

HEALTH CARRIER CLAIM AUDIT GUIDELINES MODEL ACT

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Section 1. Title

This Act shall be known and may be cited as the Health Carrier Claim Audit Guidelines Model Act.

Section 2. Purpose and Intent

The purpose of this Act is to provide for the reasonable standardization of statewide claim audit guidelines of health care bills for health care services and their reimbursement by health carriers, preferred provider organizations, third party administrators, or any other health benefit plan to determine whether data in a health care record of an institutional provider is supported by services listed on the claim for payment of an insured or an institutional provider. It is further the purpose of this Act to alleviate the potential conflict of the audit with medical uses of the health record and to reduce the cost of conducting a necessary audit.

Drafting Note: States should consider coordinating with other state agencies and amending other state laws to provide for sanctions against institutional providers that violate provisions of state insurance law.

Section 3. Definitions

For purposes of this Act:

- A. “Ambulatory surgical center” means an establishment with an organized medical staff of physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, with continuous physician services and registered professional nursing services available whenever a patient is in the center, that does not provide services or other accommodations for patients to stay overnight, and that offers the following services whenever a patient is in the center: drug services as needed for medical operations and procedures performed, provisions for physical and emotional well-being of patients, provision of emergency services, organized administrative structure and administrative, statistical and medical records.
- B. “Claim audit” means a process to determine whether data in a claimant’s medical record for health care documents health care services listed on a claim for payment submitted to a carrier. Claim audit does not mean a review of the medical necessity of the services provided, or the reasonableness of charges for the services.

- C. “Claimant” means an insured or enrollee under a health benefit plan who receives surgical or inpatient care, the costs of which are submitted to a carrier for payment, either by the claimant or by another on the claimant’s behalf.
- D. “Final claim” means the final itemized bill from an institutional provider detailing all the charges for which the institutional provider is seeking payment.
- E. “Health benefit plan” means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.
- F. “Health care services” means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.
- G. “Health carrier” or “carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a provider-sponsored organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.
- H. “Institutional provider” means an institution providing health care services in a health care setting, including but not limited to hospitals, other licensed inpatient centers, ambulatory surgical centers, skilled nursing centers and residential treatment centers.
- I. “Medical record” means a compilation of charts, records, reports, documents, and other memoranda maintained by an institutional provider wherever located, to record or indicate the past or present condition, sickness or disease, and treatment rendered, physical or mental, of a patient.
- J. “Qualified claim auditor” means a person employed by a corporation or firm that is recognized as competent to perform or coordinate claim audits and that has explicit policies and procedures protecting the confidentiality and disposal of all patient information in its possession.
- K. “Underbilled charges” means the volume of services indicated on a claim is less than the volume identified in the institutional provider’s medical documentation; also known as undercharges.
- L. “Unbilled charges” means charges or services provided for and not billed.
- M. “Unsupported charges” or “undocumented charges” means the volume of services indicated on a claim exceeds the total volume identified in the institutional provider’s medical documentation; also known as overcharges.

Section 4. Applicability and Scope

This Act shall apply to all health carriers. The institutional provider accepting assignment of benefits of an insured shall be responsible for the conduct and results of the claim audit whether conducted by an employee or by contract with another firm. The institutional provider and carrier shall:

- A. Exercise proper supervision of the process to ensure that the audit is conducted in accordance with the requirements of this Act;
- B. Be aware of the actions being undertaken by the auditor in connection with the claim audit and its related activities; and
- C. Take prompt remedial action if inappropriate behavior by the auditor is discovered.

Section 5. Qualifications of Auditors and Institutional Provider Audit Coordinators

- A. All persons performing claim audits as well as persons functioning as institutional provider audit coordinators shall have appropriate knowledge, experience, and expertise in health care including, but not limited to, the following areas:
 - (1) Format and content of the health record as well as other forms of medical and clinical documentation;
 - (2) Generally accepted auditing principles and practices as they apply to claim audits;
 - (3) Billing claims forms, including the UB92 and the HCFA 1500, and charging and billing procedures;
 - (4) All state and federal regulations concerning the use, disclosure and confidentiality of patient records;
 - (5) Specific critical care units, specialty area, and ancillary units involved in a particular audit; and
 - (6) Coding, including ICD-9, CPT, HCPCS and medical terminology.
- B. Institutional providers or carriers that encounter audit personnel who do not meet these qualifications shall immediately contact the auditor's firm or sponsoring party.
- C. Audit personnel shall conduct themselves in a professional manner and adhere to ethical standards and confidentiality requirements, and shall remain objective. They shall completely document their findings and problems.
- D. All unsupported, unbilled or underbilled charges identified in the course of an audit shall be documented in the audit report by the auditor.

- E. Individual audit personnel shall not be placed in a situation through their remuneration, benefits, contingency fees or other instructions that would call their findings into question. Compensation of audit personnel shall be structured so that it does not create incentives to produce questionable audit findings. Institutional providers or carriers that encounter an individual who appears to have a conflict of interest shall contact the appropriate management of the sponsoring organization.

Section 6. Notification of Audit

- A. Carriers and institutional providers shall make every effort to resolve claim inquiries directly. The name, contact telephone number and facsimile number of each carrier or institutional provider representative shall be exchanged no later than at the time of billing for an institutional provider and the point of first inquiry by a carrier.

Drafting Note: Subsection A states that resolution of questionable charges may be resolved telephonically. It often happens that an auditor representing a carrier must travel many miles and incur hotel, plane, and other expenses in order to perform an on-site audit. If the institutional provider is unable to resolve charges at the time of audit, resolution by telephone or fax saves time and money for the carrier and removes the incentive to postpone audit completion for the institutional provider.

- B. If a satisfactory resolution of the questions surrounding the bill is not achieved by carrier and institutional provider representatives, then a full audit process may be initiated by the carrier.
- C. Claim audits require documentation from or review of a patient's health record and other similar medical or clinical documentation. Health records exist primarily to ensure continuity of care for a patient; therefore, the use of a patient's record for an audit must be secondary to its use in patient care.
- D. All carrier claim audits shall begin with a notification to the institutional provider of an intent to audit. Notification to the institutional provider by the qualified claim auditor shall occur within six (6) months following receipt of the final claim for payment by the carrier. Once notified, the institutional provider shall respond to the qualified claim auditor within one month with a schedule for the conduct of the audit. The qualified auditor shall complete the audit within twelve (12) months of receipt of the final claim by the carrier. When there is a substantial and continuing relationship between a carrier and an institutional provider, this relationship may warrant a notification, response and audit schedule other than that outlined in this Act. Each party shall make reasonable provisions to accommodate circumstances in which the schedule specified cannot be met by the other party. The carrier will not request nor accept audits after twelve (12) months from the date of receipt of the final claim.
- E. All claim audits shall be conducted on the premises of the institutional provider ("on-site") except in instances where an institutional provider chooses to allow individual, reasonable requests for off-site audits.
- F. All requests for claim audits, whether telephonically, electronically or written, shall include the following information:
 - (1) The basis of the carrier's intent to conduct an audit on a particular bill or group of bills. When the intent is to audit only specific charges or portions of the bills, this information should be included in the notification request;

- (2) Name of the patient;
 - (3) Admit and discharge dates;
 - (4) Name of the auditor and the name of the audit firm;
 - (5) Medical record number and institutional provider's patient account number; and
 - (6) Whom to contact to discuss the request and scheduled audit.
- G. Institutional providers that cannot accommodate an audit request that conforms to these guidelines shall explain why the request cannot be met in a reasonable period of time and shall be provided with a reasonable period to reschedule the audit. Auditors shall group audits to increase efficiency whenever possible.
- H. It shall be the responsibility of the institutional provider seeking payment of a claim or reimbursement under a managed care contract to notify the auditor prior to the scheduled date of audit, if the auditor will have problems accessing records. As a condition for payment, the institutional provider shall be responsible for supplying the auditor with any information that could affect the efficiency of the audit once the auditor is on-site.

Section 7. Institutional Provider Audit Coordinators

- A. Institutional providers shall designate an individual to coordinate all claim audit activities. An audit coordinator shall have the same qualifications as required for an auditor pursuant to Section 5 of this Act. The duties of an audit coordinator include, but are not limited to, the coordination of the following areas:
- (1) Scheduling an audit;
 - (2) Advising other institutional provider personnel and departments of a pending audit;
 - (3) Ensuring that the condition of admission statement is part of the medical record;
 - (4) Verifying that the auditor is an authorized representative of the carrier;
 - (5) Gathering the necessary documents for the audit;
 - (6) Coordinating auditor requests for information, space in which to conduct an audit, and access to records and institutional provider personnel;
 - (7) Orienting auditors to hospital/surgery center audit procedures, record documentation conventions, and billing practices;
 - (8) Acting as a liaison between the auditor and other institutional provider personnel;
 - (9) Conducting an exit interview with the auditor to answer questions and review audit findings;

- (10) Reviewing the auditor's final written report and following up on any charges still in dispute;
- (11) Arranging for payment as applicable; and
- (12) Arranging for any required adjustment to bills or refunds.

Section 8. Conditions and Scheduling of Audits

A. In order to have a fair, efficient, and effective audit process, institutional providers and carrier auditors shall adhere to the following requirements:

- (1) Whatever the original intended purpose of the claim audit, all parties shall agree to recognize, record or present any identified unsupported, unbilled or underbilled charges discovered by the audit parties;
- (2) The scheduling of an audit shall not preclude late billing;
- (3) The parties involved in the audit shall mutually agree to set and adhere to a predetermined time frame for the resolution of any discrepancies, questions or errors that surface in the audit;
- (4) An exit conference and a written report shall be part of each audit; if the institutional provider waives the exit conference, the auditor shall note that action in the written report. The specific content of the final report shall be restricted to those parties involved in the audit;
- (5) The institutional provider shall be afforded sixty (60) days to contest all findings, after which the audit shall be considered final;
- (6) Once both parties agree to the audit findings, audit results are final;
- (7) All personnel involved shall maintain a professional, courteous manner and resolve all misunderstandings amicably; and
- (8) At times, the audit will note ongoing problems either with the billing or documentation process. When this situation occurs, and it cannot be corrected as part of the exit process, the management of the institutional provider and carrier shall be contacted to apprise them of the situation. The institutional providers and carriers shall take appropriate steps to resolve the identified problem. Parties to an audit shall eliminate ongoing problems or questions whenever possible as part of the audit process.

Section 9. Confidentiality and Authorizations

- A. All parties to a claim audit shall comply with all federal and state laws and any contractual agreements regarding the confidentiality of patient information.
- B. The release of medical records requires authorization from the patient. An authorization shall be provided for in the condition of admission or equivalent statement procured by the institutional provider upon admission of the patient. If no such statement is obtained, an authorization for a claim audit is required. The authorization need not be specific to the insurer or auditor conducting the audit.

- C. The authorization shall be obtained by the claim audit firm or institutional provider and shall include at least the following information:
 - (1) The name of the carrier and, if applicable, the name of the audit firm that is to receive the information;
 - (2) The name of the institution that is to release the information;
 - (3) The full name, birth date, and address of the patient whose records are to be released;
 - (4) The extent or nature of the information to be released, with inclusive dates of treatment;
 - (5) The institutional provider's patient account number if included on the bill; and
 - (6) The signature of the patient or his legal representative and the date the consent is signed.
- D. A patient's assignment of benefits shall include a presumption of authorization to review records.
- E. The audit coordinator or medical records representative shall confirm for the audit representative that a condition of admission statement is available for the particular audit that needs scheduling.
- F. The institutional provider will inform the requestor, on a timely basis, if there are any federal or state laws prohibiting or restricting review of the medical record and if there are institutional confidentiality policies and procedures affecting the review. These institutional confidentiality policies shall not be specifically oriented in order to delay an external audit.

Section 10. Documentation

- A. Verification of charges shall include the investigation of whether or not:
 - (1) Charges are reported on the bill accurately;
 - (2) Services are documented in medical or other appropriate records as having been rendered to the patient; and
 - (3) Services were delivered by the institution in compliance with the physician's plan of treatment. In appropriate situations, professional staff may provide supplies or follow procedures that are in accordance with established institutional policies, procedures, or professional licensure standards. Many procedures include items that are not specifically documented in a record but are referenced in medical or clinical policies. All those policies shall be reviewed, approved, and documented as required by the Joint Commission on Accreditation of Healthcare Organizations or other accreditation agencies. Policies shall be available for review by the auditor.

- B. The medical record documents clinical data on diagnoses, treatments and outcomes. It is not designed to be a billing document. A patient medical record generally documents pertinent information related to care. The medical record may not back up each individual charge on the patient bill. Other signed documentation for services provided to the patient may exist within the institutional provider's ancillary departments in the form of department treatment logs, daily records, individual service or order tickets, and other documents.
- C. Auditors may have to review a number of other documents to determine valid charges. Auditors must recognize that these sources of information are accepted as reasonable evidence that the services ordered by the physician were actually provided to the patient. Institutional providers must ensure that proper policies and procedures exist to specify what documentation and authorization must be in the health record and in the ancillary records and logs. These procedures document that services have been properly ordered for and delivered to patients. When sources other than the health record are providing documentation, the institutional provider shall notify the auditor and make those sources available to the auditor.

Section 11. Fees and Payments

- A. A health carrier shall make prompt payment of a bill and shall not delay payment for an audit process. Payment on a submitted bill from a third-party carrier shall be based on amounts billed and covered by the patient's health benefit plan.
- B.
 - (1) A payment of ninety-five percent (95%) of the insurance liability shall be an acceptable amount of payment under Subsection A prior to the scheduling of an audit. Based on ninety-five percent (95%) of payment of the insurance liability by the payer, all hospital audit fees shall be waived.
 - (2) A payment of less than ninety-five percent (95%) of the insurance liability is appropriate when state regulations, federal regulations or contractual agreements apply.
 - (3) In no case shall an audit fee exceed \$100.
- C. Audit fees, if required, are to be paid upon commencement of the on-site claim audit. A payment identified in the audit results that is owed to either party by the other, shall be settled by the audit parties within a reasonable period of time not to exceed thirty (30) days after completion of the audit unless the parties agree otherwise.
- D. Photocopying and duplication charges shall not exceed [fifty-cents] per page.

Drafting Note: Parties are entitled to reimbursement of costs for duplication charges. Insert the appropriate monetary amount reflecting the average duplication charges in your state.

Drafting Note: Many carriers have ongoing relationships with institutional providers. If a negative balance exists between the carrier and the institutional provider, that balance may be settled as future claims arise.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1999 Proc. 1st Quarter 8, 9, 537, 544, 596-601 (adopted).

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This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state’s activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column or Related State Activity column based on the definitions listed below. The NAIC’s interpretation may or may not be shared by the individual states or by interested readers.

This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.

HEALTH CARRIER CLAIM AUDIT GUIDELINES MODEL ACT

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KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

RELATED STATE ACTIVITY: Examples of Related State Activity include but are not limited to: older versions of the NAIC model, statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column **only** (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner**.

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Alabama	NO CURRENT ACTIVITY	
Alaska	NO CURRENT ACTIVITY	
American Samoa	NO CURRENT ACTIVITY	
Arizona	NO CURRENT ACTIVITY	
Arkansas	NO CURRENT ACTIVITY	
California	NO CURRENT ACTIVITY	
Colorado	NO CURRENT ACTIVITY	
Connecticut	NO CURRENT ACTIVITY	
Delaware	NO CURRENT ACTIVITY	
District of Columbia	NO CURRENT ACTIVITY	
Florida	NO CURRENT ACTIVITY	
Georgia	NO CURRENT ACTIVITY	
Guam	NO CURRENT ACTIVITY	
Hawaii	NO CURRENT ACTIVITY	

HEALTH CARRIER CLAIM AUDIT GUIDELINES MODEL ACT

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Idaho	NO CURRENT ACTIVITY	
Illinois	NO CURRENT ACTIVITY	
Indiana	NO CURRENT ACTIVITY	
Iowa	NO CURRENT ACTIVITY	
Kansas	NO CURRENT ACTIVITY	
Kentucky	NO CURRENT ACTIVITY	
Louisiana	LA. ADMIN. CODE 37:XIII.2501 to 37:XIII.2519 (Regulation 49) (1994).	
Maine	NO CURRENT ACTIVITY	
Maryland	NO CURRENT ACTIVITY	
Massachusetts	NO CURRENT ACTIVITY	
Michigan	NO CURRENT ACTIVITY	
Minnesota		MINN. STAT. ANN. § 62L.16 (1992/1993).
Mississippi	NO CURRENT ACTIVITY	
Missouri	NO CURRENT ACTIVITY	
Montana	NO CURRENT ACTIVITY	
Nebraska	NO CURRENT ACTIVITY	
Nevada	NO CURRENT ACTIVITY	
New Hampshire	NO CURRENT ACTIVITY	
New Jersey		N.J. STAT. ANN. §§ 17B:30-30 to 17B:30-31 (1999).
New Mexico	NO CURRENT ACTIVITY	
New York	NO CURRENT ACTIVITY	

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
North Carolina	NO CURRENT ACTIVITY	
North Dakota	NO CURRENT ACTIVITY	
Northern Marianas	NO CURRENT ACTIVITY	
Ohio	NO CURRENT ACTIVITY	
Oklahoma	NO CURRENT ACTIVITY	
Oregon	NO CURRENT ACTIVITY	
Pennsylvania	NO CURRENT ACTIVITY	
Puerto Rico	NO CURRENT ACTIVITY	
Rhode Island	NO CURRENT ACTIVITY	
South Carolina	NO CURRENT ACTIVITY	
South Dakota	NO CURRENT ACTIVITY	
Tennessee	NO CURRENT ACTIVITY	
Texas		28 TEX. ADMIN. CODE §§ 21.2801 to 21.2826 (2000/2014).
Utah	NO CURRENT ACTIVITY	
Vermont	NO CURRENT ACTIVITY	
Virgin Islands	NO CURRENT ACTIVITY	
Virginia	NO CURRENT ACTIVITY	
Washington	NO CURRENT ACTIVITY	
West Virginia	NO CURRENT ACTIVITY	
Wisconsin	NO CURRENT ACTIVITY	
Wyoming	NO CURRENT ACTIVITY	

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Proceedings Citations

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At the beginning of 1998 a new working group was formed to deal with a charge to establish health insurance claim audit guidelines. **1998 Proc. 2nd Quarter II 829.**

The issue was raised in one state because carriers had problems verifying hospital bills. There were no standards of practice as to when an audit was appropriate, what type of notice should be served, confidentiality issues, charges for the audits, who could perform the audits, and findings by the auditor. Once a law and regulation were in place there, the situation became better and all sides seemed to work fairly well under the guidelines. **1998 Proc. 3rd Quarter 660.**

A representative from a managed care organization noted that in the managed care environment there were procedures in place within provider contracts that address audit situations. A regulator agreed that the claim audit guidelines mostly impacted fee-for-service, discounted fee-for-service and diagnostic coding situations. **1998 Proc. 3rd Quarter 660.**

When the parent committee considered the model for adoption, the working group chair said the model act was designed to provide a methodology for statewide claim audit processes for institutional providers taking assignment of indemnity claims. In order for there to be effective enforcement, the state insurance department would need to coordinate with other state agencies and amend other state laws regarding standards for institutional providers. The model required institutional providers accepting assignment to comply with the act if they wanted to receive full payment for their services. **1999 Proc. 1st Quarter 544.**

Section 1. Title

Section 2. Purpose and Intent

A number of industry organizations developed billing audit guidelines in the early 1990s to combat fraud. **1998 Proc. 3rd Quarter 660.**

There was a brief discussion by the working group that insurance commissioners only have jurisdiction to regulate carriers and not providers. The working group agreed to add a drafting note regarding coordinating with other state laws to sanction institutional providers who violate the provisions of insurance laws. **1998 Proc. 4th Quarter II 750.**

Section 3. Definitions

B. After receiving comments on the first draft, the word “billing” was changed to “claim” in the definitions and many places throughout the model, where appropriate. **1998 Proc. 4th Quarter II 749.**

D. During a discussion of Section 6D and the appropriate timing for completing an audit, the solution agreed upon by the working group was to define a final claim as the final itemized bill, which would start the clock running. **1998 Proc. 4th Quarter II 749.**

H. In response to comments received on the first draft, “provider” was redefined as “institutional provider.” **1998 Proc. 4th Quarter II 749.**

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Section 4. Applicability and Scope

Staff cautioned that the model would need to be narrowly drafted so that it did not purport to regulate providers, only insurance entities over which the departments of insurance had jurisdiction. **1998 Proc. 3rd Quarter 660.**

Section 5. Qualifications of Auditors and Institutional Provider Audit Coordinators

Section 6. Notice of Audit

D. A regulator questioned what was meant by “final claim” in Subsection D. She wondered whether that meant a complete claim submission, or how long in the process it took to get to a final claim. **1998 Proc. 4th Quarter II 749.**

Discussion turned to the question of what is a reasonable period of time for an insurance company to say it would perform an audit. The first draft of the model provided for four months. A national billing guideline was six months and an interested party requested the number be changed to 12 months. She said that with the advent of electronic billing, bills tended to come in bits and pieces and it might be many months before all the pieces of the bill arrived at the insurance carrier. After all the pieces arrived, the carrier would require an itemized bill which could take up to four months to obtain. The chair suggested that the definition of final claim could be tied to the itemized bill, at which time the clock would start running on the audit process. The working group agreed with that approach. **1998 Proc. 4th Quarter II 749.**

Section 7. Institutional Provider Audit Coordinators

Section 8. Conditions and Scheduling of Audits

Section 9. Confidentiality and Authorizations

C. The working group agreed that if the patient account number was included on the bill, it would be a requirement in the model act. **1998 Proc. 4th Quarter II 749.**

Staff was directed to review the signature requirements of the Health Information Privacy Model Act to make sure there were not conflicting requirements regarding signatures on an audit. The working group agreed it did not want to require an entire new set of signatures on an audit. **1998 Proc. 4th Quarter II 750.**

Section 10. Documentation

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Section 11. Fees and Payments

B. The first draft of the model provided for a \$100 fee to be paid by the auditor to the institution. The chair sought specific comments on the appropriateness of the amount of that fee. In his state hospitals had been charging several thousand dollars just to allow an auditor to walk in the door. By guaranteeing the right to an audit at a reasonable price, insurers were willing to pay claims knowing that they could obtain any overages back from the hospital after an audit. **1998 Proc. 3rd Quarter 660.**

An interested party said that hospital audit fees had become a problem. Hospitals were charging what some considered excessive fees when a carrier conducted an audit. She compared the situation to a consumer paying a credit card company to fix an incorrect bill. She also related that hospitals used scheduling as a way to make auditing a problem; for example, only allowing audits on Monday, Wednesday and Friday. **1998 Proc. 4th Quarter II 749.**

The first draft spoke of an initial payment of the bill based on the historic error rate. An interested party requested that this requirement be deleted from the model. Her experience was that developing the information necessary to arrive at that figure was not worth the trouble, and she recommended a flat percentage of 95%. As long as the carrier paid 95% of billed charges, there would be no audit fees. If the carrier paid less than 95% of the billed charges, a \$100 audit fee could be charged. The working group agreed to that change. **1998 Proc. 4th Quarter II 749.**

D. A regulator asked if there was room to offset into the next claim period when there was an on-going relationship. For example, if a carrier had an on-going relationship with a hospital, and there was a negative balance, that amount could be taken care of as future claims arose. She suggested adding a drafting note to Section 11 regarding offset, and the working group agreed. **1998 Proc. 4th Quarter II 749.**

Chronological Summary of Actions

June 1999: Model adopted.

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