GBS Medical Claims Audit

Employer Groups have a fiduciary responsibility to ensure that benefits are adequately administered and in compliance with the ERISA rules of benefit administration by conducting thorough oversight of their third-party claims administrator(s). Gallagher's claim audits provide our clients the **peace of mind** that their third-party claims administrator, as the designated claims processing agent and co-fiduciary, is processing claims in a **timely and compliant** manner.

Gallagher independent audits help evaluate your third-party claims administrator's performance in accordance with the plan benefits and applicable regulations. Every project includes a Project Manager, an Executive Sponsor, and a Claims Auditor. Gallagher alleviates the burden of conducting an audit by facilitating the claims audit from beginning to end and providing a comprehensive written report of findings and recommendations.

Gallagher has assembled a staff of uniquely and highly qualified team members with extensive industry experience and a reputation of excellence with Gallagher's clients.

Types Of Audits

Gallagher can perform custom claim audits that suit the specific needs of our clients. The three most common types of claim audits are:

STRATIFIED
An audit of a stratified random sample of claims based on the claim paid amount.

FOCUSED
An audit focusing on certain aspects of claim processing such as high dollar claims, specific services, or benefits.

HYBRID
An audit for clients that need to conduct both a random sampling and a focused audit for a more detailed review of the overall paid dollars.

For all audit types, our auditors will thoroughly review each selected claim by conducting a webinar session or directly accessing the third-party administrator's system(s) where your company's claims are processed and conducting a detailed review of the claims to ensure accurate adjudication.

Claims End to End Review

BENEFIT ACCURACY

Review claim samples for application of the plan benefits and cost sharing as outlined in the Summary of Benefit (SPD) and provisions of ERISA, Title 1, Part 7 regulations.

CLAIMS TIMELINESS ACCURACY

Review claim processing timeliness in accordance with the contractual Performance Guarantees (PGs) and industry standards.

CLAIMS PROCESSING ACCURACY

Conduct audits to determine the accuracy of claims and payment processing.

REIMBURSEMENT ACCURACY

Review paid claims to ensure accurate claim payment per the In-Network contractual provisions (INN) or the Out-of-Network (OON) reimbursement rates.

Common Findings

Some of our common claim audit findings include but are not limited to:

- Claims paid without a valid authorization on file resulting in an overpayment.
- Claims paid when the patient was no longer eligible for the dates of services rendered, resulting in an overpayment.
- Duplicate claims paid in error resulting in an overpayment.
- Configuration issues resulting in overpayments and underpayments (e.g. incorrect provider rate, incorrect member cost share).
- Item or service paid that is not a covered benefit.
- Coordination of Benefits claims paid incorrectly resulting in an overpayment or underpayment.

Gallagher

Contact us for more information!

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