Willis

Employee Benefits Practice – Healthcare Auditing Services

A typical employer spends over $7,000 per employee per year for healthcare and that figure is steadily growing – by an average of 10+ percent each year. To help manage this burden, most employers engage insurance companies, third-party administrators and utilization review firms to pay claims accurately, monitor care and help manage ever-increasing costs. These firms are essentially given free access to your checkbook.

How do you know your claims administrator is paying claims accurately? Is your utilization review firm effective? Are they saving you money? Are provider discounts being properly applied?

Willis can help you answer these questions and ensure that the employee and corporate monies entrusted to insurers, third-party administrators and utilization review firms are being properly spent. Willis offers three types of auditing services.

1. Process audit
2. Utilization review process audit
3. Full population claim audit

Process Audit

Process audits are designed to assess a vendor's or insurer's approach to processing claims and handling employee inquiries. The audit answers the question: is the overall structure of the organization, including its systems and processes, likely to fulfill your service, reporting, management and fiduciary requirements?

- Claim data entry controls
- Pricing controls
- Benefit application controls
- Utilization review processes
- Subrogation
- Coordination of benefit processes
- Financial controls

The process audit benchmarks your administrator's procedures against industry best practices to uncover problems. Finally, we recommend corrective measures.

Utilization Review Process Audit

Utilization review, case management and disease management processes are all designed to address the six percent of the employee population that is generally responsible for over 60 percent of your health plan's total costs. These processes are paramount in controlling health plan costs as well as ensuring the proper level of service and effective interventions for your employees.

Willis' actuarial team audit involves detailed clinical review of actual pre-certification, case management and disease management cases. The audit examines key questions.

- Are the cases that would benefit from case and disease management being identified?
- Are clinical support resources intervening to improve clinical outcomes and reduce costs?
- Are appropriate data and clinical support processes in place to improve care in a collaborative fashion?
- Are files properly documented?
- Are quality control protocols and appropriateness screens up to date and effective?

Full Population Claim Audit

Our full population claim audit helps employers identify and recoup overpayments. Unlike a traditional claims payment audit that samples only a small number of randomly selected claims, our systematic claims payment audit covers the entire population of claims payments for the most recent 18-24 months.

The population audit identifies overpayment errors due to:

- Duplicate payments
- Eligibility issues
- Covered benefits inappropriately applied
- Unauthorized services
- Incorrectly applied fee schedules
- Other systematic and random errors

As a follow-up to the audit, our experts work with claims processors to track and report the progress made in recovering payments and refunding monies due to you.

With so much at stake as a plan sponsor, you need to be sure that the best possible processes are in place to address unnecessary utilization and to help ensure high-quality, appropriate care. Willis' auditing services are available to assist you with this important task.