Claim Administration Audit

SPECIFIC FINDINGS REPORT

State of Montana Medical Plans
Administered by Allegiance

Audit Period: January 1, 2016 through December 31, 2017

Presented to

State of Montana

June 28, 2018

Presented by

CLAIM TECHNOLOGIES
INCORPORATED

Known in Montana as CTI Claim Audit Technologies Corp.

TABLE OF CONTENTS

INTRODUCTION

This ***Specific Findings Report*** contains information, findings, and conclusions from CTI's audit of Allegiance's (Allegiance's) claim administration of the State of Montana (State) plan(s). The statistics, observations, and findings in this report constitute the basis for the analysis and recommendations presented under separate cover in the ***Executive Summary***. We provide this ***Specific Findings Report*** to State, the plan sponsor and Allegiance, the claim administrator. We have included a copy of Allegiance's response to these findings in Appendix B of this report.

The information in this report is confidential and intended for the sole use of the Montana legislature, the State of Montana, Allegiance and CTI in their efforts to serve the interests of the plan participants of the State of Montana Medical Plans.

We base our audit findings on the data and information provided by State and Allegiance and the validity of those findings rely upon the accuracy and completeness of that information. CTI conducted the audit according to the standards and procedures accepted and in practice for claim audits in the health insurance industry. We have observed all confidentiality, non-disclosure and conflict of interest requirements with respect to the audit process and have not received anything of value or any benefit of any description while performing audit services.

We planned and performed the audit to obtain a reasonable assurance claims were adjudicated according to the terms of the contract between Allegiance and State as well as the approved plan documents and other approved communications. In some instances, we may cite errors the administrator subsequently identified and corrected to help facilitate process and system improvement.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of your claim administrator's policies, procedures, processes, and systems relative to claims paid for State during the audit period.

Audit Objectives

The objectives of CTI's audit of Allegiance claims administration were to:

- Determine whether the administrator followed the terms of the services agreement;
- Determine whether the administrator paid claims according to the provisions of the plan documents and if those provisions were clear and consistent;
- Determine whether members were eligible and covered by the sponsor's medical plans at the time a service paid by Allegiance was incurred;
- Determine whether any fundamental systems or processes associated with claim administration or eligibility maintenance may need improvement.

Audit Scope

CTI audited Allegiance's claim administration of the State's medical plan(s) for the period of January 1, 2016 through December 31, 2017. The population of claims and amount paid during that period were:

Total Paid Amount	$221,838,814
Total Number of Claims Paid/Denied/Adjusted	778,500

The audit included the components described below:

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 Analysis**
   - Plan documents and other approved communications
   - Administrative services agreement
   - Review, identification, and resolution of ambiguities and inconsistencies

3. **100% Electronic Screening with 30 Targeted Samples (ESAS®)**
   - Systematic analysis of 100% of paid services
   - Eligibility verification (if elected)
   - Problem identification and quantification

4. **Random Sample Audit of 180 Claims**
   - Statistical confidence at 95% +/- 3%
   - Performance level determined for Key Indicators
   - Benchmarking
   - Problem identification and prioritization
   - Recommendations

5. **Data Analytics**
   - Systematic claims analysis for:
     - Provider Discounts
     - Sanctioned Provider Identification
     - Preventive Services Payment Compliance
     - National Correct Coding Initiative Editing Compliance
     - Global Surgery Prohibited Fee Period Analysis

OPERATIONAL REVIEW

Objective

The objectives of the Operational Review were to evaluate the systems, staffing, and procedures related to Allegiance's claim administration of the State plan(s) and to observe any deficiencies that might materially affect their ability to control risk and accurately pay claims on behalf of the plan(s).

Scope

The scope of the Operational Review included:

- Claim administrator information
  - Insurance and bonding of the claim administrator
  - Conflicts of interest
  - Internal audit
  - Financial reporting
  - Business continuity planning
  - Claim payment system and coding protocols
  - Security of data and systems
  - Staffing
- Claim funding
  - Claim funding mechanism
  - Check processing and security
  - COBRA/direct pay premium collections
- Claim adjudication, customer service, and eligibility maintenance procedures
  - Exception claims processing
  - Eligibility maintenance and investigation
  - Overpayment recovery
  - Customer service call and inquiry handling
  - Network utilization
  - Utilization review, case management, and disease management
  - Appeals processing
- HIPAA compliance

Methodology

CTI gathered information from Allegiance through the use of an operational review questionnaire. We model our questionnaire after the audit tool used by Certified Public Accounting firms when conducting an SSAE-16 audit of a service administrator. We modified that tool to obtain information specific to the administration of your plan(s).

Through our review of your administrator's responses and the supporting documentation they provided to us, we gained an understanding of the procedures, staffing and systems-related to the administration of the State plan(s). This allowed us to more effectively conduct your audit.

In addition to the operational review questionnaire, we used our proprietary ESAS® software to identify the best cases to test operational processes. We selected a targeted sample of 30 cases and distributed a substantive testing questionnaire to collect information on each. Your administrator's responses were used to validate that procedures were followed to control risk and accurately pay claims.

List of ESAS screening categories used to identify candidate cases for operational review testing:

ESAS® Screening Categories
Duplicate Payments to Providers and/or Employees
Fraud, Waste, and Abuse
Subrogation/Right of Recovery from Third Party
Workers' Compensation
Coordination of Benefits
Specific Reinsurance Reimbursements (if applicable)
Large Claim Review
Case Management
Provider Discounts and Fees
Dependent Child Eligibility

Findings

Claim Administrator Information

CTI reviewed information about Allegiance including background information, financial reports, types and levels of insurance protection, dedicated staffing, systems and software, the disclosure of fees and commissions, performance standards, and internal audit practices. We offer the following observations from our review:

- Allegiance assigned an Account Manager, Health Operations Manager and Service Team leader to State account.
- Allegiance complied with the standards of the American Institute of Certified Public Accountants (AICPA) through the issuance of a Statement on Standards for Attestation Engagements (SSAE) No. 16, reporting on controls at a service organization. Under SSAE 16, the administrator was required to provide its own description of its system, which the service auditor validates. The administrator's external auditor, Wipfli, LLP, reported on the period from July 1, 2015 through June 30, 2016 and did not note any deviations in the 52 controls tested for operational effectiveness.
- Allegiance provided copies of certificates of liability for crime coverage for employee theft, forgery, computer fraud, and funds transfer of $2,000,000 and client coverage of $1,000,000 per occurrence/per claim limits. Managed care errors and omissions coverage provided $5,000,000 per occurrence/per claim while cyber liability was covered with an aggregate limit of liability of $5,000,000. State should review the limits of coverage with its own risk

management experts to confirm the coverage is adequate to protect Allegiance in the event of a loss.

- Allegiance provided an explanation of its business continuity procedures for protecting customer data and safeguarding operations and assets in case of disaster or other business interruptions. Some of the safeguards to mitigate business operation stoppages included a secondary location with like security and technology, nightly data backups and retention of end-of-the-year backup tapes indefinitely.
- Allegiance reported there were performance standards in place for administration of State's account for claim payment, timeliness and turnaround as well as customer service measures for call response time, abandonment rate, quality, customer satisfaction and first call resolution. A report provided for each quarter of 2016 and 2017 showed the only measures met or exceeded during each of the eight quarters was the financial payment measure of accuracy of paid benefit dollars and customer satisfaction. All the other measures had one quarter in which targets weren't met with the exception of call abandonment which had two quarters of results below target.
- Allegiance used LuminX claims system, operational since 1999, as well as the service Bloodhound to identify coding issues for correction or additional review. Allegiance noted certain National Correct Coding Initiative (NCCI) edits developed by the Centers for Medicare and Medicaid Service (CMS) were incompatible with PPO contracts and were turned off.
- JMS Inc., located in Detroit, MI answered provider telephone inquiries which Allegiance noted State approved. The outsourced answered calls were audited as calls handled in-house were. Call volume and quality were monitored and feedback was provided to JMS on a weekly basis.

Claim Funding

CTI reviewed information specific to controls and procedures related to claim checks including claim funding, fund reconciliation, handling of refunds and returned checks, large check approval, security, disposition of stale checks and appropriate audit trail reports, and COBRA and retiree/direct pay premium collection. We offer the following observations from our review:

- Allegiance used appropriate levels of security and control within its claim funding and checks issuance procedures to protect the plan's interest and ensure all transactions were performed by authorized personnel only.
- Allegiance used pre-payment high dollar claim review procedures. Claims checks above claim authority levels of examiners were routed to appropriately authorized supervisors or managers for review and approval.
- Allegiance provided documentation of claim system security controls that include password protection, role-based access, over-ride authority assigned based on job description.

Claim Adjudication, Customer Service, and Eligibility Maintenance Procedures

CTI reviewed information specific to the controls and procedures used by Allegiance related to enrollment, eligibility maintenance, and processing of claims. We offer the following observations from our review:

- Allegiance had adequately documented training, workflow, procedures, and systems to provide consistently high levels of accuracy in the processing of claims and enrollment.
- Allegiance aggressively pursued coordination of benefits (COB) provisions at all dollar levels and screened and investigated all claims before payment. Some of the information sources included customers, enrollment forms, claims and providers. The enrollment department sent annual COB letters pan participant at open enrollment or re-enrollment. When the presence of other coverage was possible, Allegiance sent letters asking about other coverage and if no response was received after 45 days, the claim was denied until receipt of the information.
- Allegiance provided a COB report for 2016 and 2017 that showed a savings of $24,855,591.89 from participant, spouse and dependents' other coverages.
- Employee and dependent eligibility was provided electronically to Allegiance by State in a daily file.
- Dependent eligibility beyond plan limits for mentally or physically impaired children required completion of an attending physician statement.
- Approximately 84% of the claims for State were submitted electronically which decreased administrative costs associated with handling paper claims and eliminated the potential for manual data entry errors.
- Allegiance did not have a dedicated Special Investigation Unit (SIU) for detecting and investigating fraud and abuse but used state medical board websites and other sources to monitor providers. Identified fraud cases were referred to plan sponsors or local prosecutors to take action.
- Overpayment recovery was pursued for the minimum dollar amount of $50. Allegiance didn't have the functionality to auto-recoup overpayments from the next payment. No vendors were used to assist with overpayment recovery and for successful recoveries, a shared savings fee of 25% of recovered savings was applied. We recommend State talk to Allegiance about their overpayment recovery procedures and the cost benefit of pursuing all overpayments and not just those in excess of $50.
- The reasons for refunds for overpayments were tracked but a report was unavailable and we encourage State to request periodic reports of overpayment activity for continuous quality improvement purposes and to identify and mitigate emerging issues.
- Allegiance reported 98% of claims for State during the audit period were submitted by participating providers and global contracts.
- Medicare reference-based pricing was used to establish pricing for both professional and institutional claims.
- Out-of-network claim payment negotiations were conducted by the Provider Relations department and only under specific service circumstances and used State's specified Medicare reference pricing.
- Allegiance flagged potential third-party liability claims and sent inquiries to members for additional information to determine what, if any, plan benefits were payable. There was a $1,000 minimum claim payment amount that must be issued before an investigation was

initiated. We suggest asking Allegiance to quantify the number of third-party liability cases of less than $1,000 not pursued to evaluate if this process is cost-effective.

- Allegiance outsourced some subrogation recovery for State's plan to PHIA Group, a national third-party recovery specialist, based in Braintree, MA from January 2016 through mid-year 2016.
- Precertifications were performed by Allegiance's sister company, StarPoint Healthcare Group, who assessed the medical necessity and appropriateness of admissions as compared against Milliman Care Guidelines and Cigna medical policy.
- Claims eligible for large case management were identified by reviews of claims, ICD-10 codes, predictive modeling software, customer service, reports and the Interdisciplinary Risk Management Task Force. StarPoint Health Group performed large case management for Allegiance.
- Disease management of chronic illnesses was performed by American Health Holding on cases identified by predictive modeling, claim triggers and utilization and case management coordination.
- Claim turnaround time was measured from the date the claim was received to the date the adjudication process was completed. If a claim was adjudicated on the next day after receipt, the calculated turnaround time was one day. For adjustments, turnaround time was calculated based on the date the additional information from the provider or member was received.
- Allegiance tracked appeals but declined to provide a report of appeals handled for the plan's participants during the audit period. We recommend State obtain periodic reports of appeals activity and their resolution status in case there are process improvement and enhanced member communication opportunities

HIPAA Compliance

CTI reviewed information specific to the systems and processes Allegiance had in place to maintain compliance with HIPAA regulations. The objective of this questionnaire segment was to determine if the administrator was aware of the HIPAA regulations and was compliant at the time of the audit. We offer the following observations from our review:

- Allegiance had appropriate levels of security and controls in place to protect the plan sponsor's medical plan(s) records and data and was compliant with HIPAA requirements at the time of the audit.
- Allegiance provided a copy of its Internal Privacy Policies and Procedures that detailed how it used and disclosed PHI it received, how an individual may access or amend any PHI that it received, and what administrative procedures it implemented and maintained to protect the privacy of PHI it received.
- Company-wide compliance with HIPAA was under the oversight of Privacy Official. The Privacy Official was responsible for developing and overseeing the implementation and enforcement of the privacy program and assisting business areas in resolving privacy and security-related issues.
- All Allegiance employees completed online HIPAA training at hire and annually thereafter. Additional training may occasionally be offered more frequently.

- During the audit period, Allegiance reported no breaches triggering notification requirements for State.

ESAS and Targeted Samples of Administrative Procedures

We tested Allegiance's controls and procedures by selecting specific claim cases processed during the audit period. We prepared substantive testing questionnaires for each and sent to the administrator for completion. A CTI auditor reviewed the responses and supporting documentation.

After a thorough review, there were no process improvement opportunities identified.

PLAN DOCUMENTATION ANALYSIS

Objective

The objective of the Plan Documentation Analysis was to evaluate the documents governing the administration of State's medical plan(s) and identify inconsistencies, ambiguities, or mission provisions that might negatively impact accurate claim administration. Through this evaluation, we gained an understanding of Allegiance's administrative service responsibilities related to claim administration of State's medical plan(s). This understanding allowed us to be more effective throughout the audit.

Scope

Our auditors evaluated the following:

- Plan documents, descriptions and amendment(s)
- Administrative services agreement

Methodology

CTI obtained a copy of the plan documentation from State and/or Allegiance. Our auditors reviewed the applicable documents closely to better understand the provisions your administrator should be applying to adjudicate all medical claims. To assist in understanding your plan provisions we used a tool developed for this purpose called a benefit matrix. CTI's benefit matrix is a composite listing of the benefit provisions, exclusions, and limitations we expect to see in a plan document. When completed, the matrix allows us to identify inconsistencies, ambiguities, or missing provisions.

CTI obtained clarification from State regarding any inconsistencies in the plan document(s). The benefit matrix was then used by our auditors as a cross-reference tool as they audited claims.

Findings

There were no inconsistencies, ambiguities, or mission provisions identified in our Plan Document Analysis.

100% ELECTRONIC SCREENING WITH TARGETED SAMPLES (ESAS®)

Objective

The objective of our 100% Electronic Screening with Targeted Samples (ESAS) was to identify and quantify potential claim administration payment errors. If over or underpayments were identified and subsequently verified, State and Allegiance can work together to determine an appropriate resolution to correct the errors.

Scope

CTI electronically screened 100% of the 1,863,054 service lines processed by Allegiance during the audit period. The accuracy and completeness of the data provided by the administrator directly impacted the screening categories we were able to complete and the integrity of our findings. We screened the following high-level ESAS categories to identify potential amounts at risk:

- Duplicate Payments to Providers and/or Employees
- Plan Limitations and Exclusions
- Multiple Surgical Procedures

Methodology

We followed these procedures to complete our ESAS with targeted sampling process of claim data:

- *Electronic Screening Parameters Set* – We used the provisions of State's medical plan document(s) to set the parameters in our electronic screening system.
- *Data Conversion* – We converted and validated the claim data provided by Allegiance and reconciled it against control totals and checked for reasonableness.
- *Electronic Screening* – We systematically screened 100% of the service lines processed by Allegiance and flagged claims not processed according to plan parameters.
- *Auditor Analysis* – If flagged claims within an ESAS screening category represented a material amount, our auditors analyzed the category findings to confirm results were valid. When using electronic screening to identify payment errors, false positives might have occurred because claim data was incomplete. CTI auditors made every effort to identify and remove false positives.
- *Targeted Samples* – From the categories identified with material amounts at risk, we selected the best examples of potential over or underpayments to test. As cases were not randomly selected, we do not extrapolate test results. For this audit, we selected a total of 30 flagged cases and sent a substantive testing questionnaire for each to Allegiance for completion. Targeted samples verified if the claim data provided by the administrator supported our electronic screening; and, if our understanding of the plan provision governing how that service should be adjudicated matched that of Allegiance.
- *Audit of Administrator Response and Documentation* – We reviewed Allegiance's questionnaire responses and performed further analysis of the ESAS findings. We removed any false positives that could be systematically identified from the potential amounts at risk.

Findings

While we are confident in the accuracy of our ESAS results, please note the dollar amounts associated with the results represent ***potential*** payment errors and process improvement opportunities. Additional testing would be required to substantiate findings and provide the basis for remedial action planning or reimbursement.

The following report shows, by category, the number of line items or claims and the total potential amount at risk remaining at the conclusion of our analysis, targeted samples, and removal of verified false positives. Following the report is a detailed explanation of our substantive testing results, findings, and recommendations for all screening categories where, in our opinion, process improvement or recovery/savings opportunities exist.

In the case of State's plan(s), CTI could not run the following ESAS screenings because the data provided did not support our doing so:

- Coordination of Benefits – COB code does not identify primary/secondary coverage (etc.)
- Provider Indicator Not Provider and/or provider discount not provided
- Allowed Amount and/or URC Not Provided
- Network Indicator Not Provided

ESAS Summary Report

Categories for Potential Amount At Risk					
Client: The State **Screening Period:** January 1, 2016 through December 31, 2017					
Category	**Lines**	**Claimants**	**Charge**	**Benefit**	**Potential at Risk**
Duplicate Payments to Providers and/or Employees					
Duplicate Payments to Providers and/or Employees	3,147	545	$317,484	$601,179	$283,696
Plan Limitations					
Ambulance Services	3,826	912	$6,305,635	$2,669,704	$2,669,134
Plan Exclusions					
Dental, Other Preventive Services	2	2	$10,255	$9,186	$6,805
Weight Loss Surgical Treatment	4	2	$8,659	$7,668	$7,203
Durable Medical Equipment Over Medicare Allowance					
DME in Excess of 150% of Medicare	529	104	$117,120	$100,560	$57,224

Duplicate Payments

Electronic screening of all service lines processed revealed services might have 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 allowed amount for that service. Our analysis of the service lines confirmed the potential for process improvement and the overpayment of claims proved to be sufficiently material to warrant further testing.

We sent substantive testing questionnaire (QID) numbers 1 - 6 to Allegiance for their written response. After review of their response and any additional information provided, CTI confirmed the potential for process improvement and overpayment of claims.

Recommendations

Subcategory	Potential Recovery Amount	Number of Claimants	Recommendations
Duplicates	$283,696	545	The State should talk with Allegiance about conducting a focused audit to determine recovery potential and determine if system edits could be refined to prevent paying duplicate claims going forward.

Detail Report

QID	Error Description	Overpayment	Administrator Response	Final CTI Response
2	Duplicate Allowed	$0	Disagree. Both ventilators approved.	Procedural deficiency remains. No documentation provided as to why duplicate $20,400 ventilators were approved.
3	Duplicate Claim	$7,224.65	Agree.	Procedural deficiency and overpayment remain.
5		$682.79	Agree.	Procedural deficiency and overpayment remain. Refund received on 3/8/18.
6		388.72	Agree.	Procedural deficiency and overpayment remain. Refund received on 1/29/18.

Plan Limitations

Electronic screening of all service lines processed revealed services potentially overpaid as a result of exceeding the plan's limitations for coverage of ambulance services. Our analysis of the service lines confirmed the potential for process improvement and the overpayment of claims proved to be sufficiently material to warrant further testing.

We sent substantive testing questionnaire (QID) numbers 7 - 14 to Allegiance for their written response. After review of their response and any additional information provided, CTI confirmed the potential for process improvement and overpayment of claims.

Recommendations

Subcategory	Potential Recovery Amount	Number of Claimants	Recommendations
Ambulance Services	$2,669,134	912	The State should talk with Allegiance about conducting a focused audit to determine recovery potential and if system edits could be refined to prevent paying for services limited by the plan going forward.

Detail Report

QID	Error Description	Overpayment	Administrator Response	Final CTI Response
9	Ambulance Services	$831.54	Agree. Refunded $831.54.	Procedural deficiency and overpayment remain. Claim was processed as non-participating without discount applied.

Plan Exclusions

Electronic screening of all service lines processed revealed services potentially overpaid as a result of paying for services excluded in the plan documents. Our analysis of the service lines confirmed the potential for process improvement and the overpayment of claims proved to be sufficiently material to warrant further testing.

We sent substantive testing questionnaire (QID) numbers 19 - 24 to Allegiance for their written response. After review of their response and any additional information provided, CTI confirmed the potential for process improvement and overpayment of claims.

Recommendations

Subcategory	Potential Recovery Amount	Number of Claimants	Recommendations
Dental, Other Preventive Services	$6,805	2	The State should talk with Allegiance about conducting a focused audit to determine recovery potential and if system edits could be refined to prevent paying for services excluded by the plan going forward.
Weight Loss Surgical Treatment	$7,203	2	

Detail Report

QID	Error Description	Overpayment	Administrator Response	Final CTI Response
19	Dental, Other Preventive Services	$6,492.34	Disagree. Approved by medical review.	Procedural deficiency and overpayment remain. Page 41 of SPD states exclusions for "Charges for dental treatment on or to the teeth." The only allowance listed for dental is for accidental injury.
24	Weight Loss Surgical Treatment	$5,847.22	Disagree. Approved by medical review.	Procedural deficiency and overpayment remain. Page 41 of SPD states exclusion for "Charges in connection with services or supplies provided for the surgical treatment of obesity and medications regardless of medical necessity, and regardless of other condition, diagnosis or co-morbidity, are specifically excluded."

Durable Medical Equipment Over Medicare Allowance

Electronic screening of all durable medical equipment benefit in excess of 150% of the allowable amount for Medicare was performed. Our analysis of the service lines confirmed the potential for process improvement and the overpayment of claims proved to be sufficiently material to warrant further testing.

We sent substantive testing questionnaire (QID) number 17 to Allegiance for their written response. After review of their response and any additional information provided, CTI confirmed the potential for process improvement and overpayment of claims.

Recommendations

Subcategory	Potential Recovery Amount	Number of Claimants	Recommendations
DME in Excess of 150% of Medicare	$57,224	104	The State should talk with Allegiance about conducting a focused audit to determine recovery potential and if system edits could be refined to prevent paying for services billed in excess of 150% of Medicare.

Detail Report

QID	Error Description	Overpayment	Administrator Response	Final CTI Response
17	DME in Excess of 150% of Medicare	$572.04	Disagree.	A procedural deficiency and overpayment remain. Allegiance paid $34,532.99 or a $25,854.69 overpayment on the entire claim because they are allowing billed charge even with documentation showing an allowance on the charges by the provider.

Additional Observations

During the ESAS review, our auditors observed the following procedures or situations that might not have caused an error on the sampled claim – but might have an impact on future claims or the overall quality of service. We have summarized these additional observations below.

Observation	QID
CTI would like to point out to the State provider contracts do not contain "lessor of language" and therefore will pay benefits above billed charges. This claim allowed $575.65 above billed amount.	4

RANDOM SAMPLE AUDIT

Objectives

The objectives of our Random Sample Audit were to determine if claims were paid according to plan specifications and the administrative agreement, to measure and benchmark process quality, and prioritize areas of administrative deficiency for further review and remediation.

Scope

The scope of our Random Sample Audit included a stratified random sample of 180 paid or denied claims. We audited the claims at CTI's office in Des Moines, Iowa. The statistical confidence level of the audit sample was 95%, with a 3% margin of error. A copy of the ***Sample Construction and Weighting Methodology Report*** for this audit sample is in Appendix A.

The administrator's performance was measured using Key Performance Indicators as follows:

- Financial Accuracy
- Accurate Payment
- Accurate Processing
- Adjudication
- Documentation Accuracy – Financial
- Documentation Accuracy – Frequency

We also measured claim turnaround time, which is a commonly relied upon measurement of claim administration performance.

During the audit process, our auditors may have made additional observations regarding processes or payments that went beyond the agreed-upon scope. If so, we have also documented them later in this section of the report.

Methodology

CTI's random sample audit ensures a high degree of consistency in methodology and is based upon the principles of statistical process control with a management philosophy of continuous quality improvement. Each sample claim selected was reviewed to ensure it conformed to the plan specifications, agreements, and negotiated discounts. We recorded findings in CTI's proprietary audit system.

When applicable, we cited errors if a claim was paid or processed incorrectly based on member eligibility or plan provisions as defined in the plan documents. We observed payment errors based on the way a selected claim was paid and the information Allegiance had at the time the transaction was processed. If the sampled claim was subsequently corrected, we still cited the error so you can discuss with Allegiance how to reduce errors and re-work in the future.

CTI communicated with the administrator about any errors or observations in writing using system generated observation response forms. We sent a preliminary report to Allegiance for its review and response in writing. We considered Allegiance's response when producing the final reports.

Findings

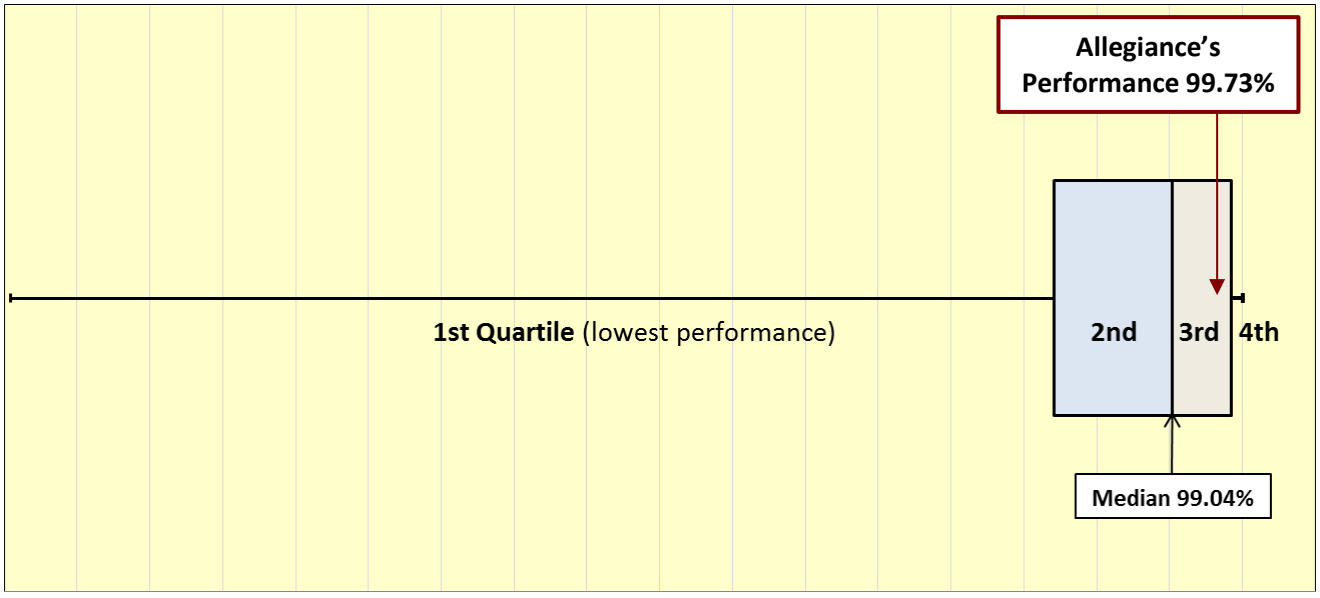
Financial Accuracy

CTI defines **Financial Accuracy** as the total correct claim payments made compared to the total dollars of correct claim payments that should have been made for the audit sample.

The claims sampled and reviewed revealed $396.00 in underpayments and $1,536.97 in overpayments, for a combined variance of $1,932.97. The correct payment total for the adequately documented claims in the audit sample should have been $470,423.75.

The weighted Financial Accuracy Rate for the claims sampled was **99.73%**.

The following box and whiskers chart demonstrates Allegiance's performance as compared to the last 100 medical audits performed by CTI. The fourth quartile represents the highest 25 performing plans, and the first quartile represents the lowest 25. The Median is the point at which 50 plans audited were above, and 50 plans were below.



Financial Accuracy and Accurate Payment Detail Report

Error Description	Audit No.	Entered Amount	Correct Amount	Under/ Over Paid	Admin Response	CTI Response	Manual or System
Entry Error	1136	$8.62	$0	$8.62	Disagree.	Error remains.	Manual
Subtotal	**1**						
Coinsurance	1069	$5,459.75	$5,123.75	$336.00	Disagree.	Error remains.	System
Subtotal	**1**						
Copay Calculation	1162	$469.08	$470.83	($1.75)	Disagree.	Error remains.	System
Subtotal	**1**						
Incorrect Medicare COB	1050	$4,273.00	$4,669.00	($396.00)	Agree.	Error remains.	System
Subtotal	**1**						

Error Description	Audit No.	Entered Amount	Correct Amount	Under/ Over Paid	Admin Response	CTI Response	Manual or System	
Adjustment Error	1108	$0	($1.87)	$1.87	Disagree.	Error remains.	Manual	
Subtotal	**1**							
Duplicate Charge	1054	$1,190.48	$0	$1,190.48	Agree.	Error remains.	Manual	
Subtotal	**1**							
TOTALS	**6**	**VARIANCE**		**$1,932.97**			**M: 3**	**S:3**

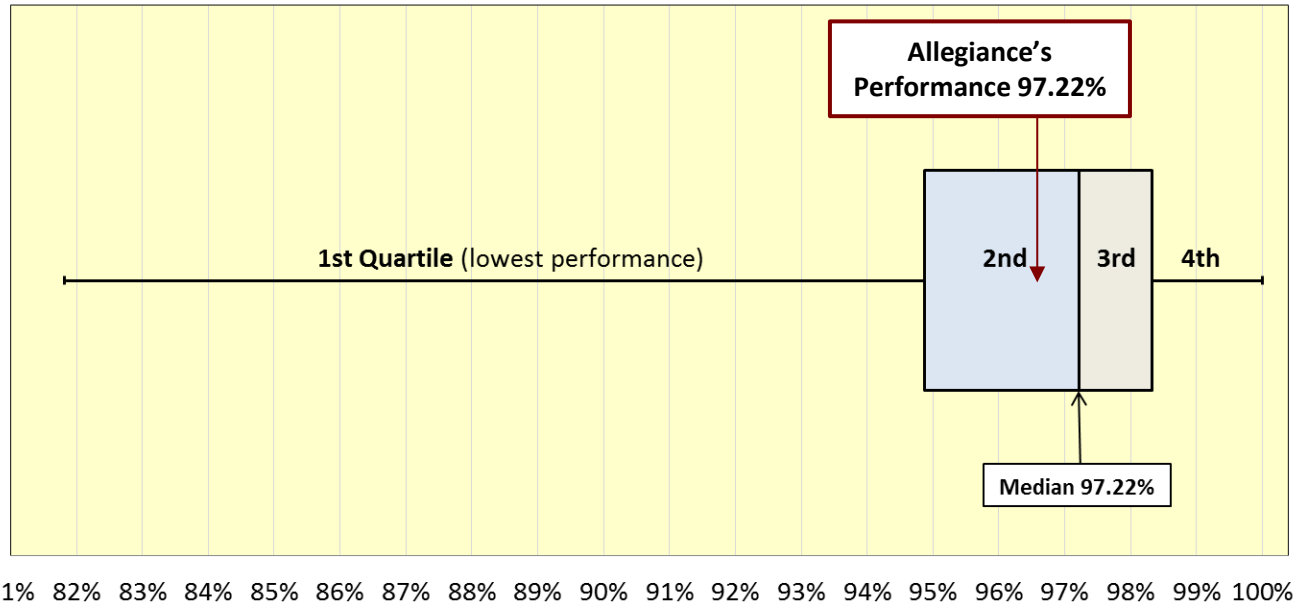
Accurate Payment

CTI defines **Accurate Payment** as the number of claims paid correctly compared to the total number of claims paid for the audit sample.

The audit sample revealed 5 incorrectly paid claims and 175 correctly paid claims. Note CTI only uses adequately documented claims for this calculation.

Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid Claims	Overpaid Claims	
180	1	4	97.22%

The following box and whiskers chart demonstrates Allegiance's performance as compared to the last 100 medical audits performed by CTI. The fourth quartile represents the highest 25 performing plans, and the first quartile represents the lowest 25. The Median is the point at which 50 plans audited were above, and 50 plans were below.



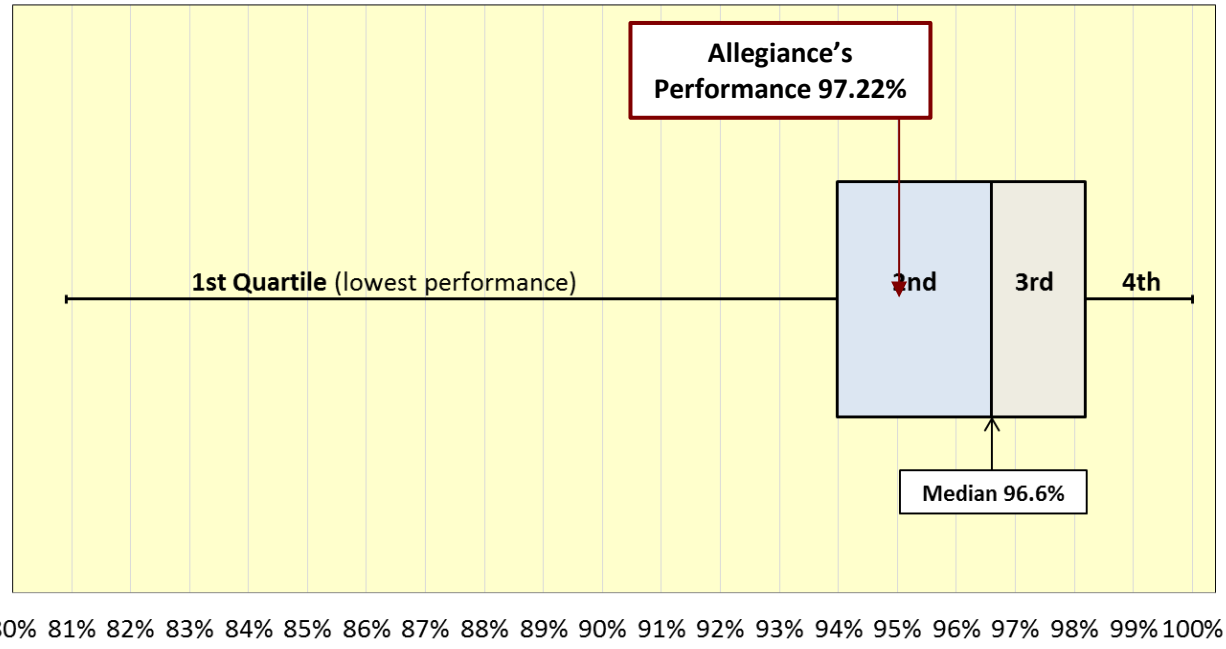
Accurate Processing

CTI defines **Accurate Processing** as the number of claims processed without errors compared to the total number of claims processed in the audit sample.

When a claim had errors that applied in more than one category, it was counted only once as a single incorrect claim for this measure.

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
175	6	3	97.22%

The following box and whiskers chart demonstrates Allegiance's performance as compared to the last 100 medical audits performed by CTI. The fourth quartile represents the highest 25 performing plans, and the first quartile represents the lowest 25. The Median is the point at which 50 plans audited were above, and 50 plans were below.



Accurate Processing Detail Report

Error Description	Audit No.	Administrator Response	CTI Response	Manual or System
Coordination of Benefits				
Investigation	1136	Disagree.	Error remains.	Manual
	1170	Disagree.	Error remains.	System
	1178	Disagree.	Error remains.	Manual
Adjudication	1050	Agree.	Error remains.	System
Managed Care				
Copayment Calculation	1162	Disagree.	Error remains.	System
Case Management	1170	No Response.	Error remains.	System
Policy Provision				
Coinsurance Error	1069	Disagree.	Error remains.	System
Other Insurance Indicator	1108	Disagree.	Error remains.	Manual
Paid Duplicate	1054	Agree.	Error remains.	System
Not Medically Necessary	1170	Disagree.	Error remains.	System
	1175	Disagree.	Error remains.	System

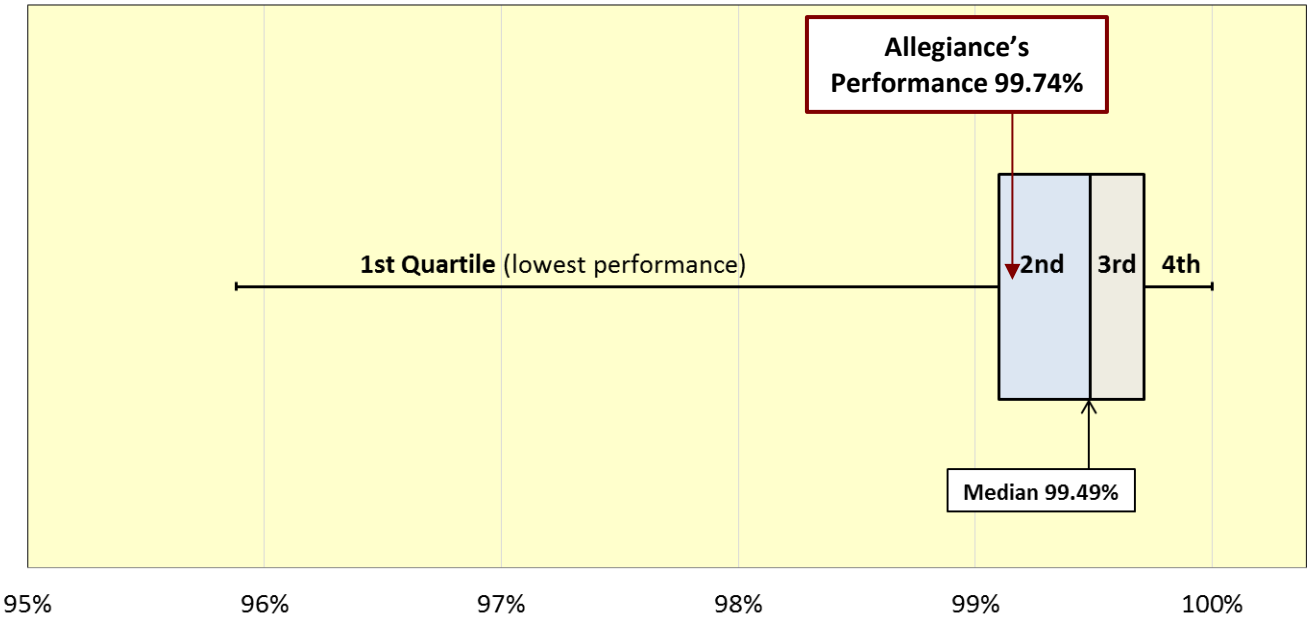
Adjudication

CTI defines **Adjudication** as the number of correct adjudication decisions made compared to the total number of adjudication decisions required for the claims within the audit sample.

There were 1,516 separate decisions reviewed during the audit period, and an average of 8.4 decisions for each claim was reviewed to determine adjudication proficiency. We observed 4 adjudication errors in the audit sample.

The Adjudication Proficiency for the claims sampled was 99.74%.

The following box and whiskers chart demonstrates Allegiance's performance as compared to the last 100 medical audits performed by CTI. The fourth quartile represents the highest 25 performing plans, and the first quartile represents the lowest 25. The Median is the point at which 50 plans audited were above, and 50 plans were below.



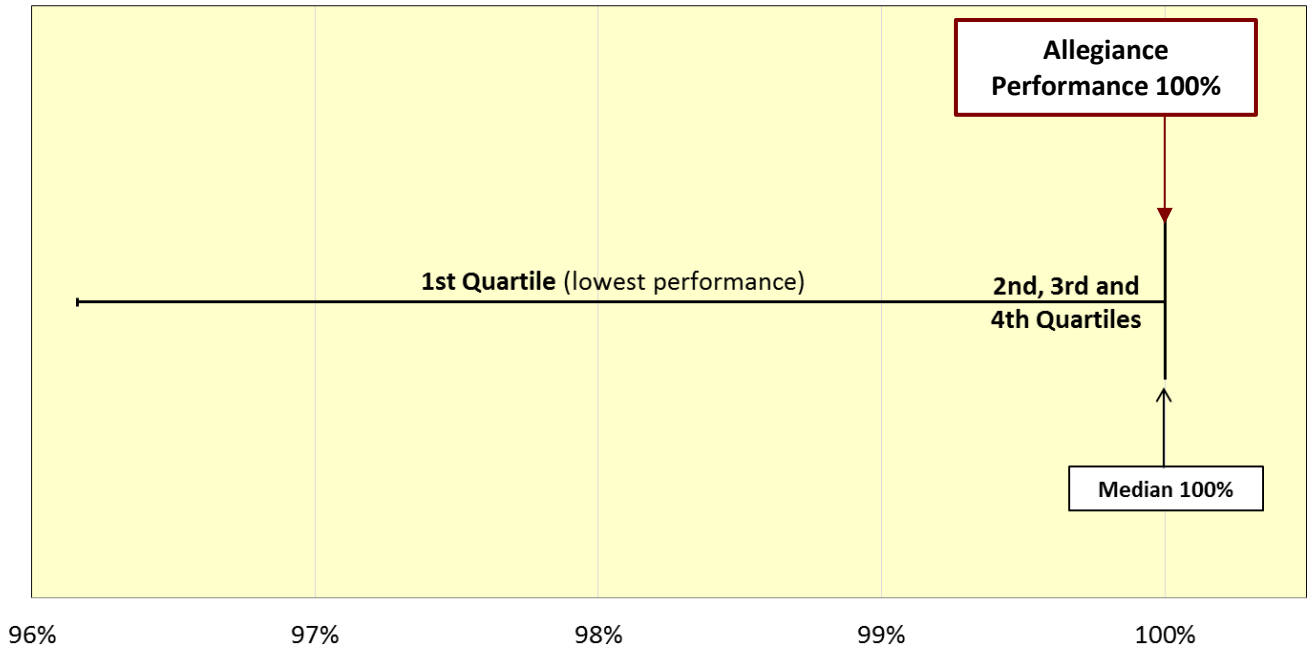
Documentation Accuracy, Financial

CTI defines **Documentation Accuracy, Financial** as the dollar amounts processed with documentation adequate to substantiate payment or denial compared to the dollar amounts processed in the audit sample.

The audit sample revealed documentation needed to support all payments was present.

The weighted Documentation Accuracy – Financial rate for the claims sampled was 100%.

The following box and whiskers chart demonstrates Allegiance's performance as compared to the last 100 medical audits performed by CTI. The fourth quartile represents the highest 25 performing plans, and the first quartile represents the lowest 25. The Median is the point at which 50 plans audited were above, and 50 plans were below.



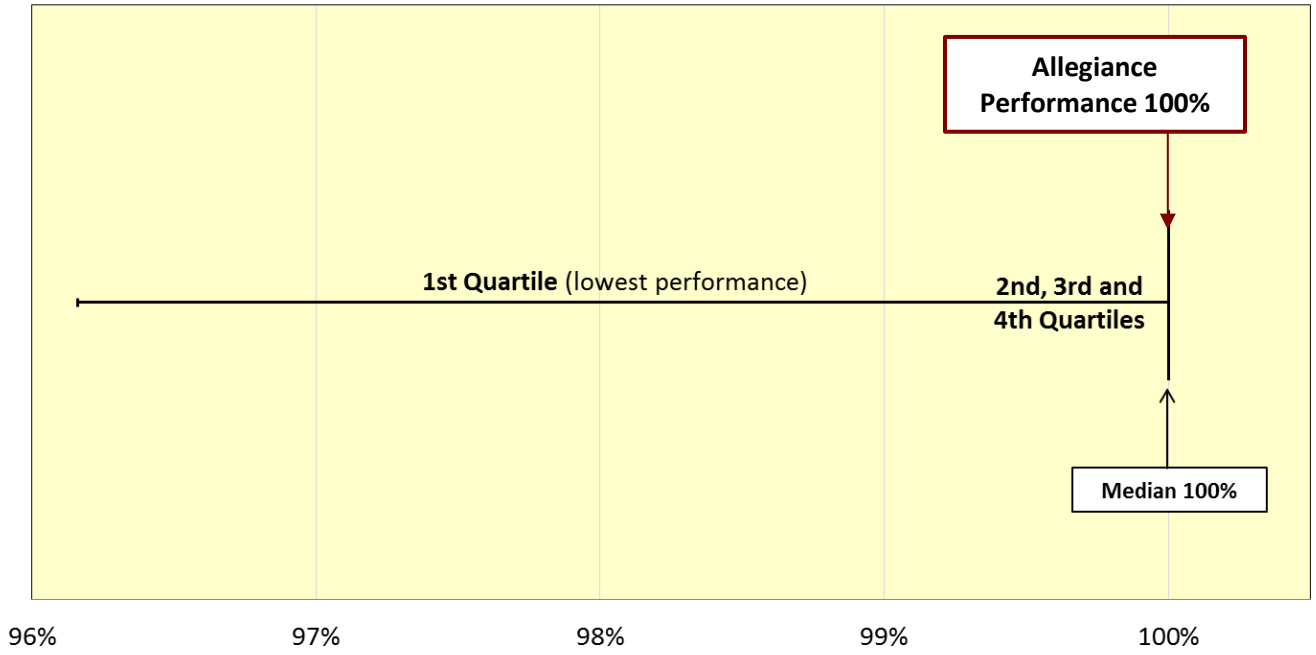
Documentation Accuracy, Frequency

CTI defines **Documentation Accuracy, Financial** as the number of claims processed with documentation adequate to substantiate payment or denial compared to the total number of claims processed in the audit sample.

The audit sample revealed no inadequately documented payments.

The Documentation Accuracy – Frequency rate for the audit sample was 100%**.**

The following box and whiskers chart demonstrates Allegiance's performance as compared to the last 100 medical audits performed by CTI. The fourth quartile represents the highest 25 performing plans, and the first quartile represents the lowest 25. The Median is the point at which 50 plans audited were above, and 50 plans were below.



Claim Turnaround

CTI defines **Claim Turnaround** as the number of calendar days required to process a claim – from the date the claim is received by the administrator to the date a payment, denial or additional information request is processed – expressed as both the Mean and Median for the audit sample.

Claim administrators commonly measure claim turnaround time in mean days. Median days, however, is a more meaningful measure for the administrator to focus on when analyzing claim turnaround because it prevents one or a few claims with extended turnaround time from distorting the true performance picture.

Same day turnaround on claims is the fastest turnaround time that can be achieved – but it is not necessarily the best turnaround time. The administrator should balance claim turnaround by handling all types of claims as efficiently as possible.

Median	Mean	+45 Days to Process
6	12	4

Additional Observations

During the Random Sample Audit, our auditors observed the following procedures or situations that might not have caused an error on the sampled claim – but might have an impact on future claims or the overall quality of service. We have summarized these additional observations below.

Observation	Audit Number(s)
Montana should be aware that Allegiance contract languages do not include lessor than language and benefits are being paid above billed charges in some cases. Montana may wish to discuss having lessor than language added to the provider contracts. In the following audits the savings would have been: Audit — Financial impact 1014 — $2,730.91 1053 — $318.01 1101 — $37.95 1121 — $3,849.50 1123 — $3,046.93 1144 — $22,685.47	1014, 1053, 1101, 1121, 1123, 1144
CTI would like to note that this member's policy termed 11/30/16 and $290.82 has been paid for this member on dates of service after the termination date and an additional $348.10 has been paid on other family members since the 11/30/16 termination date.	1138

DATA ANALYTICS

This component of our audit used the electronic claim data to identify improvement opportunities and potential recoveries. The informational categories we analyzed include:

- Validation of Provider Discounts
- Sanctioned Provider Identification
- Patient Protection and Affordable Care Act (PPACA) Preventive Services Payment Compliance
- National Correct Coding Initiative (NCCI) Editing Compliance
- Global Surgery Prohibited Fee Period Analysis

The following pages provide the objectives, scope, and report of each data analytic to enable more-informed decisions about ways State can maximize benefit plan administration and performance.

Provider Discounts

The **Provider Discount** report provides an evaluation of provider network discounts obtained during the audit period. Since discounts can be calculated differently by administrators, carriers, and benefit consultants, we believe calculating discounts in the same manner for all clients allow for meaningful comparisons to be made.

Scope

CTI compared submitted charges to allowable charges for all claims paid during the audit period. The review was divided into three subsets:

- In-network
- Out-of-network
- Secondary networks

Each of the above-mentioned subsets was further delineated into four subgroups:

- Ancillary services
- Non-facility services
- Facility inpatient
- Facility outpatient

Report

The following report relied on the data provided by the administrator and only used the data fields provided with no assumptions made when necessary data fields were not provided by the administrator.

Provider Discount Review
State of Montana - Allegiance
Paid Dates 1/1/2016 through 12/31/2017

Proprietary and Confidential Information. Do not reproduce without express permission of Claim Technologies Inc.

Total of All Claims

Claim Type	Eligible Charge	Provider Discount		Paid
Ancillary	$12,793,320	$4,179,670	32.7%	$7,070,757
Non-Facility	$121,473,140	$34,489,963	28.4%	$66,339,989
Facility Inpatient	$78,293,250	$12,728,910	16.3%	$60,390,201
Facility Outpatient	$105,284,385	$27,454,519	26.1%	$63,459,301
Total	**$317,844,094**	**$78,853,062**	**24.8%**	**$197,260,248**

In-Network

Claim Type	Eligible Charge	Provider Discount		Paid
Ancillary	$11,160,693	$4,175,001	37.4%	$5,602,978
Non-Facility	$119,773,103	$34,424,547	28.7%	$65,492,513
Facility Inpatient	$77,787,237	$12,726,030	16.4%	$59,956,747
Facility Outpatient	$104,557,537	$27,440,632	26.2%	$62,963,312
Total In-Network	**$313,278,570**	**$78,766,210**	**25.1%**	**$194,015,549**
% of Eligible Charge -	98.6%	% Claim Frequency -	93.5%	

Out of Network

Claim Type	Eligible Charge	Provider Discount		Paid
Ancillary	$1,632,627	$4,669	0.3%	$1,467,779
Non-Facility	$1,700,037	$65,416	3.8%	$847,477
Facility Inpatient	$506,013	$2,880	0.6%	$433,454
Facility Outpatient	$726,847	$13,887	1.9%	$495,989
Total Out of Network	**$4,565,524**	**$86,851**	**1.9%**	**$3,244,699**
% of Eligible Charge -	1.4%	% Claim Frequency -	6.5%	

Secondary

Claim Type	Eligible 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 Eligible Charge -	0.0%	% Claim Frequency -	0.0%	

Utilization of network or secondary network providers by State members was very high at 98.6% of all allowed charges and 93.5% of all claims. The average discount off allowed charges from network and secondary network providers was at expected levels.

Sanctioned Provider Identification

The Sanctioned Provider Identification report identifies services rendered by providers included on the Office of Inspector General (OIG)'s List of Excluded Individuals/Entities (LEIE). OIG's LEIE provides information to the healthcare industry, patients and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid, and all other Federal health care programs.

Scope

We received and converted an electronic data file of all claims processed during the audit period. The claims screened included all medical (not including prescription drug) claims paid or denied during the audit period. Through electronic screening, we identified all claims in the audit universe that were non-facility claims, i.e. claims submitted by providers of service other than hospitals, nursing or skilled care facilities, or durable medical equipment suppliers. These claims predominantly include services by physicians and other medical professionals.

Report

We screened 100% of the claims from non-facility providers against the OIG's LEIE and identified no claims paid to providers on the OIG's LEIE.

Affordable Care Act Preventive Services Payment Compliance

The **Preventive Services Payment Compliance** report confirms administrator processed preventive services as required by PPACA and as regulated by the Department of Health and Human Services (HHS). The federal PPACA mandate for all health plans (unless grandfathered) is certain preventive services, if performed by a network provider, must be covered at 100% without copayment, coinsurance or deductible. Our review analyzes in-network preventive care services to determine if your administrator paid services in compliance with PPACA guidelines.

Scope

Our review included all in-network services we believe should be categorized as preventive and paid at 100%. The guidance provided by HHS is somewhat vague regarding the definition of preventive services, leaving it up to individual health plans to define their system edits. In addition to the U.S. Preventive Services Task Force recommendations, CTI researched best practices of major health plan administrators to develop a compliance review we believe reflects the industry's most comprehensive overview of procedures to be paid at 100%.

Our review ***did not*** include services:

- Performed by an out-of-network provider
- Adjusted or paid more than once (duplicate payments) during the audit period
- For which PPACA requirements suggest a frequency limitation such as one per year

Our data analytics parameters relied upon the published recommendations from the sources HHS used to create the list of preventive services for which it has mandated coverage.

Report

We analyzed the payments to determine if they were compliant. Types of services in which non-compliance was identified (if any) are listed first and the percentage of allowed charge paid is 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 100% of these services performed by network providers were paid and that 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 ineligible at the time it was performed), less than 100% of the preventive services may be paid.

The preventive services compliance review shows the frequency of claims paid at less than required benefit levels. (i.e., claims reduced payment due to the application of deductibles, coinsurance, and/or copayments). There were 78 categories of preventive services screened electronically as part of CTI's preventive services compliance review. These 78 categories match the preventive care services specified by the HHS including immunizations, women's health, tobacco use counseling, cholesterol and cancer screenings, and wellness examinations. This review either confirms compliance with PPACA preventive services coverage requirements or highlights areas where improvements can be achieved.

The following report provides an outline for discussion between State and Allegiance. The claim detail supporting each finding can be provided upon request.

Preventive Care Services Compliance Review												
State of Montana - Allegiance												
Audit Period 1/1/2016 - 12/31/2017												
		Claims Submitted	Denied	Applied Deductible		Applied Copay		Applied Coinsurance		Paid @100%		
Edit Guideline	Preventive Service Benefit	#	#	#	Amount	#	Amount	#	Amount	#	Amount	%
USPSTF-A	Ambulatory blood pressure screening - adult	3	0	2	$144	0	$0	1	$18	0	$0	.00%
USPSTF-B	Depression screening - 12-18	21	5	13	$187	0	$0	2	$4	1	$35	4.76%
HHS	Gestational diabetes screening - women	1,200	18	586	$12,747	2	$60	518	$3,235	76	$1,666	6.33%
USPSTF-A	Hypothyroidism screening - 0-90 days	21	0	6	$170	0	$0	9	$72	6	$157	28.57%
USPSTF-A	Hepatis B screening - women	363	4	176	$4,444	0	$0	76	$556	107	$2,898	29.48%
USPSTF-A,B	Rh incompatibility screening - pregnant women	414	12	158	$5,406	4	$115	102	$717	138	$2,524	33.33%
USPSTF-A	HIV screening - pregnant women	324	7	130	$5,693	0	$0	53	$622	134	$4,739	41.36%
USPSTF-B	Hearing loss screening - 0 - 90 days	40	1	15	$1,486	0	$0	4	$70	20	$1,810	50.00%
USPSTF-A	Hemoglobinopathies or sickle cell screening 0-90 days	17	0	6	$158	0	$0	2	$28	9	$427	52.94%
USPSTF-A	Syphilis screening - pregnant women	185	8	41	$1,095	0	$0	36	$291	100	$1,518	54.05%
USPSTF-A	Phenylketonuria (PKU) screening 0-90 days	19	1	5	$78	0	$0	2	$12	11	$290	57.89%
USPSTF-B	Breast cancer chemoprevention counseling- >17	111	0	1	$65	45	$1,355	0	$0	65	$12,030	58.56%
HHS	Breastfeeding support and counseling - women	78	2	1	$156	26	$680	2	$74	47	$14,030	60.26%
USPSTF-B	BRCA screening counseling - women	204	4	9	$975	56	$1,760	7	$177	128	$17,974	62.75%
USPSTF-B	Depression screening - >18	36	2	11	$92	0	$0	0	$0	23	$825	63.89%
USPSTF-B	Gonorrhea screening - women	940	24	127	$6,353	3	$54	80	$1,533	706	$49,372	75.11%
USPSTF-B	Hepatitis C Virus (HCV) Screening	543	28	60	$2,697	0	$0	44	$588	411	$18,526	75.69%
USPSTF-B	Diabetes screening	55	2	9	$190	0	$0	1	$26	43	$1,354	78.18%
USPSTF-B	Healthy diet counseling	158	28	1	$120	2	$48	3	$107	124	$9,865	78.48%
USPSTF-A	Syphillis screening	39	2	5	$179	0	$0	0	$0	32	$527	82.05%
USPSTF-B	Vision screening - 3- 5	162	3	22	$455	0	$0	2	$9	135	$2,423	83.33%
USPSTF-B	Alcohol misuse - screening and counseling	30	3	0	$0	2	$50	0	$0	25	$998	83.33%
USPSTF-A,B	Chlamydia infection screening - women	1,049	29	74	$6,531	0	$0	63	$1,457	883	$59,034	84.18%
HHS	Wellness Examinations - women	7,616	97	56	$10,170	825	$21,326	208	$14,174	6,430	$1,215,155	84.43%
ACIP	Immunizations - DTP >18	1,682	34	110	$14,072	5	$627	85	$2,703	1,448	$58,194	86.09%
ACIP	Immunizations - Pneumococcal >18	253	8	12	$1,542	0	$0	11	$371	222	$19,223	87.75%
HHS	Contraceptive methods - women	2,552	52	142	$20,970	0	$0	89	$10,174	2,269	$710,364	88.91%
Bright Futures	Lead screening - <21	227	6	16	$409	0	$0	2	$20	203	$5,972	89.43%
ACIP	Immunizations - Herpes Zoster >59	109	1	5	$862	0	$0	4	$182	99	$21,312	90.83%
USPSTF-A	HIV screening - >14	321	12	10	$635	0	$0	7	$125	292	$10,325	90.97%
HHS	Wellness Examinations - >18	2,152	92	27	$4,279	52	$1,390	16	$674	1,965	$387,942	91.31%
ACIP	Immunizations - Hepatitis B >18	131	2	2	$445	0	$0	6	$513	121	$9,049	92.37%
ACIP	Immunizations - Varicella >18	15	1	0	$0	0	$0	0	$0	14	$1,558	93.33%
USPSTF-A,B	Cholesterol abnormalities screening - women >19	901	13	25	$781	0	$0	5	$71	858	$38,676	95.23%
USPSTF-A	Tobacco use counseling - >18	105	5	0	$0	0	$0	0	$0	100	$2,524	95.24%
ACIP	Immunization Administration - >18	5,772	103	58	$3,370	5	$207	87	$1,331	5,519	$206,681	95.62%
USPSTF-A	Cervical cancer screening - women	3,472	57	48	$2,921	0	$0	12	$246	3,355	$181,381	96.63%
USPSTF-A	Colorectal cancer screening - 50-75	2,010	31	20	$6,511	0	$0	15	$3,117	1,944	$1,302,483	96.72%
USPSTF-A	Cholesterol abnormalities screening - men >34	1,100	12	20	$872	0	$0	4	$59	1,064	$34,649	96.73%
HHS	Human papillomavirus DNA testing - women >29	1,025	21	9	$1,163	0	$0	3	$125	992	$75,841	96.78%
ACIP	Immunizations - Influenza Age >18	2,444	23	17	$365	0	$0	34	$324	2,370	$46,847	96.97%
HRSA/HHS	Wellness Examinations - <19	6,839	149	11	$1,471	38	$1,100	2	$16	6,639	$1,110,195	97.08%
ACIP	Immunizations - Hepatitis A >18	235	1	1	$169	0	$0	4	$144	229	$16,263	97.45%
Bright Futures	Tuberculin testing - <21	52	1	0	$0	0	$0	0	$0	51	$733	98.08%
ACIP	Immunizations - Meningococcal <19	626	5	4	$791	0	$0	0	$0	617	$80,530	98.56%
ACIP	Immunizations - Hepatitis B <19	71	1	0	$0	0	$0	0	$0	70	$2,011	98.59%
Bright Futures	Iron Supplement - <21	405	4	1	$5	0	$0	0	$0	400	$2,314	98.77%
ACIP	Immunizations - Human papillomavirus	1,122	8	3	$1,013	0	$0	2	$185	1,109	$221,262	98.84%
USPSTF-B	Breast cancer mammography screening - >39	9,155	54	43	$3,063	0	$0	5	$65	9,053	$961,270	98.89%
ACIP	Immunization Administration - <19	10,147	81	4	$161	0	$0	24	$296	10,038	$481,048	98.93%
ACIP	Immunizations - Meningococcal >18	189	1	0	$0	0	$0	1	$70	187	$33,656	98.94%
ACIP	Immunizations - Inactivated Poliovirus <19	95	1	0	$0	0	$0	0	$0	94	$3,398	98.95%
ACIP	Immunizations - Measles, Mumps, Rubella <19	356	1	2	$564	0	$0	0	$0	353	$69,798	99.16%
ACIP	Immunizations - DTP <19	2,527	12	6	$799	0	$0	1	$48	2,508	$160,801	99.25%
Bright Futures	Dyslipidemia screening - 2-20	136	1	0	$0	0	$0	0	$0	135	$4,015	99.26%
ACIP	Immunizations - Influenza <19	2,162	4	6	$168	0	$0	3	$11	2,149	$44,099	99.40%
ACIP	Immunizations - Rotavirus <19	908	5	0	$0	0	$0	0	$0	903	$96,564	99.45%
ACIP	Immunizations - Hepatitis A <19	1,079	5	0	$0	0	$0	0	$0	1,074	$40,597	99.54%
ACIP	Immunizations - Varicella <19	592	0	1	$87	0	$0	0	$0	591	$63,350	99.83%
Bright Futures	Developmental Autism screening - <3	633	1	0	$0	0	$0	0	$0	632	$9,888	99.84%
ACIP	Immunizations - Human Papillomavirus 19-26	25	0	0	$0	0	$0	0	$0	25	$4,379	100.00%
USPSTF-B	Cholesterol abnormalities screening - men 20-34	6	0	0	$0	0	$0	0	$0	6	$205	100.00%
ACIP	Immunizations - Pneumococcal <19	4	0	0	$0	0	$0	0	$0	4	$302	100.00%
ACIP	Immunizations adult - Influenza Age (FluMist) 19-49	3	0	0	$0	0	$0	0	$0	3	$74	100.00%
USPSTF-B	Obesity screening and counseling - >18	2	0	0	$0	0	$0	0	$0	2	$54	100.00%
ACIP	Immunizations - Measles, Mumps, Rubella >18	1	0	0	$0	0	$0	0	$0	1	$166	100.00%
	Totals	**75,269**	**1,088**	**2,117**	**$127,080**	**1,065**	**$28,772**	**1,637**	**$44,641**	**69,362**	**$7,938,167**	**92.15%**

National Correct Coding Initiative Editing Capability

The Centers for Medicare & Medicaid Services (CMS) mandates several initiatives to prevent improper payments of Medicare and Medicaid claims due to incorrect provider billing through its National Correct Coding Initiative (NCCI). While there are no universally accepted correct coding guidelines among private insurers and administrators, CMS, the nation's largest payer for health care, took the initiative to provide valuable guidance when applied to medical benefit plans.

Scope

The two CMS NCCI initiatives that can offer the greatest return benefit to self-funded employee benefit plans are the:

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

It is difficult to establish the extent to which administrators and carriers are using NCCI edits; however, CTI recommends these reports be discussed with the administrators 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 further efforts toward standardized code-editing systems for all payers.

Procedure-to-Procedure Edits Report

Procedure-to-Procedure Edits compare procedure codes from multiple claim lines on the same day to identify when procedures from multiple lines of a claim cannot be billed together. Our reports are grouped by outpatient hospital services and non-facility claims using quarterly updated data provided by CMS. If your administrator is not currently using these CMS edits, CTI's reports will help you evaluate the savings potential if the Procedure-to-Procedure Edits had been in place.

Procedure to Procedure Edits								
State of Montana - Allegiance								
Based on Paid Dates 1/1/2016 through 12/31/2017								
Outpatient Hospital Services (facility claims with codes not designated inpatient)								
Primary		**Secondary**		**Modifier**	**Primary Description**	**Secondary Description**	**Line**	**Secondary**
Code	**Mod**	**Code**	**Mod**	**Allowed**			**Count**	**Paid**
36224		36223		YES	Place cath carotd art	Place cath carotid/inom art	1	$65,488
					CPT Manual or CMS manual coding instructions			
74177		96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	99	$10,876
					Standards of medical / surgical practice			
93641		93621		YES	ELECTROPHYSIOLOGY EVALUATION	ELECTROPHYSIOLOGY EVALUATION	1	$9,149
					Mutually exclusive procedures			
61798		77371		NO	SRS CRANIAL LESION COMPLEX	SRS MULTISOURCE	1	$7,941
					CPT Manual or CMS manual coding instructions			
77385		77338		YES	Intensity modulated radiation treatment delivery (I	DESIGN MLC DEVICE FOR IMRT	2	$6,127
					CPT Manual or CMS manual coding instructions			
97150	GO	97530	GP	YES	GROUP THERAPEUTIC PROCEDURES	THERAPEUTIC ACTIVITIES	13	$6,030
					Mutually exclusive procedures			
92526	GN	97530	GO	YES	ORAL FUNCTION THERAPY	THERAPEUTIC ACTIVITIES	75	$5,994
					Misuse of column two code with column one code			
45390		45381		YES	resection	COLONOSCOPY SUBMUCOUS INJ	1	$5,903
					CPT Manual or CMS manual coding instructions			
28296		28285		YES	CORRECTION OF BUNION	REPAIR OF HAMMERTOE	1	$5,857
					Standards of medical / surgical practice			
92526	GN	97530	GP	YES	ORAL FUNCTION THERAPY	THERAPEUTIC ACTIVITIES	76	$5,748
					Misuse of column two code with column one code			
						Top 10 TOTAL	**270**	**$129,114**
						GRAND TOTAL	**2,829**	**$1,999,729**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)								
Primary		Secondary		Modifier	Primary Description	Secondary Description	Line	Secondary
Code	Mod	Code	Mod	Allowed			Count	Paid
37242		75774		YES	Vascular embolization or occlusion	ARTERY X-RAY EACH VESSEL	14	$11,603
					CPT Manual or CMS manual coding instructions			
90471		99396		YES	IMMUNIZATION ADMIN	PREV VISIT EST AGE 40-64	50	$9,963
					CPT Manual or CMS manual coding instructions			
44970		99219	57	YES	LAPAROSCOPY APPENDECTOMY	INITIAL OBSERVATION CARE	24	$5,652
					CPT Manual or CMS manual coding instructions			
90471		99213		YES	IMMUNIZATION ADMIN	OFFICE/OUTPATIENT VISIT EST	36	$3,975
					CPT Manual or CMS manual coding instructions			
90471		99214		YES	IMMUNIZATION ADMIN	OFFICE/OUTPATIENT VISIT EST	21	$3,549
					CPT Manual or CMS manual coding instructions			
90460		99392		YES	IM ADMIN 1ST/ONLY COMPONENT	PREV VISIT EST AGE 1-4	21	$3,493
					CPT Manual or CMS manual coding instructions			
21249		21248		YES	RECONSTRUCTION OF JAW	RECONSTRUCTION OF JAW	2	$3,000
					HCPCS/CPT procedure code definition			
98941		99212		YES	Chiropract manj 3-4 regions	OFFICE/OUTPATIENT VISIT EST	153	$2,921
					CPT Manual or CMS manual coding instructions			
77470	26	77432		NO	SPECIAL RADIATION TREATMENT	STEREOTACTIC RADIATION TRMT	1	$2,881
					Mutually exclusive procedures			
96372		99213		YES	THER/PROPH/DIAG INJ SC/IM	OFFICE/OUTPATIENT VISIT EST	23	2326.4
					Standards of medical / surgical practice			
						Top 10 TOTAL	**345**	**$49,364**
						GRAND TOTAL	**1469**	**$453,524**

Medically Unlikely Edits Report

A Medically Unlikely Edit (MUE) is 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. The MUE rule for a given code is the maximum number of service units a provider should report for a single day of service. The cause of MUE errors could be incorrect coding, inappropriate services performed, or fraud. MUEs do not require Medicare contractors to perform a manual review or suspend claims; rather, claim lines are denied and must be correctly resubmitted by providers, typically with a lesser payment amount.

The MUEs analyses provided by CTI are grouped into three separate reports:

- Outpatient hospital
- Non-facility
- Ancillary

NCCI MUE Edits				
State of Montana - Allegiance				
Based on Paid Dates 1/1/2016 through 12/31/2017				
Outpatient Hospital Services (facility claims with codes not designated inpatient)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line Count**	**Benefit Paid**
J9228	1100	IPILIMUMAB INJECTION	1	$186,000
		Rationale: Prescribing Information		
J1561	300	Gamunex-C/Gammaked	1	$47,799
		Rationale: Prescribing Information		
50590	1	FRAGMENTING OF KIDNEY STONE	3	$34,221
		Rationale: Anatomic Consideration		
99219	1	INITIAL OBSERVATION CARE	89	$26,175
		Rationale: Code Descriptor / CPT Instruction		
99217	1	OBSERVATION CARE DISCHARGE	119	$23,396
		Rationale: Code Descriptor / CPT Instruction		
A0435	999	FIXED WING AIR MILEAGE	1	$23,126
		Rationale: Clinical: Data		
A0436	300	ROTARY WING AIR MILEAGE	1	$20,952
		Rationale: Clinical: Data		
99070	1	Special supplies phys/qhp	23	$15,365
		Rationale: Code Descriptor / CPT Instruction		
80307	1	DRUG TEST PRSMV INSTRMNT CHEMISTRY ANALYZER	72	$14,935
		Rationale: Code Descriptor / CPT Instruction		
80053	1	COMPREHEN METABOLIC PANEL	12	$13,268
		Rationale: CMS Policy		
		Top 10 TOTAL	**322**	**$405,236**
		GRAND TOTAL	**839**	**$618,824**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line count**	**Benefit Paid**
0365T	7	Adaptive behavior treatment by protocol, administ	572	$284,514
		Rationale: Clinical: CMS Workgroup		
0369T	7	Adaptive behavior treatment with protocol modific	131	$56,548
		Rationale: Clinical: CMS Workgroup		
J0178	4	Aflibercept injection	3	$27,789
		Rationale: Prescribing Information		
95165	30	ANTIGEN THERAPY SERVICES	20	$25,307
		Rationale: Clinical: Data		
J0878	1500	DAPTOMYCIN INJECTION	3	$21,540
		Rationale: Clinical: Society Comment		
96152	6	INTERVENE HLTH/BEHAVE INDIV	63	$14,107
		Rationale: Clinical: Data		
J2357	90	OMALIZUMAB INJECTION	1	$7,778
		Rationale: Clinical: Data		
0364T	1	Adaptive behavior treatment by protocol, administ	36	$7,098
		Rationale: Code Descriptor / CPT Instruction		
86255	5	FLUORESCENT ANTIBODY SCREEN	7	$6,451
		Rationale: Clinical: Data		
0361T	3	Observational behavioral follow-up assessment, ir	14	$5,914
		Rationale: Clinical: CMS Workgroup		
		Top 10 TOTAL	**850**	**$457,046**
		GRAND TOTAL	**1,281**	**$579,259**

Ancillary (All other claims not flagged Inpatient,Outpatient Hospital, or non-facility)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line count**	**Benefit Paid**
B4087	1	GASTRO/JEJUNO TUBE, STD	10	$3,603
		Rationale: Published Contractor Policy		
E2402	1	NEG PRESS WOUND THERAPY PUMP	1	$2,948
		Rationale: Nature of Equipment		
A7020	1	INTERFACE, COUGH STIM DEVICE	17	$2,941
		Rationale: Nature of Equipment		
B4189	1	PARENTERAL SOL AMINO ACID &	1	$1,599
		Rationale: Published Contractor Policy		
E0202	1	PHOTOTHERAPY LIGHT W/ PHOTOM	3	$1,310
		Rationale: Nature of Equipment		
E0443	1	PORTABLE 02 CONTENTS, GAS	13	1216.81
		Rationale: Code Descriptor / CPT Instruction		
E0676	1	INTER LIMB COMPRESS DEV NOS	1	$980
		Rationale: Nature of Equipment		
B4088	1	GASTRO/JEJUNO TUBE, LOW-PRO	2	$841
		Rationale: Published Contractor Policy		
A7034	1	NASAL APPLICATION DEVICE	6	$779
		Rationale: Published Contractor Policy		
E2615	1	POS BACK POST/LAT WDTH <22IN	1	$741
		Rationale: Nature of Equipment		
		Top 10 TOTAL	**55**	**$16,958**
		GRAND TOTAL	**153**	**$21,257**

Global Surgery Prohibited Fee Period Analysis

The nation's largest payer, CMS, created a definition of a global surgical package to make payments for the same services consistent for services provided by a surgeon before, during and after procedures. The objective of CTI's Global Surgery Prohibited Fee Period Analysis is to compare paid surgical claims to Medicare's payment guidelines to identify instances of unbundling and improper use of evaluation and management (E/M) coding.

Scope

The scope of the Global Surgery Prohibited Fee Period Analysis is surgery charges provided in any setting, including an inpatient hospital, outpatient hospital, ambulatory surgical center (ASC), and physician's office. In addition, claims for surgeon visits in an intensive care or critical care unit are also included in the global surgical package. The analysis encompasses the three types of procedures with global surgical packages: simple, minor and major. Each of the three types of global surgery procedures has specific global periods:

- *Simple* – One day
- *Minor* – Ten days
- *Major* – Ninety days

CMS allows providers to bill for an E/M service after surgery if the patient's condition required a significant, separately identifiable E/M service beyond the usual pre-operative and post-operative care associated with the surgery. When this occurs, the provider can add a modifier 25 or 57 to the E/M service procedure code but must submit supporting documentation with such claims.

Report

The report provides a summary of:

1. Top 10 providers with and without E/M charges during prohibited periods and associated charges.
2. Analysis of the same providers' surgeries with modifier 25 or 57 when Medicare would have required supporting documentation before payment.
3. Analysis of the same providers' surgeries without modifier 25 or 57 when Medicare would have denied payment.

Payment of unbundled E/M services post-surgery during the global fee increases a claims cost. While there are no universally accepted global surgery fee periods with 25 or 57 modifier guidelines among private insurers and administrators, some states and groups mandate providers must accept assignment of benefits which mitigates the financial impact to plans when unbundling and improper coding occurs. Discussion of CTI's findings will promote identification of strategies to monitor and eliminate occurrences of unbundling within your plan.

Audit Period 1/1/2016 - 12/31/2017											
State of Montana - Allegiance			Surgeries with 'CMS Defined' Prohibiited Global Fee Periods					Evaluation and Management Services using Same ID as Surgeon and Within Prohibited Global Fee Period			
			Surgeries without E/M Procedures during Prohibited Global Fee Periods		Surgery with E/M Charge during Prohibited Global Fee Periods			E/M Procedure Codes with Modifier 25 or 57		E/M Procedure Codes without Modifier 25 or 57	
NPI	Specialty	Provider Name	Count	Allowed Charge	Count	% Surgeries with E/M Charges during Prohibited Gobal Fee Periods	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge
1124276340	PLASTIC SURGERY	NATHAN A SANDERS DO	257	$129,232	187	42.1%	$53,369	183	$42,875	3	$281
1366543985	OTOLARYNGOLOGY	SCOTT R PARGOT DO	344	$206,685	181	34.5%	$48,426	179	$28,389	3	$461
1063701431	PODIATRIST	JASON SMITH DPM	71	$24,272	159	69.1%	$20,415	154	$18,047	0	$0
1063525988	OBY - GYN	ANDREW MARK MALANY MD	82	$31,206	83	50.3%	$18,253	83	$15,592	0	$0
1255311106	PHYSICAL MEDICINCE	PHILLIP STEELE MD	173	$21,680	130	42.9%	$15,630	126	$11,633	0	$0
1659392983	PODIATRIST	ANTHONY QUEBEDEAUX DPM	320	$68,342	74	18.8%	$10,940	58	$8,634	11	$1,667
1740406412	ORTHOPAEDIC SURGERY	ERIK BERGQUIST MD	191	$145,736	71	27.1%	$30,548	60	$8,178	7	$753
1275795320	FAMILY PRACTICE	EUGENE WALTON MD	60	$8,063	87	59.2%	$9,418	82	$8,764	0	$0
1477644227	PHYSICIAN ASSISTANT	KELLI SEBESTYEN PAC	242	$21,764	89	26.9%	$6,923	84	$7,910	4	$505
1952545311	SURGEON	CARL K SCHILLHAMMER MD	32	$34,723	44	57.9%	$8,607	39	$7,205	3	$394
		Top 10 TOTAL	**1,772**	**$691,703**	**1,105**	**38.4%**	**$222,530**	**1,048**	**$157,226**	**31**	**$4,062**
		Overall Total	**25,307**	**$9,359,319**	**5,177**	**17.0%**	**$1,192,636**	**4,743**	**$584,936**	**260**	**$31,160**

APPENDIX

APPENDIX A – SAMPLE CONSTRUCTION AND WEIGHTING METHODOLOGY

Client: MTAllegiance17
Audit Period: January 01, 2016 - December 31, 2017

Claim Universe (as converted)

Stratum	Claim Count	Total Charge Amount	Total Paid Amount
1	653,824	$94,705,760	$42,707,115
2	107,614	$143,857,606	$55,254,893
3	17,062	$326,456,482	$123,876,806
Total	778,500	$565,019,848	$221,838,814

Audit Stratification

Stratum	Audit Universe (# Claims)	Proportion (Weight by Count)	Sample
1	653,824	83.99%	60
2	107,614	13.82%	60
3	17,062	2.19%	60
Total	778,500	100.00%	180

Audit Sample Overview

Category	Count	Paid
Claims requested for audit	180	$471,564.72
Claims for which records not received	0	$0.00
Claims outside scope of audit	0	$0.00
Claims as entered included in audit sample	180	$471,564.72
Audit sample if all claims paid correctly	180	$470,425.50
Claims with inadequate documentation	0	$0.00
Total claim payments remaining in audit sample	180	$470,425.50

APPENDIX B – ADMINISTRATOR RESPONSE AND CTI REBUTTAL

Your administrator's response to the report and CTI's rebuttal follows.

Allegiance Response

Allegiance Benefit Plan Management Objections to Certain Audit Findings
State of Montana Medical Plan/CTI Audit

Allegiance Benefit Plan Management is submitting this objection to certain audit findings regarding the above audit. Allegiance does so after several attempts to explain and resolve the items below with the auditor but without resolution, and a refusal by the auditor to reconsider the findings of error set out below. Allegiance strongly believes based on the facts as explained below that these are not errors and should be withdrawn from the audit findings as being errors. The items being objected to are identified based on the number or designation of those items in the audit findings. An explanation regarding the objection is provided separately with each object.
TS2- Ventilators – The Audit indicates over paid by $20,400.00 +513.40 = 20,913.40 because two ventilators were approved. This was sent for independent review by a board certified specialty match doctor. That independent review indicated two ventilators were medically necessary, one as a backup because of the patient's condition. The auditors were provided a copy of the review.

1169 – The Auditor found an overpayment of $366.00. Auditor saying the out of pocket maximum was not met at the time we paid the claim. This is incorrect but requires a system processing explanation. The explanation is:
Claims XXXXXXXX3757, XXXXXXXXAG91, XXXXXXXX4738, XXXXXXXX0502 and XXXXXXXX1260 on lines 53 – 62 of the report paid at 100% when the OOP was not met. Starting at claim XXXXXXXX0936 on lines 63 – 87 you can see based on the claim number that is was received on 8/23/16, you can also see from the AJD DT column this claim was not adjudicated until 9/14/18. The date received on that claim is prior to the date we adjudicated claims listed above on lines 53 – 62. And the date for lines 63 – 87 adjudicated is after the date the other claims were adjudicated. When claim XXXXXXXX0936 came into the system at least some of the lines on that claim were in status 5 and applying to OOP. With those charges in status 5 and applying to OOP, when the other claims adjudicated the system was counting the OOP amounts from XXXXXXXX0936 and with those counting there was only $178.92 left to meet the OOP. So when XXXXXXXX3757 adjudicated it applied $178.92 to OOP meeting the OOP and therefore the remaining amounts on that claim and the other claims on lines 55 – 63 paid at 100%. Then on 9/14/18 claim XXXXXXXX0936 was denied as a duplicate because a corrected claim had been received. When that claim was denied, whatever had been applied to OOP when it was in status 5 was backed out and therefore OOP was no longer met.

TS5 – $682.79 was found by the auditor to be an overpayment. However, as part of Allegiance's internal audit and review procedures, this overpayment was found by Allegiance and a refund was requested and received as a result of those procedures on 3/8/18, well before the audit. Finding these types of claims and correcting them is part of Allegiance's process the same as initial adjudication and when recover is obtained through this process, it is not an error. It was corrected as part of normal business processes and not as the result of the audit

TS6 – $388.72 was found by the auditor to be an error. However, as part of Allegiance's internal audit and review procedures, this overpayment was found by Allegiance and a refund was requested and received as a result of those procedures on 1/29/18, well before the audit. Finding these types of claims and correcting them is part of Allegiance's process the same as initial adjudication and when recover is obtained through this process, it is not an error. It was corrected as part of normal business processes and not as the result of the audit.

TS25 –The auditor found an error based on a dental code paid under the medical plan. The medical plan pays certain dental procedures based on the Plan terms. Further, a copy of the medical policy and procedure for this situation was sent to auditor explaining how dental claims paid under medical are handled. Medical records were obtained and determination was made based on this policy and procedure to allow under medical. This is not a processing or payment error.

1108 - $1.87 selected claim was a duplicate payment that was corrected. This is a claim not part of the sample requested by the Auditor. Because it is not part of the sample requested by the Auditor, there is no documentation for the Auditor to review to make this determination and these claims are not being added to the sample number because they were never requested.

1054 – $1,190.48 was found to be an overpayment by the Auditor. However, as part of Allegiance's internal audit and review procedures, this overpayment was found by Allegiance and a refund was requested and received as a result of those procedures in September 2016, well before the audit. Finding these types of claims and correcting them is part of Allegiance's process the same as initial adjudication and when recover is obtained through this process, it is not an error. It was corrected as part of normal business processes and not as the result of the audit.

1138 - $638.925 was identified by Auditor on claims of other family members which again were not part of the sample claims requested by the Auditor and as a result is not based on any underlying documentation because these claims were not part of the sample and underlying documentation was therefore never provided. Had the documentation been reviewed, the Auditor would have found this overpayment occurred because the Plan did not provide Allegiance notice that the member who incurred these claims had terminated coverage several months before. Therefore Allegiance had no ability to change the eligibility of this member in its system to prevent this payment. Eligibility was later retroactively termination by the Plan which results in an appearance only of a payment error by Allegiance.

Allegiance believes that a reasonable review of the above facts leads to the conclusion that the errors; listed above were not in fact errors, and are the result of a lack of understanding of the facts and the processes used to process claims by the Auditor. Therefore, Allegiance respectfully requests that these items be removed from the audit findings as errors and the audit results be re calculated.

CTI Rebuttal

CTI thanks Allegiance for its comments and response to the draft audit findings report. We considered Allegiance's feedback throughout the audit process, which led to the removal of some of the errors originally cited.

Our final audit results, errors cited, and conclusions stand for the following reasons:

- Errors and observations are based upon the iteration of the claim randomly selected. We understand administrators frequently find and correct errors unprompted and this is ideal. However, if the claim we selected has an error, we report that error regardless of what may have happened to the claim previously or subsequently. This helps facilitate process and plan language improvements.
- Additional observations are simply observations. They are not considered errors and are not factored into any of the performance or benchmarking metrics. We report observations to help facilitate process and plan language improvements.
- It is not uncommon for third party administrators that also process fully-insured claims to apply their fully-insured policies and procedures to their self-funded business. This may be appropriate in some situations, but self-funded groups financially have more at stake than do fully-insured groups. As such, it is critical for administrators to adhere to Plan language rather than defaulting to their own policies and procedures.

Thank you again for the opportunity to audit the administration of the State's self-insured medical plan.

CLAIM TECHNOLOGIES INCORPORATED

100 Court Avenue – Suite 306 • Des Moines, IA 50309

Telephone: (515) 244-7322 • Fax: (515) 244-8650 • Website: claimtechnologies.com