

LEGISLATIVE AUDIT DIVISION

Tori Hunthausen, Legislative Auditor
Deborah F. Butler, Legal Counsel



Deputy Legislative Auditors:
Cindy Jorgenson
Angus Maciver

November 2014

The Legislative Audit Committee
of the Montana State Legislature:

Enclosed is the report on the audit of the medical and dental claims for the Montana University System benefit plans administered by Blue Cross and Blue Shield, Allegiance, Pacific Source, Delta Dental, and Med Impact for the two fiscal years ended June 30, 2014.

The audit was conducted by Claim Technologies Incorporated 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 administrators' written responses to the report recommendations are included in the back of the audit report.

Respectfully submitted,

/s/ Tori Hunthausen

Tori Hunthausen, CPA
Legislative Auditor

13C-09

Comprehensive Claim Administration Audit

EXECUTIVE SUMMARY

Montana University System Medical Plan

Administered by Allegiance Benefit Plan Management, Inc.

Audit Period: July 1, 2013 to June 30, 2014

Presented to

Legislative Audit Division, State of Montana

Montana University System

October 31, 2014

Presented by



**CLAIM TECHNOLOGIES
INCORPORATED**

PREFACE

This ***Executive Summary*** presents the key findings and recommendations from Claim Technologies Incorporated's (CTI's) Comprehensive Audit of Allegiance Benefit Plan Management, Inc.'s (Allegiance's) claim administration of the Montana University System (MUS) plan(s). The information that these key findings and recommendations are based on is detailed in the ***Specific Findings Report***.

The information in this report is intended for the sole use of the Montana legislature, MUS, Allegiance and CTI in their efforts to serve the interests of the plan participants of the MUS plan(s). The findings in this report are based on data and information MUS, the plan sponsor and Allegiance, the claim administrator provided to CTI and their validity relies upon the accuracy and completeness of that information. CTI conducted the audit according to the standards and procedures generally accepted and in common practice for claim audits in the health insurance industry.

The audit was planned and performed to obtain a reasonable assurance that claims were adjudicated according to the terms of the contract between the claim administrator and the plan sponsor as well as the benefit descriptions (summary plan descriptions(s), plan document(s) or other communications) approved by the plan sponsor.

CTI is a firm specializing in audit and control of health plan claim administration. Accordingly, the statements made by CTI relate narrowly and specifically to the overall efficacy of the claim administrator's policies, processes and systems relative to the plan sponsor's paid claims during the audit period.

CLAIM TECHNOLOGIES INCORPORATED



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- B. Key Performance Indicators and Operational Definitions
- C. Claim Administrator’s Response



OBJECTIVES AND SCOPE

Audit Objectives

The specific objectives of CTI's Comprehensive Audit of Allegiance's claims administration were to:

- Quantify dollar amounts associated with claims that the administrator did not pay accurately;
- Determine the terms of the agreement for administrative services between the plan sponsor and claim administrator were followed;
- Determine if claims were paid according to the provisions of the summary plan description and the terms of the summary plan description were clear and consistent;
- Determine if members were eligible and covered by the sponsor's medical plans at the time a medical service paid by Allegiance was incurred;
- Determine if any fundamental systems or processes associated with claim administration or eligibility maintenance may need improvement.

Audit Scope

CTI performed a Comprehensive Audit of Allegiance's claim administration of the sponsor's medical plan(s) for the 12-month period of July 1, 2013 to June 30, 2014. The population of claims and amount paid by the plan(s) during the audit period was:

Total Paid Amount	\$17,514,859
Total Number of Claims Paid/Denied/Adjusted	78,652

The audit included five components as described below; the objective, scope, methodology and findings of each component are found in the following sections of this report.

1. Operational Review

- Operational Review Questionnaire
 - Claim administrator information
 - Claim administrator claim fund account
 - Claim adjudication and eligibility maintenance procedures
 - HIPAA compliance
- Onsite examination and testing

2. Random Sample Audit

- Statistical confidence at 95% +/- 3%
- Performance level determined for Key Indicators
- Measurement and benchmarking
- Problem identification and prioritization

3. Data Analytics

- Provider Discount Review
- Preventive Services Compliance Review
- Correct Coding Review
- Ad Hoc data mining as requested by plan sponsor/manager

KEY FINDINGS

In this section we present the findings from each of the components of the Comprehensive Audit on the basis of relevance and materiality to the plan sponsor followed by recommendations.

Random Sample Audit

CTI's Random Sample Audit system categorizes errors into one or more of six Key Performance Indicators. Systematic labeling of errors and calculation of performance is the basis for CTI's benchmarks which are generated using the results of the most recent 100 medical claim audits completed by CTI.

The following table demonstrates that the claim administrator's performance was above the median average in the six benchmarked Key Performance Indicators. For more specific information on CTI's benchmarks and how the administrator performed in this audit, see the box and whiskers charts in Exhibit A.

Key Performance Indicators	Administrative Performance by Quartile			
	Bottom Quartile	2 nd Quartile	3 rd Quartile	Top Quartile
Documentation Accuracy – Financial				100%
Documentation Accuracy – Frequency				100%
Financial Accuracy			99.35%	
Accurate Payment Frequency			98.33%	
Adjudication Proficiency			99.76%	
Accurate Processing Frequency				98.33%

The definition for each Performance Indicator can be found in Exhibit B.

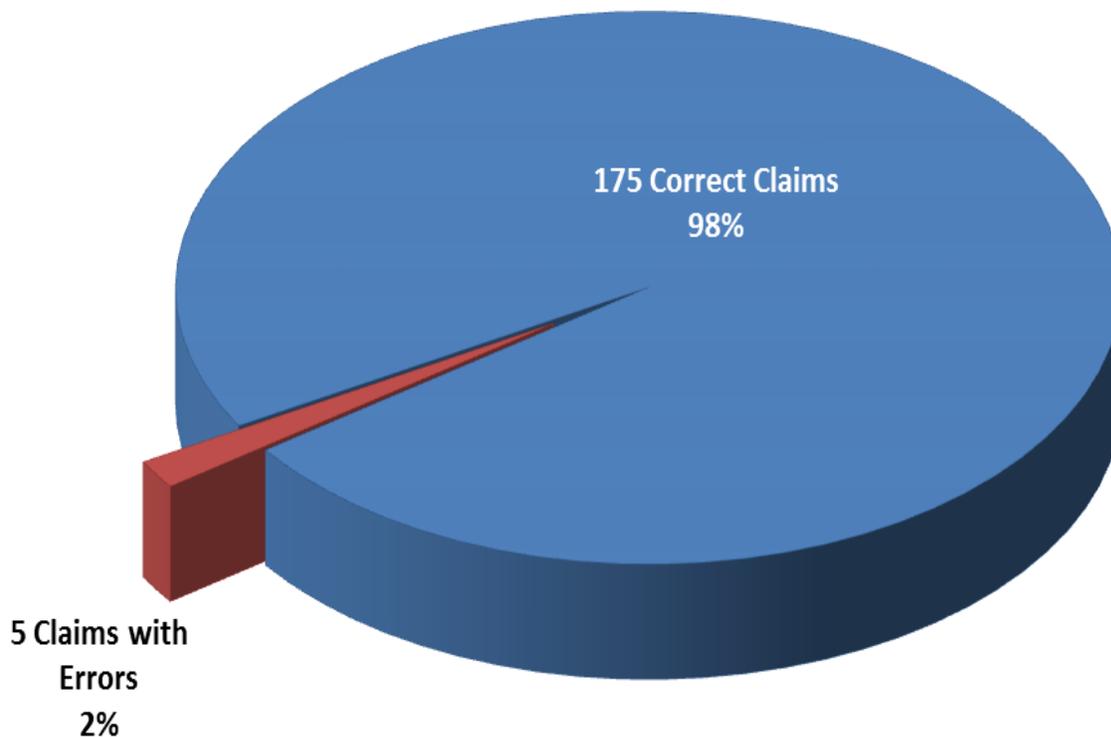
Prioritization of Process Improvement Opportunities Based on Type and Frequency of Errors Cited During Random Sample Audit

The financial improvement opportunity demonstrated by the Random Sample Audit based on a 0.65% Financial Accuracy error rate and annual paid claims of \$17,514,859 is \$113,847. This is the potential annual financial improvement that could be achieved by improving Financial Accuracy from 99.35% to the benchmark high performance of 100%.

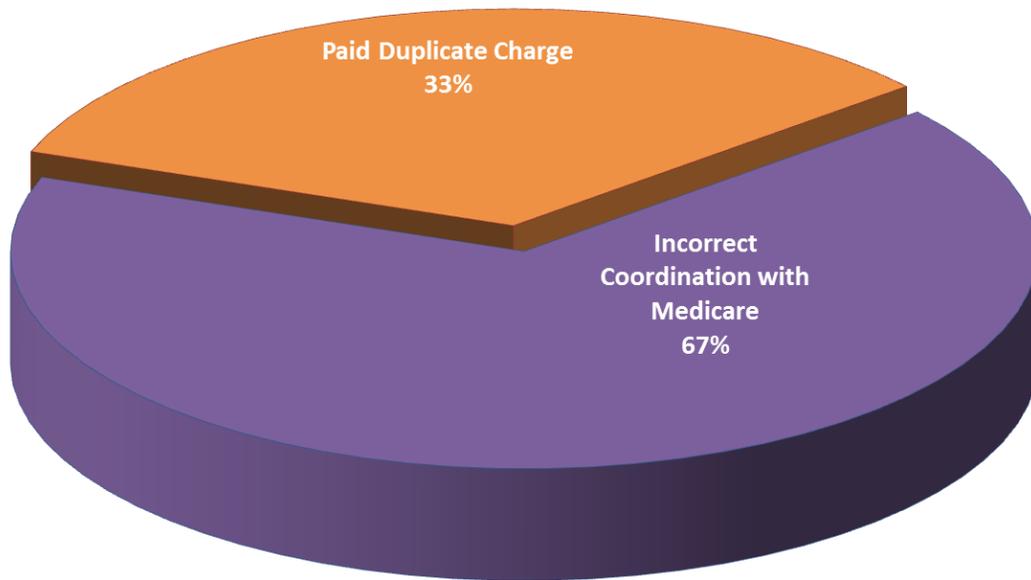
Note that Financial Accuracy is based on the absolute value of payment errors, meaning that over- and under-payments are included. While overpayments represent opportunity for initiating recovery and saving money for the sponsor’s plan, underpayments are also of concern. Each underpaid claim is likely to result in an appeal from a provider or the plan sponsor’s employee with a corresponding claims adjustment which will increase administrative costs and dissatisfaction with plan coverage.

Derived from the Random Sample Audit data, the following pie charts will assist in prioritizing improvement and/or recovery opportunities based on savings and service impact; and in pinpointing problem causes. CTI has offered recommendations in this report to facilitate next steps and discussion.

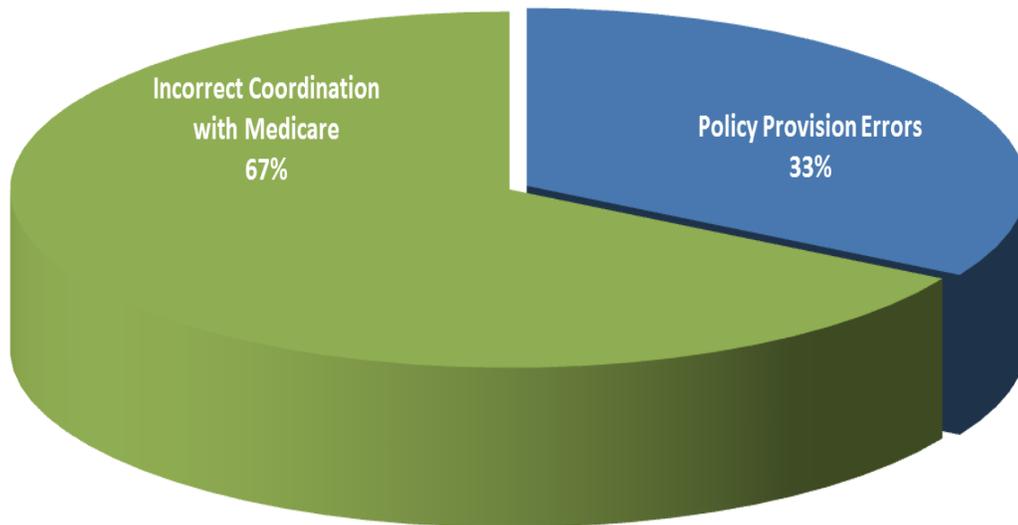
Overall Accurate Processing Frequency



Frequency of Financial Errors by Type



Frequency of Adjudication Errors by Type

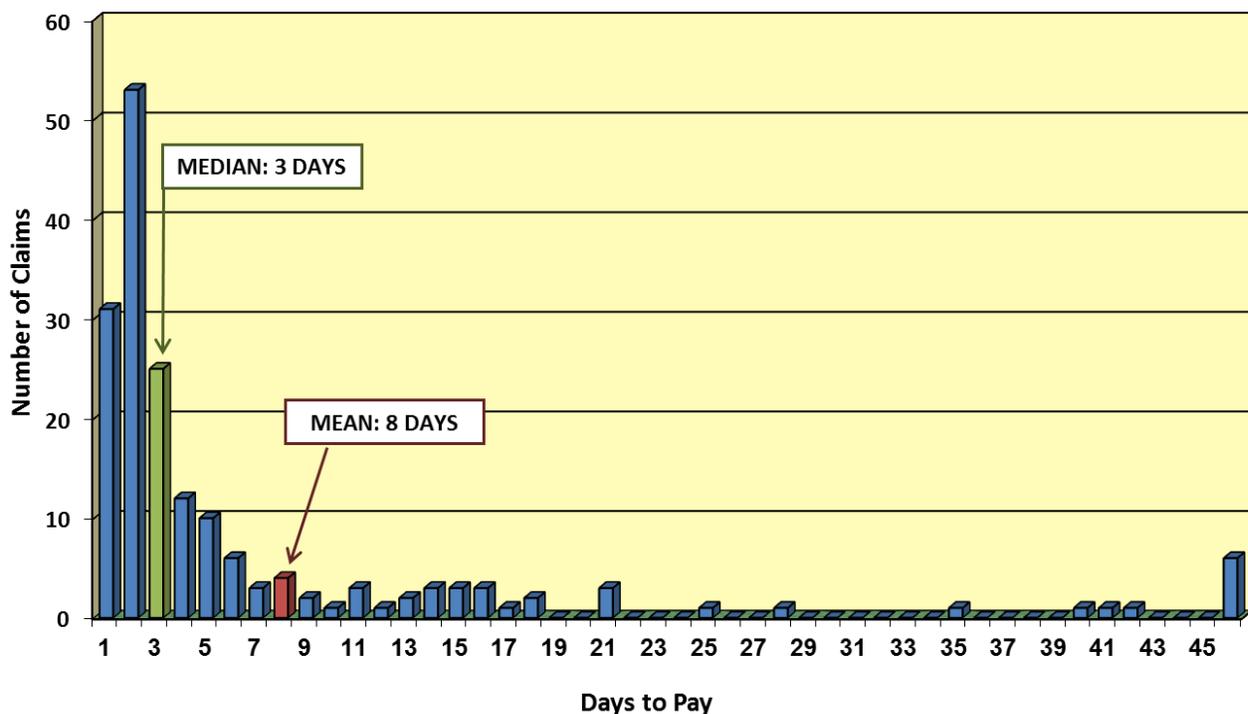


Claim Turnaround Time

A final measure of claim administration performance, and one that claim administrators commonly report on is Claim Turnaround Time. Claim Turnaround often is measured in Mean Average days. Median days, however, is a more meaningful measure for the administrator to focus on when analyzing Claim Turnaround because it prevents a few claims with extended Turnaround Time from distorting the true performance picture. For the claims included in the Random Sample Audit, the claim administrator's Claim Turnaround from *date received* to *date processed* is shown in the following chart. In CTI's opinion, the demonstrated performance of **3 median day(s)** was optimal.



Median and Mean Claim Turnaround



Operational Review

Our Operational Review indicated that Allegiance:

- Met MUS' required performance guarantees for claims, customer service and administration for the three calendar quarters from July 2013 through March 2014. Results for the fourth calendar quarter of April through June 2014 were pending at the time of this report.
- Met required the required performance target of 99% Financial Payment Accuracy based on CTI's use of this audit to validate Allegiance's performance.
- Dedicates staff for customer service and processing to MUS, along with back-up staff if required.
- Used pre-payment high dollar claim review procedures. Checks of \$125,000 or more were reviewed by the Director of Technical Claims Services prior to issuance.
- Does not pursue overpayments of \$50 or less.

Data Analytics

The Data Analytics conducted by CTI included:

- Network provider utilization and discount savings
- Sponsor plan's compliance with Affordable Care Act Preventive Services Coverage requirement
- Administrator's claim system code editing capability

As a component of our comprehensive audit, CTI reports on the value of discounts given by Network providers as a percentage of all claims processed during the audit period. According to the data received, during the audit period, Allegiance achieved 18.2% off billed charges on all claims processed. The average discount on in-network claims was 19.4%. More than 92% of all provider charges came from network providers and but only 77% of all claims came from network providers. The following chart illustrates the average discount percent by type of service during the audit period.

Total of All Claims				
Claim Type	Allowed Charge	Provider Discount		Paid
Ancillary	\$1,138,962	\$151,881	13.3%	\$556,516
Non-Facility	\$11,553,813	\$2,595,413	22.5%	\$5,881,550
Facility Inpatient	\$8,419,258	\$1,359,607	16.1%	\$5,235,675
Facility Outpatient	\$9,935,056	\$1,557,060	15.7%	\$5,841,118
Total	\$31,047,089	\$5,663,961	18.2%	\$17,514,859

CTI’s **Preventive Care Services Compliance Review Report** was used to confirm that the claim administrator was processing preventive services as required by the Patient Protection and Affordable Care Act (PPACA) and as regulated by the Department of Health and Human Services (HHS). The federal mandate under PPACA for all health plans (unless the plan is grandfathered as defined under PPACA) is that certain preventive services, if performed by a network provider, must be covered at 100% without copayment or coinsurance or deductible. The review analyzes in-network preventive care services to determine whether or not those services have been paid in compliance with the PPACA guidelines. CTI’s review found several preventive services were not paid at 100% as required by federal regulations. A complete listing and detailed breakdown by preventive benefit is included in the **Specific Findings Report**. Since not all preventive services were paid at 100%, the plan sponsor should discuss this analysis with the claims administrator to ensure that it is processing claims in compliance with ACA requirements.

CTI analyzed claims paid by the administrator to determine the degree to which coding used to process claims conformed to National Correct Coding Initiative guidelines used by the Centers for Medicare & Medicaid Services (CMS) for Medicare Part B and Medicaid claims. While these edits are not mandatory for non-Medicare/Medicaid medical plans, it is important that the plan sponsor understand the benefit of these initiatives and their potential value when applied to medical benefit plans. The two CMS initiatives that can offer the greatest return benefit to self-funded employee benefit plans are the:

- Procedure to Procedure Edits, and
- Medically Unlikely Edits (MUEs).

Areas where our Data Analytics indicated potential savings opportunities that should be discussed between the plan sponsor and the claim administrator include:

- Procedure to Procedure analysis shows that \$64,838 in outpatient hospital services and \$64,187 in non-facility claims did not conform to CMS edits.

- MUE CCI edits found \$132,229 paid that would have been disallowed by Medicare and Medicaid and the provider would need to have resubmitted with correct coding in order for the service to be allowed.

A complete listing of procedure codes affected is included with the ***Specific Findings Report***. CTI recommends this analysis be discussed with Allegiance to determine the extent CMS edits could be used. Use of these edits would result in a reduction of claim expenses for employers and their employees, as well as furthering efforts toward a standardized code-editing system for all payers.

RECOMMENDATIONS

Based on the key findings of our Comprehensive Audit of the claim administrator, we recommend the following next steps.

1. Meet with claim administrator to discuss audit findings and focus specifically on the steps needed to improve Accurate Payment Frequency and Accurate Processing Frequency. To facilitate this discussion, you should request the administrator to review each of the financial errors identified by our Random Sample Audit and determine if system changes should be made to reduce or eliminate errors of a similar nature in the future.
2. CTI recommends that MUS request a COB savings report and review it on a regular basis to monitor COB savings attained.
3. CTI recommends that MUS discuss the \$50 threshold used for overpayment recovery with Allegiance. CTI notes this amount is greater than used by many administrators and exposes MUS to liability for overpayments less than \$50 that are not pursued. We recommend that MUS ask Allegiance for an analysis of the cost-effectiveness of this policy as well as the capability of Allegiance to recoup overpayments to network providers from future payments.
4. MUS should discuss BCBSMT's procedures for identifying preventive procedures to ensure that it is processing claims in compliance with ACA requirements.
5. Meet with the claim administrator to discuss audit findings related to CMS edits and determine whether these may be implemented for additional savings to MUS.
6. CTI recommends MUS conduct regular audits of Allegiance to identify other opportunities for improvement and savings and to ensure the high level of performance is maintained.

We understand that you will need to review these recommendations to determine the subject of immediate action. Should MUS decide that additional assistance in implementing or performing any of the required tasks would be beneficial, our contract offers 10 hours of post-audit time to provide you with further assistance.

The claim administrator cooperated with this audit and made every effort to provide us with the data and documentation we requested.

We have considered it a privilege to have worked for, and with, your staff in these important endeavors and would welcome any opportunity to assist you in achieving your future objectives. Thank you again for choosing CTI.





EXHIBITS

- A. Performance Measurements and Benchmarking**
- B. Key Performance Indicators**
- C. Claim Administrator's Response**

EXHIBIT A

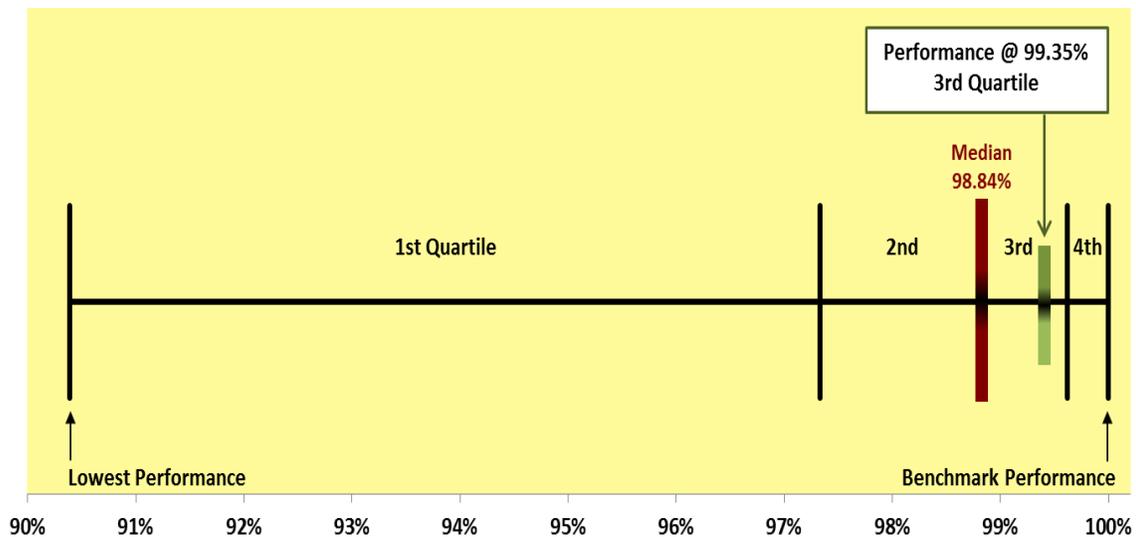
Performance Measurement and Benchmarking

The following box and whisker charts are based on the 100 most recent claim administration audits performed by CTI. The charts are used to demonstrate the claim administration performance when compared to the other plans against each of our seven Key Performance Indicators.

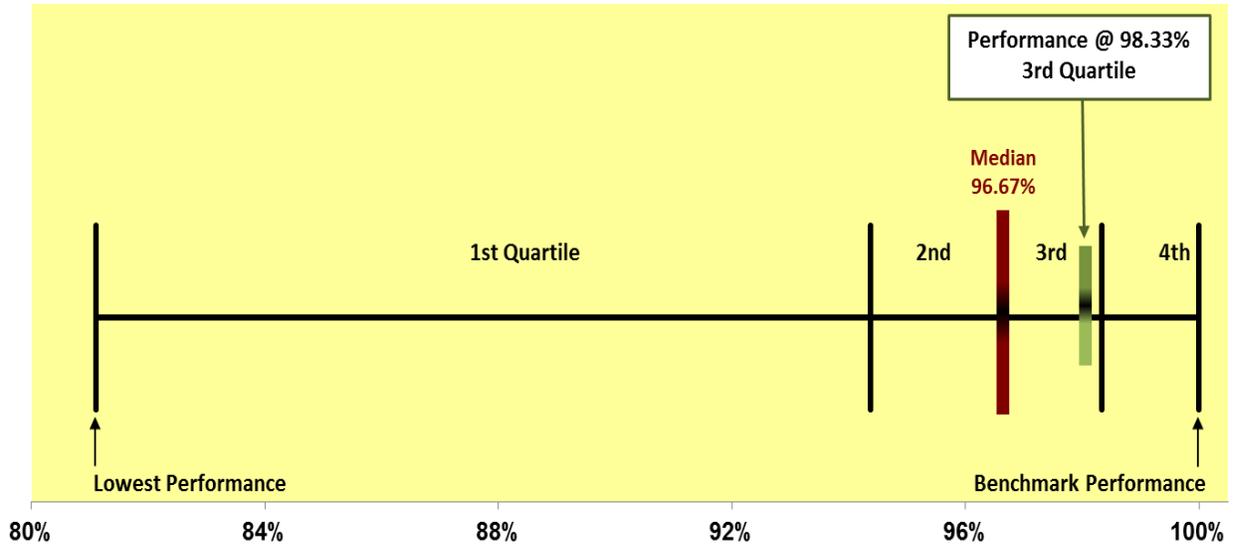
Each chart contains the following information:

- The claim administrator's performance
- Benchmark performance
- Lowest performance
- Performance levels by quartile – with the 4th quartile representing the highest 25 performing plans and the 1st quartile representing the lowest 25 plans
- Performance level relative to the Median – or the level at which 50 of the plans audited were higher and 50 were reported to be lower

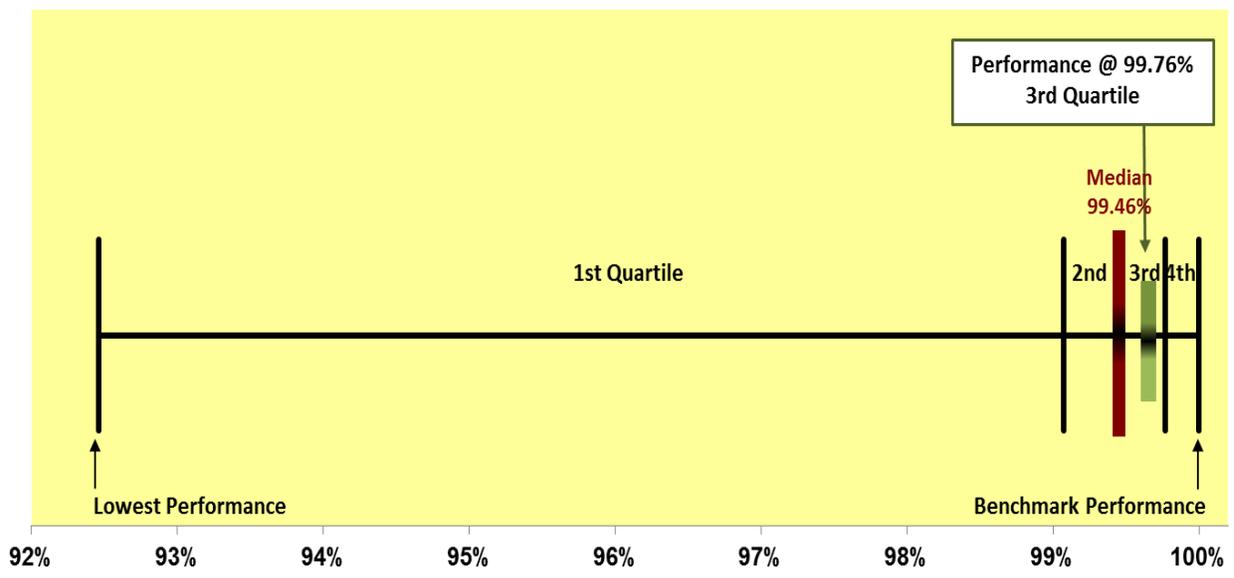
Financial Accuracy – Performance vs. Other Plans Audited by Quartile



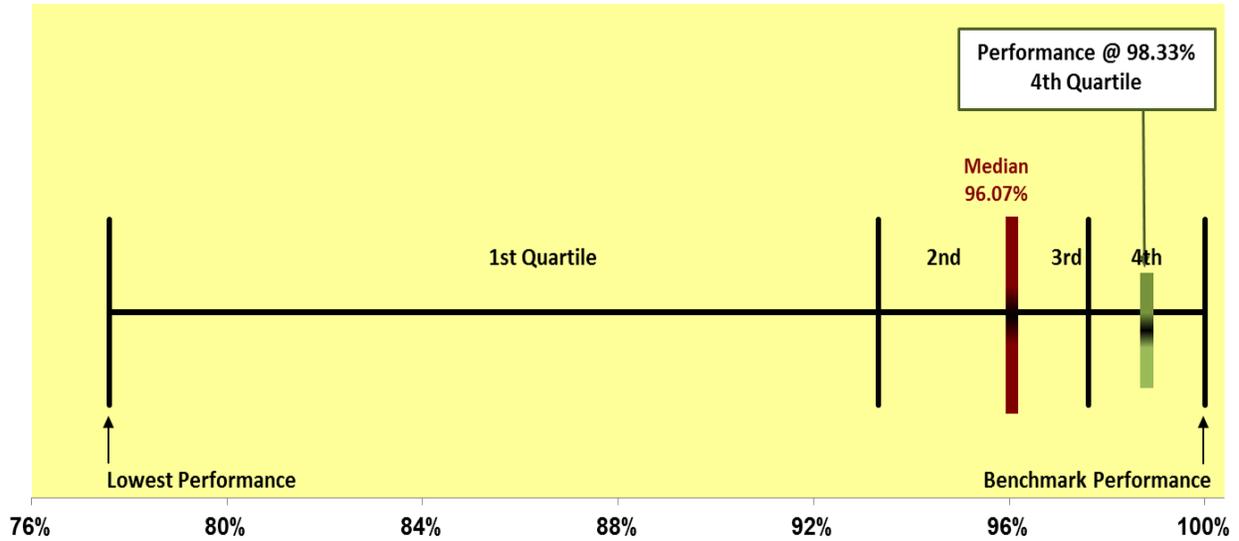
Accurate Payment Frequency – Performance vs. Other Plans Audited



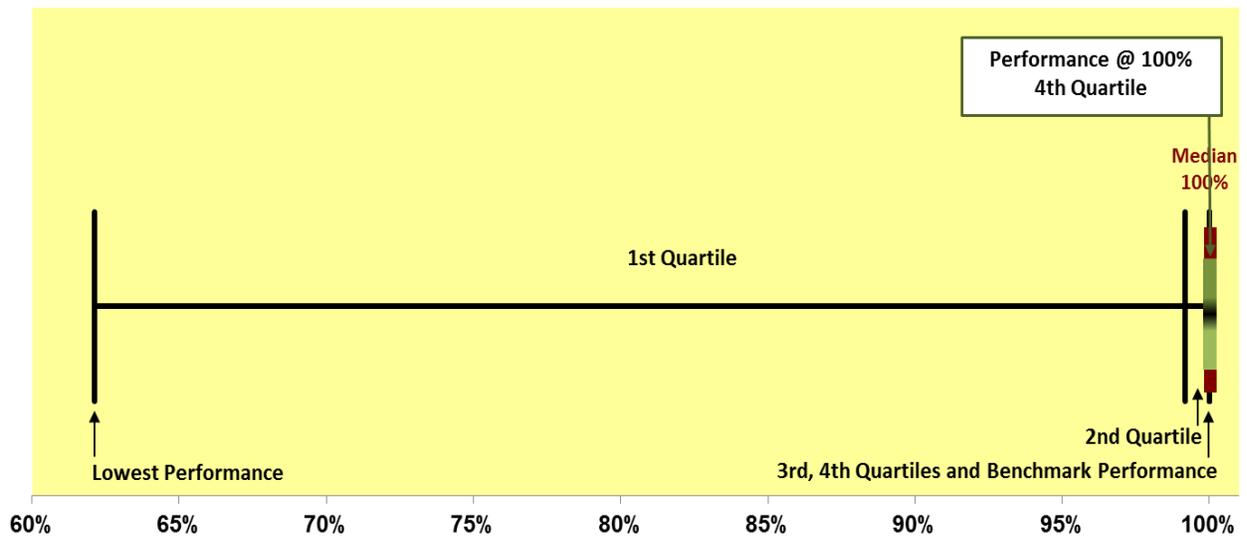
Adjudication Proficiency – Performance vs. Other Plans Audited



Accurate Processing Frequency – Performance vs. Other Plans Audited



Documentation Accuracy Financial – Performance vs. Other Plans Audited



Documentation Accuracy Frequency – Performance vs. Other Plans Audited

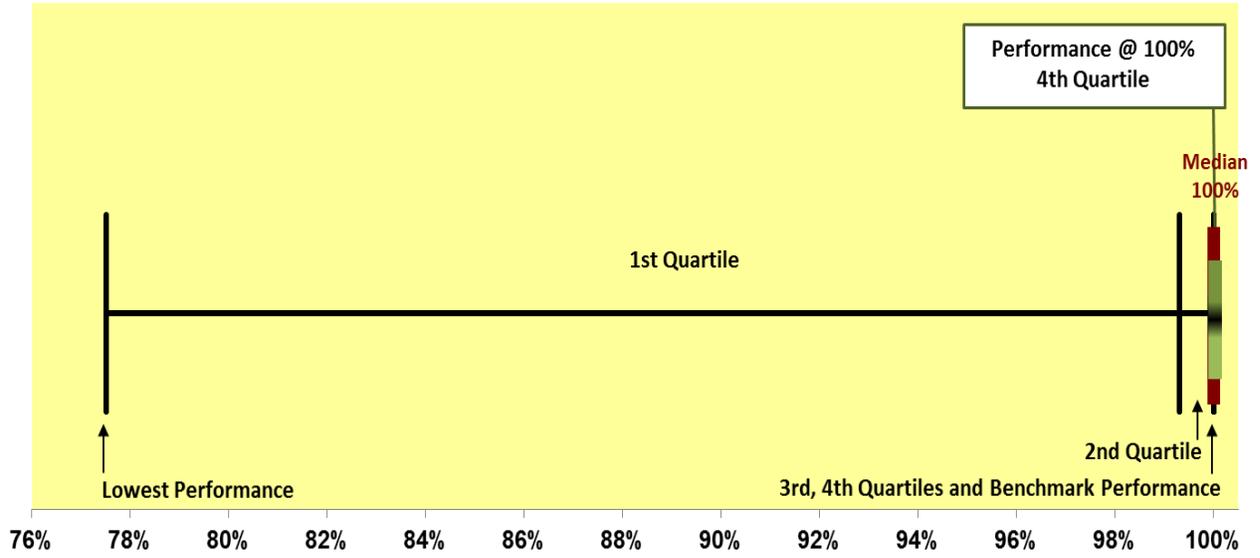


EXHIBIT B

Benchmarked Key Performance Indicators and Operational Definitions

Financial Accuracy – compares the total dollars associated with correct claim payments to the total dollars of correct claim payments that should have been made.
Accurate Payment Frequency – compares the number of bills paid correctly to the total number of bills paid.
Documentation Accuracy Financial – compares the number of dollars processed with documentation adequate to substantiate payment or denial to the total number of dollars processed.
Documentation Accuracy Frequency – compares the number of claims processed with documentation adequate to substantiate payment or denial to the total number of claims processed.
Adjudication Proficiency – compares the number of correct adjudication decisions made to the total number of adjudication decisions required.
Accurate Processing Frequency – compares the number of bills processed without errors of any type (financial or non-financial) to the total number of bills processed.

Non-Benchmarked Key Performance Indicator and Operational Definition

Claim Turnaround – is the number of calendar days required to pay a claim from the date the claim is received by the administrator to the date a payment or denial is mailed.
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EXHIBIT C



October 20, 2014

Claims Technologies Incorporated (CTI)

Montana State University System Audit

After reviewing the audit results for Montana State University System provided to Allegiance on October 7, 2014, Allegiance has no requested corrections or qualifications nor any objections to the findings of the auditors.

A handwritten signature in black ink that reads 'Robyn S. Kammerer'.

Robyn S. Kammerer

Allegiance Benefits Plan Management, Inc.



**CLAIM TECHNOLOGIES
INCORPORATED**

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Comprehensive Claim Administration Audit

EXECUTIVE SUMMARY

**Montana University System Medical Plan
Administered by Blue Cross Blue Shield of Montana**

Audit Period: July 1, 2013 through June 30, 2014

Presented to

**Legislative Audit Division, State of Montana
Montana University System**

October 31, 2014

Presented by



**CLAIM TECHNOLOGIES
INCORPORATED**

PREFACE

This **Executive Summary** presents the key findings and recommendations from Claim Technologies Incorporated's (CTI's) Comprehensive Audit of Blue Cross Blue Shield of Montana's (BCBSMT's) claim administration of the Montana University System (MUS) plan(s). The information that these key findings and recommendations are based on is detailed in the **Specific Findings Report** which has been provided to MUS and BCBSMT under separate cover.

The information in this report is intended for the sole use of the Montana legislature, MUS, BCBSMT and CTI in their efforts to serve the interests of the plan participants of the MUS plan(s). The findings in this report are based on data and information MUS, the plan sponsor and BCBSMT, the claim administrator provided to CTI and their validity relies upon the accuracy and completeness of that information. CTI conducted the audit according to the standards and procedures generally accepted and in common practice for claim audits in the health insurance industry.

The audit was planned and performed to obtain a reasonable assurance that claims were adjudicated according to the terms of the contract between the claim administrator and the plan sponsor as well as the benefit descriptions (summary plan descriptions(s), plan document(s) or other communications) approved by the plan sponsor.

CTI is a firm specializing in audit and control of health plan claim administration. Accordingly, the statements made by CTI relate narrowly and specifically to the overall efficacy of the claim administrator's policies, processes and systems relative to the plan sponsor's paid claims during the audit period.

CLAIM TECHNOLOGIES INCORPORATED



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- B. Key Performance Indicators and Operational Definitions
- C. Claim Administrator’s Response



OBJECTIVES AND SCOPE OF COMPREHENSIVE AUDIT

Audit Objectives

The specific objectives of CTI's Comprehensive Audit of BCBSMT's claims administration were to:

- Quantify dollar amounts associated with claims that the administrator did not pay accurately;
- Determine whether the terms of the agreement for administrative services between the plan sponsor and claim administrator were followed;
- Determine if claims were paid according to the provisions of the summary plan description and the terms of the summary plan description were clear and consistent;
- Determine if members were eligible and covered by the sponsor's medical plans at the time a medical service paid by BCBSMT was incurred;
- Determine whether any fundamental systems or processes associated with claim administration or eligibility maintenance may need improvement.

Audit Scope

CTI performed a Comprehensive Audit of BCBSMT's claim administration of the sponsor's medical plan(s) for the 12-month period of July 1, 2013 through June 30, 2014. The population of claims and amount paid by the plan(s) during the audit period was:

Total Paid Amount	\$33,667,345
Total Number of Claims Paid/Denied/Adjusted	125,857

The audit included three components as described below; the objective, scope, methodology and findings of each component are found in the following sections of this report.

1. Operational Review

- Operational Review Questionnaire
 - Claim administrator information
 - Claim administrator claim fund account
 - Claim adjudication and eligibility maintenance procedures
 - HIPAA compliance
- Onsite examination and testing

2. Random Sample Audit

- Confidence at 95% +/- 3%
- Performance level determined for Key Indicators
- Measurement and benchmarking
- Problem identification and prioritization

3. Data Analytics

- Provider Discount Review
- Preventive Services Compliance Review
- Correct Coding Review
- Ad Hoc data mining as requested by plan sponsor/manager

KEY FINDINGS

In this section we present the findings from each of the components of the Comprehensive Audit on the basis of relevance and materiality to the plan sponsor followed by recommendations.

Random Sample Audit

CTI's Random Sample Audit system categorizes errors into one or more of six Key Performance Indicators. Systematic labeling of errors and calculation of performance is the basis for CTI's benchmarks which are generated using the results of the most recent 100 medical claim audits completed by CTI.

The following table demonstrates that the claim administrator's performance was above the median average in the six benchmarked Key Performance Indicators. For more specific information on CTI's benchmarks and how the administrator performed in this audit, see the box and whiskers charts in Exhibit A.

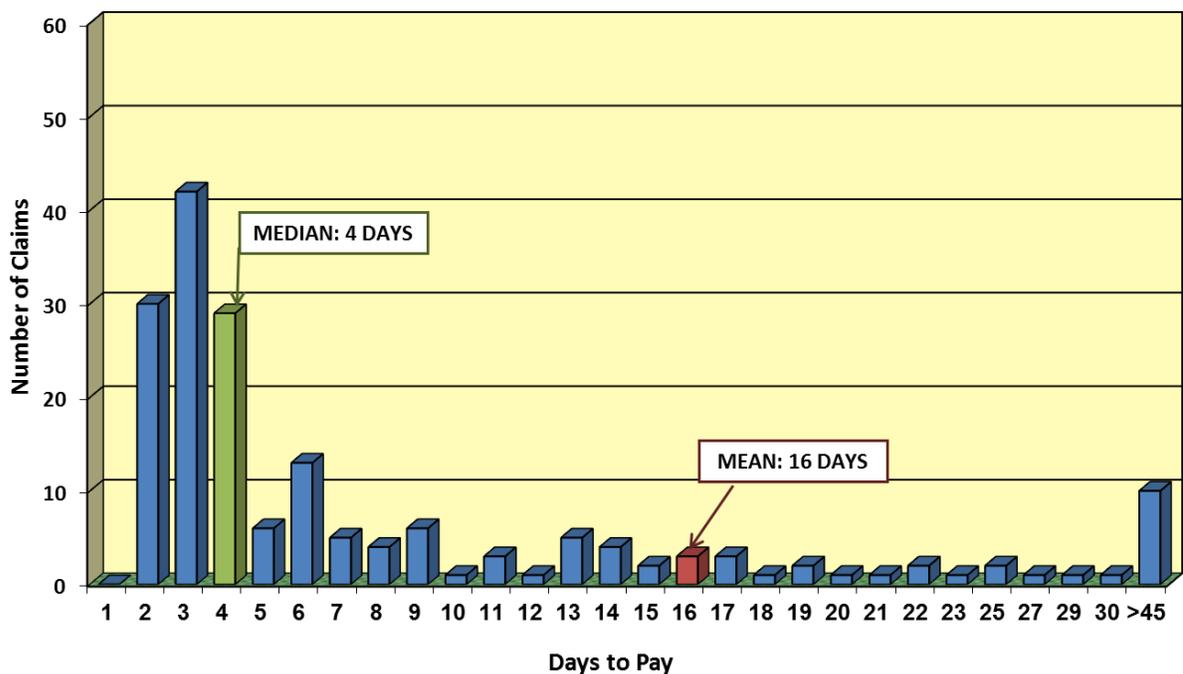
Key Performance Indicators	Administrative Performance by Quartile			
	Bottom Quartile	2 nd Quartile	3 rd Quartile	Top Quartile
Documentation Accuracy – Financial				100%
Documentation Accuracy – Frequency				100%
Financial Accuracy				100%
Accurate Payment Frequency				100%
Adjudication Proficiency				100%
Accurate Processing Frequency				100%

The definition for each Performance Indicator can be found in Exhibit B.

Claim Turnaround Time

A final measure of claim administration performance, and one that claim administrators commonly report on is Claim Turnaround Time. Claim Turnaround often is measured in Mean Average days. Median days, however, is a more meaningful measure for the administrator to focus on when analyzing Claim Turnaround because it prevents a few claims with extended Turnaround Time from distorting the true performance picture. For the claims included in the Random Sample Audit, the claim administrator's Claim Turnaround from *date received* to *date processed* is shown in the following chart. In CTI's opinion, the demonstrated performance of **4 median day(s)** was optimal. Ten of the 180 claims in the sample took greater than 45 days to process which are claims that have been adjusted while still retaining their original date of receipt.

Median and Mean Claim Turnaround



Prioritization of Process Improvement Opportunities Based on Type and Frequency of Errors Cited During Random Sample Audit

CTI's Random Sample Audit utilizes our proprietary audit system to provide insight into the overall accuracy of claim administration. This system quantifies errors by primary cause allowing for meaningful prioritization of improvement opportunities. BCBSMT performed at the highest level as the result of CTI's Comprehensive Audit. No errors were found by our auditors.

Operational Review

Our Operational Review indicated that BCBSMT:

- Assigned designated account services staff to the plan sponsor's account.
- Provides services to MUS through its contract with the Montana Association of Health Care Purchasers (MAHCP). This contract has no minimum service levels with associated

performance guarantees. We recommend that performance guarantees be included in the MAHCP agreement upon its renewal, especially since MUS' agreements with other administrators do include guarantees.

- BCBSMT has very effective procedures to avoid paying for claims for dependents that may be covered by other primary insurance. An annual questionnaire is sent seeking information regarding other insurance coverage. Claims will be denied if the questionnaire is not returned.
- BCBSMT has very robust procedures for investigation of subrogation and workers' compensation. Members who have claims that may be subrogatable or related to workers' compensation must respond to requests for information about the injury or accident prior to payment being made. Subrogation recoveries are approved by MUS.
- BCBSMT has worked with its parent, HCSC, to conduct an internal security assessment to identify critical areas of risk and to mitigate or accept those risks as appropriate.

Data Analytics

The Data Analytics conducted by CTI included:

- Network provider utilization and discount savings
- Sponsor plan's compliance with Affordable Care Act Preventive Services Coverage requirement
- Administrator's claim system code editing capability

As a component of our comprehensive audit, CTI reports on the value of discounts given by Network providers as a percentage of all claims processed during the audit period. According to the data received, during the audit period BCBSMT achieved 26.8% off billed charges as the average discount on all claims. Discounts for network provider services were 26.7%. More than 99% of all provider charges came from network providers and almost 99% of all claims came from network providers. The following chart illustrates the average discount percent by type of service during the audit period.

Total of All Claims				
Claim Type	Allowed Charge	Provider Discount		Paid
Ancillary	\$2,130,623	\$848,810	39.8%	\$1,056,691
Non-Facility	\$28,105,080	\$8,824,445	31.4%	\$15,577,576
Facility Inpatient	\$12,868,263	\$3,012,358	23.4%	\$8,742,005
Facility Outpatient	\$11,590,941	\$1,978,603	17.1%	\$8,291,073
Total	\$54,694,908	\$14,664,216	26.8%	\$33,667,345

CTI's *Preventive Care Services Compliance Review Report* was used to confirm that the claim administrator was processing preventive services as required by the Patient Protection and Affordable Care Act (PPACA) and as regulated by the Department of Health and Human Services (HHS). The federal mandate under PPACA for all health plans (unless the plan is grandfathered as defined under PPACA) is that certain preventive services, if performed by a network provider, must be covered at 100% without copayment or coinsurance or deductible. The review analyzes in-network preventive care services to determine whether or not those services have been paid in



compliance with the PPACA guidelines. CTI's review found several preventive services (for example, wellness examinations for women and colorectal cancer screening) were not paid at 100% consistently as required by federal regulations. A complete listing and detailed breakdown by preventive benefit is included in the ***Specific Findings Report***.

CTI analyzed claims paid by the administrator to determine the degree to which coding used to process claims conformed to National Correct Coding Initiative guidelines used by the Centers for Medicare & Medicaid Services (CMS) for Medicare Part B and Medicaid claims. While these edits are not mandatory for non-Medicare/Medicaid medical plans, it is important that the plan sponsor understand the benefit of these initiatives and their potential value when applied to medical benefit plans. The two CMS initiatives that can offer the greatest return benefit to self-funded employee benefit plans are the:

- Procedure to Procedure Edits, and
- Medically Unlikely Edits (MUEs).

Areas where our Data Analytics indicated potential savings opportunities that should be discussed between the plan sponsor and the claim administrator include:

- Procedure to Procedure analysis shows that \$37,660 in outpatient hospital services and \$671,111 in non-facility claims did not conform to CMS edits.
- MUE CCI edits found \$21,377 paid that would have been disallowed by Medicare and Medicaid and the provider would need to have resubmitted with correct coding in order for the service to be allowed.

A complete listing of procedure codes affected is included with the ***Specific Findings Report***. CTI recommends that this analysis be discussed with BCBSMT to determine the extent that CMS edits could be used. Use of these edits would result in a reduction of claim expenses for employers and their employees, as well as furthering efforts toward a standardized code-editing system for all payers.

RECOMMENDATIONS

Based on the key findings of our Comprehensive Audit of the claim administrator, we recommend the following next steps.

1. Continue regular audits of BCBSMT to validate performance at the current high levels.
2. Meet with the claim administrator to discuss audit findings related to CMS edits and determine whether these may be implemented for additional savings to MUS.
3. Discuss BCBSMT's procedures for identifying preventive procedures to ensure that it is processing claims in compliance with ACA requirements.

We understand that you will need to review these recommendations to determine the subject of immediate action. Should MUS decide that additional assistance in implementing or performing any of the required tasks would be beneficial, our contract offers 10 hours of post-audit time to provide you with further assistance.



The claim administrator cooperated with this audit and made every effort to provide us with the data and documentation we requested.

We have considered it a privilege to have worked for, and with, your staff in these important endeavors and would welcome any opportunity to assist you in achieving your future objectives. Thank you again for choosing CTI.



EXHIBITS

- A. Performance Measurements and Benchmarking**
- B. Key Performance Indicators**
- C. Claim Administrator's Response**

EXHIBIT A

Performance Measurement and Benchmarking

The following box and whisker charts are based on the 100 most recent claim administration audits performed by CTI. The charts are used to demonstrate the claim administration performance when compared to the other plans against each of our six benchmarked Key Performance Indicators.

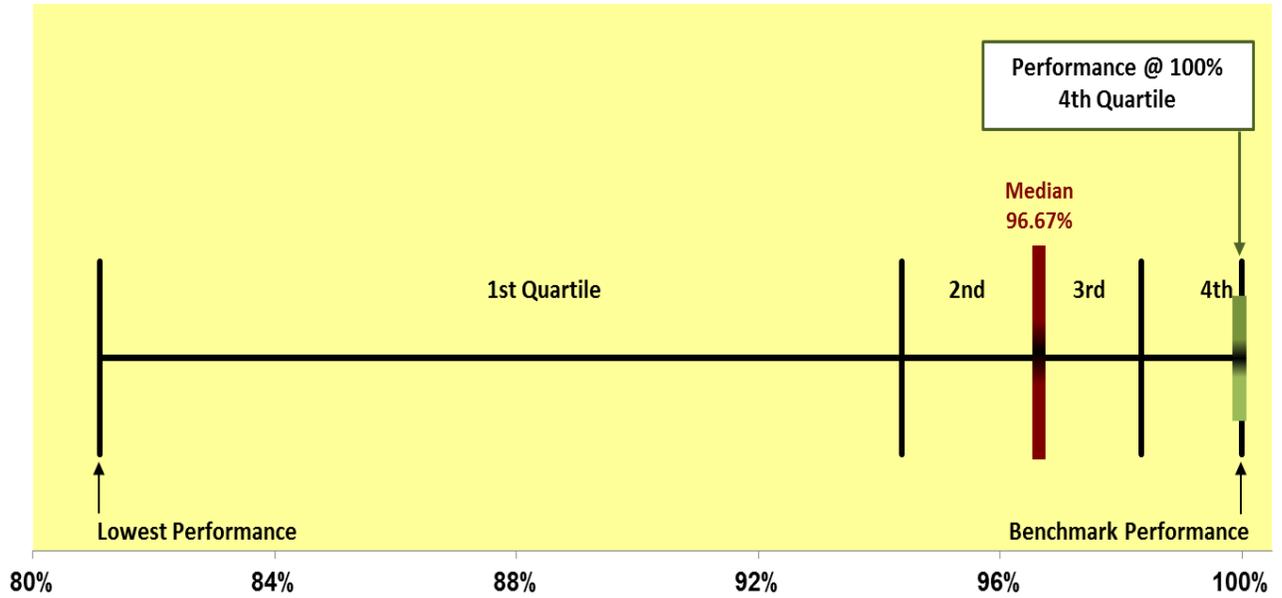
Each chart contains the following information:

- The claim administrator’s performance
- Benchmark performance
- Lowest performance
- Performance levels by quartile – with the 4th quartile representing the highest 25 performing plans and the 1st quartile representing the lowest 25 plans
- Performance level relative to the Median – or the level at which 50 of the plans audited were higher and 50 were reported to be lower

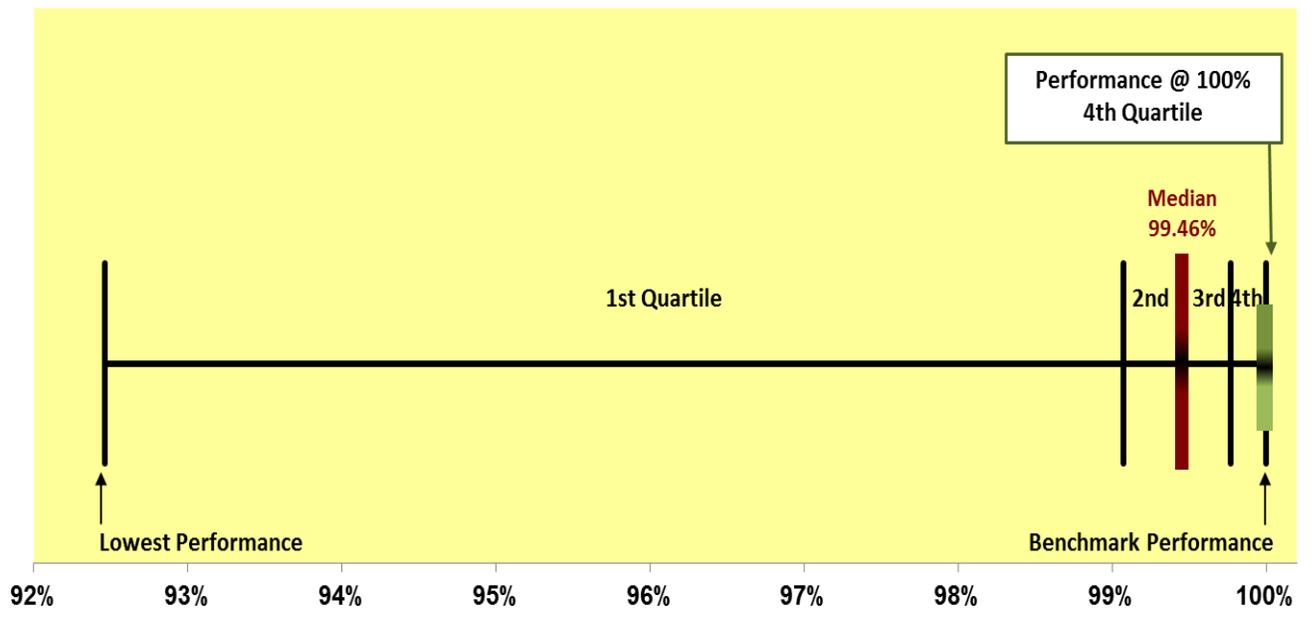
Financial Accuracy – Performance vs. Other Plans Audited by Quartile



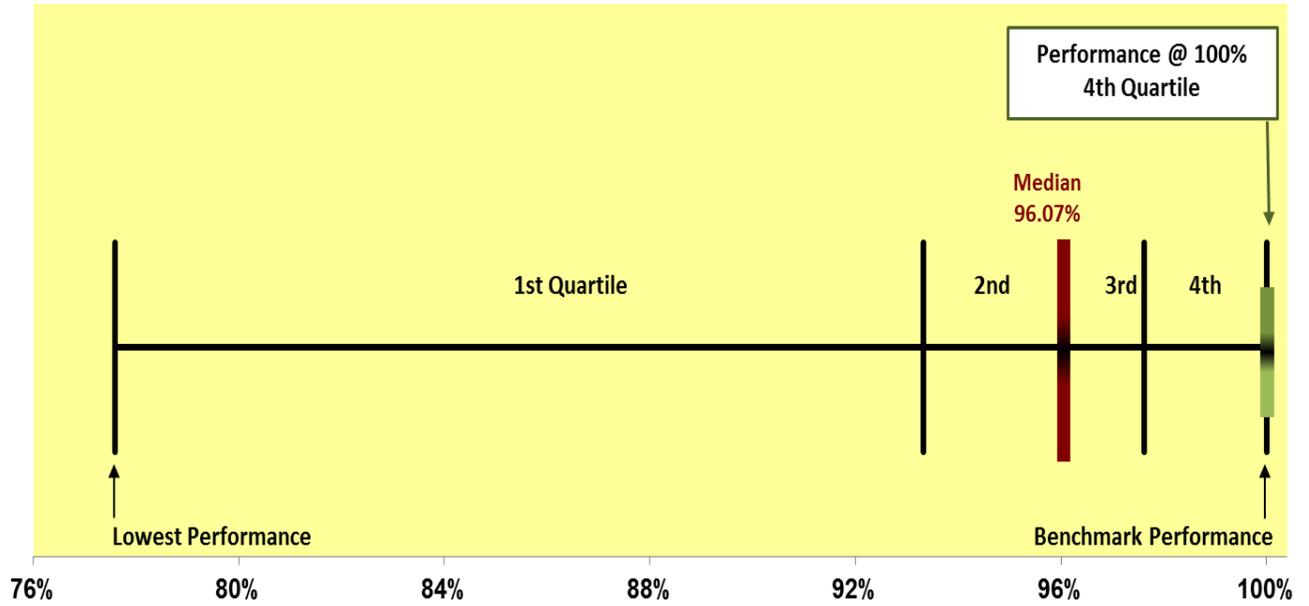
Accurate Payment Frequency – Performance vs. Other Plans Audited



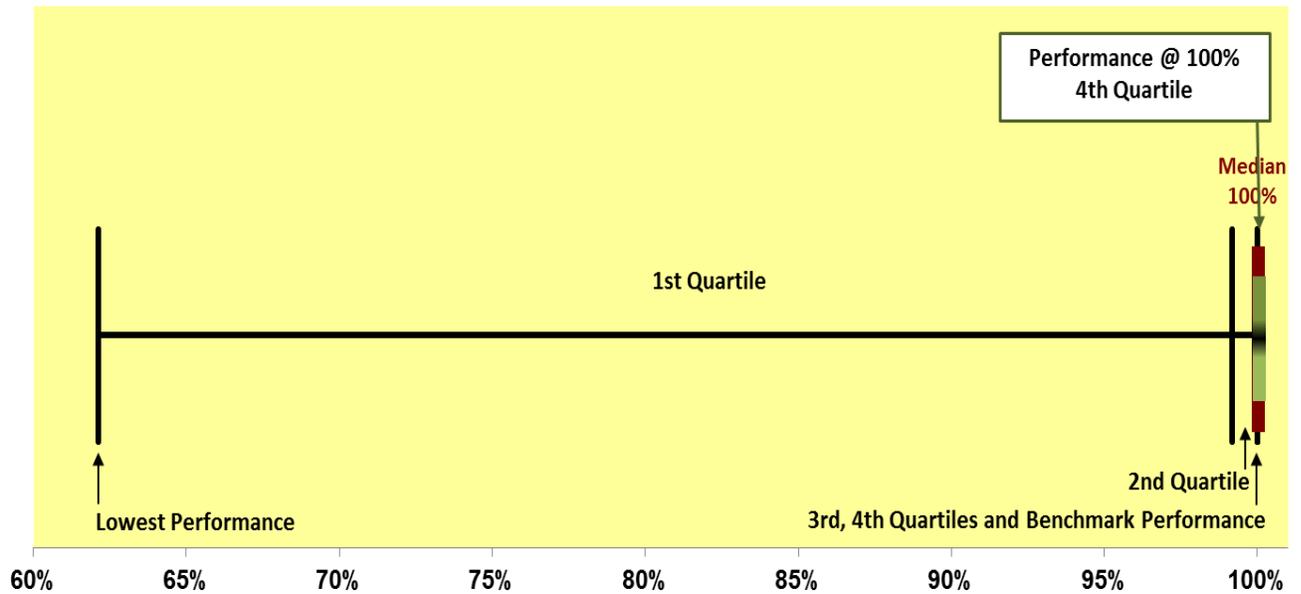
Adjudication Proficiency – Performance vs. Other Plans Audited



Accurate Processing Frequency – Performance vs. Other Plans Audited



Documentation Accuracy Financial – Performance vs. Other Plans Audited



Documentation Accuracy Frequency – Performance vs. Other Plans Audited

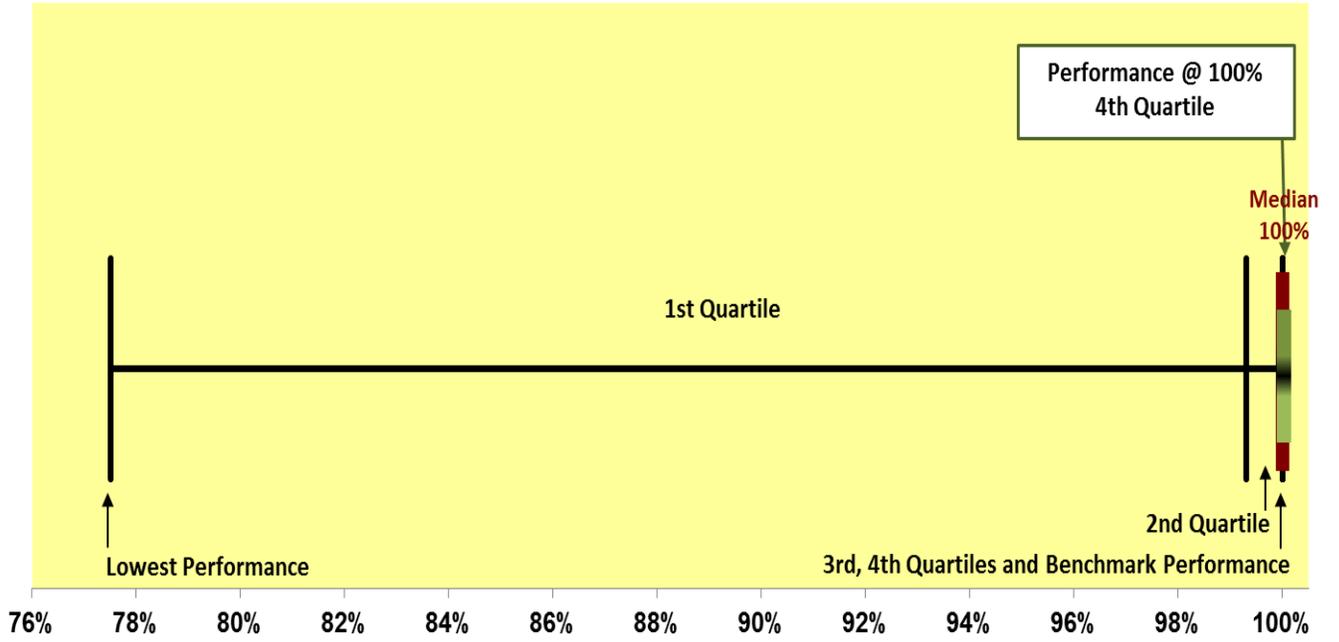


EXHIBIT B

Benchmarked Key Performance Indicators and Operational Definitions

Financial Accuracy – compares the total dollars associated with correct claim payments to the total dollars of correct claim payments that should have been made.
Accurate Payment Frequency – compares the number of bills paid correctly to the total number of bills paid.
Documentation Accuracy Financial – compares the number of dollars processed with documentation adequate to substantiate payment or denial to the total number of dollars processed.
Documentation Accuracy Frequency – compares the number of claims processed with documentation adequate to substantiate payment or denial to the total number of claims processed.
Adjudication Proficiency – compares the number of correct adjudication decisions made to the total number of adjudication decisions required.
Accurate Processing Frequency – compares the number of bills processed without errors of any type (financial or non-financial) to the total number of bills processed.

Non-Benchmarked Key Performance Indicator and Operational Definition

Claim Turnaround – is the number of calendar days required to pay a claim from the date the claim is received by the administrator to the date a payment or denial is mailed.
--

EXHIBIT C



October 6, 2014

Daniel Montgomery
Claim Technologies Incorporated
100 Court Ave, Ste 306
Des Moines IA 50309

Dear Mr. Montgomery:

Blue Cross Blue Shield of MT (BCBSMT) has reviewed the draft report and recommendations as provided by Claim Technologies Incorporated (CTI) on 10/02/14. BCBSMT has no rebuttal and approves the report as presented in the draft. Thank you for the opportunity to respond.

Sincerely,

A handwritten signature in blue ink that reads "Arlene Troy".

Arlene Troy
Senior Audit Specialist
BCBSMT Audit Services

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A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

350471.1213



**CLAIM TECHNOLOGIES
INCORPORATED**

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Claim Administration Audit

SPECIFIC FINDINGS REPORT

**Montana University System Medical Plan
Administered by Pacific Source**

Audit Period: July 1, 2012 through June 30, 2014

Presented to

**Legislative Audit Division, State of Montana
Montana University System**

October 31, 2014



**CLAIM TECHNOLOGIES
INCORPORATED**

PREFACE

The enclosed ***Specific Findings Report*** contains detailed information, findings, and conclusions that the Claim Technologies Incorporated (CTI) audit team has drawn from their Audit of Pacific Source's (Pacific Source) claim administration of the Montana University System (MUS) self-insured medical plan(s).

The information in this report is intended for the sole use of the Montana legislature, MUS, Pacific Source and CTI in their efforts to serve the interests of the plan participants of the MUS plan(s). The findings in this report are based on data and information the plan sponsor and claim administrator provided to CTI and their validity relies upon the accuracy and completeness of that information. CTI conducted the audit according to the standards and procedures generally accepted and in common practice for claim audits in the health insurance industry.

The audit was planned and performed to obtain a reasonable assurance that claims were adjudicated according to the terms of the contract between the claim administrator and the employer as well as the benefit descriptions (summary plan descriptions(s), plan document(s) or other communications) approved by the plan sponsor.

CTI is a firm specializing in audit and control of health plan claim administration. Accordingly, the statements made by CTI relate narrowly and specifically to the overall efficacy of the claim administrator's policies, processes and systems relative to the plan sponsor's paid claims during the audit period.

CLAIM TECHNOLOGIES INCORPORATED



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INTRODUCTION

Audit Objectives

The specific objectives of CTI's audit of Pacific Source's claims administration were to:

- Assure that members were eligible and covered by the MUS medical plan(s) at the time a medical service paid by Pacific Source was incurred;
- Assure that the terms of the agreement for administrative services and the stop loss policy (if applicable) between MUS and Pacific Source were followed;
- Assure that claims were paid according to the provisions of the summary plan description and identify dollar amounts associated with claims that Pacific Source did not pay accurately;
- Identify any fundamental systems or processes associated with claim administration or eligibility maintenance that may need improvement.

Audit Scope

CTI performed an Audit of Pacific Source's claim administration of the MUS medical plan(s) for the 24-month period of July 1, 2012 through June 30, 2014. The population of claims and amount paid by the plan during the audit period was:

Total Paid Amount	\$4,736,763
Total Number of Claims Paid/Denied/Adjusted	20,279

The audit included two components as described below; the objective, scope, methodology and findings of each component are found in the following sections of this report.

1. 100% Electronic Screening With Targeted Samples (ESAS®)

- Systematic analysis of 100% of paid medical services
- Eligibility verification (if elected)
- Targeted sampling
- Problem identification

2. Data Analytics

- Systematic analysis of network provider utilization and discount savings
- Systematic analysis of compliance with Affordable Care Act Preventive Services Coverage requirement
- Systematic analysis of claim system code editing capability
- Other data analytics if requested/elected by plan sponsor



**100% ELECTRONIC SCREENING WITH
TARGETED SAMPLES (ESAS®)**

100% ELECTRONIC SCREENING WITH TARGETED SAMPLES ESAS®

ESAS Objective

The objective of ESAS is to identify and quantify potential claim administration payment errors. If over- or under-payments are identified and subsequently verified, the employer and claim administrator can reach agreement on a reimbursement methodology going forward.

ESAS Scope

CTI electronically screened 100% of the service lines processed by the claim administrator during the audit period of July 1, 2012 through June 30, 2014. During that period Pacific Source processed 20,279 claims (including adjustments) for 1,238 MUS claimants representing 42,296 separate service line items and resulting in \$4,736,763 in payment by the plan(s). CTI screens claims in up to 90 different categories and applies more than 500 unique algorithms when electronically screening claim data. The accuracy and completeness of the claim data we were provided by the claim administrator directly impacts which screening categories we are able to run and the integrity of our findings. A high level summary of the ESAS screening categories and subcategories we screened for is shown below:

Summary of ESAS® Screening Categories to Identify Potential Amounts at Risk
Duplicate Payments to Providers and/or Employees
Duplicates from two claims
Duplicates from three or more claims
Plan Limitations
Specific to plan provisions such as: <ul style="list-style-type: none">• Dollar limitations• Number of visit limitations
Payments after timely filing limit
Plan Exclusions
Specific to plan provisions such as: <ul style="list-style-type: none">• Hearing aids• Cosmetic surgery• Weight loss treatment• Dental• Nutritional counseling
Multiple Surgical Procedures
Multiple procedures should be reduced fees

ESAS Methodology



The procedures followed to complete our ESAS process of claim data for MUS were:

- *Electronic Screening Parameters Set* – The plan provisions of the MUS medical plan SPD(s) were relied on to set the parameters in our electronic screening system. These provisions were validated by the plan sponsor prior to screening.
- *Data Conversion* – We converted and validated the claim data provided by Pacific Source. The converted data was reconciled against control totals and checked for reasonableness.
- *Electronic Screening* – We systematically screened 100% of the service lines processed by Pacific Source during the audit period of July 1, 2012 through June 30, 2014. Claims that were not processed in accordance with the parameters of the plan(s) as set up in our system are flagged, CTI refers to these potential errors as red flagged.
- *Auditor Analysis* – If the red flagged claims within an ESAS screening category represented material amounts, our auditors analyzed the category findings to confirm that the findings appeared valid. When using electronic screening to identify payment errors in medical claims, false positives typically occur because certain claim data was misleading or inadequate. CTI auditors make every effort through the analysis to identify and remove false positives.
- *Targeted Sampling* – From the categories where material amounts were identified, CTI auditors selected the best examples of potential over- or under-payments to test. These cases are not selected randomly therefore no extrapolation of the test results can be made. For this audit a total of 30 red flagged cases were selected. For each case a Substantive Testing Questionnaire was prepared and sent to the claim administrator for completion. Targeted sampling serves to verify if the claim data provided by the claim administrator supported our electronic screening, and if our understanding of the plan provision governing how that service should be adjudicated matches the claim administrator's.
- *Audit of Administrator Response and Documentation* – A CTI auditor reviewed the Substantive Testing Questionnaire responses. Copies of the administrator's responses to the questionnaires are provided in the work papers that accompany this report. (Questionnaire responses presented in the work papers have been redacted to eliminate personal health information.) Based on the responses from Pacific Source and further analysis of the ESAS findings in light of those responses, we removed any false positives that could be systematically identified from the potential amounts at risk.

ESAS Findings

While we are confident in the accuracy of our electronic screening results, it is important to note that the dollar amounts associated with the results shown represent potential, not actual, payment errors and process improvement opportunities. Additional testing of these claims would be required to substantiate the findings and to provide the basis for remedial action planning or reimbursement. Additionally, CTI was and is not authorized to tell the administrator to recover overpaid amounts. The process and impact of recovering overpayments must be discussed by the employer and the administrator. If recovery is not pursued, these findings still represent the opportunity for future savings if systems and procedures can be improved to eliminate future similar payment errors.

The following **ESAS Summary Report** shows, by category, the number of line items or claims and the total potential amount at risk that remain now at the conclusion of our analysis, targeted sampling and removal of verified false positives. Following the **ESAS Summary Report** is a detailed explanation of our Substantive Testing results, findings and recommendations for any screening category where it is our opinion that process improvement or recovery/savings opportunities exist. Note: If CTI is making an improvement recommendation, it will be denoted by a “Yes” in the final column of the **ESAS Summary Report**.

In the case of MUS plan(s), CTI could not run the following ESAS screens because the data did not support our doing so:

DEXX – Denial of Mandated Benefits – Decline Payment indicator was not provided.

MCRP – Retired Employee, Plan should be secondary to Medicare – Employee/Retiree indicator was not provided.

ESAS SUMMARY REPORT

ESAS - Summary (as of 10/07/2014)

Categories for Potential Amount At Risk

Client: Montana Univ Pacific Source

Screening Period: 07/01/2012 - 06/30/2014

Analysis Final Results

Claims Red Flagged	377
Claimants Red Flagged	148
Paid Amount Red Flagged	\$82,994
Potential Amount at Risk:	\$68,724

Category	Lines	Cmnts	Description	Charge Amount	Paid Amount	Potential Amount At Risk	Improvement Recommended
Duplicate Payments to Providers and/or Employees							
DP2B	4	1	Duplicate Payments to Providers and/or Employees	\$175	\$254 *	\$73	Yes
Plan Limitations							
TFLM	4	1	Timely Filing (Last service date to received date)	\$1,338	\$347	\$347	
Plan Exclusions							
EX19	53	44	Vision Refractions	\$1,676	\$423	\$423	
EX28	10	1	Abortions, Elective	\$1,405	\$827	\$827	
EX29	23	4	Genetic Counseling and/or Testing	\$3,652	\$2,851	\$2,851	
EX32	13	2	Infertility Treatment	\$870	\$502	\$502	
EX34	46	20	Contraceptives	\$14,782	\$9,264	\$9,264	
EX40	9	3	Non-Emergency Transportation	\$2,451	\$2,451	\$2,451	
EX54	1	1	Cognitive Therapy	\$46	\$30	\$30	
EX58	85	12	Educational Therapy & Supplies	\$6,245	\$6,210	\$6,210	
EX61	22	9	Nutritional Counseling (Non-diabetic)	\$1,545	\$996	\$996	
EX63	17	10	Physicals, Work, Insurance, School	\$1,201	\$997	\$997	
EX64	78	18	Massage Therapy	\$1,124	\$964	\$964	
EX68	8	4	TMJ - Temporomandibular Joint Disorder	\$398	\$274	\$274	
EX70	2	1	Weight Loss Surgical Treatment	\$12,230	\$8,066	\$8,066	
EX71	61	13	Weight Loss Treatment (non-surgical)	\$31,134	\$21,334	\$21,334	
EX76	19	4	Diabetic Syringes	\$3,810	\$2,097	\$2,097	
EXCF	1	1	Varicose Vein Treatment (sclerosing solutions)	\$446	\$278	\$278	
Multiple Surgical Procedures							
MSPC	47	18	Multiple Surgical Procedures Should be Reduced Fee	\$36,918	\$25,163	\$10,732	

* The amount detailed is based on Benefit Total, which equals Coinsurance + Copayment + Deductible + Paid



ESAS - Summary (as of 10/07/2014)

Categories for Operational Review

Client: Montana Univ Pacific Source
Screening Period: 07/01/2012 - 06/30/2014

Analysis Final Results

Claims Red Flagged	4,641
Claimants Red Flagged	791
Paid Amount Red Flagged	\$969,461
Potential Amount at Risk:	\$84,796

Category	Lines	Cmnts	Description	Charge Amount	Paid Amount	Potential Amount At Risk	Improvement Recommended
Fraud, Waste, and Abuse							
LGEE	53	14	Large Payments Direct to Employees	\$15,188	\$12,571		
NCST	3	2	Unnecessary Nerve Conduction Studies	\$1,065	\$745		
WA02	1	1	Diagnostic Arthroscopy-SB in surgical arthroscopy fee	\$1	\$1		
WA03	51	31	Casts (Initial & Removal) should be in fracture care fee	\$10,486	\$3,263		
Subrogation/Right of Recovery from Third Party							
SBxx	2350	310	Subrogation/Right of Recovery from Third Party	\$609,574	\$274,137		
Workers' Compensation							
WCxx	182	25	Workers Compensation	\$74,873	\$34,643		
Coordination of Benefits							
CB01	159	19	Paid Primary Should be Secondary to Other Group Insurance	\$18,655	\$9,487		Yes**
Large Claim Review							
CMLG	307	1	Claimants over \$100,000	\$373,048	\$211,854		
Case Management							
CMxx	1366	121	Case Management	\$239,258	\$161,264		
Provider Discounts and Fees							
UI80	338	157	In-Network UCR at 80th, at 10.00 tolerance	\$156,668	\$112,687	\$34,124	
UO80	32	7	Out-of-Network UCR at 80th, at 10.00 tolerance	\$12,454	\$8,415	\$4,403	
PDSC	2266	546	PPO Provider and No Discount Taken	\$230,058	\$194,841		
PPCO	182	36	Non-PPO Provider with Incorrect Copayment	\$37,171	\$20,042		
Dependent Child Eligibility							
GCxx	421	20	Payments for Ineligible Grandchildren	\$61,078	\$36,902	\$36,902	
OVxx	56	4	Payments for Over Age Dependents	\$13,678	\$9,366	\$9,366	

* The amount detailed is based on Benefit Total, which equals Coinsurance + Copayment + Deductible + Paid

**** Please refer to Work Papers - Substantive Testing Questionnaire Responses and CTI Conclusions for additional detail on the category of Coordination of Benefits findings.**



Duplicate Payments

Objective: Identify provider services paid more than once. We also identify procedural deficiencies of the administrative process and conservatively quantify the additional cost to a plan caused by duplicate payments.

Initial Screening and Analysis

Electronic screening of all service lines processed revealed certain service lines had potentially been paid more than once, resulting in a benefit total (the accumulation of payment, deductible and coinsurance applied to the out of pocket accumulation) greater than the charged amount for that service. Additional analysis of the service lines flagged confirmed the potential for process improvement and overpayment of claims to be sufficiently material to warrant further testing.

Substantive Testing

Substantive Testing Questionnaire (QID) number(s) 1 – 3 were sent to Pacific Source. Copies of the responses are provided in the work papers.

Substantive Testing results are shown in the following report entitled ***Substantive Testing Detail Report – Duplicate Payments***.

The results confirmed the potential for process improvement and overpayment of claims.

Recommendation(s)

In the category of Duplicate Payments – after removal of any cases that Pacific Source was able to document that were not overpaid – we recommend the following:

1. **Recovery Opportunity** – \$73 on 1 claimant involving 4 lines of service (tested and confirmed by Pacific Source). Pacific Source should advise MUS of the status of the overpayment recovery.
2. **Process Improvement Opportunity** – In the category of Duplicate Payments, after removal of any cases that Pacific Source was able to document as not having been overpaid, CTI recommends continued monitoring and review of internal controls to ensure that system edits and manual overrides to system edits are monitored for accuracy and frequency.

SUBSTANTIVE TESTING DETAIL REPORT – DUPLICATE PAYMENTS

Client: MUS Pacific Source Medical

Audit Period 7/1/2012 - 6/30/2014

Questionnaire ID Numbers: 1 - 3 (see Work Papers – Substantive Testing Questionnaire Responses)

QID No:	Flag Type	Flag Description	Overpaid Amt	Pacific Source Response (For full response see questionnaire in Exhibit A)
1	DP1C	Service line paid twice within same claim number	\$0.00*	Disagree, provided documentation to show service line is not a duplicate
2	DP1C	Service line paid twice within same claim number	\$0.00*	Disagree, provided documentation to show service line is not a duplicate
3	DP2B	Service line paid twice on separate claim numbers	\$72.74*	Agree to error

*Potential overpayments that were tested and determined to not be overpaid have been removed from total potential overpaid, however other cases identified by ESAS® cannot be removed without further investigation.



Plan Limitations

Objective: Identify services that exceeded plan limitations on quantity, frequency or benefit amount. We also identify procedural deficiencies in the administrative process and conservatively quantify the additional cost to the plan(s) caused by payments in excess of the plan(s) limitations.

Initial Screening and Analysis

Electronic screening of all service lines processed revealed certain service lines had potentially been overpaid as a result of exceeding the plan's limitations for coverage of:

- Outpatient Mental Nervous Visits
- Physical, Occupational, Speech, Cardiac, Respiratory, and Pulmonary Therapies

Substantive Testing

Substantive Testing Questionnaire (QID) number(s) 4 – 7 were sent to Pacific Source. Copies of the responses are provided in the work papers.

Recommendation(s)

In the category of Plan Limitations, after removal of any cases that Pacific Source was able to document as not having been overpaid, CTI recommends continued monitoring and review of internal controls to ensure that system edits and manual overrides to system edits are monitored for accuracy and frequency.

SUBSTANTIVE TESTING DETAIL REPORT – PLAN LIMITATIONS

Client: MUS Pacific Source Medical

Audit Period 7/1/2012 - 6/30/2014

Questionnaire ID Numbers: 4 - 7 (see Work Papers – Substantive Testing Questionnaire Responses)

QID No:	Flag Type	Flag Description	Overpaid Amt	Pacific Source Response (For full response see questionnaire in Exhibit A)
4	PL02	MNOP 40 visits/PY	\$0.00*	Disagree, provided documentation to show limitation was not exceeded
5	PL02	MNOP 40 visits/PY	\$0.00*	Disagree, provided documentation to show limitation was not exceeded
6	PL02	MNOP 40 visits/PY	\$0.00*	Disagree, provided documentation to show limitation was not exceeded
7	PL07	2012 -2013 PT OT ST Card Resp Pulm Therapies	\$0.00*	Disagree, provided documentation to show limitation was not exceeded



Plan Exclusions

Objective: Identify services that should have been denied due to specific plan exclusions. Further, to identify procedural deficiencies in the administrative process and to quantify conservatively the additional cost to a plan(s) caused by the payment of excluded expenses.

Initial Screening and Analysis

Electronic screening of service lines processed revealed certain service lines had potentially been overpaid as a result of paying services that should have been denied due to Plan Exclusions for:

- Genetic Counseling and/or Testing
- Infertility Treatment
- Contraceptives
- Non-Emergency Transportation
- Educational Therapy and Supplies
- Breast Reduction
- Eye Surgery (Cosmetic) Blepharoplasty

Substantive Testing

Substantive Testing Questionnaire (QID) number(s) 8 – 14 were sent to Pacific Source. Copies of the responses are provided in the work papers.

The results of the Substantive Testing are shown in the following report entitled ***Substantive Testing Detail Report – Plan Exclusions***.

Recommendation(s)

In the category of Plan Exclusions, after removal of any cases that Pacific Source was able to document as not having been overpaid, CTI recommends continued monitoring and review of internal controls to ensure that system edits and manual overrides to system edits are monitored for accuracy and frequency.

SUBSTANTIVE TESTING DETAIL REPORT – PLAN EXCLUSIONS

Client: MUS Pacific Source Medical

Audit Period 7/1/2012 - 6/30/2014

Questionnaire ID Numbers: 8 - 14 (see Work Papers – Substantive Testing Questionnaire Responses)

QID No:	Flag Type	Flag Description	Overpaid Amt	Pacific Source Response (For full response see questionnaire in Exhibit A)
8	EX29	Genetic Counseling and/or Testing	\$0.00*	Disagree, provided documentation to show payment was correct
9	EX32	Infertility Treatment	\$0.00*	Disagree, provided documentation to show payment was correct
10	EX34	Contraceptives	\$0.00*	Disagree, provided documentation to show payment was correct
11	EX40	Non-Emergency Transportation	\$0.00*	Disagree, provided documentation to show payment was correct
12	EX58	Educational Therapy and Supplies	\$0.00*	Disagree, provided documentation to show payment was correct
13	EXC4	Breast Reduction	\$0.00*	Disagree, provided documentation to show payment was correct
14	EXC8	Eye Surgery (Cosmetic) Blepharoplasty	\$0.00*	Disagree, provided documentation to show payment was correct





DATA ANALYTICS

DATA ANALYTICS

Data Analytics Objective

The objective of this component of the Comprehensive Audit of Pacific Source for MUS was to use the electronic claim data to provide meaningful additional information relevant to the plan sponsor of this/these self-insured plan(s). The standard informational categories we analyze the data for include:

- Network provider utilization and savings
- Compliance with the Preventive Services Coverage requirement under the Patient Protection and Affordable Care Act
- Administrator claim system code editing capability as compared to the Centers for Medicare & Medicaid Services National Correct Coding Initiatives (CCI)

Other data analytics can be performed at the employer's request if the claim data provided by the claim administrator supports it.

Data Analytics Scope

CTI performed data analytics using tested queries on the claim data provided by Pacific Source for the MUS medical plan(s).

Data Analytics Methodology and Findings

For each category of Data Analytics a brief description of the parameters used to analyze the data and the findings from the analysis follows.

Preferred Provider Utilization

Using the data provided by Pacific Source, CTI independently calculated the discount percentages obtained through provider networks. We also calculated the in-network percentage of claims to compare with out-of-network utilization. ***Please Note:*** there were minor differences between the method used by CTI to calculate discounts and the methodology used by the administrator. Since Pacific Source exceeded the minimum discount, the differences in calculation methods were immaterial.

PROVIDER DISCOUNTS REPORT

Total of All Claims				
Claim Type	Allowed Charge	Provider Discount		Paid
Ancillary	\$178,899	\$32,803	18.3%	\$111,461
Non-Facility	\$4,974,670	\$1,382,440	27.8%	\$2,756,568
Facility Inpatient	\$1,696,014	\$279,199	16.5%	\$1,198,154
Facility Outpatient	\$977,061	\$153,027	15.7%	\$670,580
Total	\$7,826,644	\$1,847,469	23.6%	\$4,736,763

In-Network				
Claim Type	Allowed Charge	Provider Discount		Paid
Ancillary	\$172,889	\$32,803	19.0%	\$107,999
Non-Facility	\$4,780,602	\$1,381,940	28.9%	\$2,676,851
Facility Inpatient	\$1,475,583	\$279,199	18.9%	\$1,023,894
Facility Outpatient	\$942,608	\$153,027	16.2%	\$650,406
Total In-Network	\$7,371,683	\$1,846,969	25.1%	\$4,459,151

% of Allowed Charge 94.2%

% Claim Frequency 92.6%

Out of Network				
Claim Type	Allowed Charge	Provider Discount		Paid
Ancillary	\$6,010	\$0	0.0%	\$3,462
Non-Facility	\$194,068	\$500	0.3%	\$79,716
Facility Inpatient	\$220,431	\$0	0.0%	\$174,259
Facility Outpatient	\$34,453	\$0	0.0%	\$20,175
Total Out of Network	\$454,961	\$500	0.1%	\$277,612

% of Allowed Charge 5.8%

% Claim Frequency 7.4%

Secondary				
Claim Type	Allowed Charge	Provider Discount		Paid
Ancillary	\$0	\$0	0.0%	\$0
Non-Facility	\$0	\$0	0.0%	\$0
Facility Inpatient	\$0	\$0	0.0%	\$0
Facility Outpatient	\$0	\$0	0.0%	\$0
Total Secondary	\$0	\$0	0.0%	\$0

% of Allowed Charge 0.0%

% Claim Frequency 0.0%

Allowed Charge = Provider Discount + Deductible + Copayment + Coinsurance + Paid Amount

Facility Inpatient = Any claim with a Room and Board Revenue Code (100-219)

Facility Outpatient = Any claim with Revenue Codes not Flagged as Inpatient

Non-Facility = Any claim with CPT Codes: 00100 - 99999

Ancillary = All other claims not flagged in Inpatient, Outpatient and Non-Facility



Preventive Services Compliance Review

The objective of this Preventive Care Services Compliance Review was to confirm that the claim administrator was processing preventive services as required by the Patient Protection and Affordable Care Act (PPACA). The federal mandate under PPACA for all health plans (unless the plan is grandfathered as defined under PPACA) is that certain preventive services, if performed by a network provider, must be covered at 100% without copayment or coinsurance or deductible. Department for Health and Human Services (HHS) is responsible for ensuring that all health plans are compliant with the requirement for covering these services.

Our data analytics parameters rely on the published recommendations from the sources that HHS used to create the list of preventive services for which it has mandated coverage. We also have looked at best practices of health claim administrators to identify covered preventive services. We believe this Preventive Services Compliance Review reflects best practice in the health care insurance industry for payment of covered services as defined under PPACA.

The following report shows the covered preventive services processed during the audit period. We analyzed the payments to determine if they were compliant. Types of services on which non-compliance was identified (if any) are listed first and the percent of allowed charge paid is shown in the last column. To demonstrate full compliance with PPACA's requirement for coverage of preventive services, the last column of this report should show that 100% of these services performed by network providers were paid and no deductible, coinsurance or copayment was applied. Because services may be denied for a reason other than exclusion or limitation of non-covered services (e.g. a service could be denied because the patient was not eligible at the time it was performed), if less than 100% of the preventive services were paid, the employer should discuss the finding with the claim administrator. The claim detail supporting each finding can be provided upon request.

Not included in this review were:

- Services performed by an out-of-network provider
- Services with dates of service prior to January 1, 2013 (the federal requirement to cover preventive services became effective on the plan's first renewal date on or after August 1, 2012)
- Services that were adjusted or paid more than once (duplicate payments) during the audit period
- Services where the PPACA requirements suggested a frequency limitation such as one per year (There were few of these and because of the impact our audit period might have on accuracy of screening, we did not include these.)

PREVENTIVE CARE SERVICES REPORT

Client : Montana University

Administrator: Pacific Source

Audit Range: 07/01/2012 - 06/30/2014

Plans: All

Filters: Exclude- Treatments before 01/01/13, Out of network, Adjustments, Duplicates, Edits with frequency limits

Edit Guideline	Preventive Service Benefit	Charge	Zero	Applied Deductible		Applied Copay		Applied Coinsurance		Paid = Allowed		Priority
		Count	Allowed Count	Count	Amount	Count	Amount	Count	Amount	Count	Amount	Percent
USPSTF-B	Healthy diet counseling - adults	5	0	2	\$78	3	\$45	0	\$0	0	\$0	0%
USPSTF-B	Obesity screening and counseling - adults	5	0	2	\$78	3	\$45	0	\$0	0	\$0	0%
USPSTF-B	BRCA screening counseling - women	1	0	0	\$0	1	\$15	0	\$0	0	\$0	0%
USPSTF-B	Breast cancer chemoprevention counseling - women 18 and older	3	1	0	\$0	1	\$15	0	\$0	1	\$203	33%
HHS	Gestational diabetes screening - women	19	0	3	\$51	0	\$0	7	\$38	9	\$130	47%
Bright Futures	Dyslipidemia screening - children 2-20	6	1	1	\$15	0	\$0	1	\$23	3	\$61	50%
Bright Futures	Lead screening - children 20 and younger	6	3	0	\$0	0	\$0	0	\$0	3	\$78	50%
Bright Futures	Iron Supplement - children 20 and younger	12	4	0	\$0	0	\$0	0	\$0	8	\$46	67%
USPSTF-B	Anemia screening - pregnant women	3	0	1	\$11	0	\$0	0	\$0	2	\$20	67%
USPSTF-B	Gonorrhea screening - women	16	0	1	\$53	0	\$0	3	\$44	12	\$808	75%
HHS	Contraceptive methods - women	47	1	6	\$1,120	0	\$0	7	\$970	36	\$8,524	77%
AMA	Modifier 33	23	2	2	\$637	0	\$0	3	\$295	18	\$15,889	78%
ACIP	Immunizations adult - Pneumococcal 19 and older	17	1	0	\$0	0	\$0	0	\$0	14	\$1,249	82%
USPSTF-A,B	Chlamydia infection screening - women	23	0	1	\$53	0	\$0	3	\$44	19	\$1,214	83%
ACIP	Immunizations adult - Diphtheria, Tetanus, Pertussis 19 and older	68	1	7	\$588	0	\$0	2	\$120	58	\$2,453	85%
USPSTF-A	HIV screening - adults 15 and older	14	0	2	\$27	0	\$0	0	\$0	12	\$296	86%
ACIP	Immunization Administration - adults	195	8	8	\$238	5	\$260	2	\$22	169	\$4,825	87%
USPSTF-A	Colorectal cancer screening - adults 50 to 75	115	10	1	\$61	0	\$0	3	\$440	101	\$60,047	88%
USPSTF-A	HIV screening - pregnant women	25	0	3	\$38	0	\$0	0	\$0	22	\$645	88%
ACIP	Immunizations adult - Influenza Age 19 - 99	82	2	4	\$45	0	\$0	0	\$0	74	\$1,077	90%
USPSTF-A	Cervical cancer screening - women	196	18	0	\$0	0	\$0	0	\$0	177	\$10,011	90%
HHS	Wellness Examinations - adults 19 and older	121	11	0	\$0	0	\$0	0	\$0	110	\$19,767	91%
HHS	Wellness Examinations - women	426	29	0	\$0	0	\$0	0	\$0	394	\$64,091	92%
ACIP	Immunizations child - Influenza 18 and younger	123	5	0	\$0	0	\$0	0	\$0	115	\$2,158	93%
USPSTF-A,B	Cholesterol abnormalities screening - women 20 and older	31	1	0	\$0	0	\$0	1	\$9	29	\$1,052	94%
HRSA/HHS	Wellness Examinations - children 18 and younger	224	11	0	\$0	0	\$0	0	\$0	213	\$31,012	95%
ACIP	Immunizations child - Rotavirus 18 and younger	22	1	0	\$0	0	\$0	0	\$0	21	\$2,250	95%
USPSTF-A	Cholesterol abnormalities screening - men 35 and older	46	0	2	\$43	0	\$0	0	\$0	44	\$1,276	96%
ACIP	Immunizations child - Measles, Mumps, Rubella 18 and younger	25	1	0	\$0	0	\$0	0	\$0	24	\$3,033	96%
ACIP	Immunization Administration - children 18 and younger	347	7	0	\$0	2	\$104	1	\$13	334	\$13,028	96%
Bright Futures	Developmental Autism screening - children 20 and younger	27	1	0	\$0	0	\$0	0	\$0	26	\$386	96%
ACIP	Immunizations child - Haemophilus influenzae type b 18 and younger	30	1	0	\$0	0	\$0	0	\$0	29	\$1,124	97%



Edit Guideline	Preventive Service Benefit	Charge	Zero	Applied Deductible		Applied Copay		Applied Coinsurance		Paid = Allowed		Priority
		Count	Count	Count	Amount	Count	Amount	Count	Amount	Count	Amount	Percent
ACIP	Immunizations child - Diphtheria, Tetanus, Pertussis 18 and younger	63	2	0	\$0	0	\$0	0	\$0	61	\$4,090	97%
ACIP	Immunizations child - Pneumococcal 18 and younger	37	1	0	\$0	0	\$0	0	\$0	36	\$5,858	97%
ACIP	Immunizations child - Hepatitis A 18 and younger	61	0	0	\$0	0	\$0	0	\$0	61	\$2,423	100%
ACIP	Immunizations child - Human papillomavirus 18	38	0	0	\$0	0	\$0	0	\$0	38	\$5,799	100%
ACIP	Immunizations child - Meningococcal 18 and younger	20	0	0	\$0	0	\$0	0	\$0	20	\$2,622	100%
ACIP	Immunizations child - Varicella 18 and younger	16	0	0	\$0	0	\$0	0	\$0	16	\$1,740	100%
ACIP	Immunizations adult - Hepatitis A 19 and older	10	0	0	\$0	0	\$0	0	\$0	10	\$701	100%
ACIP	Immunizations adult - Hepatitis B 19 and older	10	0	0	\$0	0	\$0	0	\$0	10	\$1,448	100%
USPSTF-A	Syphilis screening - pregnant women	6	0	0	\$0	0	\$0	0	\$0	6	\$73	100%
ACIP	Immunizations adult - Herpes Zoster 60 and older	5	0	0	\$0	0	\$0	0	\$0	5	\$938	100%
ACIP	Immunizations child - Hepatitis B 18 and younger	5	0	0	\$0	0	\$0	0	\$0	5	\$124	100%
USPSTF-A,B	Rh incompatibility screening - pregnant women	5	0	0	\$0	0	\$0	0	\$0	5	\$49	100%
ACIP	Immunizations adult - Meningococcal 19 and older	4	0	0	\$0	0	\$0	0	\$0	4	\$537	100%
USPSTF-B	Diabetes screening - adults	2	0	0	\$0	0	\$0	0	\$0	2	\$51	100%
ACIP	Immunizations adult - Human Papillomavirus 19-26	2	0	0	\$0	0	\$0	0	\$0	2	\$325	100%
ACIP	Immunizations adult - Influenza Age (FluMist) 19 - 49	2	0	0	\$0	0	\$0	0	\$0	2	\$40	100%
ACIP	Immunizations adult - Measles, Mumps, Rubella 19 and older	2	0	0	\$0	0	\$0	0	\$0	2	\$129	100%
ACIP	Immunizations child - Inactivated Poliovirus 18 and younger	2	0	0	\$0	0	\$0	0	\$0	2	\$66	100%
Bright Futures	Tuberculin testing - children 20 and younger	2	0	0	\$0	0	\$0	0	\$0	2	\$38	100%
USPSTF-B	Alcohol misuse - adult screening and counseling	1	0	0	\$0	0	\$0	0	\$0	1	\$56	100%
USPSTF-B	Osteoporosis screening - women 65 and older	1	0	0	\$0	0	\$0	0	\$0	1	\$435	100%
USPSTF-B	Abdominal aortic aneurysm screening - men 65 to 75	0	0	0	\$0	0	\$0	0	\$0	0	\$0	100%
USPSTF-B	Breast cancer mammography screening - women 40 and older	0	0	0	\$0	0	\$0	0	\$0	0	\$0	100%
HHS	Breastfeeding support and counseling - women	0	0	0	\$0	0	\$0	0	\$0	0	\$0	100%
USPSTF-B	Cholesterol abnormalities screening - men 20 to 34	0	0	0	\$0	0	\$0	0	\$0	0	\$0	100%
USPSTF-B	Depression screening - adolescents 12 to 18	0	0	0	\$0	0	\$0	0	\$0	0	\$0	100%
USPSTF-B	Depression screening - adults 19 and older	0	0	0	\$0	0	\$0	0	\$0	0	\$0	100%
USPSTF-B	Hearing loss screening - newborns 0 - 90 days	0	0	0	\$0	0	\$0	0	\$0	0	\$0	100%
USPSTF-A	Hemoglobinopathies or sickle cell screening - newborns 0 - 90 days	0	0	0	\$0	0	\$0	0	\$0	0	\$0	100%
USPSTF-A	Hepatis B screening - women	0	0	0	\$0	0	\$0	0	\$0	0	\$0	100%
USPSTF-C	HIV screening - adolescents 14 and younger	0	0	0	\$0	0	\$0	0	\$0	0	\$0	100%
HHS	Human papillomavirus DNA testing - women 30 and older	0	0	0	\$0	0	\$0	0	\$0	0	\$0	100%
USPSTF-A	Hypothyroidism screening - newborns 0 - 90 days	0	0	0	\$0	0	\$0	0	\$0	0	\$0	100%
ACIP	Immunizations adult - Influenza Age (FluZone) 65 - 99	0	0	0	\$0	0	\$0	0	\$0	0	\$0	100%
ACIP	Immunizations adult - Varicella 19 and older	0	0	0	\$0	0	\$0	0	\$0	0	\$0	100%
USPSTF-B	Obesity screening and counseling - children	0	0	0	\$0	0	\$0	0	\$0	0	\$0	100%
USPSTF-A	Phenylketonuria (PKU) screening newborn 0-90 days	0	0	0	\$0	0	\$0	0	\$0	0	\$0	100%

Edit Guideline	Preventive Service Benefit	Charge	Zero	Applied Deductible		Applied Copay		Applied Coinsurance		Paid = Allowed		Priority
		Count	Count	Count	Amount	Count	Amount	Count	Amount	Count	Amount	Percent
USPSTF-B	Sexually transmitted infection screening - children 18 and younger	0	0	0	\$0	0	\$0	0	\$0	0	\$0	100%
USPSTF-B	Sexually transmitted infections counseling - adults 19 and older	0	0	0	\$0	0	\$0	0	\$0	0	\$0	100%
USPSTF-B	Sexually transmitted infections counseling - women 19 and older	0	0	0	\$0	0	\$0	0	\$0	0	\$0	100%
USPSTF-A	Syphilis screening - adults	0	0	0	\$0	0	\$0	0	\$0	0	\$0	100%
USPSTF-A	Tobacco use counseling - adults 19 and older	0	0	0	\$0	0	\$0	0	\$0	0	\$0	100%
USPSTF-B	Tobacco use counseling - children	0	0	0	\$0	0	\$0	0	\$0	0	\$0	100%
USPSTF-A	Tobacco use counseling - pregnant women	0	0	0	\$0	0	\$0	0	\$0	0	\$0	100%
USPSTF-A	Urinary tract infection screening - pregnant women	0	0	0	\$0	0	\$0	0	\$0	0	\$0	100%
USPSTF-B	Vision screening - children 3 to 5	0	0	0	\$0	0	\$0	0	\$0	0	\$0	100%



Correct Coding Initiatives

The Centers for Medicare & Medicaid Services (CMS) mandates several initiatives that prevent improper payments of Medicare Part B and Medicaid claims. These initiatives are referred to by CMS as the National Correct Coding Initiatives (CCI). The goal of CCI is to reduce payment errors by Medicare and Medicaid claim administrators by identifying and addressing erroneous provider billing. While these edits are not mandatory for employer sponsored medical plans such as the MUS medical plan(s), we believe the benefits and the potential value to the sponsor of a non-Medicare or Medicaid plan of knowing that your claim administrator is following the CCI or using a system that performs as well or better than CCI is clear. The AMA supports the standardization of the CMS CCI code-edits and advocates the coordination of effort among all medical claim payers to standardize rules for correct coding of services by providers. To encourage this, CMS provides the CCI edits free of charge and they update them on a quarterly basis. The CCI coding policies are based on the following:

- Coding conventions defined by the American Medical Association (AMA)
- Current Procedural Terminology (CPT) codes
- Healthcare Common Procedure Coding System (HCPCS)
- National and local Medicare policies and edits
- Coding guidelines developed by national societies
- Standard medical and surgical practice

CMS implemented five separate claim review programs to help control the cost of the Medicare and Medicaid programs. The two CMS initiatives that CTI believes can have the greatest impact on controlling cost for self-funded medical plans are:

- Procedure-to-Procedure Edits
- Medically Unlikely Edits (MUEs)

CTI utilized the CCI parameters to analyze the benefit allowance and payments by Pacific Source. The following two reports show the services which would not have been paid if the CMS Procedure-to-Procedure Edits and MUE coding guidelines had been utilized. These reports reflect potential overpayments for the plan(s) being audited and can be used to help employers evaluate the strength of their administrator's prepayment claim review methodologies.

Procedure-to-Procedure Edits

The CCI Procedure-to-Procedure Edits compare procedure codes from multiple claim lines on the same day. These edits dictate when procedures from multiple lines of a claim cannot be billed together. There are numerous edit algorithms required, as well as many exceptions when code modifiers are used; all good reasons to verify that these edits are being properly implemented and maintained by the claim administrator. If the administrator is not currently using these CMS edits, this audit report will help evaluate the savings potential as if the Procedure-to-Procedure Edits had been in place. CMS splits the Procedure-to-Procedure Edits into two parts and the findings are reported separately for each:

- Outpatient hospital services
- Non-facility claims (CPT codes 00100-99999)



PROCEDURE TO PROCEDURE EDITS REPORT



Procedure to Procedure Edits

Greater than \$1,000 Paid

Based on Paid Dates 07/01/2012 thru 06/30/2014

Outpatient Hospital Services (facility claims with codes not designated inpatient)								
Primary		Secondary		Modifier Allowed	Primary Description	Secondary Description	Line Count	Secondary Paid
Code	Modifier	Code	Modifier					
						TOTAL over \$1,000	0	\$0
						GRAND TOTAL	78	\$5,014
Non-Facility (non-facility claims with CPT Codes: 00100 - 99999)								
Primary		Secondary		Modifier Allowed	Primary Description	Secondary Description	Line Count	Secondary Paid
Code	Modifier	Code	Modifier					
90471		99214		YES	IMMUNIZATION ADMIN	OFFICE/OUTPATIENT VISIT EST	9	\$1,430
90471		99396		YES	IMMUNIZATION ADMIN	PREV VISIT EST AGE 40-64	7	\$1,199
						TOTAL over \$1,000	16	\$2,629
						GRAND TOTAL	100	\$13,952



Medically Unlikely Edits

The CCI Medical Unlikely Edits (MUEs) are designed to limit fraud and/or unintentional coding errors. The MUE rule for a given CPT/HCPCS code is the maximum number of service units that a provider should report for a single day of service. An MUE is defined as an edit that tests claim lines for the same beneficiary, procedure code, date of service, and billing provider against a maximum allowable number of service units. In automated claim processing systems MUEs often represent an upper limit that unquestionably requires further supporting documentation. For example, electro-cardiogram tracing (CPT code 93005) is limited to three tests per day (three service units) as a hospital outpatient. If the service units exceed three, the fourth and additional services should be denied until the provider submits documentation supporting why four or more electro-cardiogram tracings were medically necessary and appropriate.

MUEs are generally based on biological considerations, like number of limbs or organs and are performed on units billed per line-of-service. The same code billed on different lines for the same date-of-service is subject to duplicate adjudication edits where CPT Modifiers like 59, 76, and 77 may impact the payment. MUEs do not require that Medicare contractors perform manual review or suspend claims; rather, claim lines should be denied and correctly resubmitted by the providers.

Consistent with CCI the MUEs identified by CTI were grouped into three separate categories in the following report:

- Outpatient hospital services
- Non-facility
- Ancillary

MEDICALLY UNLIKELY EDITS REPORT



MUE Edits

Greater than \$1000 Paid

Based on Paid Dates 07/01/2012 thru 06/30/2014

Outpatient Hospital Services (facility claims with codes not designated inpatient)				
Procedure Code	Service Unit Limit	Procedure Description	Line Count	Benefit Paid
99220	1	INITIAL OBSERVATION CARE	2	\$3,205
62310	1	Inject spine cerv/thoracic	1	\$1,604
		TOTAL OVER \$1,000	3	\$4,809
		GRAND TOTAL	13	\$6,338
Non-Facility (non-facility claims with CPT Codes: 00100 - 99999)				
Procedure Code	Service Unit Limit	Procedure Description	Line Count	Benefit Paid
46250	1	REMOVE EXT HEM GROUPS 2+	1	\$1,055
		TOTAL OVER \$1,000	1	\$1,055
		GRAND TOTAL	35	\$3,206
Ancillary (All other claims not flagged Inpatient, Outpatient Hospital, and Non-Facility)				
Procedure Code	Service Unit Limit	Procedure Description	Line Count	Benefit Paid
		TOTAL OVER \$1,000	0	\$0
		GRAND TOTAL	4	\$351



Correct Coding Initiative Findings Summary

To focus our analysis on the procedures where the greatest amount was paid, the Correct Coding Initiative reports shows the categories where more than \$1,000 was identified. In the Procedure to Procedure analysis we see that \$18,966 was paid by Pacific Source for procedures that Medicare and Medicaid would have disallowed. The MUE CCI edits found \$9,895 paid that would have been disallowed by Medicare and Medicaid and the provider would need to have resubmitted with correct coding in order for the service to be allowed. The findings in these two reports represent services that may have been unintentionally coded incorrectly by the provider, were performed inappropriately, or were fraudulently submitted. Pacific Source should discuss the coding edit system and software Pacific Source is using and whether it can be improved to more consistently apply the same level of edits as Medicare and Medicaid.



APPENDIX

ADMINISTRATOR'S RESPONSE TO DRAFT REPORT

Administrator response can be found on the following pages.



October 22, 2014

Claim Technologies Inc.
100 Court Ave Suite 306
Des Moines, IA 50309

Re: Specific Findings Report – Audit Response

Thank-you for the detailed findings report that listed the audit results for the period of July 1, 2012 through June 30, 2014 for Montana University System’s medical plan.

We have reviewed the audit findings and below is our response. I have listed the page number and questionnaire number to reference back to, if applicable.

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Coordination of Benefits - Questionnaire ID – 20

In regards to the Coordination of Benefits situation on this member in question, it is our policy to review the member history for potential overpayments if we discover that a member has other coverage after claims have already been paid.

For the claim in question (date of service 9-15-2012), the primary carrier applied this to deductible, so PacificSource would have processed this claim as primary regardless, since the primary did not pay anything. After further review, this claim is processed correctly.

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Questionnaire ID – 3

In regards to the duplicate payment made on this claim, we are tracking the status of the refund request sent to the provider on 9-16-14. As of 10-22-14, this refund has not been received. A follow-up refund request letter will be sent by the end of October.

Our Claims team has reporting in place to track outstanding refunds and routinely follows up with providers when the refund is not received in a timely manner. At this time, we do not have auto recovery available on our PacificSource Administrator plans (it’s only available on our Commercial plans), but are looking at adding this functionality in 2015. This would allow us to auto recover funds from future claims payments, if the refund is not received within two months of the request.

Duplicate Claim Rules:

Our current configuration for duplicate rules has multiple levels. It first reviews for an exact duplicate and if found, it will auto deny as a duplicate claim or claim line. If some of the criteria matches, but it's not an exact duplicate, it will pend the claim for manual review from one of our Claims Analysts. We have specific Claims Analysts trained in reviewing and researching duplicate claims.

Our Claims team currently receives a pre-payment and post-payment audit report of potential duplicates. Several Claims Analysts are responsible for auditing each report to determine if duplicates exist that need to be denied (or a refund requested if it was paid in error).

Our configuration team, Facets Business Support (FBS), is currently working on a project to test our existing duplicate claim rules and review possibilities to utilize some new functionality in our claims system that allows us to separate the duplicate rules between hospital and medical claims. Our initial testing is going well and we expect to have our configuration changes fully tested and in our Production system by the end of this year.

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Plan Limitations

The claims for questions 4-7 were re-reviewed and confirmed to be processed correctly based on either the plan benefits for MUS or by Montana state regulations.

Our claims processing system, Facets, has controls in place, in regards to limits. We use the Limit Rules application (LTLT) for all benefits that are based on either calendar year, plan year or lifetime. Our configuration team, FBS, routinely audits our limit rules configuration for issues or errors.

When a member reaches a benefit maximum, the claim will automatically deny as a maxed benefit. For an adjudicator to pay on a line that is being denied as maxed benefit, they have to enter an override to "Bypass Plan Limits". We have security controls on this override, so only higher level adjudicators have access to use this override. It is our policy that they enter a claim note to document the reason for the override. In addition, claims with this override pend to our Claims Audit team to review for accuracy.

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Plan Exclusions

The claims for questions 8 – 14 were re-reviewed and confirmed to be processed correctly based on plan benefits for MUS.

Controls that we currently have in place:

- Claims in question are sent to our Health Services team for review of medical necessity. Claims are processed accordingly based on their review.

- We have stops in place (via Workflow in Facets) to pend claims for review, if applicable, based on many different factors, including high dollar review.
- Our Claims Audit team performs a 3% random audit of all claims processed (including claims that are auto adjudicated). They audit against the plans benefits, providers agreement and they check to ensure that our system is processing the claim correctly. Issues discovered are entered in a HelpDesk ticket for our FBS team to review further and resolve, if applicable.
- During a group's renewal period, their benefit plan is thoroughly audited and any new updates for the next benefit period are configured in the system. Upon completion of the plan set up in our Facets system, our FBS team does a complete audit of the product and claim configuration as well as Benefit Summary application that our Customer Service team uses to quote benefits from.

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Correct Coding Initiatives

PacificSource uses an Optum product called iCES, which is a clinical editing software program that all of our medical and hospital claims go through during processing.

In regards to the Procedure-to-Procedure edits – we have multiple unbundle edit rules. Optum uses CCI edits as one of the resources to establish the unbundle edit logic.

PacificSource has a policy that we allow providers to bill immunization administration charges in addition to an office visit or preventive care exam. This is the reason why these are paid in the audit examples, even though there is a standard unbundle edit to deny the immunization charge when billed in addition to an exam. We have rules in place to bypass this edit based on our company policy.

In regards to the Medically Unlikely Edits – our iCES software also edits for this and alerts the adjudicator when a claim line has too many units allowed for the code. We process the claim by subtracting out the additional units from the line allowed amount and add an explanation code to the claim line to notify the provider why the reimbursement is reduced.

One of the examples in the audit was in regards to a claim line where the provider billed 45 units on CPT 99220 for one day. This provider billed this incorrectly, intending for the 45 units to indicate 45 minutes in observation. They also billed this line with a Modifier 59, which bypassed the clinical edit that would have flagged on this line. This provider is contracted with PacificSource on a percent of billed contract, which means our allowed amount is the same regardless of the 45 minutes that was billed as units.

Our configuration team, FBS, routinely audits our iCES system for updates to rules and to the knowledgebase. We are currently planning to upgrade to a newer version of iCES in early 2015, which means that extensive testing and validating will occur prior to this upgrade getting promoted to our Production system.



If you have any questions in regards to our responses to the audit findings, please contact me and I will be happy to assist further. Thank-you for your time and assistance during this audit process.

Sincerely,

Kristen Awmiller
Facets Business Support & Commercial Claims Manager
Kristen.awmiller@pacificsource.com
541-684-5423



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Comprehensive Claim Administration Audit

EXECUTIVE SUMMARY

**Montana University System Dental Plan
Administered by Delta Dental Insurance Company**

Audit Period: July 1, 2013 through June 30, 2014

Presented to

**Legislative Audit Division, State of Montana
Montana University System**

October 31, 2014

Presented by



**CLAIM TECHNOLOGIES
INCORPORATED**

PREFACE

This ***Executive Summary*** presents the key findings and recommendations from Claim Technologies Incorporated's (CTI's) Comprehensive Audit of Delta Dental Insurance Company's (Delta's) claim administration of the Montana University System (MUS) plan(s). The information that these key findings and recommendations are based on is detailed in the ***Specific Findings Report***.

The information in this report is intended for the sole use of the Montana legislature, MUS, Delta and CTI in their efforts to serve the interests of the plan participants of the MUS plan. The findings in this report are based on data and information the plan sponsor and claim administrator provided to CTI and their validity relies upon the accuracy and completeness of that information. CTI conducted the audit according to the standards and procedures generally accepted and in common practice for claim audits in the health insurance industry.

The audit was planned and performed to obtain a reasonable assurance that claims were adjudicated according to the terms of the contract between the claim administrator and the plan sponsor as well as the benefit descriptions (summary plan descriptions(s), plan document(s) or other communications) approved by the plan sponsor.

CTI is a firm specializing in audit and control of health plan claim administration. Accordingly, the statements made by CTI relate narrowly and specifically to the overall efficacy of the claim administrator's policies, processes and systems relative to the plan sponsor's paid claims during the audit period.

CLAIM TECHNOLOGIES INCORPORATED



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OBJECTIVES AND SCOPE

Audit Objectives

The specific objectives of CTI's Comprehensive Audit of Delta's claims administration were to:

- Quantify dollar amounts associated with claims that the administrator did not pay accurately;
- Determine whether the terms of the agreement for administrative services between the plan sponsor and claim administrator were followed;
- Determine if claims were paid according to the provisions of the summary plan description and the terms of the summary plan description were clear and consistent;
- Determine if members were eligible and covered by the sponsor's dental plans at the time a service paid by Delta was incurred;
- Determine whether any fundamental systems or processes associated with claim administration or eligibility maintenance may need improvement.

Audit Scope

CTI performed a Comprehensive Audit of Delta's claim administration of the sponsor's dental plan(s) for the 12-month period of July 1, 2013 through June 30, 2014. The population of claims and amount paid by the plan(s) during the audit period was:

Total Paid Amount	\$5,101,534
Total Number of Claims Paid/Denied/Adjusted	32,105

The audit included five components as described below; the objective, scope, methodology and findings of each component are found in the following sections of this report.

1. Operational Review

- Operational Review Questionnaire
 - Claim administrator information
 - Claim administrator claim fund account
 - Claim adjudication and eligibility maintenance procedures
 - HIPAA compliance

2. Plan Documentation Review

- Summary plan description(s) and/or plan document(s)
- Administrative services agreement
- Review and identification of ambiguities and inconsistencies

3. 100% Electronic Screening With Targeted Samples (ESAS®)

- Systematic analysis of 100% of paid dental services
- Targeted samples
- Problem identification

4. Random Sample Audit

- Statistical confidence at 95% +/- 3%
- Performance level determined for Key Indicators
- Measurement and benchmarking
- Problem identification and prioritization

KEY FINDINGS

In this section we present the findings from each of the components of the Comprehensive Audit on the basis of relevance and materiality to the plan sponsor followed by recommendations.

Random Sample Audit

CTI's Random Sample Audit system categorizes errors into one or more of six Key Performance Indicators. Systematic labeling of errors and calculation of performance is the basis for CTI's benchmarks which are generated using the results of the most recent 100 dental claim audits completed by CTI.

The following table demonstrates that the claim administrator's performance was above the median average in four of the six benchmarked Key Performance Indicators. For more specific information on CTI's benchmarks and how the administrator performed in this audit, see the box and whiskers charts in Exhibit A.

Key Performance Indicators	Administrative Performance by Quartile			
	Bottom Quartile	2 nd Quartile	3 rd Quartile	Top Quartile
Documentation Accuracy – Financial				100%
Documentation Accuracy – Frequency				100%
Financial Accuracy	96.99%			
Accurate Payment Frequency			97.22%	
Adjudication Proficiency		99.53%		
Accurate Processing Frequency			97.22%	

The definition for each Performance Indicator can be found in Exhibit B.

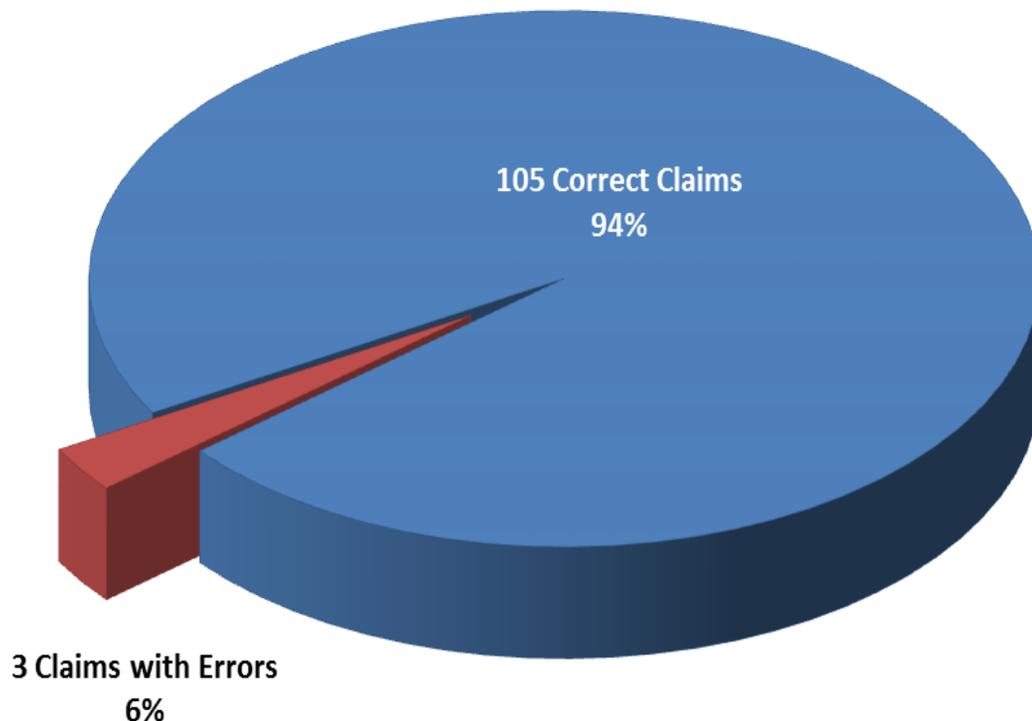
Prioritization of Process Improvement Opportunities Based on Type and Frequency of Errors Cited During Random Sample Audit

The financial improvement opportunity demonstrated by the Random Sample Audit based on a 3.01% Financial Accuracy error rate and annual paid claims of \$5,101,534 is \$153,556. This is the potential annual financial improvement that could be achieved by improving Financial Accuracy from 96.99% to the benchmark high performance of 100%.

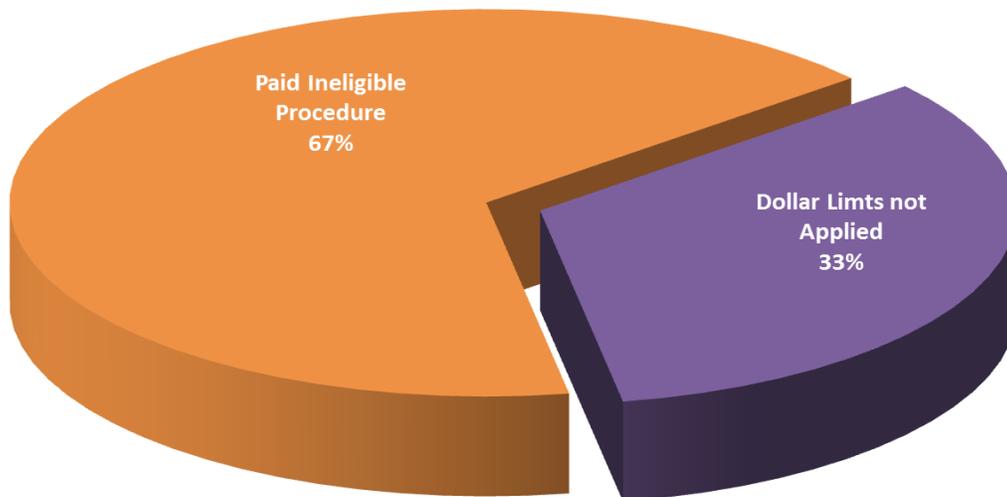
Note that Financial Accuracy is based on the absolute value of payment errors, meaning that over- and under-payments are included. While overpayments represent opportunity for initiating recovery and saving money for the sponsor’s plan, underpayments are also of concern. Each underpaid claim is likely to result in an appeal from a provider or the plan sponsor’s employee with a corresponding claims adjustment which will increase administrative costs and dissatisfaction with plan coverage.

Derived from the Random Sample Audit data, the following pie charts will assist in prioritizing improvement and/or recovery opportunities based on savings and service impact; and in pinpointing problem causes. CTI has offered recommendations in this report to facilitate next steps and discussion.

Overall Accurate Processing Frequency



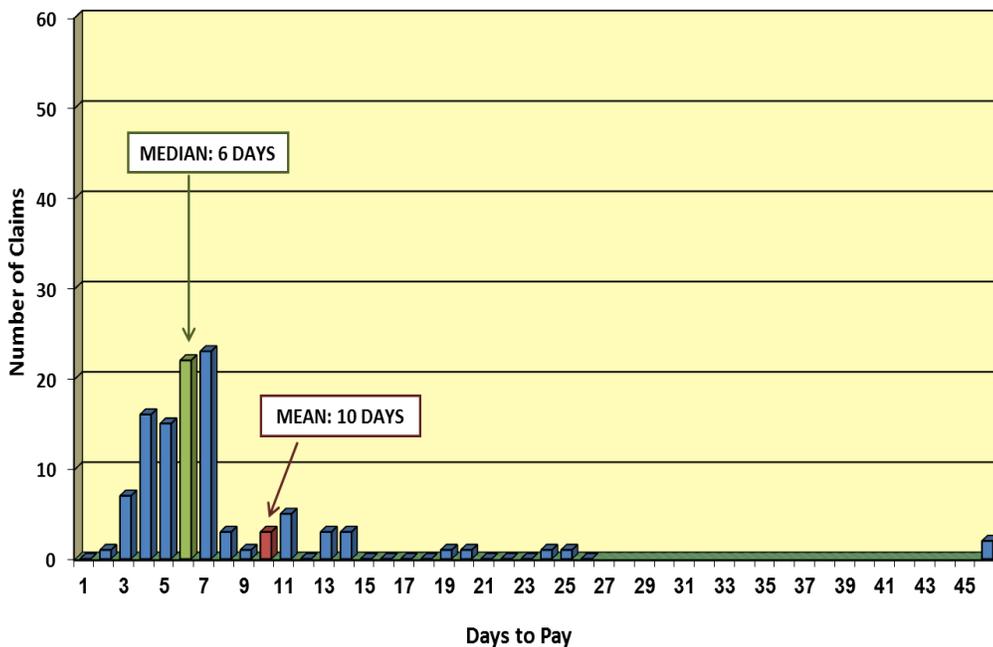
Frequency of Financial Errors by Type



Claim Turnaround Time

A final measure of claim administration performance, and one that claim administrators commonly report on is Claim Turnaround Time. Claim Turnaround often is measured in Mean Average days. Median days, however, is a more meaningful measure for the administrator to focus on when analyzing Claim Turnaround because it prevents a few claims with extended Turnaround Time from distorting the true performance picture. For the claims included in the Random Sample Audit, the claim administrator's Claim Turnaround from *date received* to *date processed* is shown in the following chart. In CTI's opinion, the demonstrated performance of **6 median day(s)** was optimal.

Median and Mean Claim Turnaround



100% Electronic Screening With Targeted Samples (ESAS®)

In addition to the Random Sample Audit, CTI employed ESAS to further analyze claim payment accuracy and opportunities for system and process improvement. CTI used its proprietary ESAS software to screen 100% of the dental services processed by the claim administrator during the audit period plus the previous 12 months. We selected targeted samples from the screening results to validate the findings. The following table shows the number and amount of dental services identified to be potentially overpaid. It is important to note that the dollar amounts shown represent potential payment errors; additional testing would be required to substantiate the findings and to provide the basis for remedial action planning or recovery.

For more specific information on the over- and under-payments that were identified, see the ESAS section of the *Specific Findings Report*.

ESAS Candidates for Additional Testing	Potential Recovery/Savings
Duplicate Payments:	\$41
Plan Limitations: <ul style="list-style-type: none">• Timely Filing:	\$3,411

Operational Review

Our Operational Review indicated that Delta:

- Assigned designated account management staff to MUS, but does not provided dedicated claim or customer service support.
- Provided self-reported performance reports for measures subject to guarantees during the audit period that indicate goals were met for each measure except for *Customer Services Guarantees for Percentage of Calls Answered within 30 Second* in January and March of 2014 and for *Call Abandonment Rate of 2% or Less* in January of 2014. Penalty payments, if any, are due on the basis of annual performance so no payments have been made to MUS during the audit period. CTI notes that Delta would not have met the performance guarantee for Claims Quality specified in the Administrative Agreement based on the results of our audit.
- Has appropriate levels of security and control within its claim funding and checks issuance procedures to protect MUS' interests and to ensure that transactions are performed by only authorized personnel.
- Has effective procedures for recovering overpayments from either participating dentists or members. Overpayments are recovered by withholding overpaid amounts from subsequent payments made to dentists or from members as appropriate. If Delta is responsible for an overpayment and funds are irretrievable, Delta will credit MUS' account for the amount of the overpayment.

- Does not require multiple signatures for higher-dollar payment checks. Delta indicates that claims involving higher amounts typically require review by dental consultants, rather than claim examiners
- Validates coordination of benefits on a claim-by-claim basis. CTI notes that most administrators systematically require updates of COB information on a periodic basis, as claims for which other coverage may be available do not always include other carrier payment information.
- Did not increase PPO fees in 2012 or 2013.
- Does not have a minimum threshold for overpayment as Delta has the ability to offset overpayment amounts by withholding from future payments.
- Reports that 47.1% of claims come from participating providers
- Provided a copy of the complaint report during the 12-month period of 8/1/2013 – 7/31/2014. A total of four complaints were received from MUS members and, on average, it took 26 days to resolve the complaints. Delta’s original claim decision was upheld in 25% of the appeals

Plan Documentation Review

Our Plan Documentation Review indicated the plan sponsor’s SPD:

- Does not match the schedule of benefits included in the MUS dental plan description. CTI identified eight Items in this category.
- Does not include services that are covered on Delta’s fee schedule. CTI identified 24 items in this category.

RECOMMENDATIONS

Based on the key findings of our Comprehensive Audit of the claim administrator, we recommend the following next steps.

1. MUS should meet with Delta to review Random Sample Audit findings and develop a plan to focus on errors affecting Financial Accuracy.
2. MUS should develop a plan to ensure that updates to Delta’s schedule of covered services and revisions to the fee schedule are included in plan documents. This is especially important since more than half of claims are submitted by non-network providers and paid according to the fee schedule.
3. MUS should monitor complaints from employees regarding Delta’s network participation rates since PPO fees did not increase in 2012 and 2013. If some areas of the state experience the loss of network dentists who are dissatisfied with fee schedules, member satisfaction with the dental plan may be adversely affected.
4. MUS should clarify performance guarantees by enhancing the contractual definition of claim accuracy measures that form the basis for performance guarantees. The report provided by Delta relies upon self-reported measures and results that are lower than observed by CTI in this audit.

5. MUS should monitor the reversal rate of Delta's original claim decision. Although the number of overall complaints reviewed during the audit period was low, only 25% of Delta's original claim decisions were upheld on appeal.
6. MUS should conduct regular audits of Delta to determine if improvements have been made to improve audit results.

We understand that you will need to review these recommendations to determine the subject of immediate action. Should MUS decide that additional assistance in implementing or performing any of the required tasks would be beneficial, our contract offers 10 hours of post-audit time to provide you with further assistance.

The claim administrator cooperated with this audit and made every effort to provide us with the data and documentation we requested.

We have considered it a privilege to have worked for, and with, your staff in these important endeavors and would welcome any opportunity to assist you in achieving your future objectives. Thank you again for choosing CTI.



EXHIBITS

- A. Performance Measurements and Benchmarking**
- B. Key Performance Indicators**
- C. Claim Administrator's Response**

EXHIBIT A

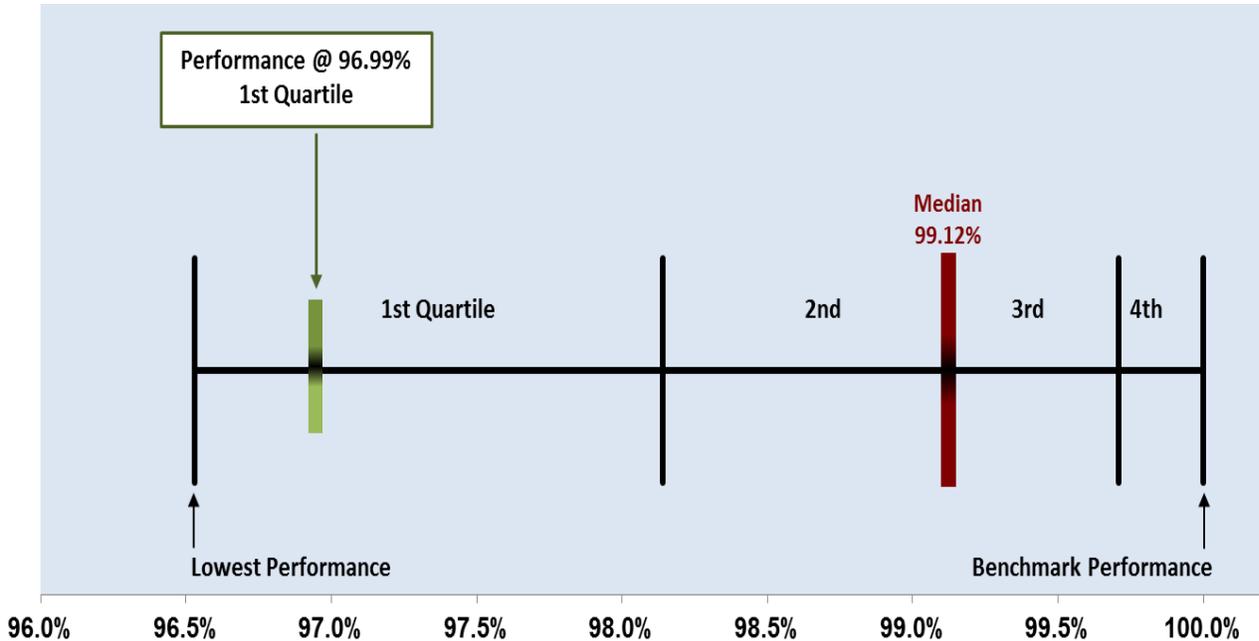
Performance Measurement and Benchmarking

The following box and whisker charts are based on the 100 most recent claim administration audits performed by CTI. The charts are used to demonstrate the claim administration performance when compared to the other plans against each of our seven Key Performance Indicators.

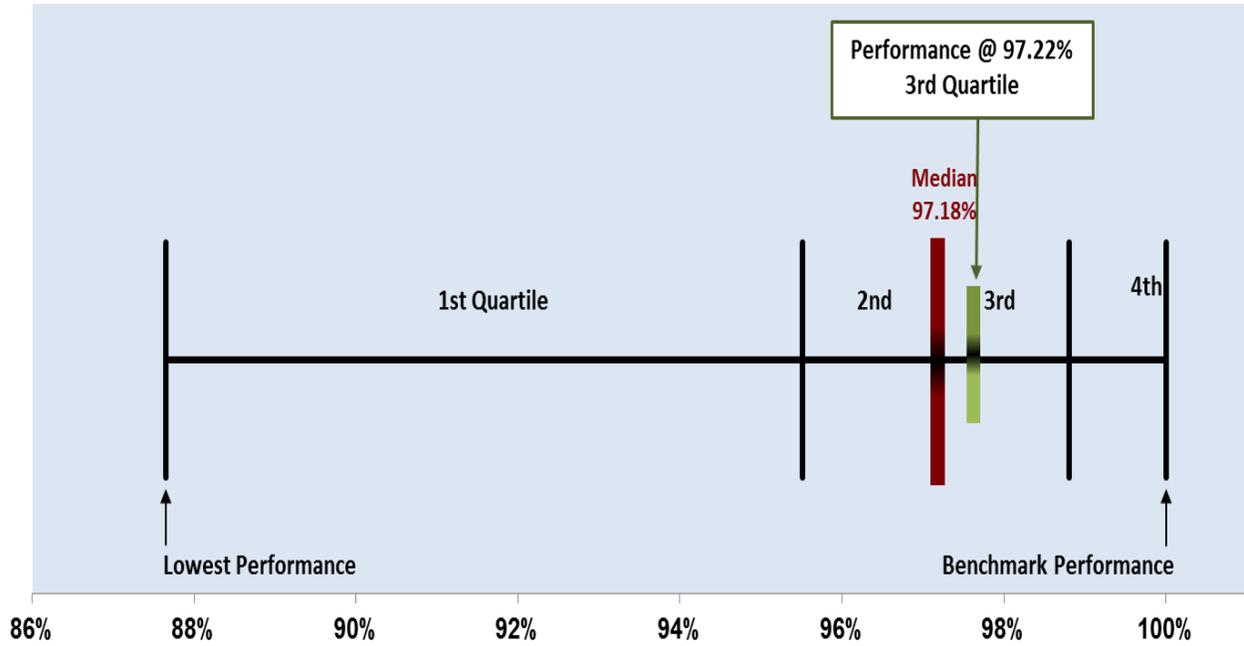
Each chart contains the following information:

- The claim administrator’s performance
- Benchmark performance
- Lowest performance
- Performance levels by quartile – with the 4th quartile representing the highest 25 performing plans and the 1st quartile representing the lowest 25 plans
- Performance level relative to the Median – or the level at which 50 of the plans audited were higher and 50 were reported to be lower

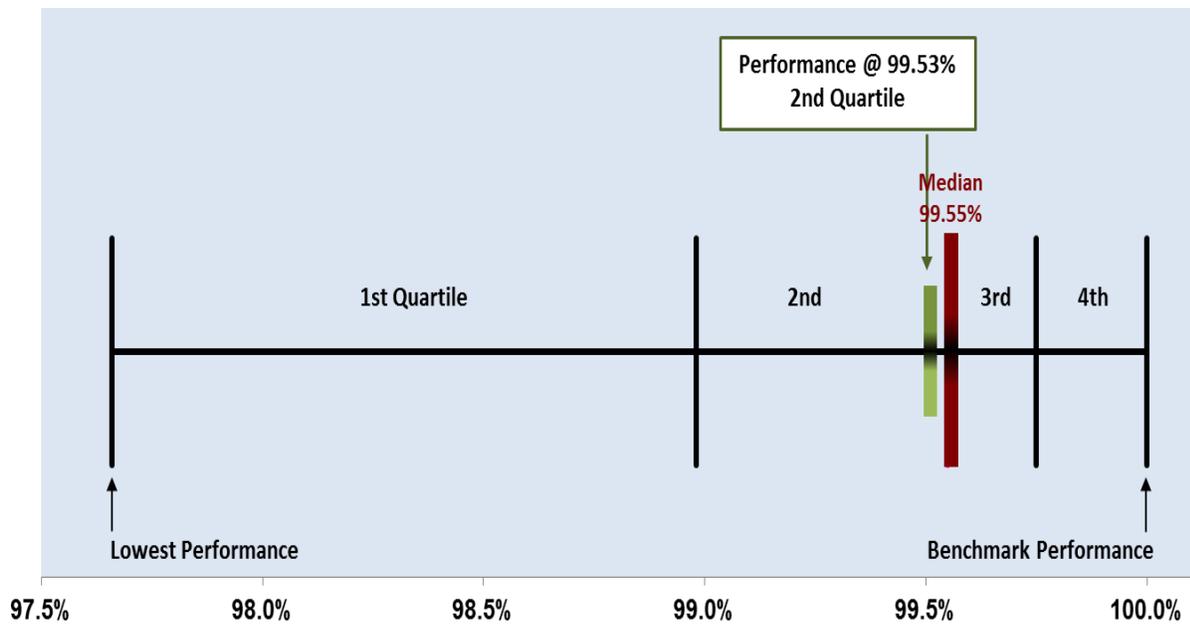
Financial Accuracy – Performance vs. Other Plans Audited by Quartile



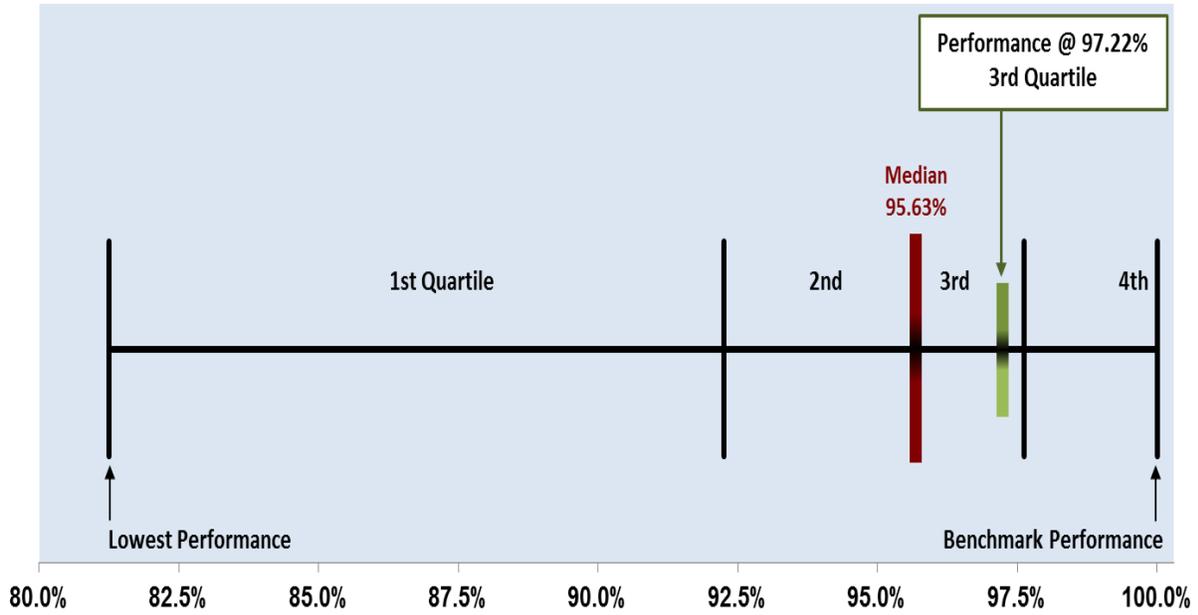
Accurate Payment Frequency – Performance vs. Other Plans Audited



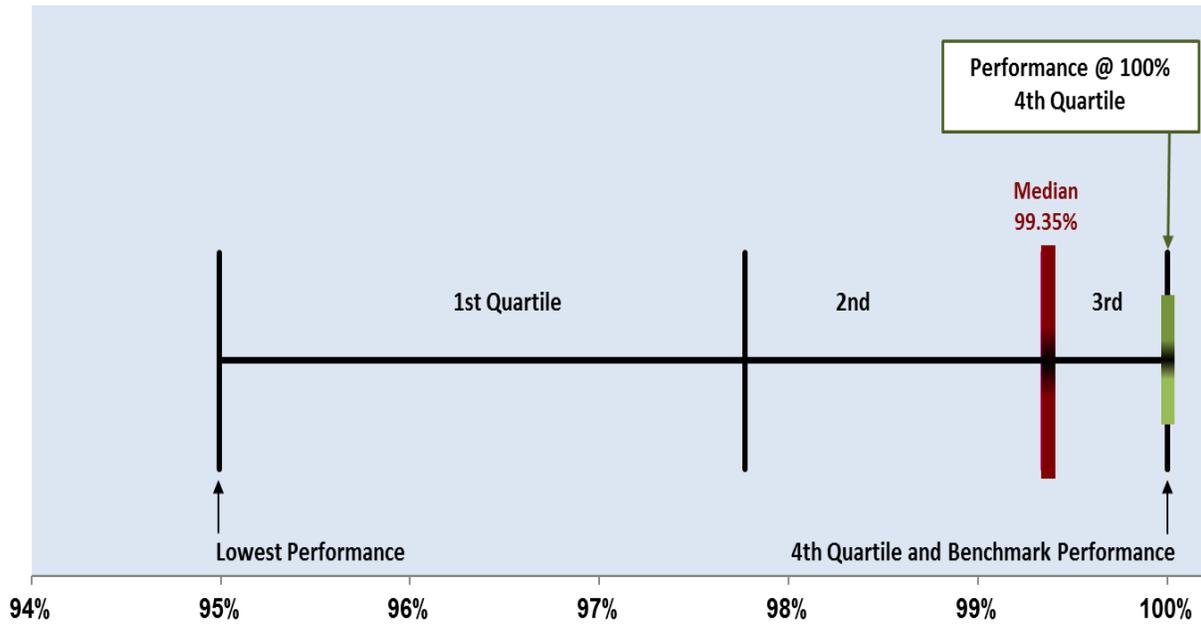
Adjudication Proficiency – Performance vs. Other Plans Audited



Accurate Processing Frequency – Performance vs. Other Plans Audited



Documentation Accuracy Financial – Performance vs. Other Plans Audited



Documentation Accuracy Frequency – Performance vs. Other Plans Audited

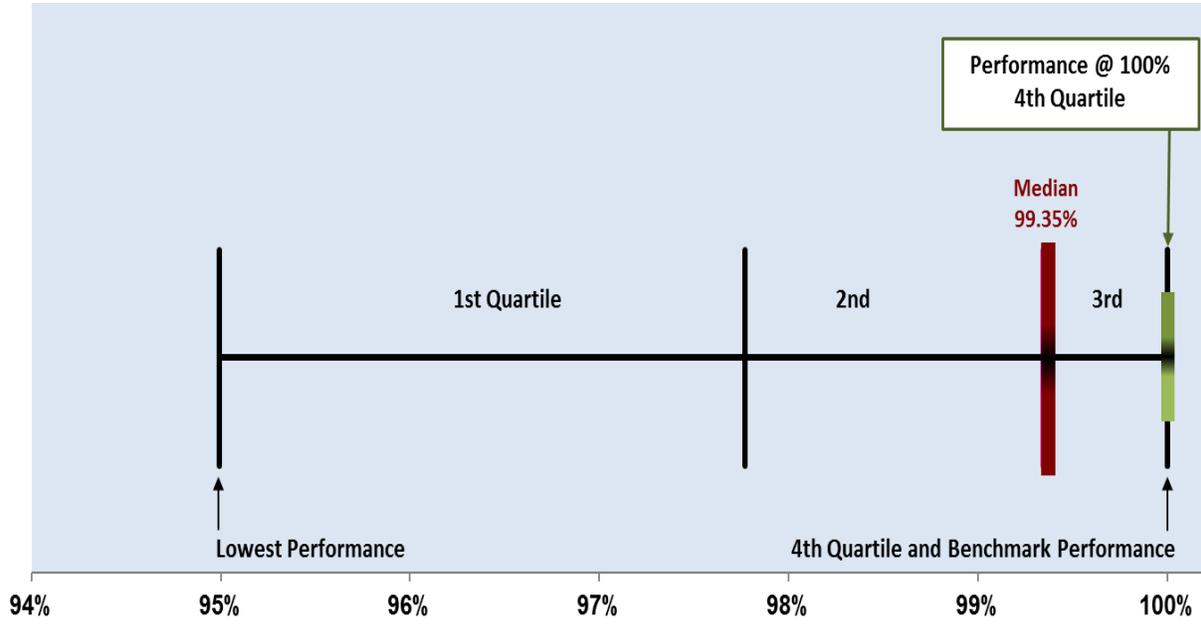


EXHIBIT B

Benchmarked Key Performance Indicators and Operational Definitions

Financial Accuracy – compares the total dollars associated with correct claim payments to the total dollars of correct claim payments that should have been made.
Accurate Payment Frequency – compares the number of bills paid correctly to the total number of bills paid.
Documentation Accuracy Financial – compares the number of dollars processed with documentation adequate to substantiate payment or denial to the total number of dollars processed.
Documentation Accuracy Frequency – compares the number of claims processed with documentation adequate to substantiate payment or denial to the total number of claims processed.
Adjudication Proficiency – compares the number of correct adjudication decisions made to the total number of adjudication decisions required.
Accurate Processing Frequency – compares the number of bills processed without errors of any type (financial or non-financial) to the total number of bills processed.

Non-Benchmarked Key Performance Indicator and Operational Definition

Claim Turnaround – is the number of calendar days required to pay a claim from the date the claim is received by the administrator to the date a payment or denial is mailed.
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EXHIBIT C



Delta Dental Insurance Company

October 22, 2014

Claim Technologies Incorporated (CTI)
Attn: Mr. Daniel Montgomery
100 Court Avenue, Suite 306
Des Moines, IA 50309-2295

RE: Montana University System

Dear Mr. Montgomery,

It was a pleasure working with you and the CTI team during the recent audit for the Montana University System.

Please find Delta Dental's responses to the final audit report below.

Page 5 – Performance Guarantees

The performance guarantee are tracked monthly; however, any penalties are based on the annual results.

Page 6 – Coordination of Benefits (COB)

Delta Dental analyzes each claim on a line-by-line basis when coordinating benefits with another carrier.

Page 11 – Updated Fee Allowances and CDT Codes

Delta Dental had notified Montana University System of the updated fee allowances for the table of allowance schedule as well as the updated CDT codes for CDT-12, CDT-13 and CDT-14. All updates were approved by Montana University System and they were advised to update their SPD of the same.

Pages 19, 21, 23 – Audit Period

Please note that the audit period was 7/1/13 through 6/30/14, not 7/1/12 through 6/30/14.

Respectfully submitted,

Sharon M. Miller

Sharon M. Miller
Audits Project Manager

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Suite 101
Helena, MT 59601

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Let the Data Drive Your Decisions

Prescription Benefit Management Audit Executive Summary

Montana University System

Administered by: MedImpact®

Audit Period: July 1, 2012 – June 30, 2014

Prepared by:

TRICAST, Inc.

Subcontractor to
Claim Technologies Incorporated

October 31, 2014



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Executive Summary

On behalf of Montana University System, TRICAST Inc. (TRICAST), as subcontractor to Claim Technologies Incorporated (CTI), conducted an audit of the pharmacy benefit program administered by MedImpact for the audit period of July 1, 2012 through June 30, 2014. The audit utilized electronic re-processing of 100% of Montana University System's prescription claims to verify Prescription Benefit Manager (PBM) performance as well as significant exchange of information and data with MedImpact.

TRICAST conducted this audit to determine if prescription drug claims were processed according to the specifications of the contract between Montana University System and MedImpact, plan specifications, and industry standards. Additionally, TRICAST sought to identify potential opportunities for recoveries or adjustments for lack of performance and future cost savings opportunities.

Basic claim statistics for the audit period are summarized below.

Audit Period	7/1/2012 through 6/30/2014
Client Name	Montana University System
PBM Name	MedImpact
Claims Count	380,770
Claims Paid	\$32,281,098

Audit Objectives

The specific objectives of the audit were:

- Verification that Montana University System's claims were processed in accordance with the pricing terms specified in the contract with MedImpact
- Verification of the accuracy of claims processing with respect to Montana University System's benefit plan provisions
- Verification of HIPAA policies and procedures to ensure compliance
- Verification that MedImpact is performing agreed upon Coordination of Benefit (COB) duties
- Validation that MedImpact is meeting contractually approved Performance Guarantees
- Confirmation of MedImpact's monitoring and clinical oversight of potential Fraud Waste and Abuse

Audit Scope

The audit included the following components:

- Pricing Audit
- Plan Design Audit
- HIPAA Compliance
- Coordination of Benefits (COB)
- Performance Guarantees
- Fraud, Waste, and Abuse (FWA)

Auditor's Opinion

Based on the audit findings, and in our opinion, MedImpact did consistently administer Montana University System's pharmacy benefit plan accurately however it is our recommendation that MedImpact implement a process improvement for the following areas: 1.) MedImpact should be able to provide drug lists utilizing the date each NDC was implemented in their system instead of the requested effective date on the Business Change Request; 2.) MedImpact should provide indicators on the claim records to identify members with "grandfathering" status.

Summary of Findings and Recommendations

TRICAST's findings for each audit component are summarized briefly in the following sections. Detailed explanations of the findings are found in the Specific Findings Report.

Pricing Audit

Discount Findings

The actual overall discounts were greater than the rates MedImpact was contractually obligated to provide for Montana Association of Health Care Purchasers (MAHCP), reflecting an over-performance in the retail brand and retail generic categories shown above of approximately \$62,930 for 7/1/2012-6/30/2013 (2013). For the time period 7/1/2013-6/30/2014 (2014) TRICAST found that MedImpact fell short of the minimum discount guarantee in the retail brand and retail generic categories shown above for Montana University System by \$86,324.

Dispensing Fees Findings

Dispensing fees were under billed for retail brand and generic claims by MedImpact in the amount of \$44,568 for the time period 7/1/2012-6/30/2013 and \$24,003 for the time period 7/1/2013-6/30/2014.

MedImpact responded for discounts and dispensing fees that, "All contracted financial guarantees are measured in aggregate (discounts + dispensing fees) and are reported at the MAHCP level which is inclusive of all groups under MAHCP. Any under or over-performance reported for purposes of this audit are specific to Montana University System and are not subject to any true-up payments or adjustments."

Benefit Plan Design Administration

Copayment Findings

TRICAST depends on information provided by MedImpact. There are two main reasons why an overall variance exists when TRICAST re-adjudicates Montana University's claims.

1. The drug lists for each tier contained effective dates for each NDC. Those effective dates were loaded into our system and claims were re-adjudicated accordingly. As identified in prior audits for Montana University, the effective dates provided for each NDC were not the actual dates the plan changes were implemented in MedImpact's system.
2. MedImpact provided TRICAST with a drug list of NDC's that were grandfathered. Grandfathering allows certain NDC's that are moving tiers to adjudicate at a copay, usually lower, than the higher cost tier. MedImpact's responses indicate that some members were grandfathered. When grandfathering is at a member level,

MedImpact does not provide an identifier on the claim record therefore the claim records show a variance. TRICAST had to obtain additional documentation from MedImpact to verify a member's grandfathering status.

Both issues are a contributing factor to the overall results identified in this report. TRICAST validated MedImpact's responses to the sample claims. Claims are adjudicating according to plan design documents with the exception of eleven claims that were allowed to pay without a Prior Authorization (PA).

Drug Exclusion/Prior Authorization Findings

Claims for XTANDI and VICTRELIS paid incorrectly as a PA edit was not coded in the benefit, causing the claim to approve. MedImpact added a PA edit into the system for XTANDI effective 10/16/2013 and VICTRELIS effective 10/10/2014. TRICAST identified 10 claims for XTANDI and one claim for VICTRELIS for a total cost of \$84,077.05.

MedImpact responded that, "Of the 11 identified claims that processed without a PA, 10 of them have subsequently had a PA approved for the same therapy (for 2 members), thus no liability has accrued for these 10 PA claims. The final claim for VICTRELIS is still being researched to see if PA criteria would have been met."

Based on the response from MedImpact and the logic provided, TRICAST still finds these claims to have been paid outside of the benefit design. Utilization of a PA for different medication, though utilized for the same disease state, that was put in place subsequent to 10/16/2013, is not deemed to qualify as being within the defined benefit design.

TRICAST recommends that Montana University System pursue recovery of \$84,077.05 for the claims that processed without a PA.

Quantity Limit Findings

TRICAST is in agreement with MedImpact's responses that claims were within the appropriate quantity limit.

Administration of Age Rules Findings

TRICAST notes no rule violations.

HIPAA Compliance

TRICAST reviewed MedImpact's policies and procedures and found they demonstrate comprehensive control procedures, employee awareness and business protocols to maintain PHI in compliance with the HIPAA standard. MedImpact has implemented and is exercising best HIPAA practices.

Coordination of Benefits (COB) Verification

The analysis of Montana University System's COB claims revealed MedImpact is performing claim subrogation and coordination.

Performance Guarantees

Of the 39 total performance guarantees listed in the Service Agreement, 16 are measurable at the client, or individual group level (Montana University System- MTN02) while 23 are measured at the MAHCP level.

Montana University System MTN02 Level:

- 2012 and 2013: All 16 of the client or individual group level performance guarantees applicable to the Montana University System were met.

Fraud, Waste, and Abuse

MedImpact agreed that case management would benefit the two individuals identified in TRICAST's specific findings report.

Recommendations

TRICAST's pricing analysis shows that for 2013 there was a \$86,324 under-performance in retail brand and generic discounts and dispensing fees were under billed at retail by \$24,003 resulting in an overall amount due of \$62,321 to MAHCP. MedImpact's true-up documents for 2013 show a shortfall and amount due of \$40,526 for retail claims. When comparing our audit results to MedImpact's true-up documents, TRICAST finds an additional \$21,795 is due to MAHCP. Based on the terms of the contract between MAHCP and MedImpact, TRICAST agrees any shortfalls can be offset by other groups' over-performance however the variance of \$21,795 still remains an open issue and requires additional research by MedImpact.

TRICAST recommends that Montana University System pursue recovery for XTANDI and VICTRELIS claims, that processed without a PA, in the amount of \$84,077.05.



Prescription Benefit Manager's Response

Please see the following page for the PBM's response.

November 11, 2014

Re: #658 Montana University System PBM Oversight Audit | Final Draft – MedImpact Responses

**Tricast Finding #1:
Final Outcome: Pricing Audit**

TRICAST's analysis shows a slight under-performance on mail claims. However, MAHCP has contracted with AmeriPharm for the mail order discounts and dispensing fee rates. As the mail contract is not between MedImpact and AmeriPharm, MedImpact does not include mail as part of their guarantee calculations.

TRICAST analysis shows that for 2014 there was a \$86,324 under-performance in retail brand and generic discounts and dispensing fees were under billed at retail by \$24,003 resulting in an overall amount due of \$62,321 to MAHCP. MedImpact's true-up documents for 2014 show a shortfall and amount due of \$40,526 for retail claims. When comparing our audit results to MedImpact's true-up documents, TRICAST finds an additional \$21,795 is due to MAHCP.

MedImpact responded that, "All contracted financial guarantees are measured in aggregate (discounts + dispensing fees) and are reported at the MAHCP level which is inclusive of all groups under MAHCP. Any under or over-performance reported for purposes of this audit are specific to Montana University System and are not subject to any true-up payments or adjustments. The variance reported within the audit report is the difference between TRICAST's true-up reporting and MedImpact's true-up reporting; regardless of the calculated amounts, no true-up payments or adjustments are due to Montana University System."

Based on the terms of the contract between MAHCP and MedImpact, TRICAST agrees any shortfalls can be offset by other groups' over-performance however the variance of \$21,795 still remains an open issue and requires additional research by MedImpact.

MedImpact Response: The \$21,795 variance reported by Tricast within the audit report is the difference between Tricast's true-up reporting and MedImpact's true-up reporting. To determine the reason for the difference, Tricast & MedImpact will have to discuss their respective reporting methodologies. Regardless of the calculated amounts, no true-up payments or adjustments are due to Montana University System.

Tricast Finding #2:

Final Outcome: Drug Exclusion and Prior Authorizations

MedImpact responded to the 839 claims as follows:

- 128 claims (16 members) for REMICADE, ACTEMRA, SYNAGIS and ORENCIA where MedImpact stated, “Member restriction was entered to bypass the Prior Auth process”. Member restrictions are entered by Montana University System.
- There were a total of six claims for AMPYRA, XARELTO, and SILDENAFIL CITRATE where there was up to a two week delay from when Montana University System requested the change be made to when the change was implemented into MedImpact’s system.

Drug Name	Effective Date of PA	Date Implemented
AMPYRA	10/1/2012	10/19/2012
SILDENAFIL CITRATE	6/12/2014	6/26/2014
XARELTO	7/1/2013	7/9/2013

- Claims for XTANDI and VICTRELIS paid incorrectly as a PA edit was not coded in the benefit, causing the claim to approve. MedImpact added a PA edit into the system for XTANDI effective 10/16/2013 and VICTRELIS effective 10/10/2014. TRICAST identified 10 claims for XTANDI and one claim for VICTRELIS for a total cost of \$84,077.05.

MedImpact responded that, “Of the 11 identified claims that processed without a PA, 10 of them have subsequently had a PA approved for the same therapy (for 2 members), thus no liability has accrued for these 10 PA claims. The final claim for VICTRELIS is still being researched to see if PA criteria would have been met.”

Based on the response from MedImpact and the logic provided, TRICAST still finds these claims to have been paid outside of the benefit design. Utilization of a PA for different medication, though utilized for the same disease state, that was put in place subsequent to 10/16/2013, is not deemed to qualify as being within the defined benefit design.

- The remaining variances didn’t require a PA due to members being grandfathered.

MedImpact Response: Regarding the Ampyra and Sildenafil Citrate, the Benefit Change Request (BCR) forms to add the PA were submitted with a retroactive effective date. The Xarelto BCR requesting a PA required additional information and clarification prior to coding. The 10 Xtandi claims in question were for 2 members and each member had a subsequent PA approved for the same drug, which means the drugs in question would have been approved if the PA was in place; thus no liability has accrued for these 10 PA claims.



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