/2024) |  | **STATE OF WISCONSIN** |
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| **CLAIMS AUDIT REPORT FOR MANAGED LONG-TERM CARE MCOS** |
| **Purpose**: | Ensure that claim payments are for eligible and enrolled members, to contracted providers for authorized services at the contracted rate. |
| **Requirement:** | The report on claims testing is a required submission with the annual Managed Care Organization (MCO) financial audit report performed by an independent certified public accountant (CPA) firm to demonstrate the results of required claims sample testing. The report provides a count of the number of records in the sample that satisfy the testing requirement. Each row of the 16 test criteria identified in the table below must add up to the total sample selected. |
| **Minimum Sample Size:****Residential Services:**  | Auditors are required to select a minimum sample of at least 70 service claims processing records for each contracted managed long-term care (LTC) program. A separate sample and report must be completed for each contracted LTC program. Please see the MCO contract for a definition of the services included in the LTC benefit package. Claims processing testing of MCOs contracted to provide acute and primary (A&P) services in addition to the LTC benefit package must include at least fifteen additional claims of A&P services for a minimum sample of at least 85 records. Claims should be selected from all claims and not restricted to paid claims. Notes clarifying auditor issues, N/A responses, and unsatisfied criteria should be included in the space provided.Effective on 2/1/2021 MCOs were required to combine room and board (R&B) with the cost of care in encounter reporting if they contract with vendors and pay claims for the services separately. The DHS contract does not dictate how they contract with their residential vendors but encounter reporting must be the total paid for both components. If contracted and paid for separately the auditor will need to combine the R&B and cost of care components to match to the encountered amount. |
| Description of Elements Required in Sample Testing |
| 1. Claim Exists for Review: The auditor obtained and reviewed an image or electronic record of the original claim submitted by the service provider.
2. Claim Received Date Verified: The claim receipt date was documented.
3. Timely Claim Processing: The claim was timely filed by the service provider in accordance with the MCO’s established timely filing requirements and the MCO’s claims processing timing meets the requirements defined in the MCO contract with DHS.
4. Member Eligibility Verified: The auditor verified the member was eligible for the program on the date of service according to the ForwardHealth system.
5. Member Enrollment in the MCO Verified: The member was enrolled in the MCO on the date of the service based on the Benefit Enrollment and Maintenance (834) transactions report.
6. Legal Liability and/or Coordination of Benefits: The existence of another payer with primary liability for the claim expense is identified and either paid as the primary insurer or the MCO is subrogating to recover paid claims e.g., workman’s compensation, lawsuit, long-term care insurance policy, Medicare or other insurance available for specific services.
7. EOB Available and Reviewed: A copy of the explanation of benefits (EOB) is produced to describe the results of claims processing and provided to the service providers. An image or electronic copy of the EOB should be obtained and reviewed against the claims by the auditor.
8. Service is in the Benefit Package: The service identified in the claim and EOB is in the benefit package described in the MCO contract with DHS. If the service is not in the benefit package the auditor should verify the encounter was properly reported as a non-covered service to achieve a “satisfied” result for that record through query of the encounter record from the DHS data warehouse.
9. Provider Contracted to Provide the Services Verified: The provider contract is reviewed and the service provided is identified in the contract.
10. Provider Contracted Rate Verified: The contracted unit rate identified in the provider contract is verified against the claims processing unit rate. If the contracted rate is the Medical Assistance (MA) rate the amount paid should be verified against the MA fee schedule for the date of service.
11. Service/Units Authorized: The authorization for the member served is reviewed and the service and units are authorized. Multi-month authorizations may require the auditor review total units across all months to ensure the units paid did not exceed the total authorized units. MCOs authorize most LTC services but may not authorize all A&P services for those members served in the fully integrated Family Care Partnership (FCP) or Program of All-inclusive Care for the Elderly (PACE) programs.
12. Denial/Payment Validated: The claims processing of paid and denied services are valid based on the auditor review.
13. Claim Paid at Contracted Rate: Confirm waiver services are paid at the contracted rate and card services are paid at or below the MA fee for service rate. Services included in the LTC benefit package that do not have an MA fee for service rate are known as waiver services (see MCO contract with DHS for a description). Services with an MA fee for service rate are referred to as card services. MCOs negotiate rates with providers for waiver services and document the negotiated rates in the provider contract with that vendor. The claim should be paid at the contracted unit rate, defined by time or another unit basis.
14. Payment Recalculates: The calculation of authorized claimed units times the contracted unit rate or MA rate in effect for the date of service agrees with the actual claim payment.
15. Units Denied or Rejected Verified: Units not paid or rejected are reviewed for accurate processing. If the claim in the sample did not include denied or rejected services the review for them receives an N/A.
16. Claim and EOB Elements Trace to DHS Encounter Record: Verify that claims processing details agree with the DHS encounter record stored in the DHS data warehouse. This test must not be done on a file stored on the MCO’s server for encounter reporting submissions.

**Complete next page to document the results of the claims sample testing and submit it with the required audit reports.** |
| MCO Name      | For the Year Ending      |
| CPA Firm Name      |
| **Note:** Minimum of 70 LTC- ALL MCOs. FCP and PACE programs must also include a minimum of 15 acute and primary records for a minimum total of 85 records in the sample. |
| Total All Records      | Total Records in Sample (LTC + A&P)      | Number of LTC Records in Sample      | Number of Acute and Primary Records in Sample      |
| **Audit Report Element** | Count of Records Reviewed |
| Satisfied | Unsatisfied | N/A |
| 1. Claim Exists and Reviewed |       |       |       |
| 2. Claim Received Date Verified |       |       |       |
| 3. Timely Claim Processing-Receipt vs. Processed Dates Meet MCO Timely Filing and DHS Contract Requirement for Claims Processing |       |       |       |
| 4. Member Eligibility Verified |       |       |       |
| 5. Member Enrollment in MCO Verified |       |       |       |
| 6. Legal Liability Identified for Coordination of Benefits |       |       |       |
| 7. EOB Available and Reviewed |       |       |       |
| 8. Service is in the Benefit Package |       |       |       |
| 9. Provider Contracted to Provide the Services Verified |       |       |       |
| 10. Provider Contracted Rate Verified |       |       |       |
| 11. Service/ Units Authorized |       |       |       |
| 12. Denial / Payment Validated |       |       |       |
| 13. Claim Paid at Contracted Rate if Waiver, at or below MA Rate if Card Service after Coordination of Benefits for Other Insurance Processing |       |       |       |
| 14. Payment Recalculates |       |       |       |
| 15. Units Denied or Rejected Verified |       |       |       |
| 1. Claim and EOB Elements Trace to DHS Encounter Record
 |       |       |       |
| Auditor notes to clarify identified issues, N/A responses, and unsatisfied criteria:      |