

How to use the explanation of benefits (EOB) audit tool

1. Fill in the header information (i.e., the name of the person conducting the audit, date you conduct the audit, and date range of the received EOBs you sample).
2. Hand-tally the findings and enter them in the column titled "Enter hand-tally here." Use additional copies of the form if needed to capture the results of your sample. When you are done sampling, add up the tick marks and enter the total in the column titled "Total count for hand-tally." The results will be calculated automatically in the column titled "Percent of total sample."
3. For every claim line item you review, enter a tick mark in the row titled "Overall number of claims" to create your sample size. This number will represent the universe of claims sampled.
4. For each claim line item sampled for which there is a zero-dollar payment, enter a tick mark under the column in the row best matching the reason for the denial. If there are reasons that are not listed on your form, enter them under the "Other" row and note the reasons in the comment column. If a particular item appears frequently, note it for future tracking purposes.
5. Once you complete the sample, tally up the tick marks. Enter these numbers into the automated spreadsheet in the column titled "Total count for hand-tally." The percentages will be calculated automatically, and the overall denial rate of claim line items from the sample will be computed at the bottom in the row titled "Overall denial rate."

Sample denial management audit tool

Review of explanation of benefits (EOB) _____ Today's date _____

Auditor name _____ EOB dates processed _____

Pull EOBs dated the week of:	Tally denials found and claims reviewed and then count total for each and enter below			Comments (list any unique issues identified for further research)
	Enter hand-tally here	Total count for hand-tally	Percent of total sample	
Overall number of claims				
Denial reasons				
Member ineligible, termed, or not in PHO				
Benefit not covered or limit exceeded				
Lack of precent/no authorization				
Services covered under capitation				
Services not medically necessary				
Untimely filing of claim				
Duplicate claim; already paid				
Provider not in network				
Other: Specify reason				
Overall denial rate				

Source: Denial Management: Key Tools and Strategies for Prevention and Recovery, published by HCPro, Inc. For more information or to order, visit www.marketplace.com.