VENDOR AUDIT LETTER TEMPLATE

Date

Mr/Ms. Vendor Contact Name
Title
Company Name
Company Address
City, State Zip

Dear Mr/Ms.:

As part of our Vendor Management Program, (Name) Health Plan performs oversight of all functions which have been delegated to (Vendor Name). In preparation for this year’s audit, we are requesting information for the period (Date). This information includes data from (Claims, Credentialing, Customer Service, Compliance, Finance, Provider Relations/Network Development, Quality Management, and Utilization Management). This audit will be handled (remotely, on site); please prepare binders, tabbed by topic. If applicable, 1) the claims information binders should be separate from all other sections, 2) Medicare information must be provided separately from all other lines of business for each section. Please create two copies of each binder. The details of the audit are listed as follows:

CLAIMS

The following information is needed for the Claims Audit:

1. A claims run for claims processed for the time period (Date). This should include:
   i. Par and non par claims
   ii. Clean claims and unclean claims
   iii. Denied and paid claims

Please forward to my attention, via CD-Rom, the claims data. (Name) will then select a sample of 1% of claims processed or a minimum of 50 claims (25 Medicare and 25 Medicaid), which we will send to you via email. After we notify you of our sample selection, promptly forward to us the following:

a. Hardcopy of the claim (the claim must have vendor’s received date stamped on the claim)
b. Screen print of the claim from your claims system and the screen print(s) must contain the following:
   i. Date Claim Received
   ii. Date Paid
   iii. Check Number
iv. Provider Name
v. Provider status (par vs. non par)
vi. Tax Identification Number/NPI
vii. Procedure code/Revenue Codes
viii. Diagnosis Codes
ix. Amount Paid
x. Denial code
xi. Type of claim (clean vs. unclean)

c. A fee schedule of the claims paid included in the sample
d. Copies of the Explanation of Payment and cashed checks
e. A list of denial codes and explanation codes presented on the EOB or Remit.
f. All benefit grids in effect during the period in question
g. Authorization screen print for each claim selected
h. Line level payments – Billed Amount, Allowed Amount, Net/Paid Amount

2. All Department of Insurance (DOI) inquiries (claims payment, quality of care, treatment from office staff or provider etc) involving an (Name) member or services provided to an (Name) member. From the total, (Name) shall select a sample and request the following:
   a. A copy of the actual inquiry from the DOI
   b. A copy of the response to the DOI

3. A copy of your claims Policies and Procedures, including the claims reconciliation procedures

When sending over the claim samples, please create three (3) binders-Medical, Hospital and DOI, and include, for each claim being audited, the items requested above. Items c, e, & f need not be duplicated for each claim if the information is the same for all. We will review the claims onsite at (Name), and will then incorporate the feedback in the overall Audit Findings document.

**CREDENTIALING**

(Name) shall randomly select a sample of 5% or 50 files, whichever is less; at a minimum there will be at least 20 provider files selected (10 credentialing and 10 re-credentialing) from a provider listing from your last cycle. Please email the listing and mail copies of the selected files to my attention.

1. Credentialing and recredentialing policies and procedures (should include process for verification of participating provider credentials)
2. Confidentiality Policy
3. Copies of the credentialing committee minutes for providers selected for audit
4. Provider Termination and Appeal policy and procedures
5. If Accredited, copy of certification (i.e. URAC, NCQA or JCAHO)

CUSTOMER SERVICE

The following information is needed for the Customer Service Audit:

1. Member Service Call Log Reports
   a. Indicate if (Name) has dedicated line for calls
   b. Include detail for both mainstream member services number as well as TTY/TDD.
2. Member Services Policies and Procedures (including call triage process, TTY/TDD call handling and call scripts)
3. Abandonment Rate Reports
4. Manuals specific to assisting the Member Service Representatives
5. All Manuals and/or pamphlets that are provided to (Name) members
6. Policies and Procedures on Member Service Quality (i.e. – agents monitoring & observation) as well as any materials currently being used to perform quality on their agents.
7. Evidence of periodic testing of TTY/TDD numbers to ensure lines are working properly (should be done on a monthly basis)
8. Current Training materials, including policies and procedures, for new agent employee training as well as any follow-up training (including call training modules)
9. Complaints taken by Member Service Representatives
10. Copies of fraud issues/concerns along with the outcomes taken by the Member Services department
11. Information regarding retraining provided to new hires and/or member services representatives due to performance deficiencies
12. Template of measurements, weights, and competencies for your quality tool
13. Language capabilities

PROVIDER RELATIONS/NETWORK DEVELOPMENT

The following information is needed for the Provider Relations/Network Development Audit:

1. The process for selecting participating providers, including written policies and procedures used for review and approval of providers
2. Process of identifying network gaps
3. Site visit Policy and Procedures

QUALITY MANAGEMENT

The following information is needed for the Quality Management Audit:
1. Quality Management Plan – Program Description
2. Minutes from your Quality Management Committee ((Name) specific or generic)
3. Updated Policies and Procedures for Complaints, Grievances, and Appeals along with letter templates for all lines of business
4. All Medicare member files for appeals and grievances, including member letters, documentation of the complaint, Acknowledgement letter, Resolution letter and whether it’s an appeal or grievance
5. Documentation to support time frames for standard and expedited appeals
6. Reports with respect to Complaints, Grievances and Appeals Activity for all lines of business including:
   a. Performance Improvement Actions
7. Member Satisfaction Surveys and analysis
8. Any Clinical surveys pertinent to Medicaid, Family Health Plus and Child Health Plus population

**UTILIZATION MANAGEMENT**

The following information is needed for the Utilization Management Audit:

1. UM Policy and Procedure by product
2. Revised, signed and committee approved UM Program Description
3. Revised, signed and committee approved UM Program Evaluation including UM Subcommittee
4. Revised, signed and committee approved UM Work Plan (guiding document)
5. Utilization Metrics (Analysis of data)
6. A copy of the statement for compliance regarding confidentiality
7. Any complaints as outlined in the Quality Management section
8. Reports used to identify those members that may require Case Management
   Random cases will be reviewed to determine appropriateness of care plan development

Additionally, please submit a complete list of clinical and administrative determinations for the following Service Authorization Requests (SARs). Please be sure the list indicates the product line for each member:

   1. Prospective
   2. Concurrent
   3. Retrospective

(Name) will audit a random number of SAR’s to determine the vendor’s adherence to mandated timeframes for processing these requests. For any Medicare denials included in our random sample, we will contact you to obtain the corresponding member files so we may monitor the criteria used as well as any member correspondences.

**COMPLIANCE**

The following information is needed for the Compliance Audit:
1. Fraud & Abuse policy and procedures
2. Training program/materials related to Fraud & Abuse
3. Policies & Procedures for implementing a corrective action plan once a Fraud & Abuse violation has been identified (can refer to both vendor or provider)
4. Description of the reporting path for Compliance/Fraud
5. Investigative reports related to (Name)
6. HIPAA Policy and Procedures
7. HIPAA training materials
8. Process for documenting new employee HIPAA training
9. Policy & Procedures for destruction of PHI
10. Compliance policy and procedures
11. Review of Compliance training program
12. Review of procedures relating to the Ethics Hotline
13. Review of internal audit policy and procedures
14. Internal Audit reports & exception reports
15. Formal report with supporting documentation of all investigations and findings regarding (Name) business
16. Copies of all External Audit findings by Federal and State regulatory agencies and Corrective Action Plans
17. Copies of the Code of Conduct
18. Copies of the Conflict of Interest Form
19. Evidence that the Code of Conduct and Conflict of Interest form were provided to all employees as well as any downstream entities

FINANCE

The following information is needed for the Finance Audit:
1. Policies and Procedures
2. Copy of most recent audited financial statements
3. Certificates of insurance including Liability and Errors of Omission
4. SAE 16 Report (if applicable, formerly SAS 70)

DELIVERABLES

Please use the following address to mail the requested materials:

   Name
   Title
   Health Plan
   Address
Please send the binders and requested files by _______________. Please feel free to contact me at ###-#### if you have any questions or if additional time will be required to complete any of the sections.

Sincerely,

Name
Title
Health Plan