LEGISLATIVE AUDIT DIVISION

Scott A. Seacat, Legislative Auditor
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Deputy Legislative Auditors:
James Gillett
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November 2006

The Legislative Audit Committee
of the Montana State Legislature:

Enclosed is the report on the audit of the medical and pharmacy claims for the employee benefits plans at the State of Montana and the Montana University System for the two years ended December 31, 2005.

The audit was conducted by Wolcott & Associates under a contract between the firm and our office. The comments and recommendations contained in this report represent the views of the firm and not necessarily the Legislative Auditor.

The agencies' written responses to the report recommendations are included in the back of the audit report.

Respectfully submitted,

Scott A. Seacat
Legislative Auditor

06C-07

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STATE OF MONTANA and
MONTANA UNIVERSITY SYSTEM

ANALYSIS AND EVALUATION OF
CLAIMS PROCESSING
FOR THE PERIOD
JANUARY 1, 2004 THROUGH DECEMBER 31, 2005

ADMINISTERED BY

BLUE CROSS BLUE SHIELD OF MONTANA and
ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC.

FINAL REPORT

DECEMBER, 2006

PRESENTED BY

WOLCOTT & ASSOCIATES, INC.
12120 STATE LINE ROAD, SUITE 297
LEAWOOD, KANSAS 66209

STATE OF MONTANA AND MONTANA UNIVERSITY SYSTEM
HEALTH CARE PLAN AUDIT
OF BLUE CROSS BLUE SHIELD OF MONTANA AND
ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC.
JANUARY 1, 2004 - DECEMBER 31, 2005

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EXHIBITS

* Allegiance chose not to provide a response to the report

I - INTRODUCTION

The State of Montana (State) provides self-funded medical care and dental care benefits as part of an overall employee benefit and compensation program. The plan covers approximately 15,000 employees and retirees, plus their dependents for a total of 32,000 covered lives.

The State has negotiated a contract with Blue Cross Blue Shield of Montana (BCBSMT) to provide administration services to its indemnity medical and dental plans.

The Montana University System (MUS) is a member of the Montana Association of Health Care Purchasers, and had also contracted to have their medical and dental care benefits administered by BCBSMT until June 30, 2005. However, as of July 1, 2005 MUS contracted with Allegiance Benefit Plan Management, Inc. (Allegiance) to administer their medical and dental care benefits. The plan covers approximately 8,000 employees and retirees, plus their dependents.

PURPOSE OF SERVICE

Section 2.18.816, MCA requires the State Employee Benefits Plan to be audited every two years by or at the direction of the Legislative Audit Division. Wolcott & Associates, Inc. was awarded the audit contract for the 2002-2003 Plan Years and subsequently renewed that contract for the 2004-2005 Plan Years.

The purpose of the service is to comply with Section 2.18.816, MCA.

The State and MUS recognize that they have a fiduciary responsibility to administer this plan (and other employee benefit plans) for the benefit of plan participants and their dependents and in accordance with the plan provisions. Both plan sponsors believe it is prudent to perform periodic audit and review services to determine if the benefit plans they sponsor are meeting these objectives.

AUDIT TIMING AND STAFF

The Legislative Audit Division advised Wolcott & Associates, Inc. that the contract would be renewed June 15, 2006. All preliminary work was completed and the entrance meeting was held in Helena on September 11, 2006. On-site work at the State, MUS, BCBSMT and Allegiance was performed during the weeks of September 11 and 25, 2006.

On-site audit services were performed at:

State of Montana
State Personnel Division
Mitchell Building
Helena, Montana 59620

Montana University System
46 Last Chance Gulch
Helena, Montana 59620

Blue Cross & Blue Shield of Montana
560 North Park Avenue
Helena, Montana 59601

Allegiance Benefit Plan Management, Inc.
2806 South Garfield Street
Missoula, Montana 59801

Wolcott & Associates, Inc. staff involved in the audit are listed below:

Name	Title	On-site
Brian Wyman	Manager	Yes
Marie Pollock	Vice President, Project Director	Yes
Richard Reese	Actuary	No
Jenny Hill	Statistician	No

SCOPE OF AUDIT

The scope of audit services covered medical care and dental care benefit claims paid by BCBSMT during the period from January 1, 2004 through December 31, 2005 for State (January 1, 2004 through June 30, 2005 for MUS). Test work was performed on 211 claims for State and 105 claims for MUS previously processed claims, all of which were selected on a stratified, random (statistical) basis. In addition, a separate sample of 106 MUS claims paid by Allegiance were selected on a stratified, random basis for the period July 1, 2005 through December 31, 2005.

Claims Adjudication Audit

Elements of claims adjudication which were evaluated include:

- Turnaround time required to process each claim.
- Eligibility of claimants to receive payment.
- Administration of coordination of benefits, including Medicare.
- Administration of subrogation provisions.
- Calculation accuracy, including Usual, Customary and Reasonable (UCR) limits and computation of deductible and co-payment limits.

- Completeness of necessary information.
- Payee accuracy, including benefit assignments to service providers.
- Consistency of payments to BCBSMT and Allegiance member physicians and other physicians.
- Compliance with benefit plan structure.
- Identification of duplicate claim submissions.

Test Claims

Test claims were prepared and entered into the BCBSMT and Allegiance's system to test various aspects of the system's capabilities. The test claims addressed the following:

- Duplicate claims.
- Duplicate claim logic.
- Claims for terminated individuals.
- Claims for terminated dependents.
- Claims from a fictitious provider.
- Claims for fictitious services.
- Claims involving coordination of benefits with another health care plan.
- Claims involving fees in excess of the usual, customary and reasonable limit established for the plan.
- Claims for procedures and/or diagnosis codes that are inconsistent with the patient's sex.

II - STATISTICAL CLAIM AUDIT RESULTS - STATE & MUS

The results of our audit of previously processed claims are presented in this section.

SAMPLE SIZE AND METHODOLOGY

The proposal request stated that our sample size was to be large enough so as to express the frequency of error with a 95% confidence and a precision of + or - 3%, assuming an error rate of 5% or less. As a result, we proposed to audit a sample of 422 claims (211 claims for each plan sponsor).

The State claims were selected from the population of claims paid by BCBSMT between January 1, 2004 and December 31, 2005 and for the MUS claims January 1, 2004 through June 30, 2005. A separate sample was selected from the population of claims paid by Allegiance for the period July 1, 2005 through December 31, 2005. Prior to selection, both populations of claims was stratified.

AUDIT PROCEDURE

Information presented below describes our test work on the 422 previously processed claims (medical and dental) in our sample and the errors identified. The test involved the following:

- Review of previously processed claims to determine if selected claim is a duplicate of a previously processed claim.
- Review of member specific coverage on BCBSMT's and Allegiance's records to the coverage indicated on the plan's records.
- Verification that members are employees/retirees of the plan and covered under the plan at the time the claim was incurred.
- Review to determine that BCBSMT and Allegiance is following all procedures necessary to obtain a reasonable level of coordination of benefits (COB) recoveries.
- Recomputation of each claim selected for testing to determine its accuracy including analysis of any refunds due and/or payable.
- Review of the nature of the claim to ascertain the allowability of costs as defined in the contract (e.g., processed within the proper allowance and medical necessity guidelines, pre-certification requirements and other benefit limitation guidelines).

- Comparison of each claim to supporting documentation submitted by the member or the provider of services to ensure that the claim reflects the documentation and that it is properly authorized for payment.

- Comparison of each claim to other claims for that individual with the same date of service to ensure congruency of payment with all claims for that date of service.

- Review of the microfilm copies and source documents, when appropriate, to determine if there are any indications of fraud.

DEFINITION OF ERROR

We defined an error to be any claim where the payment to the participant or the provider did not agree with the plan document provisions.

AUDIT RESULTS - BCBSMT

Of the 316 claims, processed by BCBSMT, in our statistical sample, 6 were judged to contain a payment error. This represents a frequency of payment error of 1.9%.

Our sample contained a total payment of $7,937,314.17 for the 316 claims. The overpayments totaled $1,708.32 or 0.02% of the total. The underpayments totaled $36.10 or 0.000% of the total. This financial error rate is more favorable than the .5 to 1 percent error rate normally observed during our audits of similar plans. It is also more favorable than the BCBSMT standard of 1% and more favorable than the 2.75% reported in the prior audit report.

The frequency of payment error in our sample is more favorable than the three to five percent error rate normally observed during our audits of similar plans. It is also more favorable than the BCBSMT standard of 3%. In addition, the error rate is more favorable than the 2.1% error rate reported in the prior audit report.

It should be noted that 9 claims in our sample of 316 were processed on the new system. One claim was determined to be an error. This represents a frequency of payment error of 11%.

AUDIT RESULTS - ALLEGIANCE

Of the 106 MUS claims in our statistical sample, 1 was judged to contain a payment error. This represents a frequency of payment error of .094%.

Our sample contained a total payment of $1,489,353.71 for the 106 claims. There were no overpayments identified. The underpayment totaled $25.00 or 0.002% of the total.

This financial error rate is more favorable than the .5 to 1 percent error rate normally observed during our audits of similar plans. It is also more favorable than the Allegiance standard of 1%.

The frequency of payment error in our sample is more favorable than the three to five percent error rate normally observed during our audits of similar plans. It is also more favorable than the Allegiance standard of 3%.

POPULATION DATA - BCBSMT

Our sample was selected on a stratified basis. The basis for stratification was paid amount. This sampling method can be expected to produce sample results that differ from the results projected for the population.

We have extended the results of our sample to the population of claims paid during the audit period.

Based on this extension, we are 95% confident with a precision of + or - 0.5%, that the true frequency of error in the population is within the range of 1.4% to 2.4%.

Based on this extension, we believe that the true magnitude of payment error in the population is $422,882 or (0.31% of payments in the population). The magnitude of payment error is the sum of $292,572 in projected overpayments plus $130,310 in projected underpayments.

POPULATION DATA - ALLEGIANCE

Our sample was selected on a stratified basis. The basis for stratification was paid amount. This sampling method can be expected to produce sample results that differ from the results projected for the population.

We have extended the results of our sample to the population of claims paid during the audit period.

Based on this extension, we are 95% confident with a precision of + or - 0.5%, that the true frequency of error in the population does not exceed 0.594%.

Based on this extension, we believe that the true magnitude of payment error in the population is $8,077 or (0.03% of payments in the population). The magnitude of payment error is the sum of $8,077 in projected overpayments plus $0 in projected underpayments.

TYPES OF ERRORS

Each of the errors identified in our sample is listed in **Exhibit A and B**. A discussion of error types is presented below.

A summary of error by type for BCBSMT is presented below:

BCBSMT HEALTH CARE CLAIMS
JANUARY 1, 2004 THROUGH DECEMBER 31, 2005
SUMMARY OF ERRORS BY TYPE

ERROR TYPE	NUMBER	NET PAYMENT ERROR
Incorrect application of coinsurance	2	1,511.42
Data entry error	1	(16.10)
Incorrect application of dental implant benefit	1	(20.00)
Incorrect application of global transplant benefit	1	169.90
Incorrect application of immunization benefits	1	27.00
Total	6	$1,672.22

BCBSMT has included their response as **Exhibit D**.

A summary of error by type for Allegiance is presented below:

ALLEGIANCE HEALTH CARE CLAIMS
JULY 1, 2005 THROUGH DECEMBER 31, 2005
SUMMARY OF ERRORS BY TYPE

ERROR TYPE	NUMBER	NET PAYMENT ERROR
Incorrect application of ER copay	1	(25.00)
Total	1	$(25.00)

Allegiance has indicated to us that they will not provide a response to the findings.

RECOMMENDATIONS - BCBSMT

Our recommendations are as follows:

- We identified 2 errors that were due to clerical (data entry) errors. We recommend that further training be conducted, in order to avoid these types of errors in the future.

- We identified 2 claims that the coinsurance was not correctly applied. One of these errors was processed on the new claim system, Qnxt. BCBSMT has indicated that this is a system issue and is currently being reviewed. We recommend BCBSMT perform an analysis, in order to understand the extent of this issue in the system and the amount of overpayments it has produced.

RECOMMENDATIONS - ALLEGIANCE

We only identified one error in the sample. We do not believe this error warrants any further recommendations for Allegiance.

III - ELIGIBILITY

The plan sponsors use various methods to report new entrants, changes and termination of coverage to BCBSMT and Allegiance. This section describes the methods employed and presents the results of the verification of eligibility for the 422 (211 for the 2 plan sponsors) in our sample where a payment was made by BCBSMT or Allegiance.

STATE OF MONTANA

The State prepares and sends to BCBSMT a biweekly eligibility tape showing each individual to be covered for the coming month. BCBSMT runs this tape and compares it to the data for the prior month.

Eligibility Verification

Each of the State participants in our sample was researched on the State eligibility system to verify that the State's records indicated that coverage was in force on the date the services were rendered.

No exceptions were noted.

MONTANA UNIVERSITY SYSTEM - BCBSMT

BCBSMT receives the enrollment data from each campus on a daily basis. BCBSMT then follows the same process as the State.

Eligibility Verification

Each of the MUS participants in our sample was researched at the applicable campus to verify that the BCBSMT's records indicated that coverage was in force on the date the services were rendered. MUS records confirmed that all participants in the sample were covered as of the date the services were rendered.

No exceptions were noted.

MONTANA UNIVERSITY SYSTEM - ALLEGIANCE

Allegiance receives the enrollment data from each campus on a daily basis. The enrollment information is then updated in Allegiance's system.

Eligibility Verification

Each of the MUS participants in our sample was researched at the applicable campus to verify that the Allegiance's records indicated that coverage was in force on the date the services were rendered. MUS records confirmed that all participants in the sample were covered as of the date the services were rendered.

No exceptions were noted.

IV - BCBSMT & ALLEGIANCE REIMBURSEMENT

The State and MUS reimburse BCBSMT and Allegiance for claims paid on behalf of subscribers and their eligible dependents. BCBSMT and Allegiance credits the Plan Sponsors for overpaid claims once they are corrected.

The scope of our service included the measurement of the time required by the plan sponsors to reimburse BCBSMT and Allegiance for claims processed. The results of our test work is presented below.

REIMBURSEMENT PROCESSING TIME - BCBSMT

BCBSMT submits invoices for reimbursement for claims paid during a certain period. The frequency of the invoices and the payment terms differ for each plan sponsor. Presented below is information regarding the contractual provision and the actual time required to reimburse BCBSMT based on records made available to us.

State of Montana

The State will bank wire transfer the requested amount within 48 hours of the receipt of a phone call from BCBSMT. BCBSMT then sends the State an invoice reflecting the amount requested.

We gathered invoices from January 1, 2004 through December 31, 2005 and measured the elapsed time between the phone call and the date payment was made by the State.

A total of 5 invoices were included in our review.

We noted that the state actually reimburses BCBSMT within 48 hours of the receipt of a phone call from BCBSMT. Therefore, the state reimburses BCBSMT before the receipt of the invoice. Upon receipt of the invoice from BCBSMT, the state compares the amount requested to the wire transfer confirmation.

We noted no exceptions when comparing the wire transfer amount to the invoice amount. The amount requested, by phone, from BCBSMT was paid within 48 hours of the phone call in all 5 cases.

Montana University System

MUS will bank wire transfer the amount within 48 hours of the receipt of the invoice.

We gathered invoices from January 1, 2004 through June 30, 2005 and measured the elapsed time between the receipt of the invoice and the date payment was made by MUS.

A total of 2 invoices were included in our review.

We noted no exceptions when comparing the wire transfer amount to the invoice amount. The amount requested, by phone, from BCBSMT was paid within 48 hours of the phone call in both cases.

REIMBURSEMENT PROCESSING TIME - ALLEGIANCE

Allegiance submits invoices for reimbursement for claims paid during a certain period.

MUS will bank wire transfer the amount within 48 hours of the receipt of the invoice.

We gathered invoices from July 1, 2005 through December 31, 2005 and measured the elapsed time between the receipt of the invoice and the date payment was made by MUS.

A total of 3 invoices were included in our review.

We noted no exceptions when comparing the wire transfer amount to the invoice amount. The amount requested, by phone, from Allegiance was paid within 48 hours of the phone call in all cases.

V - CLAIM PAYMENT TURNAROUND TIME

The purpose of this section is to present our analysis of the claim turnaround time information for each of the 422 claims in our sample.

Claim Processing Time

Claim processing time or turnaround time for this audit was measured from the "received date" as entered on the claim document to the date the date the claim was processed.

Results, by plan sponsor, are presented below.

State of Montana

For all 211 claims in our sample, the turnaround time results are as follows:

Measure	Elapsed Days
Mean	12
Median	3
Mode	0

BCBSMT informed us that company policy for turnaround time is 7 day average for non-investigated claims and 21 day average for claims requiring investigation.

MUS - BCBSMT

For all 106 claims in our sample, the turnaround time results are as follows:

Measure	Elapsed Days
Mean	9
Median	3.5
Mode	1

BCBSMT informed us that company policy for turnaround time is 7 day average for non-investigated claims and 21 day average for claims requiring investigation.

MUS - ALLEGIANCE

For all 106 claims in our sample, the turnaround time results are as follows:

Measure	Elapsed Days
Mean	10
Median	6
Mode	4

Allegiance informed us that company policy for turnaround time is 7 day average for non-investigated claims and 21 day average for claims requiring investigation.

VI - COST CONTAINMENT

Discussion regarding cost containment procedures utilized at BCBSMT and Allegiance is presented below.

CASE MANAGEMENT

BCBSMT

A mandatory pre-admission notification provision is part of each plan sponsor's Plan provisions. The notification procedure is used to alert APS Healthcare Northwest, Inc. (the case management firm utilized by the plans) of potentially large claims which could be eligible for individual case management to reduce the magnitude of the claim.

Typically, participants are referred to case management based on diagnosis. However, APS has indicated that they receive these referrals from BCBSMT and in some cases from the hospital.

This procedure is can be initiated by either the individual or the provider of services.

BCBSMT did not provide us with information regarding denied claims for any of the three plan sponsors.

Allegiance

A mandatory pre-admission notification provision is part of each plan sponsor's Plan provisions. Allegiance utilizes the services of Rocky Mountain Health Network for the preauthorization process. The notification procedure is used to alert Rocky Mountain Health Network of potentially large claims which could be eligible for individual case management to reduce the magnitude of the claim.

Typically, participants are referred to case management based on diagnosis. However, Rocky Mountain Health Network has indicated that they receive these referrals from Allegiance and in some cases from the hospital.

This procedure is can be initiated by either the individual or the provider of services.

SUBROGATION

All claims that indicate an accident and/or work related accidents are forwarded to the Subrogation Department. This Department then sets up the file and sends out a letter for details of the accident. Upon receipt of the letter, BCBSMT then sends the appropriate letter(s) in order to:

(1) assert their subrogation right, (2) notify participant that the Third Party Liability coverage is primary to the plan, or (3) recover payments made related to a work related injury.

Subrogation recovery information by plan sponsor is presented below.

The State of Montana

The State's recovery information is detailed below.

Year	Auto/Medical	Subrogation	ITS (Blue Card)	Workers' Comp
1998: Recovery	($51,485.60)	$26,194.44	$13,210.73	($45,442.50)
Savings	175,922.90	31,828.04	0.00	134,190.50
1999: Recovery	(3,797.11)	36,972.67	12,718.12	50,960.27
Savings	71,130.31	25,816.17	0.00	83,304.64
2000: Recovery	18,143.31	21,858.78	13,988.66	37,802.43
Savings	70,975.74	33,217.41	114,068.58	0.00
2001: Recovery	(38,832.58)	73,850.84	5,736.33	79,115.95
Savings	127,987.48	40,491.34	0.00	185,835.91
2002: Recovery	(84,812.05)	19,418.99	844.00	(28,752.44
Savings	183,439.33	53,461.49	0.00	226,786.17
2003: Recovery	18,285.92	37,750.44	Not Reported	75,626.07
Savings	179,310.41	5,554.43	Not Reported	140,248.47
2004: Recovery	(95,996.14)	(27,447.99)	Not Reported	118,909.07
Savings	175,417.28	81,94.83	Not Reported	187,431.31
2005: Recovery	(47,325.78)	51,044.77	Not Reported	79,794.02
Savings	215,924.91	38,798.64	Not Reported	92,998.54

MUS - BCBSMT

MUS's recovery information is detailed below.

Year	Auto/Medical	Subrogation	ITS (Blue Card)	Workers' Comp
1998: Recovery	($3,631.51)	$24,281.90	$993.70	($21,327.55)
Savings	33,767.38	3,266.86	0.00	15,196.59
1999: Recovery	40,416.77	17,157.70	615.30	47,949.71
Savings	36,593.54	4,952.87	0.00	31,564.47
2000: Recovery	5,078.15	11,888.61	1,315.50	17,757.57
Savings	13,224.94	9,279.09	0.00	98,726.63
2001: Recovery	(7,030.39)	19,548.71	628.00	11,046.76
Savings	40,508.62	9,642.57	0.00	27,253.91
2002: Recovery	5,984.20	26,923.16	0.00	31,834.77
Savings	30,196.22	46,408.89	0.00	63,933.57
2003: Recovery	16,235.19	36,110.50	Not Reported	24,257.35
Savings	44,001.91	1,461.52	Not Reported	27,925.97
2004: Recovery	(75,228.19)	10,035.86	Not Reported	31,963.95
Savings	111,387.80	4,683.10	Not Reported	37,927.30
2005: Recovery	(3,155.48)	15,011.10	Not Reported	100,110.46
Savings	26,807.13	6,802.91	Not Reported	34,283.96

MUS - ALLEGIANCE

Allegiance reported no recoveries on behalf of MUS for the period July 1, 2005 through December 31, 2005. However, they did report 18 open subrogation investigations.

FRAUD INVESTIGATION - BCBSMT

An active fraud investigation function is an effective deterrent to those who may consider such activities.

BCBSMT has developed a fraud investigation program, which includes the following:

- Fraud Awareness Program for all claim processors and customer service representatives.
- EOBs are sent to the patient for every claim submitted to BCBSMT for processing.
- BCBSMT has developed a web site, for which participants may access to report possible fraud.
- BCBSMT had established a fraud hotline, which is indicated on each EOB received by the member. The web site address is listed on every EOB the member receives.
- Every out-of-state, non-network doctor is researched for licensure information from the appropriate State Board of Physicians by the BCBS plan where the provider is licensed.
- The BCBSMT claim system has the ability to flag providers that have been identified as having questionable billing practices.
- BCBSMT became a corporate member of the National Health Care Anti-Fraud Association (NHCAA) in 2001. NHCAA membership is comprised of numerous private and public sector organizations and individuals including various law enforcement agencies and 25 individual Blue Cross Blue Shield plans.
- BCBSMT developed a new corporate fraud awareness program in 2001, and training of employees from the Member Services and Support area began in the fall of 2001.

Recoveries

Recovery information for the years 1998, 1999, 2000, 2001, 2002, 2003, 2004 and 2005 is for all BCBSMT's book of business is presented below.

Year	Recovery
1998	$143,994.78
1999	$ 84,107.10
2000	$ 96,986.00
2001	$270,936.00
2002	$571,051.00
2003	$440,916.00

2004	$280,226.00
2005	$435,149.00

The above recovery dollars is based on actual recoveries, rather than projected savings.

Based on our review we conclude that the investigative procedures and staff training are further advanced than many administrators.

FRAUD INVESTIGATION - ALLEGIANCE

Allegiance does not have a formal fraud detection department. They reported no fraud recoveries or cases.

RECOMMENDATION

We recommend that Allegiance establish a formal fraud detection department.

VII - LOGIC AND OTHER TEST RESULTS

This section presents the results of test claims submitted to the BCBSMT and Allegiance claim system as a method of assessing the system's ability to identify inappropriate transactions. The tests and the results are discussed below.

To protect against issuance of actual check payments and contamination of member history, a test cycle was used for all test claims.

Duplicate Claims

The claim system contains a series of edits designed to identify duplicate claims. If an exact match with a previously processed claim, the claim is rejected as a duplicate.

To test the system's duplicate claim logic, we selected four previously processed claims. Each claim was altered as follows:

- Change the diagnosis.
- Change the billed amount.
- Change the provider code.

This resulted in twelve separate resubmissions, each with one of the above changes made. In each case, the system correctly identified the fictitious resubmissions as a duplicate claim.

Finally, we submitted 10 previously processed claims.

The system correctly identified the 10 claims as duplicates.

Overcharging By Providers

BCBSMT and Allegiance has developed fee allowances for professional services. Our review confirmed that the system will correctly calculate the allowance.

We submitted five fictitious test claims where the provider's fee exceeded the allowance. The claim processing system correctly identified all five overcharges and reduced the allowance to agree with the appropriate amount.

Unnecessary Physician Services

The claim system has several edits designed to identify potentially unnecessary physician services. These edits involve matching diagnosis codes to procedure codes, monitoring the frequency of service and comparing the procedure to the patient's gender. In addition, claims from

providers with a history of abuses or suspect billing practices are suspended for further evaluation prior to payment.

As part of our test work, we prepared and submitted five fictitious test claims where the patient's gender was not consistent with the procedure/diagnosis. Three of the five claims were correctly identified as inconsistent with the patient's gender on the BCBSMT system. Four of the five claims were correctly identified as inconsistent with the patient's gender on Allegiance's system.

We also submitted five test claims involving fictitious type of service codes. All five claims were correctly suspended as containing invalid codes.

Other Test Claims

Additional test claims processed are discussed below.

Terminated Employees and Dependents

We submitted ten fictitious claims (five for employees and five for dependents) for individuals whose coverage had terminated. Each date of service followed the date coverage terminated. The system correctly rejected all 10 of the claims as claims incurred following termination of coverage.

Fraudulent Providers

We submitted five test claims from a fictitious provider. The test claims were entered. However, according to procedures, when an invalid provider number was entered, the processor would forward the claim to the Provider Maintenance Department where further investigation is performed.

Coordination of Benefits

Five fictitious claims were prepared for individuals whose history file indicated that other insurance coverage was present. All five of these claims were suspended for COB information.

SUMMARY

Based on our test results, we conclude that the BCBSMT and Allegiance system is effective in identifying erroneous claims.

The findings from the fictitious claim testing are summarized as **Exhibit C** attached to this report.

VIII - OTHER REVIEW AREAS

The results of our review in areas requested by the two plan sponsors is as follows.

SUSPENDED CLAIMS

We requested reports from BCBSMT and Allegiance regarding the percentage of claims submitted that were suspended, reasons for suspension, and the average length of time before these claims were paid or denied.

Neither BCBSMT or Allegiance provided the requested information for any of the 2 plan sponsors. They indicated to us that this is not a report typically provided to plan sponsors.

DENIED CLAIMS

We requested reports from BCBSMT and Allegiance regarding the number of claims denied, including provider type, amount and if there were multiple denied claims for one provider. In addition, determine the percentage denied due to ineligibility of a member.

BCBSMT did not provide the requested information for any of the two plan sponsors. They indicated to us that this is not a report typically provided to plan sponsors.

Allegiance did provide the requested information for MUS.

Allegiance did not provide a count total for denied claims.

Allegiance reported that the top 5 reasons for denial were as follows:

Duplicate claim submission,
Plan limits for routine services,
- Plan limits for alternative services
- Charges prior to and/or after effective date, and
- Non-covered services

The total amount for denied claims was $7,399,123.

Allegiance did not include providers and provider type in their report.

We calculated that 258 claims were denied for member not eligible for benefits.

IX - PRIOR AUDIT RECOMMENDATIONS

The most recently completed audit for the State of Montana and Montana University System, was performed for the period January 1, 2002 through December 31, 2003.

The report for that audit, issued in December, 2004, contained the following recommendations:

HOSPITAL CLAIM REPRICING

During a portion of our audit period the MUS and the State utilized an outside vendor for repricing of inpatient hospital claims. As of August, 2003 these services were to be performed by BCBSMT. However, during a three month time period, claims for State and MUS employees were submitted with billed charges and BCBSMT was making payment with the assumption these claims had already been repriced. This has caused considerable overpayment of claims for the State and MUS (we identified $118,664.09).

We recommended that BCBSMT should review all inpatient claims processed and paid during this time period and reimburse the State and MUS for all overpayments, including our audit findings.

Comment

BCBSMT indicated to us that the overpayments identified for the State and MUS ($107,155.09 and $107,937.63 respectively) has been adjusted and credited to the plan sponsors.

ESRD PATIENT

We recommend BCBSMT reimburse the State for all overpayments made on the ESRD patient. We believe this individual's entire claim file has been overpaid.

Comment

BCBSMT indicated to us that this participant's file has been corrected and claims adjusted to reflect Medicare primary payment.

EXHIBIT A

STATE OF MONTANA & UNIVERSITY OF MONTANA
HEALTH CARE CLAIM AUDIT - BCBSMT
CLAIMS PROCESSED FROM JANUARY 1, 2004 THROUGH DECEMBER 31, 2005
SUMMARY OF FINDINGS

CLAIM #	GROUP	PAID AMOUNT	AUDITED AMOUNT	DOLLAR VALUE OF ERROR	TYPE
04065004200	State	5,361.72	5,351.50	10.22	Should have applied remaining coinsurance.
05129218330	State	-	16.10	(16.10)	Claim incorrectly denied due to clerical error.
04168410160	State	862.50	882.50	(20.00)	One line of dental implant charges was incorrectly paid due to clerical error.
65276243000	MUS	105,000.00	104,830.10	169.90	Charges for transplant. Charges were paid that should have been included in the global transplant fee.
05333e03871	State	9,113.72	7,612.52	1,501.20	Qnxt claim. Should have applied remaining coinsurance to charges. System issue.
14288305471	MUS	27.00	-	27.00	The immunization maximum had already been satisfied. This claim should have been denied. System coding issue.
	Totals	120,364.94	118,692.72	1,672.22	

EXHIBIT B

MONTANA UNIVERSITY SYSTEM
TRADITIONAL PLAN CLAIM AUDIT - ALLEGIANCE
SUMMARY OF FINDINGS
AUDIT PERIOD JANUARY 1, 2004 THROUGH DECEMBER 31, 2005

CLAIM #	PAID AMOUNT	AUDITED AMOUNT	DOLLAR VALUE OF ERROR	TYPE
200603011859	548.67	573.67	(25.00)	Should have only applied 1 ER copay.
Totals	548.67	573.67	(25.00)	

Exhibit C

STATE OF MONTANA EMPLOYEE BENEFIT PLAN (Qnxt System)
BLUE CROSS BLUE SHIELD OF MONTANA
RESULTS OF SYSTEM TESTS

	RESULTS		
TEST	**PASS**	**FAIL**	**COMMENT**
Duplicate Claims Tests	All 10		
Logic Claims Tests			
Change Diagnosis	4		
Change Billed Amount	4		
Change Provider Code	4		
Other Claims Tests			
Terminated Member	All 5		
Terminated Dependent	All 5		
Fictitious Provider	All 5		
Fictitious Service Code	All 5		
COB Claims	All 5		
Test/Allowable Data	All 5		
Inconsistent With Sex	3	2	ICD-9 codes 650 & 622.10

Exhibit C

MONTANA UNIVERSITY SYSTEM EMPLOYEE BENEFIT PLAN
ALLEGIANCE
RESULTS OF SYSTEM TESTS

	RESULTS		
TEST	**PASS**	**FAIL**	**COMMENT**
Duplicate Claims Tests	All 10		
Logic Claims Tests			
Change Diagnosis	4		
Change Billed Amount	4		
Change Provider Code	4		
Other Claims Tests			
Terminated Member	All 5		
Terminated Dependent	All 5		
Fictitious Provider	All 5		
Fictitious Service Code	All 5		
COB Claims	All 5		
Test/Allowable Data	All 5		
Inconsistent With Sex	4	1	ICD-9 code 626

BlueCross BlueShield of Montana
An Independent Licensee of the Blue Cross and Blue Shield Association

560 N. Park Avenue
P.O. Box 4309
Helena, Montana 59604
(406) 444-8200
Customer Information Line:
1-800-447-7828
Website:
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November 22, 2006

MARIE POLLOCK
WOLCOTT & ASSOCIATES, INC
12120 STATE LINE ROAD, Suite 297
LEAWOOD KS 66209

RE: Montana University System and State of Montana Traditional Claim Audit

Dear Marie:

This letter is in acknowledgement of the draft report for the Montana University System and State of Montana Traditional claim audit recently completed for the audit period January 1, 2004 through December 31, 2005.

This letter includes Blue Cross Blue Shield of Montana's (BCBSMT) responses to the Summary of Findings in Exhibit A, and Recommendations.

Exhibit A

Claim	
State	Should have applied remaining coinsurance. The claim is overpaid $10.22. **Comment:** BCBSMT agrees with this finding. $10.22 coinsurance was remaining to meet the Maximum Member Liability (MML) and should have been applied to the audit claim.
State	Claim incorrectly denied due to clerical error. Claim is underpaid $16.10 **Comment:** BCBSMT agrees with this finding. The audit claim suspended for review and the incorrect resolution code was put on the claim causing it to deny in error. The claim has been adjusted and the correct payment has been made.
State	One line of dental implant charges was incorrectly paid due to clerical error. The claim is underpaid $20.00.

Comment: BCBSMT agrees with this finding. This is an adjusted claim and the anesthesia allowance was manually reduced in error. We are in the process of adjusting this claim to correct the payment.

MUS

Charges for transplant. Charges were paid that should have been included in the global transplant fee. The claim is overpaid $169.90.

Comment: BCBSMT agrees with this finding. This occurred because the provider(s) billed direct through BlueCard rather than through the transplant network. We are currently investigating to see if claims can be adjusted to recover the overpayment.

State

QNXT claim. Should have applied remaining coinsurance to charges. System issue. The claim is overpaid $1,501.20.

Comment: BCBSMT agrees with this finding. We are investigating the extent of the issue and once we have the necessary information will be discussing it with the group.

MUS

The immunization maximum had already been satisfied. This claim should have been denied. System coding issue. The claim is overpaid $27.00

Comment: BCBSMT agrees with this finding. The system coding has been corrected.

II-3 RECOMMENDATIONS

- "We identified 2 errors that were due to clerical (data entry) errors. We recommend that further training be conducted, in order to avoid these types of errors in the future."

Comment: These issues were communicated to the individuals responsible and they have initiated adjustments on the claims. In addition training issues were reviewed with these long-term employees.

- "We identified 2 claims that the coinsurance was not correctly applied. One of these errors was processed on the new claim system, Qnxt. BCBSMT has indicated that this is a system issue and is currently being reviewed. We recommend BCBSMT perform an analysis, in order to understand the extent of this issue in the system and the amount of overpayments it has produced."

  Comment: We are investigating the extent of the issue and once we have the necessary information will be discussing it with the group.

Thank you for the opportunity to comment on this audit report. If your have any questions or comments, please contact me at (406) 447-8730.

Sincerely,

Arlene Troy
Internal Audit
Blue Cross and Blue Shield of Montana

STATE OF MONTANA and
MONTANA UNIVERSITY SYSTEM

ANALYSIS AND EVALUATION OF HMO CLAIMS PROCESSING FOR THE PERIOD JANUARY 1, 2004 THROUGH DECEMBER 31, 2005

ADMINISTERED BY

NEW WEST HEALTH PLAN
BLUE CROSS BLUE SHIELD OF MONTANA
PEAK HEALTH PLAN

FINAL REPORT

DECEMBER, 2006

PRESENTED BY

WOLCOTT & ASSOCIATES, INC.
12120 STATE LINE ROAD, SUITE 297
LEAWOOD, KANSAS 66209

STATE OF MONTANA AND MONTANA UNIVERSITY SYSTEM
HEALTH MAINTENANCE ORGANIZATION CLAIMS AUDIT
OF NEW WEST HEALTH PLAN, BLUE CROSS BLUE SHIELD OF MONTANA &
PEAK HEALTH PLAN
JANUARY 1, 2004 - DECEMBER 31, 2005

TABLE OF CONTENTS

EXHIBITS

* Peak Health Plan chose not to provide a response to the report

I - INTRODUCTION

The State of Montana (State) provides self-funded HMO medical care benefit as part of an overall employee benefit and compensation program. The plan covers approximately 3,000 employees and retirees, plus their dependents.

The State has negotiated a contract with New West Health Plan (NWHP), Blue Cross Blue Shield of Montana (BCBSMT) and Peak Health Plan (PHP) to provide administration services to its plans.

The Montana University System (MUS) is a member of the Montana Association of Health Care Purchasers, and has also contracted to have their medical and dental care benefits administered by BCBSMT, PHP and NWHP. The plan covers approximately 1,000 employees and retirees, plus their dependents.

The State invited MUS to participate in an audit of NWHP, BCBSMT and PHP's processing of medical care claims.

PURPOSE OF SERVICE

Section 2.18.816, MCA requires the State Employee Benefits Plan to be audited every two years by or at the direction of the Legislative Audit Division. Wolcott & Associates, Inc. was awarded the audit contract for the 2002-2003 Plan Years. Subsequently, our contract was renewed for the 2004-2005 Plan Years.

The purpose of the service is to comply with Section 2.18.816, MCA.

The State and MUS recognize that they have a fiduciary responsibility to administer this plan (and other employee benefit plans) for the benefit of plan participants and their dependents and in accordance with the plan provisions. Both plan sponsors believe it is prudent to perform periodic audit and review services to determine if the benefit plans they sponsor are meeting these objectives.

AUDIT TIMING AND STAFF

The Legislative Audit Division advised Wolcott & Associates, Inc. that the contract would be renewed on June 15, 2006. All preliminary work was completed and the entrance meeting was held in Helena on September 11, 2006. On-site work at the State, MUS, BCBSMT, NWHP and PHP was performed during the weeks of August 28, September 11 and 25, 2006.

On-site audit services were performed at:

State of Montana
State Personnel Division
Mitchell Building
Helena, Montana 59620

Montana University System
46 Last Chance Gulch
Helena, Montana 59620

New West Health Plan
40 West 14th Street, Suite 3
Helena, Montana 59601

Blue Cross & Blue Shield of Montana
560 North Park Avenue
Helena, Montana 59601

Peak Health Plan
2806 South Garfield Street
Missoula, Montana 59806

Wolcott & Associates, Inc. staff involved in the audit are listed below:

Name	Title	On-site
Brian Wyman	Manager	Yes
Marie Pollock	Vice President, Project Director	Yes
Richard Reese	Actuary	No
Jenny Hill	Statistician	No

SCOPE OF AUDIT

The scope of audit services covered medical care benefit claims paid by NWHP, BCBSMT and PHP during the period from January 1, 2004 through December 31, 2005. Test work was performed on 450 previously processed claims (150 claims per administrator), all of which were selected on a stratified, random (statistical) basis.

Claims Adjudication Audit

Elements of claims adjudication which were evaluated include:

- Turnaround time required to process each claim.
- Eligibility of claimants to receive payment.

- Administration of coordination of benefits, including Medicare.
- Administration of subrogation provisions.
- Calculation accuracy, including Usual, Customary and Reasonable (UCR) limits and computation of deductible and co-payment limits.
- Completeness of necessary information.
- Payee accuracy, including benefit assignments to service providers.
- Consistency of payments to member physicians and other physicians.
- Compliance with benefit plan structure.
- Identification of duplicate claim submissions.

II - STATISTICAL CLAIM AUDIT RESULTS - NEW WEST HEALTH PLAN

The results of our audit of previously processed claims are presented in this section.

SAMPLE SIZE AND METHODOLOGY

The proposal request stated that our sample size was to be large enough so as to express the frequency of error with a 95% confidence and a precision of + or - 3%, assuming an error rate of 5% or less. As a result, we proposed to audit a sample of 150 claims.

The claims were selected from the population of claims paid by NWHP between January 1, 2004 and December 31, 2005. Prior to selection, the population of claims was stratified.

AUDIT PROCEDURE

Information presented below describes our test work on the 150 previously processed claims in our sample and the errors identified. The test involved the following:

- Review of previously processed claims to determine if selected claim is a duplicate of a previously processed claim.
- Review of member specific coverage on NWHP's records to the coverage indicated on the plan's records.
- Verification that members are employees/retirees of the plan and covered under the plan at the time the claim was incurred.
- Review to determine that NWHP is following all procedures necessary to obtain a reasonable level of coordination of benefits (COB) recoveries.
- Recomputation of each claim selected for testing to determine its accuracy including analysis of any refunds due and/or payable.
- Review of the nature of the claim to ascertain the allowability of costs as defined in the contract (e.g., processed within the proper allowance and medical necessity guidelines, pre-certification requirements and other benefit limitation guidelines).
- Comparison of each claim to supporting documentation submitted by the member or the provider of services to ensure that the claim reflects the documentation and that it is properly authorized for payment.
- Comparison of each claim to other claims for that individual with the same date of service to ensure congruency of payment with all claims for that date of service.

- Review of the microfilm copies and source documents, when appropriate, to determine if there are any indications of fraud.

DEFINITION OF ERROR

We defined an error to be any claim where the payment to the participant or the provider did not agree with the plan document provisions.

AUDIT RESULTS

Of the 150 claims in our statistical sample, 7 were judged to contain a payment error. This represents a frequency of payment error of 4.7%. This is more favorable than the 12.0% error reported in the prior audit.

Our sample contained a total payment of $1,230,449.44 for the 150 claims. The overpayments totaled $3,645.86 or 0.30% of the total. The underpayments totaled $846.81 or 0.07% of the total. This financial error rate is more favorable than the .5 to 1 percent error rate normally observed during our audits of similar plans. It is also more favorable than the NWHP standard of 1%. In addition, it is more favorable than the 1.25% error rate reported in the prior audit.

The frequency of payment error in our sample is within the range of three to five percent error rate normally observed during our audits of similar plans. However, it is less favorable than the NWHP standard of 3%.

POPULATION DATA

Our sample was selected on a stratified basis. The basis for stratification was paid amount. This sampling method can be expected to produce sample results that differ from the results projected for the population.

We have extended the results of our sample to the population of claims paid during the audit period.

Based on this extension, we are 95% confident with a precision of + or - 4.0%, that the true frequency of error in the population is within the range of 0.7% to 8.7%.

Based on this extension, we believe that the true magnitude of payment error in the population is $521,184 or (4.2% of payments in the population). The magnitude of payment error is the sum of $51,150 in projected overpayments plus $470,034 in projected underpayments.

TYPES OF ERRORS

Each of the errors identified in our sample is listed in **Exhibit A**. A discussion of error types is presented below.

A summary of error by type is presented below:

NWHP HEALTH CARE CLAIMS
JANUARY 1, 2004 THROUGH DECEMBER 31, 2005
SUMMARY OF ERRORS BY TYPE

ERROR TYPE	NUMBER	NET PAYMENT ERROR
Incorrect application of co-insurance and/or deductible.	2	$ 1,681.08
Incorrect application of copay provisions.	2	(754.10) net
Incorrect repricing.	2	1,949.78
Incorrect payment of mammogram.	1	(77.71)
Total	7	$2,799.05

NWHP has included their response as **Exhibit D**.

RECOMMENDATIONS

Our recommendations are as follows:

- We believe NWHP has significant improvements to the configuration issues identified in the prior audit. However, we did identify a couple of claims that were overpaid caused by the configuration issues regarding deductible and coinsurance application. We recommend that NWHP continue running reports, in order to identify overpayments caused by the configuration issue. In addition, we recommend NWHP reimburse the State and MUS the amount of the overpayments identified.

III - STATISTICAL CLAIM AUDIT RESULTS - BCBSMT

The results of our audit of previously processed claims are presented in this section.

SAMPLE SIZE AND METHODOLOGY

The proposal request stated that our sample size was to be large enough so as to express the frequency of error with a 95% confidence and a precision of + or - 3%, assuming an error rate of 5% or less. As a result, we proposed to audit a sample of 150 claims.

The claims were selected from the population of claims paid by BCBSMT between January 1, 2004 and December 31, 2005. Prior to selection, the population of claims was stratified.

As of October 1, 2005, the claims processed on behalf of the State were processed on the new system, QNXT. Our sample did include claims processed on the new system. The MUS claims are still processed on the LRSP system.

AUDIT PROCEDURE

Information presented below describes our test work on the 150 previously processed claims in our sample and the errors identified. The test involved the following:

- Review of previously processed claims to determine if selected claim is a duplicate of a previously processed claim.
- Review of member specific coverage on BCBSMT's records to the coverage indicated on the plan's records.
- Verification that members are eligible participants of the plan and covered under the plan at the time the claim was incurred.
- Review to determine that BCBSMT is following all procedures necessary to obtain a reasonable level of coordination of benefits (COB) recoveries.
- Recomputation of each claim selected for testing to determine its accuracy including analysis of any refunds due and/or payable.
- Review of the nature of the claim to ascertain the allowability of costs as defined in the contract (e.g., processed within the proper allowance and medical necessity guidelines, pre-certification requirements and other benefit limitation guidelines).

- Comparison of each claim to supporting documentation submitted by the member or the provider of services to ensure that the claim reflects the documentation and that it is properly authorized for payment.

- Comparison of each claim to other claims for that individual with the same date of service to ensure congruency of payment with all claims for that date of service.

- Review of the microfilm copies and source documents, when appropriate, to determine if there are any indications of fraud.

DEFINITION OF ERROR

We defined an error to be any claim where the payment to the participant or the provider did not agree with the plan document provisions.

AUDIT RESULTS

Of the 150 claims in our statistical sample, 17 were judged to contain a payment error. This represents a frequency of payment error of 11.3%. The results were less favorable than the 10.7% reported in the prior audit report.

Our sample contained a total payment of $1,830,763.08 for the 150 claims. The overpayments totaled $27,658.10 or 1.5% of the total. The underpayments totaled $519.31 or 0.03% of the total. This error rate is less favorable than the .5 to 1 percent error rate normally observed during our audits of similar plans. It is also less favorable than the BCBSMT standard of 1%. In addition, the results are less favorable than the 1.29% reported in the prior audit report.

The frequency of payment error in our sample is less favorable than the three to five percent error rate normally observed during our audits of similar plans. It is also less favorable than the BCBSMT standard of 3%.

It should be noted that 12 claims in our sample of 150 were processed on the new system (Qnxt). Two claims were determined to be errors. This represents a frequency of payment error of 16.7%.

POPULATION DATA

Our sample was selected on a stratified basis. The basis for stratification was paid amount. This sampling method can be expected to produce sample results that differ from the results projected for the population.

We have extended the results of our sample to the population of claims paid during the audit period.

Based on this extension, we are 95% confident with a precision of + or - 4.9%, that the true frequency of error in the population is within the range of 6.4% to 16.2%.

Based on this extension, we believe that the true magnitude of payment error in the population is $182,895 or (1.5% of payments in the population). The magnitude of payment error is the sum of $70,523 in projected overpayments plus $112,372 in projected underpayments.

TYPES OF ERRORS

Each of the errors identified in our sample is listed in **Exhibit B**. A discussion of error types is presented below.

A summary of error by type is presented below:

BCBSMT HEALTH CARE CLAIMS
JANUARY 1, 2004 THROUGH DECEMBER 31, 2005
SUMMARY OF ERRORS BY TYPE

ERROR TYPE	NUMBER	NET PAYMENT ERROR
Incorrect application of ambulance copay.	2	$ (48.80) net
Incorrect application of ER copay provisions.	3	(221.73) net
Payment for non-covered service.	1	40.00
Incorrect application of office visit copay.	1	(70.51)
Incorrect repricing.	10	27,439.83
Total	17	$27,138.79

BCBSMT has included their response as **Exhibit E**.

RECOMMENDATIONS

Our recommendations are as follows:

- We identified 10 claims where the negotiated discount, specifically St. James and Benefis Hospital, was not applied to inpatient claims. The overpayments are significant. We recommend that BCBSMT review the entire population of claim payments to those two particular hospitals and report to the State and MUS the magnitude of overpayment. We further recommend BCBSMT should reimburse the State and MUS the overpayments in the population as a result of the failure to apply the discounts.

- We believe the errors identified in the claims that were processed on the new system (Qnxt) are due to system issues. One being failure to apply ER copay and failure to deny non-covered private room charges. We understand BCBSMT conducted an audit of the new system. However, it seems as though not all issues were identified. A follow-up audit of the new system should be conducted and results shared with the State and MUS.

- We identified 2 claims where the ambulance co-pay was not applied. This is a system issue. We recommend that this issue be addressed with the programmers and analyzed for any overpayments and/or underpayments caused by the issue. We recommend that BCBSMT report to the State and MUS the results of the analysis.

IV - STATISTICAL CLAIM AUDIT RESULTS - PEAK HEALTH PLAN

The results of our audit of previously processed claims are presented in this section.

SAMPLE SIZE AND METHODOLOGY

The proposal request stated that our sample size was to be large enough so as to express the frequency of error with a 95% confidence and a precision of + or - 3%, assuming an error rate of 5% or less. As a result, we proposed to audit a sample of 150 claims.

The claims were selected from the population of claims paid by PHP between January 1, 2004 and December 31, 2005. Prior to selection, the population of claims was stratified.

AUDIT PROCEDURE

Information presented below describes our test work on the 150 previously processed claims in our sample and the errors identified. The test involved the following:

- Review of previously processed claims to determine if selected claim is a duplicate of a previously processed claim.
- Review of member specific coverage on PHP's records to the coverage indicated on the plan's records.
- Verification that members are eligible participants of the plan and covered under the plan at the time the claim was incurred.
- Review to determine that PHP is following all procedures necessary to obtain a reasonable level of coordination of benefits (COB) recoveries.
- Recomputation of each claim selected for testing to determine its accuracy including analysis of any refunds due and/or payable.
- Review of the nature of the claim to ascertain the allowability of costs as defined in the contract (e.g., processed within the proper allowance and medical necessity guidelines, pre-certification requirements and other benefit limitation guidelines).
- Comparison of each claim to supporting documentation submitted by the member or the provider of services to ensure that the claim reflects the documentation and that it is properly authorized for payment.

- Comparison of each claim to other claims for that individual with the same date of service to ensure congruency of payment with all claims for that date of service.

  Review of the microfilm copies and source documents, when appropriate, to determine if there are any indications of fraud.

DEFINITION OF ERROR

We defined an error to be any claim where the payment to the participant or the provider did not agree with the plan document provisions.

AUDIT RESULTS

Of the 150 claims in our statistical sample, 3 were judged to contain a payment error. This represents a frequency of payment error of 2.0%. The results are more favorable than the 4.7% reported in the prior audit report.

Our sample contained a total payment of $1,269,238.50 for the 150 claims. The overpayments totaled $15.00 or 0.001% of the total. The underpayments totaled $225.00 or 0.02% of the total. This error rate is more favorable than the .5 to 1 percent error rate normally observed during our audits of similar plans. It is also more favorable than the PHP standard of 1%. In addition, the results are more favorable than the 0.24% reported in the prior audit report.

The frequency of payment error in our sample is more favorable than the three to five percent error rate normally observed during our audits of similar plans. It is also more favorable than the PHP standard of 3%.

POPULATION DATA

Our sample was selected on a stratified basis. The basis for stratification was paid amount. This sampling method can be expected to produce sample results that differ from the results projected for the population.

We have extended the results of our sample to the population of claims paid during the audit period.

Based on this extension, we are 95% confident with a precision of + or - 2.2%, that the true frequency of error in the population is within the range of 0.2% to 4.2%.

Based on this extension, we believe that the true magnitude of payment error in the population is $4,002 or (0.10% of payments in the population). The magnitude of payment error is the sum of $3,777 in projected overpayments plus $225 in projected underpayments.

TYPES OF ERRORS

Each of the errors identified in our sample is listed in **Exhibit C**. A discussion of error types is presented below.

A summary of error by type is presented below:

PHP HEALTH CARE CLAIMS
JANUARY 1, 2004 THROUGH DECEMBER 31, 2005
SUMMARY OF ERRORS BY TYPE

ERROR TYPE	NUMBER	NET PAYMENT ERROR
Incorrect application of copay provisions.	3	$ (210.00) net
Total	3	$ (210.00)

PHP has indicated to us that they will not provide a response to the report.

RECOMMENDATIONS

Our recommendation is as follows:

- The 3 errors that were identified included the incorrect application of the ER co-pay for inpatient services and one claim for an incorrect application of mental health co-pay. We recommend that PHP conduct an analysis of ER co-pays and review for possible incorrect application of the benefit. We further recommend that PHP reimburse the State and MUS for the payment errors identified in the analysis.

DISCUSSION ISSUES

We identified 2 issues that warrant further discussion between Allegiance and the State and MUS.

- The first issue is in regards to services rendered at a non-network facility. Health InfoNet will stamp a claim as "no referral needed" or "non-participating". Allegiance processes these claims with in-network benefits. However, the plan provisions do not require a referral and does allow for non-network benefits at a lower reimbursement level.

  Allegiance has indicated to us that Health InfoNet has directed them to pay these claims at the in-network level. We believe this may be contrary to the benefit provisions in the State and MUS's plan document. Allegiance and the State and MUS should discuss this issue and agree how to process these claims.

- The second issue is in regards to primary insurance and the failure of Health InfoNet to apply discounts when another plan (other than Peak) is the primary payor of benefits.

  The State and MUS may be losing discounts, if there is a primary payor and their discount may or may not be as favorable as the Health InfoNet discount. In one situation, we identified a fairly substantial claim for a participant who was involved in a motor vehicle accident. The automobile insurance made a payment, which exhausted the automobile medical benefits, of $4,000. Health InfoNet did not reprice this claim, due to the fact another insurance carrier was primary. We believe this policy could be detrimental to the magnitude of savings by the State and MUS.

V - ELIGIBILITY

The plan sponsors use various methods to report new entrants, changes and termination of coverage to BCBSMT, NWHP and PHP. This section describes the methods employed and presents the results of the verification of eligibility for the 450 (150 claims per administrator) in our sample where a payment was made by each administrator.

STATE OF MONTANA

The State prepares and sends to the vendors a biweekly eligibility tape showing each individual to be covered for the coming month. The administrators run this tape and compares it to the data for the prior month.

Eligibility Verification

Each of the State participants in our sample was researched on the State eligibility system to verify that the State's records indicated that coverage was in force on the date the services were rendered.

No exceptions were noted.

MONTANA UNIVERSITY SYSTEM

The administrator's receive the enrollment data from each campus on a daily basis. NWHP, BCBSMT and PHP then follow the same process as the State.

Eligibility Verification

Each of the MUS participants in our sample was researched at the applicable campus to verify that the administrator's records indicated that coverage was in force on the date the services were rendered. MUS records confirmed that all participants in the sample were covered as of the date the services were rendered.

No exceptions were noted.

VI - ID CARD ISSUANCE

Upon entry of the new eligibility information in each of the administrator's systems, an ID card is automatically generated. The procedures are the same in each of the three administrators.

ID cards are issued the following day after an entry warrants the issuance of the card at BCBSMT and PHP. NWHP only prints ID cards once a week, unless a request for a more immediate turnaround time is received from the plan sponsor.

We believe the ID card issuance procedures at each of the administrator's is consistent with procedures at other insurance companies and third party administrator's with which we are familiar. The only exception is the the procedure at NWHP may cause some delay with only printing ID cards once a week.

VII - CLAIM PAYMENT TURNAROUND TIME

The purpose of this section is to present our analysis of the claim turnaround time information for each of the 450 claims in our sample.

Claim Processing Time

Claim processing time or turnaround time for this audit was measured from the "received date" as entered on the claim document to the date the date the claim was processed.

Results, by plan sponsor, are presented below.

NWHP

For all 150 claims in our sample, the turnaround time results are as follows:

Measure	Elapsed Days
Mean	22
Median	9
Mode	7

NWHP informed us that company policy for turnaround time is 14 day.

BCBSMT

For all 150 claims in our sample, the turnaround time results are as follows:

Measure	Elapsed Days
Mean	7
Median	2
Mode	1

BCBSMT informed us that company policy for turnaround time is 7 day average for non-investigated claims and 21 day average for claims requiring investigation.

PHP

For all 150 claims in our sample, the turnaround time results are as follows:

Measure	Elapsed Days
Mean	12
Median	9
Mode	7

PHP informed us that company policy for turnaround time is 14 days.

COMMENT

The turnaround time results for NWHP do not meet their own turnaround time standards and do not meet industry standards. BCBSMT and PHP do meet their own turnaround time standards and industry standards.

VIII - OTHER REVIEW AREAS

The results of our review in areas requested by the three plan sponsors is as follows.

SUSPENDED CLAIMS

We requested reports from all the administrators.

NWHP provided Wolcott & Associates, Inc. this report during the conduct of the previous audit. However, NWHP did not provide it during the conduct of this year's audit.

BCBSMT did not provide the requested information for any of the plan sponsors. They indicated to us that this is not a report typically provided to plan sponsors.

PHP indicated that their system could not provide this type of report.

DENIED CLAIMS

We requested reports from all the administrators. PHP was the only administrator that provided the reports regarding the number of claims denied. In addition, determine the percentage denied due to ineligibility of a member.

NWHP provided Wolcott & Associates, Inc. this report during the conduct of the previous audit. However, NWHP did not provide it during the conduct of this year's audit.

BCBSMT did not provide the requested information for any of the plan sponsors. They indicated to us that this is not a report typically provided to plan sponsors.

Results - PHP

PHP did not provide a count total for denied claims.

PHP reported that the top 5 reasons for denial were as follows:

- Duplicate claim submission,
  Plan limits for routine services,
- Not covered benefit,
- Charges prior to and/or after effective date, and
- Pre-existing condition.

The total amount for denied claims was $837,031.26.

PHP did not include providers and provider type in their report.

We calculated that 551 claims were denied for member not eligible for benefits.

PREAUTHORIZATION

A strong recommendation for pre-admission notification is part of each plan sponsor's Plan provisions. BCBSMT and NWHP utilize resources internally. PHP utilizes the services of Rocky Mountain Health Network for the preauthorization process. The procedure can be initiated by either the individual or the provider of services. The services requiring preauthorization are typical with other plans with which we are familiar.

EXHIBIT A

STATE OF MONTANA AND MONTANA UNIVERSITY SYSTEM
MANAGED CARE CLAIM AUDIT
SUMMARY OF FINDINGS - NEW WEST HEALTH PLAN
AUDIT PERIOD JANUARY 1, 2004 THROUGH DECEMBER 31, 2005

CLAIM #	CLAIM TYPE	AMOUNT PAID	AUDITED AMOUNT	DOLLAR VALUE OF ERROR	TYPE
SHS05124011042	P	357.00	345.00	15.00	Copay should have applied. A copay was already applied for same DOS. However, this claim was for a different provider.
e989222	i	88.92	166.63	(77.71)	Charges for mammogram should have paid at 100%.
e938038	p	68.18	52.12	16.06	Second line of charges should have applied to deductible.
e674905	i	409.30	348.00	61.30	Incorrect repricing for inpatient stay.
e979761	i	2,343.56	3,112.66	(769.10)	Incorrectly applied copay to each line of charges.
e876540	i	21,921.66	20,033.18	1,888.48	Incorrect repricing for inpatient stay.
e906435	i	28,712.24	27,047.22	1,665.02	Should have applied remaining coinsurance.
Totals		53,900.86	51,104.81	2,799.05	

EXHIBIT B

STATE OF MONTANA AND MONTANA UNIVERSITY SYSTEM
MANAGED CARE CLAIM AUDIT
SUMMARY OF FINDINGS - BCBSMT
AUDIT PERIOD JANUARY 1, 2004 THROUGH DECEMBER 31, 2005

CLAIM #	GROUP	PAID AMOUNT	AUDITED AMOUNT	DOLLAR VALUE OF ERROR	TYPE
05318e04582	State	431.09	356.09	75.00	Qnxt claim. New claim system was not applying ER copay.
05215206190	MUS	70.51	141.02	(70.51)	Incorrectly applied 6 $15 copays for one charge. The unit indicator on the claim was 1, but the DOS spanned 6 days. BCBSMT incorrectly assumed 6 units.
05056005010	State	38,720.81	34,648.73	4,072.08	Claim from Benefis Hospital paid without applying 10% discount.
05168010010	State	30,434.69	27,391.22	3,043.47	Claim from Benefis Hospital paid without applying 10% discount.
05220015040	State	43,939.11	39,533.44	4,405.67	Claim from Benefis Hospital paid without applying 10% discount.
05188008030	State	11,215.75	10,094.17	1,121.58	Claim from Benefis Hospital paid without applying 10% discount.
05178006080	State	50,874.96	45,787.46	5,087.50	Claim from Benefis Hospital paid without applying 10% discount.
05138006040	MUS	41,055.00	36,826.19	4,228.81	Claim from Benefis Hospital paid without applying 10% discount.
15096108120	State	4,204.01	4,023.87	180.14	Claim from St. James Hospital paid without applying 4% discount.
15165101940	State	24,845.93	23,818.23	1,027.70	Claim from St. James Hospital paid without applying 4% discount.
15096108050	MUS	25,640.82	24,587.80	1,053.02	Claim from St. James Hospital paid without applying 4% discount.
04224009030	State	32,198.55	28,978.69	3,219.86	Claim from Benefis Hospital paid without applying 10% discount.
15259107560	MUS	3,181.43	3,330.23	(148.80)	Should have applied $100 copay for air ambulance charge.
05318e04178	State	54,036.24	53,996.24	40.00	Qnxt claim. Private room difference was not denied as non-covered.
45040810800	State	58,777.50	58,677.50	100.00	Should have applied $100 ambulance copay.
15259100100	MUS	4,141.97	4,441.97	(300.00)	Should not have applied Deductible to ER charges. System coding issue.
14160107560	State	10.61	7.34	3.27	Should have have applied remaining $3.27 to the ER copay. Other charges on claim would have allowed for the full $75 copay to be applied.
Totals		423,778.98	396,640.19	27,138.79	

EXHIBIT C

STATE OF MONTANA AND MONTANA UNIVERSITY SYSTEM
MANAGED CARE CLAIM AUDIT
SUMMARY OF FINDINGS - PEAK HEALTH PLAN
AUDIT PERIOD JANUARY 1, 2004 THROUGH DECEMBER 31, 2005

CLAIM #	GROUP	PAID AMOUNT	AUDITED AMOUNT	DOLLAR VALUE OF ERROR	TYPE
200506292481	MUS	13,266.17	13,341.17	(75.00)	Should not have applied $75 ER copay to inpatient claim.
200403300239	MUS	13,865.96	14,015.96	(150.00)	Should not have applied 2 $75 ER copays to inpatient claim.
200406153936	MUS	60.00	45.00	15.00	Should have applied $15 copay for pharmacy management for mental health condition.
	Totals	27,192.13	27,402.13	(210.00)	

November 27, 2006

Wolcott and Associates
Attention: Marie Pollock
12120 State Line Road, Suite 297
Leawood, Kansas 66209

Dear Ms. Pollock,

This letter is in response to your audit findings report regarding the Analysis and evaluation of HMO Claims processing for the period from January 2004 through December 31, 2005, which was conducted on behalf of the State of Montana University System.

New West finds the audit results overall to reflect correct findings in most areas, however, New West has comments for specific sections as detailed in the following areas of this letter. The letter is submitted by Dory Hicks on behalf of Paul Marchant; Director of Operations, who is not available for signature on the letter on this date.

1. **Section II Statistical Claim Audit Results regarding the following Wolcott comment:**

The frequency of payment error in our sample is within the range of three to five percent error rate normally observed during our audits of similar plans. However, it is less favorable than the NWHP standard of 3%.

NWHP prefers that for this audit and in future audits, comparison to our internal standard not be used as criteria for comment by Wolcott and Associates.

2. **Section II Statistical Claim Audit Results , regarding the following Wolcott comment:**

Our recommendations are as follows:

We believe NWHP has significant improvements to the configuration issues identified in the prior audit. However, we did identify a couple of claims that were overpaid caused by the configuration issues regarding deductible and coinsurance application. We recommend that NWHP continue running reports, in order to identify overpayment caused by the configuration issue. In addition, we recommend NWHP reimburse the State and MUS the amount of the overpayments identified.

NWHP would like to note that claims that were underpaid have been adjusted. Overpaid claims which were identified have been addressed with letters requesting refund from the providers. We continue to run reports and conduct internal audits to identify any issues with configuration.

3. **Section VII Claim Payment Turnaround Time, regarding the following comment:**

The turnaround time results for NWHP do not meet their own turnaround time standards and do not meet industry standards.

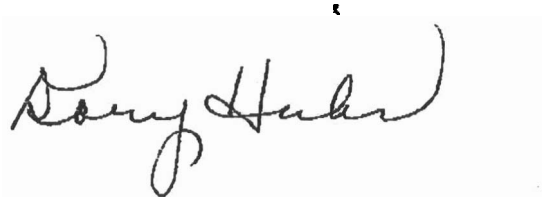
NWHP wishes to note that the NWHP standard matches the Industry standard of 14 days.

4. **Section VIII Other Review Areas regarding the following comment:**

Wolcott comments that for Suspended Claims and Denied Claims, NWHP provided Wolcott & Associates, Inc. this report during the conduct of the previous audit. However, NWHP did not provide it during the conduct of this year's audit.

NWHP agrees with these comments and will supply reports as requested in future audits.

Sincerely,



Dory Hicks

Director IT/NWHP

BlueCross BlueShield of Montana

An Independent Licensee of the Blue Cross and Blue Shield Association

560 N. Park Avenue
P.O. Box 4309
Helena, Montana 59604
(406) 444-8200
Customer Information Line:
1-800-447-7828
Website:
www.bluecrossmontana.com

November 21, 2006

MARIE POLLOCK
WOLCOTT & ASSOCIATES, INC
12120 STATE LINE ROAD, Suite 297
LEAWOOD KS 66209

RE: Montana University System and State of Montana Managed Care Claim Audit

Dear Marie:

This letter is in acknowledgement of the draft report for the Montana University System and State of Montana Managed Care claim audit recently completed for the audit period January 1, 2004 through December 31, 2005.

This letter includes Blue Cross Blue Shield of Montana's (BCBSMT) response to the Summary of Findings in Exhibit B, and Recommendations.

Exhibit B

Group	
State	QNXT claim. New claim system was not applying ER copay. The claim is overpaid $75. **Comment:** BCBSMT agrees with this finding. The system coding has been corrected. Four other claims were also affected and have been adjusted.
MUS	Incorrectly applied 6 $15 copays for one charge. The unit indicator on the claim was 1, but the DOS spanned 6 days. BCBSMT incorrectly assumed 6 units. The claim is underpaid $70.51 **Comment:** BCBSMT agrees this claim is underpaid; however, this payment error was due to a provider billing error. With a six-day span for the date of service, the system cannot select one date of service. Rather, copays are applied appropriately for each date of service billed.

State

Claim from Benefis Hospital paid without applying 10% discount. This claim is overpaid $4,072.08.

Comment: BCBSMT agrees with this finding. The system coding has been corrected. BCBSMT has identified all claims paid to Benefis Healthcare that did not appropriately apply the 10% discount. A check had to be issued and delivered to the group to address this error.

State

Claim from Benefis Hospital paid without applying 10% discount. This claim is overpaid $3,043.47.

Comment: BCBSMT agrees with this finding. The system coding has been corrected. BCBSMT has identified all claims paid to Benefis Healthcare that did not appropriately apply the 10% discount. A check had to be issued and delivered to the group to address this error.

State

Claim from Benefis Hospital paid without applying 10% discount. This claim is overpaid $4,405.67.

Comment: BCBSMT agrees with this finding. The system coding has been corrected. BCBSMT has identified all claims paid to Benefis Healthcare that did not appropriately apply the 10% discount. A check had to be issued and delivered to the group to address this error.

State

Claim from Benefis Hospital paid without applying 10% discount. This claim is overpaid $1,121.58.

Comment: BCBSMT agrees with this finding. The system coding has been corrected. BCBSMT has identified all claims paid to Benefis Healthcare that did not appropriately apply the 10% discount. A check had to be issued and delivered to the group to address this error.

State

Claim from Benefis Hospital paid without applying 10% discount. This claim is overpaid $5,087.50.

Comment: BCBSMT agrees with this finding. The system coding has been corrected. BCBSMT has identified all claims paid to Benefis Healthcare that did not appropriately apply the 10%

discount. A check had to be issued and delivered to the group to address this error.

MUS

Claim from Benefis Hospital paid without applying 10% discount. This claim is overpaid $4,228.81.

Comment: BCBSMT agrees with this finding. The system coding has been corrected. BCBSMT has identified all claims paid to Benefis Healthcare that did not appropriately apply the 10% discount. A check had to be issued and delivered to the group to address this error.

State

Claim from St. James Hospital paid without applying 4% discount. This claim is overpaid $180.14.

Comment: BCBSMT agrees with this finding. The system coding has been corrected. BCBSMT has identified all claims paid to St James Healthcare that didn't appropriately apply the 4% discount. The claims that are within the 12-month period have been adjusted as allowed by Montana Code Annotated (MCA) 33-22-150 and 33-22-151. For claims that could not be adjusted, a check had to be issued and delivered to the group to address this error.

State

Claim from St. James Hospital paid without applying 4% discount. This claim is overpaid $1,027.70.

Comment: BCBSMT agrees with this finding. The system coding has been corrected. BCBSMT has identified all claims paid to St James Healthcare that didn't appropriately apply the 4% discount. The claims that are within the 12-month period have been adjusted as allowed by Montana Code Annotated (MCA) 33-22-150 and 33-22-151. For claims that could not be adjusted, a check had to be issued and delivered to the group to address this error.

MUS

Claim from St. James Hospital paid without applying 4% discount. This claim is overpaid $1,053.02.

Comment: BCBSMT agrees with this finding. The system coding has been corrected. BCBSMT has identified all claims paid to St James Healthcare that didn't appropriately apply the 4%

	discount. The claims that are within the 12-month period have been adjusted as allowed by Montana Code Annotated (MCA) 33-22-150 and 33-22-151. For claims that could not be adjusted, a check had to be issued and delivered to the group to address this error.
State	Claim from Benefis Hospital paid without applying 10% discount. This claim is overpaid $3,219.86. **Comment:** BCBSMT agrees with this finding. The system coding has been corrected. BCBSMT has identified all claims paid to Benefis Healthcare that did not appropriately apply the 10% discount. A check had to be issued and delivered to the group to address this error.
MUS	Should have applied $100 copay for air ambulance charge. This claim is underpaid $148.80. **Comment:** BCBSMT agrees with the underpayment amount; however, disagrees with the issue as stated. The $100 copay was applied correctly but $148.80 was also applied to the deductible in error. This was due to place of service constraints within system coding. We are investigating the extent of the issue and once we have the necessary information will be discussing it with the group. Coding changes have been made and this issue will be corrected going forward.
State	QNXT claim. Private room difference was not denied as non-covered. The claim is overpaid $40.00. **Comment:** BCBSMT agrees with this finding. Our new claims processing system (QNXT) does not have the functionality to cut back to the semiprivate room rate. We are investigating the extent of the issue and once we have the necessary information will be discussing it with the group. Due to situations such as facilities having the same rate for private as for semi-private rooms, Medicare primacy, and provider discount strategies (such as DRG's) we feel that this issue will not be significant.
State	Should have applied $100 ambulance copay. The claim is overpaid $100.00.

Comment: BCBSMT agrees with this finding. We are have determined that it is related only to claims that process through BlueCard. System coding is being corrected. We are investigating the extent of the issue and once we have the necessary information will be discussing it with the group.

MUS

Should not have applied Deductible to ER charges. System coding issue. The claim is underpaid $300.00.

Comment: BCBSMT disagrees with this finding. Clarification was received from Paul Bogumill (while he was still at the State) in July of 2005 indicating deductible should also apply.

State

Should have applied remaining $3.27 to the ER copay. Other charges on claim would have allowed for the full $75 copay to be applied. The claim is overpaid $3.27.

Comment: BCBSMT disagrees with this finding. Clarification was received from Paul Bogumill (while he was still at the State) in July of 2005 indicating the $75 copay is only for revenue code 450, the actual charge for the emergency room.

III-3 RECOMMENDATIONS

1. We identified 10 claims where the negotiated discount, specifically St. James and Benefis Hospital, was not applied to inpatient claims. The overpayments are significant. We recommend that BCBSMT review the entire population of claim payments to those two particular hospitals and report to the State and MUS the magnitude of overpayment. We further recommend BCBSMT should reimburse the State and MUS the overpayments in the population as a result of the failure to apply the discounts.

Comment: As noted in the comments for Exhibit B, system coding has been corrected. BCBSMT has identified all claims paid to Benefis Healthcare and St James Healthcare that were affected by this issue. Refund checks were delivered to the groups for claims that were too old to adjust. Adjustments were performed on the remaining claims to credit the groups. BCBSMT has also implemented a new Quality Assurance check to ensure this type of error does not occur again.

---

2. We believe the errors identified in the claims that were processed on the new system (QNXT) are due to system issues. One being failure to apply ER copay and failure to deny non-covered private room charges. We understand BCBSMT conducted an audit of the new system. However, it seems as though not all issues were identified. A follow-up audit of the new system should be conducted and results shared with the State and MUS.

Comment: The system coding for the ER copay issue has been corrected and identified claims have been adjusted. We also feel that the non-covered private room rate differential will not be significant but we are investigating the extent of the issue and once we have the necessary information will be discussing it with the group.

---

3. We identified 2 claims where the ambulance co-pay was not applied. This is a system issue. We recommend that this issue be addressed with the programmers and analyzed for any overpayments and/or underpayments caused by the issue. We recommend that BCBSMT report to the State and MUS the results of the analysis.

Comment: There was only one ambulance claim identified where the copay was not applied and this issue in confined to claims processed through BlueCard. As noted in the comments for Exhibit B, system coding is being corrected. We are investigating the extent of the issue and once we have the necessary information will be discussing it with the group.

Thank you for the opportunity to comment on this audit report. If your have any questions or comments, please contact me at (406) 447-8730.

Sincerely,

Arlene Troy
Internal Audit
Blue Cross and Blue Shield of Montana

STATE OF MONTANA and
MONTANA UNIVERSITY SYSTEM

PRESCRIPTION DRUG CLAIM AUDIT

FOR THE PERIOD

JANUARY 1, 2004 THROUGH DECEMBER 31, 2005

ADMINISTERED BY

PHARMACARE MANAGEMENT SERVICES, INC.

FINAL REPORT

DECEMBER, 2006

PRESENTED BY

WOLCOTT & ASSOCIATES, INC.
12120 STATE LINE ROAD, SUITE 297
LEAWOOD, KANSAS 66209

STATE OF MONTANA AND MONTANA UNIVERSITY SYSTEM
PRESCRIPTION DRUG PLAN AUDIT
OF PHARMACARE MANAGEMENT SERVICES, INC.
JANUARY 1, 2004 - DECEMBER 31, 2005

TABLE OF CONTENTS

I - INTRODUCTION

The State of Montana (State) provides a prescription drug benefit as part of an overall employee benefit and compensation program. The plan covers approximately 15,000 employees and retirees, plus their dependents for a total of 32,000 covered.

The State is a member of the Montana Association of Health Care Purchasers. The Association has negotiated a contract with PharmaCare Management Services, Inc. (Pharmacare) to provide prescription drug benefits to employees and Association members that elect such benefits. The State has elected to have its prescription drug benefits provided by Pharmacare.

The Montana University System (MUS), has also contracted with Pharmacare for the provision of prescription drug benefits. The plan covers approximately 8,000 employees and retirees, plus their dependents.

PURPOSE OF SERVICE

Section 2.18.816, MCA requires the State Employee Benefits Plan to be audited every two years by or at the direction of the Legislative Audit Division. Wolcott & Associates, Inc. was awarded the audit contract for the 2002-2003 Plan Years and subsequently renewed that contract for the 2004-2005 Plan Years.

The purpose of the service is to comply with Section 2.18.816, MCA.

The State and MUS recognize that they have a fiduciary responsibility to administer this plan (and other employee benefit plans) for the benefit of plan participants and their dependents and in accordance with the plan provisions. Both sponsors believe it is prudent to perform periodic audit and review services to determine if the benefit plans they sponsor are meeting these objectives.

AUDIT TIMING AND STAFF

The Division advised Wolcott & Associates, Inc. that we had been awarded the audit contract. All preliminary work was completed and the entrance meeting was held in Helena on September 11, 2006.

The on-site work started on October 26, 2006 at Pharmacare's Pittsburgh corporate office.

Pharmacare Management Services
620 Epsilon Drive
Pittsburgh, PA 15238

Wolcott & Associates, Inc. staff involved in the audit are listed below:

Name	Title	On-site
Marie Pollock	Vice President	No
Brian Wyman	Manager	Yes
Richard Reese	Actuary	No

SCOPE OF AUDIT

The scope of audit services covered prescription drug benefit claims paid by Pharmacare during the period from January 1, 2004 through December 31, 2005. Test work was performed on 220 previously processed claims, 200 of which were selected on a stratified, random (statistical) basis and the remaining 20 were the top paid claims.

Scope elements included:

- Eligibility of claimants to receive payment.
- Calculation accuracy.
- Completeness of necessary information.
- Compliance with benefit plan structure.
- Identification of duplicate claim submissions.

II - STATISTICAL CLAIM AUDIT RESULTS

The results of our audit of previously processed claims are presented in this section.

SAMPLE SIZE AND METHODOLOGY

The proposal request stated that our sample size was to be large enough so as to express the frequency of error with a 95% confidence and a precision of + or - 3%, assuming an error rate of 5% or less. As a result, we proposed to audit a sample of 220 claims.

The claims were selected from the population of claims paid by Pharmacare between January 1, 2004 and December 31, 2005. Prior to selection, the population of claims was stratified.

The strata types were as follows: (1) Top 20 highest dollar amount and, (2) Electronic or Mail Order (combined).

AUDIT PROCEDURE

Each sample claim was manually reprocessed based on the plan's provisions in force as of the date the prescription was dispensed. Ingredient costs for electronic and paper (including out-of-network) claims were calculated based on Average Wholesale Prices (AWP) on the package size submitted or other applicable prices in effect on the date the prescription was dispensed. Ingredient costs for mail order claims were calculated based on AWP on package size submitted or other applicable prices in effect on the date the prescription was dispensed.

The percentage discounts, dispensing fees, and copayment amounts were compared to the plan's agreed upon provisions as of the date the prescription was dispensed.

Each sample claim's medication was identified and compared to the plan's requirements for:

- Exclusions,
- Pricing used at the time the prescription was dispensed,
- Recalculating payment amount,
- Appropriate copayment (generic, branded, etc.)
- Compliance with pre-approval requirements,
- Maximum number of days supply,
- Refill timing,
- Formulary limitations and,
- Eligibility of participant.

DEFINITION OF ERROR

All network pharmacy claim (electronic claims) payments were paid to the retail pharmacy. All mail order initial and refilled claim payments were paid to Pharmacare mail order pharmacy.

We defined an error to be any claim where the payment to the participant or the pharmacy did not agree with the plan document provisions.

AUDIT RESULTS

Of the 220 claims in our statistical sample, 7 were judged to contain a payment error. This represents a frequency of payment error of 3.18%. Of these 6 claims, 1 was an overpayment and 6 were underpayments.

Our sample contained a total payment of $165,667.44 for the 220 claims. The overpayment totaled $ 95.05 or .057% of the total. The underpayments totaled $456.30 or .28% of the total.

The sample's error magnitude, extended to the population, produces a projected overpayment of $499,031 (.71% of $70,831,900) and a projected underpayment of $14,734 (.36% of $70,831,900). The error magnitude rate in the sample differs from the error magnitude rate when extended to the population due to the weighting of the sample strata.

As a result, we are 95 percent confident that the true value of the prescription paid claims during the period ranges from $ 71,339,250 (the $70,831,900 recorded claims, minus the $484,297 projected net error, plus the $ 991,647 value of the 1.4 percent precision) and $ 69,349,946 (the $70,831,900 recorded claims, plus the $ 484,297 projected net error, less the $997,657 value of the 1.4 percent precision).

The Pharmacare standard accuracy rate is 99 percent or more of the gross dollar payments **should be paid accurately.** We understand the measurement is made by summing the overpayments and underpayments, and dividing the result by the total dollars and subtracting from 100%.

The overpayments/underpayments percentage from our results (extended to the population) total 0.33 percent. This equals a payment accuracy rate of 99.67 percent. These results are superior to the Pharmacare standard accuracy rate. They are also superior to the 99% accuracy standard established by other claim processors with which we are familiar.

TYPES OF ERRORS

Each of the errors identified in our sample is listed in **Exhibit A**. A discussion of error types is presented below.

PHARMACARE PHARMACY CLAIMS
JANUARY 1, 2004 THROUGH DECEMBER 31, 2005
SUMMARY OF ERRORS BY TYPE

ERROR TYPE	NUMBER	NET PAYMENT ERROR
Did not enter the correct DAW.	1	$95.05
Did not calculate correct discount	6	(456.30)
Total	7	$(361.25)

Corrective Action

We have discussed each of the above identified payment errors with Pharmacare. Their comments are added to our final report as **Exhibit B**. For those errors with which we agree, they have assured us that corrective action either has been or will be taken for each identified error and that steps will be taken to reduce the frequency of the types of errors observed.

CONCLUSION

Based on our audit of 220 claims, we conclude Pharmacare is processing the State and MUS claims in agreement with the plan provisions.

III - ELIGIBILITY

The State and MUS use various methods to report new entrants, changes and termination of coverage to Pharmacare. This section describes the methods employed and presents the results of the verification of eligibility for 20 of the claims in our sample.

STATE OF MONTANA

The State prepares and sends to Pharmacare a biweekly eligibility tape showing each individual to be covered for the coming month. Pharmacare runs this tape and compares it to the data for the prior month. An exception report is generated showing all errors in the file. The exception report is sent back to the State for correction or approval to load the file. If no exceptions were found, the file is loaded into the claim system.

MONTANA UNIVERSITY SYSTEM

Allegiance Benefit Plan Management, Inc. (Allegiance) processes claims for the MUS health care plan. Allegiance has also contracted to provide eligibility data to Pharmacare on behalf of MUS. Allegiance receives the enrollment data from each campus on a daily basis and transmits new entrant, change and termination data to Pharmacare electronically each day. An exception report is generated showing all errors in the file. The exception report is sent back to Allegiance for correction or approval to go ahead and load the file. If no exceptions were found, the file is loaded into the claim system.

ELIGIBILITY VERIFICATION

Each of the 20 participants in our sample was researched on Pharmacare eligibility system to verify that the participant's records indicated that coverage was in force on the date the prescription was dispensed.

No exceptions were noted.

Eligibility File Processing

During our review, Pharmacare has informed us that the eligibility files are loaded on the same day that they are received from the State or Allegiance. However, Pharmacare stated that they cannot generate a system report for verification that the turnaround time for loading eligibility files are within two business days.

We reviewed the "Reformat Summary History" report for forty files, noting the date received and the date loaded was within two business days.

Eligibility File Accuracy

During our review, Pharmacare has informed us that there is no system report that can be generated to show uploading accuracy rate is at least 98%. Pharmacare stated that if there are no exceptions found, the file is uploaded. For errors that were generated during uploading, they are sent back to the State or Allegiance for corrections or approvals.

Identification Cards Timeliness

During our fieldwork at Pharmacare office in Pittsburgh, we noted that Pharmacare generated a report showing an average turnaround time for identification cards for the following: (1) State shows an average turnaround time for the audit period is 2.33 days, (2) MUS shows an average turnaround time for the audit period is 2.52 days for new or replacement cards.

Pharmacare stated that identification card data is sent to the outsource vendor on a nightly basis to be processed the following day.

CONCLUSION

We noted no exceptions were found during our review in the eligibility area. However, Pharmacare could not provide information on uploading accuracy rate or generate a report showing all file loads were performed within two business days. Not having this information, Wolcott & Associates, Inc. could not obtain assurance that the upload accuracy rate is at least 98%, that the eligibility file uploads are performed within two business days.

Based on the results of our review activity, we conclude that Pharmacare is in compliance with terms of the Association contract as it relates to the an average turnaround time for identification card within four business days for new or replacement cards.

IV - LOGIC AND CLAIM TEST RESULTS

This section presents the results of test claims submitted to the Pharmacare claim system as a method of assessing the system's ability to identify inappropriate transactions.

LOGIC CLAIMS

We had Pharmacare entered a total of 10 fictitious electronic claims into the claim processing system at the Pittsburgh office. The electronic claims were submitted to the system in a test mode.

CLAIMS TESTED

We created a series of claims for the following situations:

- Two claims with same medication with different pharmacy,
- Two claims for medication the participant's termination date,
- Two claims over age limit,
- Two claims over days supply limit and
- Two claims requiring prior authorization.

CONCLUSION

Based on our test results, we conclude that the Pharmacare system is effective in identifying erroneous claims.

V - OTHER REVIEW ITEMS

Discussion regarding other claim review items are presented below.

PHARMACY NETWORK ACCESS

Pharmacare agreed, based upon census, that 100% of covered participants living in suburban areas will have access to at least one network pharmacy within five miles of the participant and 96.4% of covered participants living in rural areas will have access to one network pharmacy within fifteen miles of the participant.

We reviewed reports generated by Pharmacare stating that State participants had 100% access to one network pharmacy within a five mile radius in a suburban area and 92.2% had access to one network pharmacy within a fifteen mile radius in a rural area.

We reviewed reports generated by Pharmacare stating that MUS participants had 100% access to one network pharmacy within a five mile radius in a suburban area and 97% had access to one network pharmacy within a fifteen mile radius in a rural area.

The Pharmacare report made three assumptions when performing this analysis:

- The basis for the analysis was the zip code information received from the State and MUS.

- Percentages are based on all possible retail pharmacies (for the State all possible retail pharmacies met the access standard of one pharmacy within five miles for 100% of participants living in suburban areas and one pharmacy within fifteen miles for 96.5% of participants living in rural areas. For MUS all possible retail pharmacies met the access standard of one pharmacy within five miles for 100% of participants in suburban areas and one pharmacy within fifteen miles for 98.1% of participants living in rural areas.)

- Distance was measured using driving distance.

Conclusion

Based on the results of our review activity, we conclude that Pharmacare is not in compliance with the terms of the Association contract for the State as it relates to the rural areas will have 96.4%access to one network pharmacy within fifteen miles of the participant.

We conclude that Pharmacare is in compliance with all other terms of the Association contract as it relates to all other pharmacy network access.

PHARMACY AUDITING

Pharmacare has two types of retail pharmacy audits: (1) Internal desk audits and (2) On-site field audits. After the claims go through a series of system edits, claims are the selected for a desk audit. Pharmacare agreed to field audit 10% of active network pharmacies each year of the contract. An active network pharmacy is defined as any pharmacy processing at least 400 prescriptions per year.

Pharmacare has outsourced the field auditors function to a vendor with 4 field auditors. Procedural reviews with selected pharmacists are also performed during field audits. If errors are found, the pharmacy has 30 days for rebuttals.

Recoveries

Audit recovery information was obtained from Pharmacare for the year ending 2005. For the State in 2005, Pharmacare's prescription drug program was subjected to 15 field audits with $11,482.95 recovered and 6,125 claims reviewed by desk audits with $2,747.80 recovered. For the MUS in 2005, Pharmacare's prescription drug program was subjected to 9 field audits with $2,500 recovered and 2,269 claims reviewed by desk audits with $460.32 recovered. The recoveries are processed and credited to the plan sponsors by adjustments to the claim file. We verified, through discussion with Pharmacare management, the dollar recoveries are actual dollars received. Recoveries are not extrapolated to the State or MUS total population. During our interview process, we noted that part of the audit recoveries dollar amount is generated through a process called "In-cycle" recoveries. In-cycle means a pharmacy enters an erroneous amount in Pharmacare's system (1000 pills vs. 100 pills) and before the claim cycle has been completed the next day, Pharmacare discovers this mistake and contacts the pharmacy. Then the transaction is reversed and corrected.

Conclusion

Based on the results of our review activity, we conclude that Pharmacare is in compliance with the terms of the contract as it relates to the auditing of network pharmacies.

PHARMACY PARTICIPATION

Pharmacare guaranteed that no more that 25% of the network pharmacies will voluntarily terminate their contracts with Pharmacare during any calendar year.

Pharmacare has informed us that they are unable to generate a report verifying that no more than 25% of the network pharmacies voluntarily terminated their contract with Pharmacare. However, Pharmacare has indicated that no network pharmacies have terminated their contract.

Conclusion

Based on the results of our review activity, we are unable to conclude that Pharmacare is in compliance with the terms of the contract as it relates to the pharmacy participation.

CUSTOMER SERVICE RESPONSE TIME

Pharmacare guaranteed that a maximum telephone answering time averages less than 30 seconds for all customer service calls received. Pharmacare also guaranteed an abandonment rate of less than 5% for all customer service calls.

Pharmacare generated reports to verify the average speed to answer and the average abandonment rate for their whole book of business.

The report shows an average speed to answer for the whole book of business in 2004 was 20 seconds and in 2005 the average speed to answer was 29 seconds. The abandonment rate for the whole book of business in 2004 was 1.95% and in 2005 the abandonment rate was 3.62%.

Conclusion

Based on the results of our review activity, we conclude that Pharmacare is in compliance with the terms of the contract as it relates to the customer service response time. However, we understand Pharmacare cannot generate reports showing separate response time for the State or MUS.

REBATES

Pharmacare agreed to rebates in an amount to a 90% pass through with a minimum guarantee of $2.00 per rebatable retail prescription claim and a minimum of $5.25 per rebatable mail order prescription claim of the market share rebate received by Pharmacare.

Pharmacare supplied us with copies of the "Flat Rate Disbursement Detail" showing all rebatable and nonrebatable prescriptions. Pharmacare also supplied us with a copy of the corresponding check. We recalculated the invoices and traced the total dollar amount to the applicable checks without exceptions. However, we could not verify what drug was rebatable or which drug was not subject to rebate. We also noted that starting in 2005, Pharmacare changed their reimbursement rate to $1.50 for rebatable an nonrebatable retail prescription claims and $4.25 for rebatable and nonrebatable mail order prescription claims.

In 2004, Pharmacare included in their rebates for the State and MUS an escalator amount for additional reimbursement. The rebate escalator amount is calculated by comparing the weighted average per paid prescription (i.e. the discounted ingredient cost plus dispense fee before

participant cost-share) from one year to the same weighted average calculated in the second year. The percentage increase in the weighted average is the escalator. However, we could not verify that the escalator was calculated correctly and Pharmacare stopped using the escalator in 2005.

Conclusion

Based on the results of our review activity, we are unable to conclude that Pharmacare is in compliance with the terms of the contract as it relates to rebates.

DENIAL CODES

Pharmacare supplied us with reports showing the State and MUS claims that were rejected, the reason for the rejection and the pharmacy name. We sorted the reports to obtain the top 5 reasons for claim rejection. Our findings are presented below:

STATE - 2004 to 2005

Reason	Number of Claims Rejected
Plan limitations exceeded	16,595
Refill too soon	12,656
DUR reject error	8,285
Product not covered	7,047
Prior authorization required	6,217

Total number of claims rejected for 2004 to 2005 was 73,714.

Total number of claims rejected for filled after coverage has termed was 6,135.

MUS - 2004 to 2005

Reason	Number of Claims Rejected
Plan limitation exceeded	8,843
Refill too soon	5,162
Non-matched cardholder ID	4,329

DUR reject error	3,847
Filled after coverage termed	3,672

Total number of claims rejected in 2004 to 2005 was 35,976.

Conclusion

Based on the results of our review activity, we conclude that Pharmacare rejection codes are reasonable and are effective in the claim system.

PRIOR AUTHORIZATION

At the State and MUS request, Pharmacare has provide the ability to selectively approve certain drugs that would have to be preapproved by the physician prior to being filled at the pharmacy.

If a claim is entered into the claim system that requires a prior authorization, the claim is rejected and sent back to the pharmacist with the reason for the rejection. The pharmacist can call a toll free number to verify the rejection.

The physician may request a form to be faxed to their location to be completed by the physician. Once completed, the physician will fax back the prior authorization form. If the prior authorization is denied, the reason for the denial is faxed back to the physician. Pharmacare informed us that only physicians can obtain prior authorization.

If a prior authorization is denied, Pharmacare has an appeal process.

If the prior authorization is approved, the prior authorization number is entered into the system.

Pharmacare generated reports showing prior authorization denial rates and turnaround time for completed prior authorizations. Our findings are presented below:

State

Year	Denial Rate
2004	36%
2005	21%

MUS

Year	Denial Rate
2004	32%
2005	33%

The 220 claims in our sample were also reviewed to ensure that all prior authorization claims were properly identified and the prior authorization process was completed.

Pharmacare generated a report showing the average turnaround time for prior authorization cases. Between January 1, 2005 and December 31, 2005 the turnaround time for prior authorization for their whole book of business was 99.49% within three days of request. Between January 1, 2004 and December 31, 2004 the turnaround time for prior authorization for their whole book of business was 99.99% within three days of request.

Conclusion

Based on the results of our review activity, we conclude that Pharmacare prior authorization policies and procedures are being follow as prescribed.

MAIL ORDER PRESCRIPTION

Pharmacare guaranteed that 95% of all mail service pharmacist approved prescriptions will be shipped within an average of 2 business days from the date of receipt. Pharmacare guaranteed that 98% of all mail service pharmacist approved prescriptions requiring intervention will be shipped within an average of 5 business days from the date of receipt. Pharmacare also guaranteed that electronic mail order claims will be processed with a 99% accuracy rate.

Pharmacare generated reports to verify the turnaround time and processing accuracy rates. Our findings are presented below:

Performance Results for the State

Mail service processing time - non intervention:

Dates	**Completion % in 2 days**
1/01/04 to 12/31/04	100%
1/01/05 to 12/31/05	100%

Mail service processing time - intervention:

Dates	**Order fulfillment in days**
1/01/04 to 12/31/04	**Average of 1.2 days**
1/01/05 to 12/31/05	Average of 1.65 days

Dispensing Accuracy rate:

Dates	**Accuracy rate percentage**
1/01/04 to 12/31/04	99.994%
1/01/05 to 12/31/05	99.992%

Performance Results for MUS

Mail service processing time - non intervention:

Dates	**Completion % in 2 days**
1/01/04 to 12/31/04	100%
1/01/05 to 12/31/05	100%

Mail service processing time - intervention:

Dates	**Order fulfillment in days**
1/01/04 to 12/31/04	**Average of 1.25 days**
01/01/05 to 12/31/05	Average of 1.53 days

Dispensing Accuracy rate:

Dates	Accuracy rate percentage
1/01/04 to 12/31/04	100%
1/01/05 to 12/31/05	100%

Conclusion

Based on the results of our review activity, we conclude that Pharmacare is in compliance with the terms of the contract as it relates to the mail order processing time and mail order accuracy rate.

Exhibit A

STATE OF MONTANA AND MONTANA UNIVERSITY SYSTEM
PRESCRIPTION DRUG CLAIMS
CLAIMS PROCESSED FROM JANUARY 1, 2004 THROUGH DECEMBER 31, 2005
SUMMARY OF FINDINGS

CLAIM #	CLAIM TYPE	DOS	PAID AMOUNT	AUDITED AMOUNT	DOLLAR VALUE OF ERROR	TYPE
50134538981010	Mail order	01/13/05	$ 95.05	0.00	95.05	Claim was process with incorrect DAW.
51794938425010	Mail order	06/28/05	6,911.78	7,003.60	-91.82	Incorrect discount was used.
53534539857003	Mail order	12/19/05	6,911.78	7,003.60	-91.82	Incorrect discount was used.
51154545263001	Mail order	04/25/05	171.79	174.51	-2.72	Incorrect discount was used.
53425824819004	Mail order	12/08/05	7,018.60	7,108.58	-89.98	Incorrect discount was used.
52304064466009	Mail order	08/15/05	6,768.60	6,858.58	-89.98	Incorrect discount was used.
53124606467005	Mail order	10/11/05	6,932.84	7,022.82	-89.98	Incorrect discount was used.
	Totals		$27,782.55	28,148.87	(361.25)	

PharmaCare
620 Epsilon Drive
Pittsburgh, PA 15238

November 27, 2006

Wolcott & Associates, Inc.
12120 State Line Road, Suite 297
Leawood, Kansas 66209

To Whom This May Concern:

This letter is in response to the Pharmacy audit completed by Wolcott & Associates, Inc. for The State of Montana and Montana University System for the timeframes January 1, 2004 thru December 31, 2005.

PharmaCare's responses to the audit draft report are as follows:

V-1 Pharmacy Network Access

Participation in the pharmacy network is open to all pharmacies willing to accept the participation terms so offered by PharmaCare. Access standards in rural areas can be challenging when pharmacies are few in number. PharmaCare proposes to telephonically solicit any and all non-participating pharmacies within eight weeks after this response in an effort to close the slight shortfall on the access gap. If sufficient pharmacies are not available then we will report that to the State.

V-4 Rebates

Wolcott & Associates may schedule an on-site visit to PharmaCare's Lincoln, RI headquarters where they may select rebate contracts for on-site review, and then test rebate claim billing and collections as necessary. Wolcott & Associates will be required to sign a non-disclosure agreement, in conformance with the audit and confidentiality provisions of the pharmaceutical manufacturer contracts.

Sincerely,
Tammy Tarzynski, National Account Executive
PharmaCare