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Performing agreed-upon procedures engagements that address annual claims prompt payment reports as required by the New Jersey administrative code; Statement of position 02-1;

American Institute of Certified Public Accountants. New Jersey Annual Claims Prompt Payment Reports Task Force

STATEMENT OF POSITION 02-1

AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS

May 23, 2002

Performing Agreed-Upon Procedures Engagements That Address Annual Claims Prompt Payment Reports as Required by the New Jersey Administrative Code

Issued by the
Auditing Standards Board

NOTE

This Statement of Position (SOP) represents the recommendations of the AICPA's New Jersey Annual Claims Prompt Payment Reports Task Force regarding the application of Statements on Standards for Attestation Engagements (SSAEs) to agreed-upon procedures engagements performed to comply with the requirements of New Jersey Administrative Code, Title 11, Chapter 22, Subchapter 1 (NJAC 11:22-1 or the Code), which establishes Department of Banking and Insurance (Department) standards for the payment of claims relating to health benefits plans and dental plans and contains requirements for carriers to file certain reports with the Department relating to the timeliness of claims payments and the reasons for denial and late payment of claims in a format prescribed by the Department. The Department has approved the use of the agreed-upon procedures outlined in this SOP to comply with the reporting requirements of the Code. The Auditing Standards Board has found the recommendations in this SOP to be consistent with existing standards covered by Rule 202 of the AICPA Code of Professional Conduct. AICPA members should be aware of and consider these recommendations. If the auditor does not apply these recommendations, the auditor should be prepared to explain how he or she complied with the SSAE provisions addressed by these recommendations.

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Performing Agreed-Upon Procedures Engagements That Address Annual Claims Prompt Payment Reports as Required by the New Jersey Administrative Code

Introduction and Background

1. New Jersey Administrative Code, Title 11, Chapter 22, Subchapter 1 (NJAC 11:22-1 or the Code), establishes Department of Banking and Insurance (Department) standards for the payment of claims relating to health benefits plans and dental plans and contains requirements for carriers to file certain reports with the Department relating to the timeliness of claims payments and the reasons for denial and late payment of claims in a format prescribed by the Department.

2. NJAC 11:22-1 applies to any insurance company, health service corporation, medical service corporation, hospital service corporation, health maintenance organization, dental service corporation, and dental plan organization that issues health benefits plans or dental plans in the state of New Jersey and to any agent, employee, or other representative of such entity that processes claims for such entity.

3. Among other things, the Code requires carriers to report:

    - Quarterly to the Department on the timeliness of claims payments in the format set forth in Appendix A (claims payment exhibit report) of NJAC 11:22-1, and
    - Quarterly and annually on late payments of claims and the reasons for any denials (claims prompt payment report) in the format set forth in Appendix B of NJAC 11:22-1.

4. Furthermore, the Code requires that the annual claims prompt payment report, which is due to be filed with the Department on or before March 31, pursuant to NJAC 11:22-1.9(a), be accompanied by the report of a private auditing firm, which may be a Certified Public Accountant (CPA) or a firm of CPAs. However, for calendar year 2001, the report of the private auditing firm may be filed with the Department on or before July 1, 2002. The Department has specified, in Bulletin No. 02-07, that the work shall be conducted, and the report shall be prepared, in accordance with agreed-upon procedures acceptable to the Department.

Applicability

5. This Statement of Position (SOP) was developed to provide practitioners with guidance on performing agreed-upon procedures engagements that address annual claims prompt payment reports as required by the New Jersey Administrative Code. Practitioners should note that the engagement described in this SOP is designed only to satisfy the requirements of the Code. The procedures, as set forth in this SOP, are not necessarily appropriate for use in any other engagement.

The Code

Definitions

6. The following definitions are reprinted from the Code and are applicable when performing the agreed-upon procedures engagement described in this SOP.

> *Agent*—Any entity, including a subsidiary of a carrier, or an organized delivery system as defined by N.J.S.A. 17:48H-1, with which a carrier has contracted to perform claims processing or claims payment services.
>
> *Carrier*—An insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization authorized to issue health benefits plans in this State and a dental service corporation or dental plan organization authorized to issue dental plans in this State.

Claim—A request by a covered person, a participating health care provider, or a nonparticipating health care provider who has received an assignment of benefits from the covered person, for payment relating to health care services or supplies or dental services or supplies covered under a health benefits plan or dental plan issued by a carrier.

Clean claim—

1. The claim is for a service or supply covered by the health benefits plan or dental plan;
2. The claim is submitted with all the information requested by the carrier on the claim form or in other instructions distributed to the provider or covered person;
3. The person to whom the service or supply was provided was covered by the carrier's health benefits or dental plan on the date of service;
4. The carrier does not reasonably believe that the claim has been submitted fraudulently; and
5. The claim does not require special treatment. For the purposes of this subchapter, special treatment means that unusual claim processing is required to determine whether a service or supply is covered, such as claims involving experimental treatments or newly approved medications. The circumstances requiring special treatment should be documented in the claim file.

Covered person—A person on whose behalf a carrier offering the plan is obligated to pay benefits or provide services pursuant to the health benefits or dental plan.

Covered service or *supply*—A service or supply provided to a covered person under a health benefits or dental plan for which the carrier is obligated to pay benefits or provides services or supplies.

Dental plan—A benefits plan which pays dental expense benefits or provides dental services and supplies and is delivered or issued for delivery in this State by or through any carrier in this State.

Department—The Department of Banking and Insurance.

Health benefits plan—A benefits plan that pays hospital and medical expense benefits or provides hospital and medical services, and is delivered or issued for delivery in this State by or through a carrier. Health benefits plan includes, but is not limited to, Medicare supplement coverage and risk contracts to the extent not otherwise prohibited by Federal law. For the purposes of this chapter, health benefits plan shall not include the following plans, policies or contracts: accident only, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L. 1972, c.70 (N.J.S.A. 39:6A-1 et seq.) or hospital confinement indemnity coverage.

Health care provider or *provider*—An individual or entity which, acting within the scope of its license or certification, provides a covered service or supply as defined by the health benefits or dental plan. Health care provider includes, but is not limited to, a physician, dentist and other health care professional licensed pursuant to Title 45 of the Revised Statutes and a hospital and other health care facilities licensed pursuant to Title 26 of the Revised Statutes.

Reporting Requirements

7. The Code requires a carrier and its agent to remit payment of clean claims pursuant to specified time frames. The Code further requires that if a carrier or its agent denies or disputes a claim, in full or in part, the carrier or its agent must, within a specified time frame, notify both the covered person when he or she will have increased responsibility for payment, and the provider, of the basis for its decision to deny or dispute the claim.

8. The Code requires a carrier to report to the Department quarterly on the timeliness of claims payments in the format prescribed in NJAC 11:22-1, Appendix A, "New Jersey Claims Payment Exhibit." This quarterly report is not required to be subjected to an agreed-upon procedures engagement, nor is

an annual claims payment exhibit report required to be filed with the Department.

9. The Code also requires a carrier to report to the Department on a quarterly and annual basis on the late payment of claims and the reasons for denial of claims in the format prescribed in NJAC 11:22-1, Appendix B, "Quarterly (Annual) Claims Prompt Payment Report." The Code requires that the annual claims prompt payment report be accompanied by a report of a private auditing firm, which may be a CPA or a firm of CPAs.

10. The Department has indicated, in Bulletin No. 02-07, that an agreed-upon procedures engagement pursuant to this SOP may be used to satisfy the requirement that an annual claims prompt payment report be accompanied by the report of a private auditing firm. Furthermore, in Bulletin No. 02-12, issued in May 2002, the Department has indicated that it agrees to the sufficiency of the procedures included in this SOP for its purposes.

Related Professional Standards

Chapter 2, "Agreed-Upon Procedures Engagements," of Statement on Standards for Attestation Engagements No. 10 (AT Sec. 201)

11. Agreed-upon procedures engagements performed to meet the requirements of the Code are to be performed in accordance with Chapter 2, "Agreed-Upon Procedures Engagements," of SSAE No. 10, *Attestation Standards: Revision and Recodification* (AICPA, *Professional Standards*, vol. 1, AT sec. 201). As described in Chapter 2 of SSAE No. 10 (AT sec. 201.03), an agreed-upon procedures engagement is one in which a practitioner is engaged by a client to issue a report of findings based on specific procedures performed on the subject matter. Not all of the provisions of Chapter 2 of SSAE No. 10 are discussed herein. Rather, this SOP includes guidance to assist practitioners in the application of selected aspects of Chapter 2 of SSAE No. 10.

12. Chapter 2 of SSAE No. 10 (AT sec. 201.06) states, in part, that the practitioner may perform an agreed-upon proce-

dures engagement provided that, "...(c) the practitioner and the specified parties agree upon the procedures performed or to be performed by the practitioner; and (*d*) the specified parties take responsibility for the sufficiency of the agreed-upon procedures for their purposes."

13. As previously stated, Bulletin No. 02-07 from the Department states that an agreed-upon procedures engagement may be used to meet the requirement for an independent private auditing firm to report on the annual claims prompt payment reports as required by the New Jersey Administrative Code. Furthermore, the Department has approved the use of the agreed-upon procedures outlined in this SOP to comply with the reporting requirements of the Code. Accordingly, practitioners should not eliminate any of the procedures presented in Appendix B, "Agreed-Upon Procedures That Address Annual Claims Prompt Payment Reports as Required by the New Jersey Administrative Code," of this SOP or reduce the extent of the tests. The Department or the carrier may request that additional procedures be performed and the practitioner may agree to perform such procedures. In those circumstances, it would be expected that the additional procedures would be performed in the context of a separate agreed-upon procedures engagement.

Procedures to Be Performed

14. The agreed-upon procedures to be performed are applied to the carrier's annual claims prompt payment report, which reports on the late payment of claims and reasons for denial of claims in the format prescribed in NJAC 11:22-1, Appendix B.

15. The procedures to be performed in the agreed-upon procedures engagement described in this SOP are presented in Appendix B of this SOP. The procedures have been designed so that the findings resulting from the application of the procedures can be recorded in a tabular format. The findings for each procedure should be reported as *No Exception*, *Exception*, or *N/A* (not applicable). If a procedure is not applicable to a particular carrier, the procedure should be marked N/A rather than deleted from the report.

16. If any portion of a procedure results in an exception, the findings for that entire procedure should be recorded as an exception and described in the section "Description of Exceptions If Any." The practitioner should provide a brief factual explanation for each exception that will enable the specified parties to understand the nature of the findings resulting in the exception. If management informs the practitioner that the condition giving rise to the exception was corrected by the date of the practitioner's report, the practitioner's explanation of the exception may include that information; for example, "Management has advised us that the condition resulting in the exception was corrected on Month X, 20XX. We have performed no procedures with respect to management's assertion."

17. A practitioner may perform significant portions of the agreed-upon procedures engagement before the end of the period covered by the report. If, during that time, the practitioner identifies conditions that result in an exception in one or more agreed-upon procedures, he or she should report the exception in the findings section of the agreed-upon procedures report, even if management corrects the condition prior to the end of the period.

18. Chapter 2 of SSAE No. 10 (AT sec. 201.40) states the following.

> The practitioner need not perform procedures beyond the agreed-upon procedures. However, in connection with the application of agreed-upon procedures, if matters come to the practitioner's attention by other means that significantly contradict the subject matter (or written assertion related thereto) referred to in the practitioner's report, the practitioner should include this matter in his or her report. For example, if, during the course of applying agreed-upon procedures regarding an entity's internal control, the practitioner becomes aware of a material weakness by means other than performance of the agreed-upon procedure, the practitioner should include this matter in his or her report.

19. A practitioner has no obligation to perform procedures beyond the agreed-upon procedures included in Appendix B of this SOP. However, if information that contradicts the information in the carrier's annual claims prompt payment report comes to the practitioner's attention by other means,

such information should be included in the practitioner's report. This also would apply to conditions or events occurring during the subsequent-events period (subsequent to the period covered by the practitioner's report but prior to the date of the practitioner's report) that either contradict the findings in the report or that would have resulted in the reporting of an exception by the practitioner if that condition or event had existed during the period covered by the report. However, the practitioner has no responsibility to perform any procedure to detect such conditions or events.

Establishing an Understanding With the Client

20. In accordance with Chapter 2 of SSAE No. 10 (AT sec. 201.10), the practitioner should establish an understanding with the client regarding the services to be performed. Such an understanding reduces the risk that the client may misinterpret the objectives and limitations of an agreed-upon procedures engagement performed to meet the regulatory requirements of the Code. Such an understanding also reduces the risk that the client will misunderstand its responsibilities and the responsibilities of the practitioner. The practitioner should document the understanding in the working papers, preferably through a written communication with the client (an engagement letter). The communication should be addressed to the client. Matters that might be included in such an understanding are the following:

- A statement confirming that an agreed-upon procedures engagement is to be performed to meet the requirements of NJAC 11:22-1
- A statement identifying the procedures to be performed as those set forth in SOP 02-1, *Performing Agreed-Upon Procedures Engagements That Address Annual Claims Prompt Payment Reports as Required by the New Jersey Administrative Code*
- A statement identifying the client and the Department as the specified parties to the agreed-upon procedures report

- A statement acknowledging the client's responsibility for the sufficiency of the procedures in the SOP and referring to Bulletin No. 02-12, which acknowledges the Department's responsibility for the sufficiency of the procedures in the SOP
- A statement acknowledging that the practitioner makes no representation regarding the sufficiency of the procedures in the SOP
- A statement describing the responsibilities of the practitioner, including but not limited to the responsibility to perform the agreed-upon procedures and to provide the client with a report, and the circumstances under which the practitioner may decline to issue a report
- A statement indicating that the engagement will be conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants (AICPA)
- A statement indicating that an agreed-upon procedures engagement does not constitute an examination, the objective of which would be the expression of an opinion on the carrier's compliance with the requirements of NJAC 11:22-1, and that if an examination were performed, other matters might come to the practitioner's attention
- A statement indicating that the practitioner will not express an opinion or any other form of assurance
- A statement describing the client's responsibility to comply with the requirements of NJAC 11:22-1 and the client's responsibility for the information in the carrier's annual claims prompt payment report
- A statement describing the client's responsibility for providing accurate and complete information to the practitioner
- A statement indicating that the practitioner has no responsibility for the completeness or accuracy of the information provided to the practitioner

- A statement restricting the use of the report to the client and the Department
- A statement describing any arrangements to involve a specialist

Management Representations

21. Although Chapter 2 of SSAE No. 10 does not require a practitioner to obtain a representation letter from management in an agreed-upon procedures engagement, it is recommended that the practitioner obtain such a letter when performing the engagement described in this SOP. The representation letter generally should be signed by the appropriate members of management including the highest-ranking officer responsible for the carrier's compliance with the requirements of NJAC 11:22-1. Management's refusal to furnish written representations that the practitioner has determined to be appropriate for the engagement constitutes a limitation on the performance of the engagement that requires either modification of the report or withdrawal from the engagement.

22. The representations that a practitioner deems appropriate will depend on the specific nature of the engagement; however, the practitioner ordinarily would obtain the following representations from management:

    - A statement acknowledging responsibility for compliance with the requirements of NJAC 11:22-1 and responsibility for the information in the carrier's annual claims prompt payment report
    - A statement that there have been no errors or fraud that might indicate that the carrier is not in compliance with the requirements of NJAC 11:22-1 and that there are no known matters (or that management has disclosed to the practitioner all known matters) that contradict the information in the carrier's annual claims prompt payment report
    - A statement that management has disclosed to the practitioner any communications from regulatory

agencies relating to the carrier's annual claims prompt payment report

- A statement that management has made available to the practitioner all information it believes is relevant to the carrier's annual claims prompt payment report
- A statement that management has responded fully to all inquiries made by the practitioner during the engagement
- A statement that no events have occurred subsequent to the date as of which the procedures were applied that would require modification of the findings of the agreed-upon procedures

23. An illustrative representation letter is presented in Appendix C, "Illustrative Management Representation Letter," of this SOP. For additional information regarding management's written representations in an agreed-upon procedures engagement, see Chapter 2 of SSAE No. 10 (AT secs. 201.37-.39).

Restriction on the Performance of Procedures

24. As previously stated, a practitioner should not agree to eliminate any of the procedures presented in Appendix B of this SOP. If circumstances impose restrictions on the performance of the agreed-upon procedures, the practitioner should attempt to obtain agreement from the specified users for modification of the agreed-upon procedures presented in Appendix B of this SOP. When such agreement cannot be obtained, the practitioner should describe the restriction(s) on the performance of procedures in his or her report or withdraw from the engagement.

Dating the Report

25. The date of completion of the agreed-upon procedures should be used as the date of the practitioner's report.

Effective Date

26. This SOP is effective upon issuance and is applicable only to agreed-upon procedures engagements that report on annual claims prompt payment reports as required by the NJAC.

APPENDIX A

Illustrative Agreed-Upon Procedures Report

The following is an illustrative agreed-upon procedures report based on the guidance in Chapter 2, "Agreed-Upon Procedures Engagements," of Statement on Standards for Attestation Engagements (SSAE) No. 10, *Attestation Standards: Revision and Recodification* (AICPA, *Professional Standards*, vol. 1, AT sec. 201).

Independent Accountant's Report
on Applying Agreed-Upon Procedures

To the Management of ABC Carrier:

We have performed the applicable procedures enumerated in the American Institute of Certified Public Accountants' Statement of Position (SOP) 02-1, *Performing Agreed-Upon Procedures Engagements That Address Annual Claims Prompt Payment Reports as Required by the New Jersey Administrative Code*, which were agreed to by ABC Carrier and the New Jersey Department of Banking and Insurance (the Department), solely to assist you in complying with the reporting requirements of New Jersey Administrative Code, Title 11, Chapter 22, Subchapter 1.9 (NJAC 11:22-1.9) for Appendix B 20XX Annual Report (Exhibit I) for the year ended December 31, 20XX. Management of ABC Carrier is responsible for compliance with the requirements of NJAC 11:22-1. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of ABC Carrier and the Department. Consequently, we make no representation regarding the sufficiency of the procedures described in the attached Appendix either for the purpose for which this report has been requested or for any other purpose.

The procedures performed and the findings are included in the attached Appendix.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on ABC Carrier's compliance with the requirements of NJAC 11:22-1 for the year ended December 31, 20XX. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the management of ABC Carrier and the State of New Jersey Department of Banking and Insurance, and is not intended to be and should not be used by anyone other than these specified parties.

[*Signature*]

[*Date*]

APPENDIX B

Agreed-Upon Procedures That Address Annual Claims Prompt Payment Reports as Required by the New Jersey Administrative Code

Procedures	Findings: No Exception	Exception	N/A
The following procedures were applied to the ABC Carrier's 20XX Appendix B annual claims prompt payment report.			
We obtained supporting documentation used by management to prepare the Annual New Jersey Prompt Payment Report, and for each of the five categories (physician, dental, other health care professional, hospital, or other health care facilities), where applicable, compared the number of claims and the amount of claims for each quarter and the annual period from the supporting documentation used by management to prepare the Annual New Jersey Prompt Payment Report to the following columns of the report:			
• Total claims	_____	_____	_____
• Denied ineligible	_____	_____	_____
• Denied document	_____	_____	_____
• Denied coding/enrollment	_____	_____	_____
• Denied for amount	_____	_____	_____

(continued)

Procedures	Findings: No Exception	Findings: Exception	Findings: N/A
• Time limit special	_____	_____	_____
• Time limit other	_____	_____	_____
• Denied referred fraud	_____	_____	_____
• Interest paid	_____	_____	_____
• Interest amount paid	_____	_____	_____
• Total paid	_____	_____	_____
We selected 10 percent of the claims from ABC Carrier's supporting documentation used by management to prepare the Annual New Jersey Prompt Payment Report, with the selections distributed throughout the year. If 10 percent of the claims exceeded 50, then the number of items selected was limited to 50. If 10 percent of the claims resulted in less than 10 claims, then the number of items selected was 10, and for each item selected we:			
1. Compared the following information to ABC Carrier's claim payment system:			
• Paid amount	_____	_____	_____
• Claim finalization or payment date	_____	_____	_____
• Claim received date	_____	_____	_____
• Denial code	_____	_____	_____
• Claim category (physician, dental, other health care professional, hospital, or other health care facilities)	_____	_____	_____
2. Compared the following information to the original claim information submissions:			

Procedures	Findings: No Exception	Findings: Exception	Findings: N/A
• Date received	_____	_____	_____
• Amount billed	_____	_____	_____
• Category (physician, dental, other health care professional, hospital, or other health care facilities)	_____	_____	_____
3. Noted whether, per ABC Carrier's member records, original claim information submission, or both, the claim related to a policy issued in the state of New Jersey	_____	_____	_____
4. If a selected claim was denied, compared denial reason indicated in ABC Carrier's claims system records to supporting documentation used by management to prepare the Annual New Jersey Prompt Payment Report	_____	_____	_____
5. If a selected claim is a "clean claim," as defined in NJAC 11:22-1.2, and as determined by ABC Carrier, recalculated the amount of interest paid on the selected claim in accordance with the requirements of NJAC 11:22-1.5	_____	_____	_____
We selected 10 claims from ABC Carrier's primary claims system, with the selections distributed throughout the year, and for each item selected, traced the selected claims covered under New Jersey contracts to the supporting documentation used by management to prepare the Annual New Jersey Prompt Payment Report.	_____	_____	_____

(continued)

Procedures	Findings		
	No Exception	Exception	N/A
We proved the arithmetic accuracy of ABC Carrier's 20XX Appendix B annual claims prompt payment report.	_____	_____	_____

Description of Exceptions If Any

APPENDIX C

Illustrative Management Representation Letter

[*ABC Carrier's Letterhead*]

[*Date*]

[*CPA Firm's Name and Address*]

In connection with your engagement to apply the agreed-upon procedures enumerated in the American Institute of Certified Public Accountants' Statement of Position (SOP) 02-1, *Performing Agreed-Upon Procedures Engagements That Address Annual Claims Prompt Payment Reports as Required by the New Jersey Administrative Code*, which were agreed to by ABC Carrier and the New Jersey Department of Banking and Insurance, solely to assist us in complying with the requirements of New Jersey Administrative Code, Title 11, Chapter 22, Subchapter 1 (NJAC 11:22-1.9), for Appendix B 20XX Annual Report (Exhibit I) for the period from January 1, 20XX through December 31, 20XX, we confirm, to the best of our knowledge and belief, the following representations made to you during your engagement:

1. We are responsible for compliance with the requirements of NJAC 11:22-1 and for the information in ABC Carrier's annual claims prompt payment report.
2. During the year ended December 31, 20XX, there have been no errors or fraud that would indicate that ABC Carrier is not in compliance with the requirements of NJAC 11:22-1.
3. We have disclosed to you all known matters contradicting the information in ABC Carrier's annual claims prompt payment report.
4. There have been no communications from regulatory agencies relating to ABC Carrier's annual claims prompt payment report, including communications received between December 31, 20XX, and the date of this letter.

5. We have made available to you all information that we believe is relevant to ABC Carrier's annual claims prompt payment report.
6. We have responded fully to all inquiries made to us by you during the engagement.

To the best of our knowledge and belief, no events have occurred subsequent to December 31, 20XX, and through the date of this letter that would require adjustment to or modification of the findings of the agreed-upon procedures.

[*Signature*]

[*Title*]

[*Signature*]

[*Title*]

New Jersey Annual Claims Prompt Payment Reports Task Force

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