2019

State of Montana

Employee Group Benefits Claim Audit

Prepared Under Contract With:
MONTANA LEGISLATIVE BRANCH, AUDIT DIVISION
PO Box 201705, Helena MT 59620-1705

LEGISLATIVE AUDIT DIVISION

Angus Maciver, Legislative Auditor
Deborah F. Butler, Legal Counsel

Deputy Legislative Auditors:
Cindy Jorgenson
Joe Murray

April 2020

The Legislative Audit Committee
of the Montana State Legislature:

Enclosed is the report on the claim audit of the State of Montana employee benefits plans for the two calendar years ended December 31, 2019, including:

- Allegiance – Medical
- Delta Dental – Dental
- Navitus Health Solutions – Pharmacy

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 agency's written response to the report recommendations is included in the back of each report.

Respectfully submitted,

/s/ Angus Maciver

Angus Maciver
Legislative Auditor

19C-09

Room 160 · State Capitol Building · P.O. Box 201705 · Helena, MT · 59620-1705
Phone (406) 444-3122 · FAX (406) 444-9784 · E-Mail lad@mt.gov
https://leg.mt.gov/lad

TABLE OF CONTENTS

Claim Administration Audit

EXECUTIVE SUMMARY

State of Montana Medical Plan
Administered by Allegiance Benefit Plan Management, Inc.

Audit Period: January 1, 2018 through December 31, 2019

Presented to

Montana Legislative Audit Division

March 31, 2020

Presented by

CLAIM TECHNOLOGIES INCORPORATED

TABLE OF CONTENTS

INTRODUCTION

This ***Executive Summary*** contains findings and recommendations from CTI's audit of Allegiance Benefit Plan Management, Inc.'s (Allegiance) claim administration of the State of Montana's plans. For detail that supports these findings and recommendations, refer to CTI's ***Specific Findings Report***.

CTI conducted the audit according to current, accepted standards and procedures for claim audits in the health insurance industry. We base our audit findings on the data and information provided by the State of Montana and Allegiance. Their validity is reliant upon the accuracy and completeness of that information. While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind.

We planned and performed the audit to obtain a reasonable assurance claims were adjudicated according to the terms of the contract between Allegiance and the State of Montana as well as all approved plan documents and communications.

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 policies, procedures, and systems Allegiance used to pay the State of Montana's claims during the audit period.

OBJECTIVES AND SCOPE

CTI's objectives for Allegiance's claim administration audit were to determine whether:

- Allegiance followed the terms of the services agreement;
- Allegiance paid claims according to the provisions of the plan documents and if those provisions were clear and consistent;
- Members were eligible and covered by State of Montana's plan at the time a service paid by Allegiance was incurred; and
- Any claim administration systems or processes need improvement.

CTI audited Allegiance's claim administration of the State of Montana medical plan for the period of January 1, 2018 through December 31, 2019. The population of claims and amount paid during that period were:

Total Paid Amount	$255,079,037
Total Number of Claims Paid/Denied/Adjusted	831,355

The audit included the following components:

- Random Sample Audit of 180 claims
- 100% Electronic Screening with 30 Targeted Sample Analysis (ESAS®)
- Plan Documentation Analysis
- Operational Review
- Data Analytics

AUDIT FINDINGS AND RECOMMENDATIONS

Random Sample Findings

CTI validated claim processing accuracy based on a sample of 180 medical claims paid or denied by Allegiance during the audit period. We selected the random sample (stratified by the claim billed amount and the date processed) to provide a statistical confidence level of 95% +/- 3% margin of error.

CTI's Random Sample Audit categorizes errors into key performance indicators. We use this systematic labeling of errors and calculation of performance as the basis for the benchmarks generated using results from our most recent 100 medical claim audits.

The following table illustrates Allegiance's performance was above the median in all three of CTI's benchmarked performance indicators.

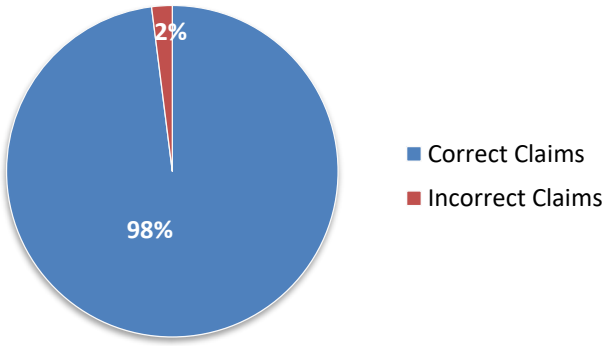
Key Performance Indicators	Administrator's Performance by Quartile				
	Quartile 1	Quartile 2	MEDIAN	Quartile 3	Quartile 4
	Lowest →				*Highest*
Financial Accuracy: Compares total dollars associated with correct claim payments to total dollars of correct claim payments that should have been made.			**98.58%**		**100.00%**
Accurate Payment: Compares number of correctly paid claims to total number of claims paid.			**96.53%**		**99.44%**
Accurate Processing: Compares number of claims processed without any type of error (financial or non-financial) to total number of claims processed.			**96.03%**		**97.78%**

Prioritization of Process Improvement Opportunities

The following charts can help to prioritize improvement and/or recovery opportunities based on savings and service impact and also to pinpoint problem causes.

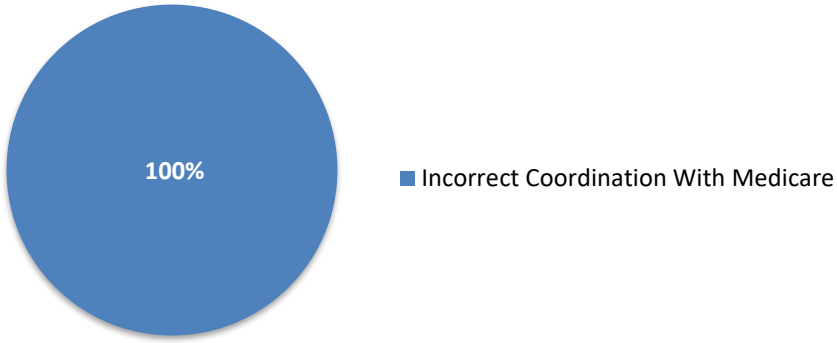
Of the 180-claim sample, CTI identified four claims that were processed incorrectly.

Overall Accurate Processing



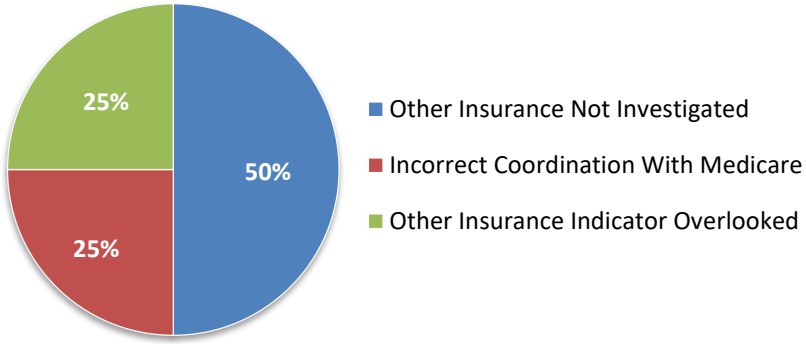
Of the 180-claim sample, CTI identified one claim with a financial error.

Financial Accuracy by Error Type



Of the 180-claim sample, CTI identified four claims that were processed incorrectly.

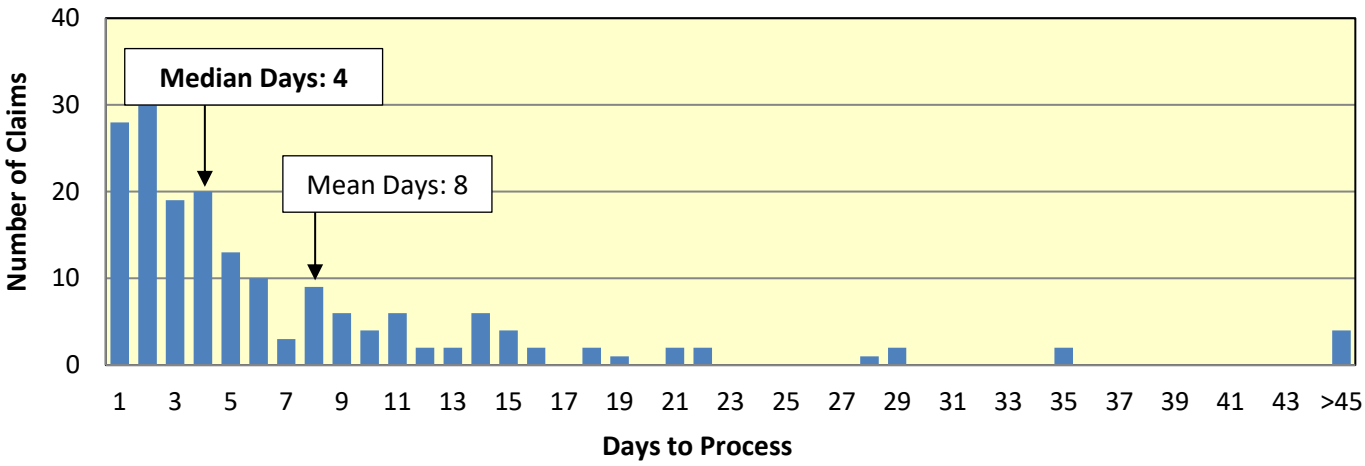
Accurate Processing by Error Type



Claim Turnaround Time

A final measure of claim administration performance is claim turnaround time. Through the audit sample, Allegiance demonstrated its median turnaround time on a complete claim submission was four days from the date it received a complete claim to the date the claim was paid or denied.

Median and Mean Claim Turnaround



Random Sample Recommendations

CTI suggests that the State of Montana meet with Allegiance to discuss the audit findings and to focus specifically on its coordination of benefits processes for commercial and Medicare coverages to improve its Accurate Processing Frequency. To facilitate this discussion, you should request that Allegiance review each of the four processing errors identified in our random sample audit and determine if system changes or examiner training could help reduce or eliminate errors of a similar nature in the future.

100% Electronic Screening with Targeted Samples Findings

We used our proprietary Electronic Screening and Analysis System (ESAS) software to further analyze claim payment accuracy and opportunities for system and process improvement. We screened 100% of claims paid or denied during the audit period, and our Technical Lead Auditor selected a targeted sample of 30 electronically screened claims to validate findings and test Allegiance's claim administration systems.

The following table shows the medical services identified as potentially overpaid. It is important to note that the amount shown represents ***potential payment errors***; additional testing would be required to substantiate the findings and provide the basis for remedial action planning or recovery.

ESAS Candidates for Additional Testing	Potential Recovery/Savings
Duplicate Payments	**$197,404**
Plan Exclusions	**$206,871**
• Custodial Care	$2,496
• Elastic Support	$16,503
• Impotency	$182,145
• Routine Foot Care	$5,727
Fraud, Waste and Abuse	**$41,195**
• UCR Provider Specialty – Assistant Surgeon	$41,195

For specific information on the over and underpayments identified, see the ESAS section of CTI's ***Specific Findings Report***.

100% Electronic Screening with Targeted Samples Recommendations

We recommend the State of Montana talk to Allegiance about conducting a focused analysis of the claims flagged through ESAS to determine if they were paid correctly. The findings may highlight a need for overpayment recovery and/or system improvements to reduce or eliminate similar errors going forward. For the issues identified by ESAS, CTI can prepare claim detail for Allegiance to use in its analysis.

Operational Review Findings

Allegiance completed our Operational Review Questionnaire that provided information on its:

- Systems, staffing, and workflow;
- Claim administration and eligibility maintenance procedures; and
- Internal control risk mechanisms, e.g., HIPAA protections; internal audit policies and practices; and fraud, waste, and abuse detection and prevention.

Allegiance reported the following:

- Allegiance provided copies of declaration pages for fidelity bond, errors and omissions, and cyber liability coverage. The pages showed fidelity bond coverage of $2 million with a $25,000 retention, errors and omissions coverage with an aggregate of $5 million with a $50,000 retention, and commercial general liability coverage with a $2 million aggregate.
- Allegiance and the State of Montana have a performance agreement with measure categories of Claim Quality, Claim Timeliness, and Customer Service. Allegiance provided performance reports for 2018 and 2019 showing that it met or exceeded all measures. Allegiance reports on a client-specific basis, a best practice.
- Allegiance indicated that it had been audited for compliance 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. 18, reporting on controls at a service organization. Under SSAE 18, the administrator is required to provide its own description of its system, which the service auditor validates. CTI has a copy of Allegiance's SOC 1 Type 2 audit report and we can confirm that Allegiance's external auditor did not note any deviations in the installation and maintenance of customer benefits, enrollment information, and healthcare provider agreements control, or in the claim adjudication and claim payment and customer funding controls.
- Since 1999, Allegiance has used LuminX claim administration software. Allegiance also contracts with Zelis to detect claim unbundling. Allegiance has adopted most NCCI edits but some are turned off because they are incompatible with provider contracts.
- Allegiance uses appropriate levels of security and control within its claim funding and checks issuance procedures to protect the plan's interest and ensure all transactions are performed by authorized personnel only.
- Allegiance had adequately documented training, workflow, procedures, and systems to provide consistently high levels of accuracy in the processing of claims and enrollment.
- Allegiance provided COB savings reports for 2018 and 2019 showing $19,000,217 and $19,944,278 in savings, respectively.

- 95.2% of the State of Montana's claims were submitted electronically, decreasing administrative costs and reducing the potential for manual data entry errors. However, only 53.9% of the State of Montana's claims auto-adjudicate.
- Allegiance performs overpayment recovery for amounts over $50. Allegiance tracks the reasons for overpayment, a best practice. Allegiance performs overpayment recovery for amounts over $50. Allegiance tracks the reasons for overpayment, a best practice. Allegiance provided a report for dates of service from 2017 to 2019 showing total overpayments of $851,257.52, total recoveries of $649, 656.70 (76%), and $201,600.82 outstanding.
- Allegiance performs subrogation on a pursue and pay basis when $1,000 in claims has been paid. Montana law requires that plan participants to be made whole prior to the plan being reimbursed. As such, the State of Montana is very rarely, if ever, reimbursed through the subrogation process when member claims were caused by or contributed to by third-party liability. The State of Montana must approve any lien waivers or reductions, a best practice.
- Allegiance identifies potential Workers' Compensation claims through ICD-10 codes, provider notes, and member notification. These claims are held until an accident claim form has been completed. There must be at least $1,000 in claim payments before an investigation is undertaken.
- Allegiance keeps an internal log to track appeal timeframes and resolution. Allegiance provided 2018 and 2019 summary reports. For 2018, there were 160 appeals, 69% of which were upheld, 30% overturned, and 1% partially upheld/overturned. 91% of appeals were handled in a timely fashion in 2018. For 2019, there were 146 appeals, 73% of which were upheld, 21% overturned, and 6% partially upheld/overturned. 96% of appeals were handled in a timely fashion in 2019. Allegiance also provided detailed lists of the reasons appeals were not handled timely.
- Allegiance's claim system does not track the date adjustments are identified; it defaults to the original claim receipt date. As a result, adjustments are excluded from claim turnaround time calculations and the corresponding performance guarantee.
- Allegiance does not have staff dedicated to detecting and investigating fraud, waste, and abuse. Allegiance's credentialing team researches past fraud and sanctions as it is credentialing providers. Zelis's code editing service provides fraud detection, as well.
- Allegiance provided a Network Savings report showing discounts of 26.5% and 27.1% for 2018 and 2019, respectively. Network utilization was high at 96% in 2018 and 98% in 2019. State of Montana members traveling or domiciled outside of Montana can access Cigna's OAP network which helps drive network savings.
- Allegiance compensates out-of-network providers using a fee schedule based on the percentage of Medicare used for all service reimbursements. The State of Montana's reference-based pricing network is the primary driver of network savings.
- Allegiance has appropriate levels of security and controls in place to protect the plan sponsor's medical plan records and data and was compliant with HIPAA requirements at the time of the audit.
- During the audit period, Allegiance reported it did not have any breaches triggering notification requirements for the State of Montana.

Operational Review Recommendations

We recommend the following:

- With 53.9% of the State's claims auto-adjudicating, almost half of the State's claims are being reviewed and paid manually, thereby increasing the opportunity for error. We suggest discussing with Allegiance, what plans, if any, are underway to increase its auto-adjudication rate and eliminate manual processes.
- Allegiance tracks reasons for overpayments, an industry best practice, and many are the result of provider billing errors and corrections. For overpayments not generated by providers, we recommend discussing the reasons and any people, process and technology initiatives that can be undertaken to decrease the volume.
- For 2018 and 2019, the overturned rates for appeals were 30% and 21%, respectively. We recommend analysis of the overturned appeals to determine the root causes to identify any needed system or process improvements to decrease the volume.
- Allegiance reported adjustments are excluded from claim turnaround time calculations and the corresponding performance guarantee. We recommend periodically requesting reports of adjustment volumes and reasons to determine what volume of claims fall outside the turnaround time performance guarantee, identify emerging trends as well as process improvement opportunities.

Plan Documentation Analysis Findings and Recommendations

Plan Documentation

Our Plan Documentation Analysis indicated the State of Montana should determine its benefit intent for genetic counseling and update the plan documentation accordingly to ensure member understanding. Note that genetic counseling is covered under the Affordable Care Act in some circumstances.

Data Analytics Findings

CTI used electronic claim data provided by Allegiance to identify improvement opportunities and potential recoveries. The informational categories we analyzed include:

- Network Provider Utilization and Discount Savings;
- Sanctioned Provider Identification;
- Patient Protection and Affordable Care Act (PPACA) Preventive Services Payment Compliance;
- National Correct Coding Initiative (NCCI) Editing Compliance; and
- Global Surgery Prohibited Fee Period Analysis.

Network Provider Utilization and Discount Savings

CTI compared submitted charges to allowable charges for all claims paid for the plan during the audit period. The analysis relied on data provided by Allegiance and we made no assumptions when necessary data fields were not provided. The following table shows the results of CTI's analysis of the value of discounts given by network providers as a percentage of all claims processed during the audit period. Paid claims totals do not include claims paid for members 65 and older.

Total of All Claims				
Claim Type	**Eligible Charge**	**Provider Discount**		**Paid**
Ancillary	$13,541,537	$4,050,512	29.9%	$7,857,206
Non-Facility	$137,806,958	$41,596,955	30.2%	$75,096,892
Facility Inpatient	$85,086,793	$20,367,192	23.9%	$61,643,606
Facility Outpatient	$138,334,908	$38,113,030	27.6%	$82,662,703
Total	**$374,770,195**	**$104,127,689**	**27.8%**	**$227,260,406**

State of Montana members had network utilization with 99.2% of all allowed charges and 92.2% of all claims. The average discount off allowed charges from network and secondary network providers was at expected levels.

Sanctioned Provider Identification

CTI screened 100% of non-facility provider claims from Allegiance against the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE). No claims were paid to sanctioned providers during the audit period.

PPACA Preventive Services Coverage Compliance

CTI's analysis found that 90.13% of the procedure codes identified as preventive services were paid by Allegiance at 100% when provided in-network. CTI can provide a detailed list of the other 9.87% upon request.

NCCI Editing Capability

CTI analyzed Allegiance's claim system code editing capability to determine the degree to which it conformed to the Centers for Medicare & Medicaid Services' (CMS) NCCI guidelines used for Medicare Part B and Medicaid claims.

While not mandatory for non-Medicare/Medicaid plans, it is important to understand the benefit and potential value of these initiatives. The two CMS initiatives offering the greatest return to self-funded benefit plans are Procedure to Procedure Edits and Medically Unlikely Edits.

Our claim system code editing analysis identified claims for services submitted to State of Montana and paid by Allegiance that Medicare and Medicaid would have denied. Since Allegiance paid the billed charges, the payments represent a potential savings opportunity to State of Montana.

Claim System Code Editing Capability Analysis by CMS NCCI Initiative		
	Procedure-to-Procedure Edits	**Medically Unlikely Edits**
Facility	$565,390	$845,036
Non-Facility	$108,894	$284,469
Ancillary	N/A	$94,164

Global Surgery Prohibited Fee Period Analysis

CTI's claim system code editing analysis identified evaluation and management (E/M) procedure codes that were submitted and paid by Allegiance that Medicare would have been denied using the defined CMS global surgery fees. Payment of post-surgery E/M services that should have been submitted as part of the

physician's surgery charge is an example of unbundling, a provider billing practice that drives up cost. Since Allegiance paid allowed charges, those payments represent a potential savings opportunity to the State of Montana.

E/M Services Using Same Provider ID as Surgeon Within Prohibited Global Fee Period			
CMS Would Deny Without Documentation *E/M Procedure Codes with Modifier 24, 25 or 57*		**CMS Would Deny** *E/M Procedure Codes without Modifier 24, 25 or 57*	
Total Count (0/10/90 days)	**Allowed Charge**	**Total Count** (0/10/90 days)	**Allowed Charge**
4,894	**$1,204,933**	**4,484**	**$29,213**

Data Analytics Recommendations

- We recommend the State of Montana use the information provided from the Data Analytics findings to talk to Allegiance about the potential for additional cost savings to the plan. While Allegiance has incorporated some of the CMS edits, CTI found $1,927,166 in claims that would have been denied by CMS and provide savings to the Plan.
- We recommend review of the in-network preventive claims flagged for not being paid at 100% with no patient cost share to ensure administration is consistent with the State's plan language and intent.

CONCLUSION

We understand you will need to review these findings and recommendations to determine your priorities for action. Should the State of Montana desire additional assistance with this, our contract offers eight hours of post-audit time to help you create an implementation plan.

CTI also suggests that the State of Montana perform a follow-up audit to verify that Allegiance continues to perform above benchmark, and no new processing issues occur.

We consider it a privilege to have worked for, and with, your staff and we welcome any opportunity to assist you in the future. Thank you again for choosing CTI.

APPENDIX – ADMINISTRATOR'S RESPONSE TO DRAFT REPORT

ALLEGIANCE BENEIT PLAN MANAGEMENT'S RESPONSE TO CTI AUDIT RESULTS FOR THE STATE OF MONTANA EMPLOYEE HEALTH BENEFIT PLAN FOR PERIOD JANUARY 1, 2018 THROUGH DECEMBER 31, 2019

Allegiance Benefit Plan Management, Inc. (Allegiance) has reviewed the results issued by CTI of its performance audit for the period from January 1, 2018 through December 31, 2019 of the State of Montana Employee Health Benefit Plan for which Allegiance provides third party administrator services. Based upon that review, Allegiance in large part agrees with the audit findings which confirm the superior quality of services provided by Allegiance. However Allegiance has identified 3 findings to which Allegiance disagrees.

First, on page 7 there is a reference to NCCI coding edits in part being turned off. This has been discussed in prior audits:

Coding edits are turned on for professional claims through an editing service company called Zelis and for institutional claims through the reference based pricing performed by Payer Compass. As we have discussed, code editing is very complex with hundreds of thousands of coding rules from the National Comprehensive Coding Initiative (Medicare), the CPT and HCPCS coding manuals, and various Association rules and recommendations. The reason that an edit may not always trigger is that there is a significant difference between the existence of an edit and the processing of an edit such that quite often the edit is allowed to be bypassed in the coding rules. One such situation is through the use of modifiers. Use of modifier 25 (Significant, Separately Identifiable Evaluation and Management Service by the same Physician), 57 (Decision for Surgery), or 59 (Distinct Procedural Service) will all allow edits to by bypassed in certain situations. There are also many more such modifiers and other qualifiers that allow edits to be bypassed even when they are turned on. In addition some specific edits have been customized to be turned off. For example, the edit which denies the charge for drawing blood has been turned off because the minimal charge, and especially the minimal payment after PPO discount, is not a risk to the Plan and is a good investment when compared to the displeasure and discontent it causes the members, HR and providers. In summary, just because an edit exists does not mean it will always apply per the rules or that it always makes sense to apply it.

Second, on page 26 of the Specific Findings Report there is an "observation" related to a claim paid to the Mayo Clinic of Arizona and a statement from the auditor That the Cigna contract with the this provider could allow payment of inappropriately coded item. Allegiance has provided the Cigna network for discounts and rates outside the State of Montana with significant cost saving to the State Plan. However to use the Cigna network Allegiance and therefore the State Plan must abide by the contracts Cigna has negotiated with medical providers, including the contract with this provider. Allegiance has done so with the claims being referenced and processed them as required for the State Plan to use the Cigna network pricing.

Next, and more importantly, there are several providers to which the auditor assigns error to in a grid on page 30 of the Specific Findings Report. The error assignment is based upon a review by the auditor of "Global Surgery Fee" review. This review was done using Medicare standards as stated in the report. Allegiance does not use Medicare standards for claims edits or standards. There has never been any agreement or representation between Allegiance and the State Plan for use of Medicare standards and there are few commercial payers who use them because many are inapplicable to employee health benefit plan claims adjudication. Therefore the assigned error is based on standards that are not and have not ever been applied by Allegiance to this plan or required by the Plan.

However, when Allegiance requested the auditors provide specific claims that fall within the global periods being referenced, the initial report provided by CTI appears to be assistant surgeon claims. Upon review of each provider of service on the report, there are no other claims within the global period from the provider referenced on the report. Upon further review CTI provided additional claims information, however Allegiance response is not impacted by this additional information.

Kimberly A. McGuire-Browne 4/1/2020

Kimberly A. McGuire-Browne
Senior Vice-President
Allegiance Benefit Plan Management, Inc

CLAIM TECHNOLOGIES
INCORPORATED

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

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

Claim Administration Audit

EXECUTIVE SUMMARY

State of Montana Dental Plan
Administered by Delta Dental Insurance Company

Audit Period: January 1, 2018 through December 31, 2019

Presented to

Montana Legislative Audit Division

April 7, 2020

Presented by

CLAIM TECHNOLOGIES INCORPORATED

TABLE OF CONTENTS

INTRODUCTION

This ***Executive Summary*** contains findings and recommendations from CTI's audit of Delta Dental Insurance Company's (Delta Dental) claim administration of the State of Montana plan. For detail that supports these findings and recommendations, refer to CTI's ***Specific Findings Report***.

CTI conducted the audit according to current, accepted standards and procedures for claim audits in the health insurance industry. We base our audit findings on the data and information provided by the State of Montana and Delta Dental. Their validity is reliant upon the accuracy and completeness of that information. While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind.

We planned and performed the audit to obtain a reasonable assurance claims were adjudicated according to the terms of the contract between Delta Dental and the State of Montana as well as all approved plan documents and communications.

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 policies, procedures, and systems Delta Dental used to pay the State of Montana's claims during the audit period.

OBJECTIVES AND SCOPE

The audit objectives of Delta Dental's claims administration were to determine whether:

- Delta Dental followed the terms of the services agreement;
- Delta Dental paid claims according to the provisions of the plan documents and if those provisions were clear and consistent;
- Members were eligible and covered by the State of Montana's plan at the time a service paid by Delta Dental was incurred;
- Any claim administration systems or processes need improvement.

CTI audited Delta Dental's claim administration of the State of Montana dental plan for the period of January 1, 2018 through December 31, 2019. The population of claims and amount paid during that period were:

Total Paid Amount	$14,548,794
Total Number of Claims Paid/Denied/Adjusted	104,422

The audit included the following components:

- Random Sample Audit of 110 claims
- 100% Electronic Screening with 15 Targeted Sample Analysis (ESAS®)
- Plan Documentation Analysis
- Operational Review
- Data Analytics

AUDIT FINDINGS AND RECOMMENDATIONS

Random Sample Findings

CTI validated claim processing accuracy based on a sample of 110 dental claims paid or denied by Delta Dental during the audit period. We selected the random sample (stratified by the claim billed amount and the date processed) to provide a statistical confidence level of 95% +/- 3% margin of error.

CTI's Random Sample Audit categorizes errors into key performance indicators. We use this systematic labeling of errors and calculation of performance as the basis for the benchmarks generated using results from our most recent 40 dental claim audits.

The following table illustrates Delta Dental's performance was above the median on CTI's three benchmarked performance indicators.

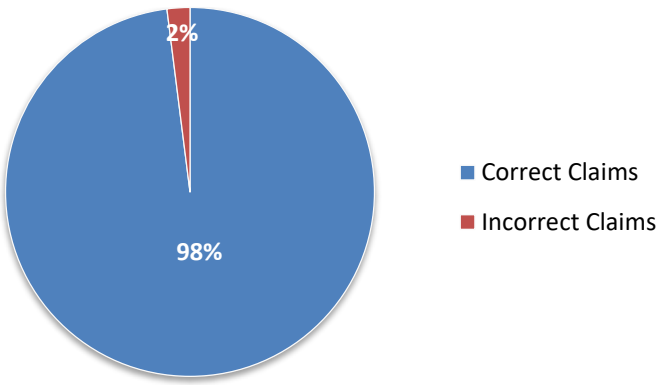
Key Performance Indicators	Administrator's Performance by Quartile				
	Quartile 1	Quartile 2	MEDIAN	Quartile 3	Quartile 4
	Lowest →				*Highest*
Financial Accuracy: Compares total dollars associated with correct claim payments to total dollars of correct claim payments that should have been made.			**99.53%**	**99.84%**	
Accurate Payment: Compares number of correctly paid claims to total number of claims paid.			**98.33%**	**99.09%**	
Accurate Processing: Compares number of claims processed without any type of error (financial or non-financial) to total number of claims processed.			**97.62%**	**98.18%**	

Prioritization of Process Improvement Opportunities

The following charts can help to prioritize improvement and/or recovery opportunities based on savings and service impact and also to pinpoint problem causes.

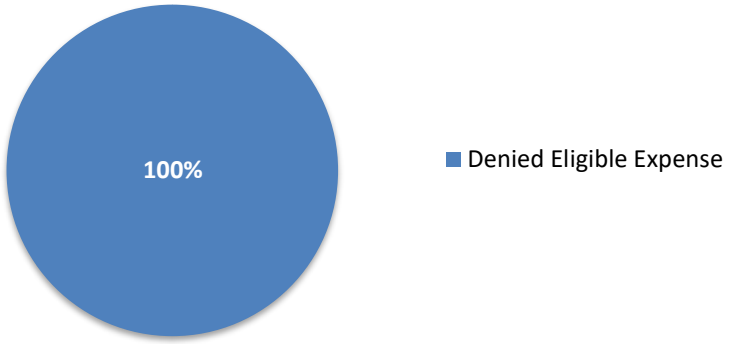
Overall, CTI identified two claims that were processed incorrectly in the 110 claim sample.

Overall Accurate Processing



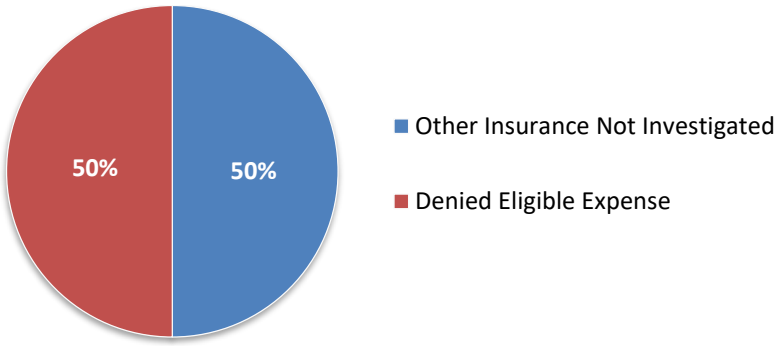
CTI identified one claim a with financial error in the 110 claim sample.

Financial Accuracy by Error Type



CTI identified two claims that were processed incorrectly in the 110 claim sample.

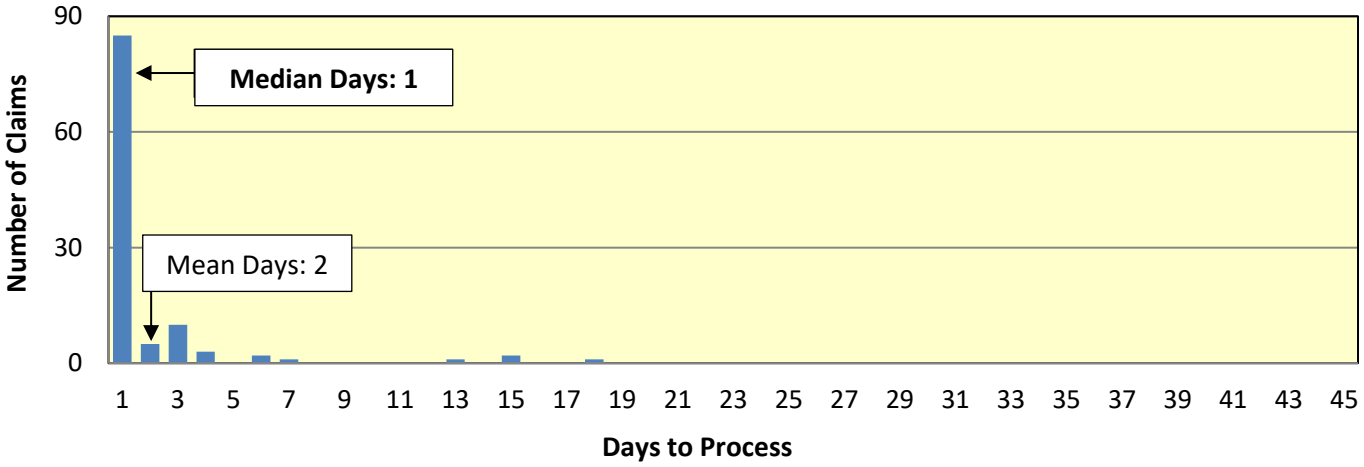
Accurate Processing by Error Type



Claim Turnaround Time

A final measure of claim administration performance is claim turnaround time. Through the audit sample, Delta Dental demonstrated its median turnaround time on a complete claim submission was 1 day from the date it received a complete claim to the date the claim was paid or denied.

Median and Mean Claim Turnaround



Random Sample Recommendations

CTI suggests that the State of Montana meet with Delta Dental to discuss the audit findings and to focus specifically on steps necessary to improve Financial Accuracy, Accurate Payment Frequency and Accurate Processing Frequency. To facilitate this discussion, you should request that Delta Dental review the one financial and two adjudication errors identified in our random sample audit and determine if system changes or examiner training could help reduce or eliminate errors of a similar nature in the future.

100% Electronic Screening with Targeted Samples Findings

We used our proprietary Electronic Screening and Analysis System (ESAS) software to further analyze claim payment accuracy and opportunities for system and process improvement. We screened 100% of claims paid or denied during the audit period, and our Technical Lead Auditor selected a targeted sample of 15 electronically screened claims to validate findings and test Delta Dental's claim administration systems.

After review of Delta Dental's responses to the substantive testing questionnaires we sent for each of the 15 targeted samples, we did not identify any potential payment errors or process improvement opportunities.

Operational Review Findings

Delta Dental completed our Operational Review Questionnaire that provided information on its:

- Systems, staffing, and workflow;
- Claim administration and eligibility maintenance procedures; and
- Internal control risk mechanisms, e.g., HIPAA protections; internal audit policies and practices; and fraud, waste, and abuse detection and prevention.

Highlights of our Operational Review include:

- Delta Dental provided a copy of its fidelity bond declaration page that showed a $15 million aggregate and $200,000 deductible. A copy of its cyber liability policy declaration page showed a $5 million aggregate with a deductible of $1 million. Delta Dental also provided a copy of its errors and omissions insurance declaration page showing a $10 million aggregate and $1 million deductible.
- Delta Dental and the State of Montana had a performance agreement in place for each year of the audit period with targets in the following categories:
  - Claims Turnaround Time
  - Overall Claims Accuracy
  - Customer Service Response Time
  - Customer Service Response
  - Account Management
  - Provider Monitoring
  - Timely Reporting

  All measures with the exception of Account Management and Timely Reporting are measured globally for Delta Dental's entire client pool. Delta Dental's self-reported results for 2018 and 2019 showed that all targets had been met or exceeded.
- Delta Dental indicated it had been audited for compliance 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. 18, reporting on controls at a service organization. Under SSAE 18, the administrator is required to provide a description of its system, which the service auditor validates. CTI has a copy of Delta Dental's SSAE 18 Bridge Letter and we can confirm that Delta Dental's external auditor did not note any deviations in the installation and maintenance of customer benefits, enrollment information, and healthcare provider agreements control, or in the claim adjudication and claim payment and customer funding controls.

- Delta Dental maintains a comprehensive Business Continuity and Disaster Recovery program designed to ensure the continuation of all vital corporate and business functions in the event of a disaster.
- Delta Dental appeared to have appropriate levels of security and control within its check issuance procedures to protect the State of Montana's interest and ensure all transactions were performed by authorized personnel only.
- Delta Dental provided documentation of claim system controls that include secure log-on passwords, separation of duties and access, and limitations on system override authority.
- Delta Dental has adequately documented training, workflow, procedures, and systems.
- Delta Dental follows the standard industry process for coordination of benefits (COB) to ensure that combined benefits from all payers do not exceed 100% of its covered amount.
- Delta Dental does not report COB savings separately for the State of Montana.
- Delta Dental pursues overpayment recovery on all amounts either by requesting repayment or withholding from future checks. Delta Dental does not typically seek to recover overpayments made to enrollees; those amounts are not charged back to the client. If Delta Dental is responsible for an overpayment and the funds are irretrievable, Delta Dental credits the client's account at its own expense. Delta Dental tracks reasons for overpayments but does not provide reports to clients.
- CTI requested and Delta Dental declined to provide reports showing provider savings and discount amounts.
- Delta Dental had appropriate levels of security and controls in place to protect the plan sponsor's dental plan records and data and was compliant with HIPAA requirements at the time of the audit.
- Delta Dental indicated it did not have any breaches triggering notification requirements for the State of Montana.

Operational Review Recommendations

We recommend the following:

- Obtain and review periodic coordination of benefits reports to identify savings to the plan generated by enrollees other coverages and the potential financial impact should those other coverages end;
- Regularly review reports of outstanding overpayments to providers and enrollees and discuss root causes with Delta Dental to determine if system or process improvements would reduce the volume of overpayments; and
- Request reports of member appeals activity to identify areas of administrative process improvement as well as areas for enhanced member communication.

Plan Documentation Analysis Findings and Recommendations

Our Plan Documentation Analysis did not find any missing or ambiguous provisions in our review of the State of Montana's plan documents.

Data Analytics Findings

CTI used electronic claim data provided by Delta Dental to identify improvement opportunities and potential recoveries. The informational categories we analyzed include:

- Network Provider Utilization and Discount Savings;
- Sanctioned Provider Identification;

Network Provider Utilization and Discount Savings

We were unable to calculate provider discounts for the State of Montana because Delta Dental considers its contracted discounts confidential information and does not provide them in electronic format.

Sanctioned Provider Identification

CTI screened 100% of non-facility provider claims from Delta Dental against the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE). No claims were paid to sanctioned providers during the audit period.

Data Analytics Recommendations

- Delta Dental declined to share provider discounts within its claims data, so if not already provided, we recommend the State of Montana obtain periodic reports of the savings generated by members receiving care from network providers.
- Investigate what, if any, strategic additions to the Delta Dental network could boost savings as well as increase member satisfaction.

CONCLUSION

We understand you will need to review these findings and recommendations to determine your priorities for action. Should the State of Montana desire additional assistance with this, our contract offers eight hours of post-audit time to help you create an implementation plan.

CTI also suggests that the State of Montana perform a follow-up audit to verify that Delta Dental has made the recommended improvements, that performance results against benchmarks are improving, and that no new processing issues have arisen.

We consider it a privilege to have worked for, and with, your staff and we welcome any opportunity to assist you in the future. Thank you again for choosing CTI.

APPENDIX – ADMINISTRATOR'S RESPONSE TO DRAFT REPORT

DELTA DENTAL®

deltadentalins.com

March 30, 2020

Ms. Vivian Hayashi
Claims Technologies Incorporated
100 Court Abe, Suite 306
Des Moines, IA 50309

Re: State of Montana Audit of Delta Dental

Dear Vivian:

Thank you for providing the audit findings for our mutual customer, State of Montana.

State of Montana is a valued customer of Delta Dental. We are committed to administering their benefits accurately and according to contract.

We have thoroughly reviewed the findings and have provided a response to each in the grid below.

Audit Finding	Page Number	sample Number	Delta Dental Response	Delta Dental Supporting Detail
Coverage for this service is currently being paid at 100%, however, this code is a periodontal code. Plan reflects that periodontics is covered under the Basic Benefits and payable at 80%. An adjudication error is cited with an overpayment of $14.20.	16	1085	Disagree with auditors finding.	As a standard Delta Dental allows the D4346-(scaling in presence of generalized moderate or severe gingival inflammation – full mouth) is treated as preventative procedure because it is more similar to a D1110

Response to observation:

Audit Finding	Page Number	Item Number	Delta Dental Response	Delta Dental Supporting Detail
The billing provider was Medicaid. Other insurance payment amounts were entered on the BCBS system. However, the claim billed did	16	1092	Agree with auditors' findings	The claims examiner did not follow all desk level procedures when the claim pended for examiner review. The examiner incorrectly entered COB information. However, the

Delta Dental Insurance Company
55 West 14th Street
Suite 101
Helena, MT 59601

Telephone: 406-449-0255
800-547-1986
Facsimile: 406-495-0322

not contain this information. The claim was denied for tooth numbers not being listed on the bill when BCBS would also need the other insurance information in order to process this claim				claim ultimately denied, and no overpayments were made. The claim examiner was coached, and additional training was provided.
A. The charge amount was entered as $69.00 and should have been entered as $89.00. A data coding error is cited. B. Eligible expenses for Nikayla were denied on this claim. This should have been covered under her policy. An adjudication error is cited with an underpayment of $107.00.	16	1096	Agree with auditors' findings	The mailroom team member did not follow all desk level procedures and failed to separate the claims forms for the sibling. We apologize for the error. The claim has since been processed under the Nikayla account. Payment along with interest will go to the provider.

We look forward to jointly discussing the results of this audit at a future meeting with the State of Montana. Once again, thank you for your partnership.

Sincerely,

Jeffrey Almonte

Audit Project Manager

Account Manager

CLAIM TECHNOLOGIES
INCORPORATED

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

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

Prescription Benefit Management Audit

EXECUTIVE SUMMARY

State of Montana
Administered by Navitus Health Solutions, LLC

Audit Period: January 1, 2018 – December 31, 2019

Presented to

State of Montana

April 10, 2020

Prepared by

PillarRx
Consulting

Subcontractor to

CLAIM TECHNOLOGIES INCORPORATED

PREFACE

This ***Executive Summary*** contains detailed information, findings, and conclusions that the PillarRx Consulting, LLC (PillarRx) audit team has drawn from their Prescription Benefit Management Audit of Navitus Health Solutions, LLC's (Navitus) administration of the State of Montana pharmacy plan. This ***Executive Summary*** is provided to the State of Montana, the plan sponsor, and Navitus, the pharmacy benefit manager.

The findings in this Executive Summary were based on data and information the State of Montana, as the plan sponsor, and Navitus, as the pharmacy benefit manager (PBM) provided to PillarRx and their validity relies upon the accuracy and completeness of that information.

The audit was planned and performed to obtain a reasonable assurance that prescription drug claims were adjudicated according to the terms of the contract between Navitus and the plan sponsor, as well as the benefit descriptions (summary plan descriptions, plan documents or other communications) approved by the State of Montana.

PillarRx is a firm specializing in audit and control of pharmacy benefit plan administration. The statements made by PillarRx in this report relate narrowly and specifically to the overall efficacy of Navitus' policies, processes and systems relative to the State of Montana's paid claims during the audit period.

PillarRx Consulting, LLC

TABLE OF CONTENTS

ACRONYMS USED IN THIS EXECUTIVE SUMMARY

Acronym	Definition
AWP	Average Wholesale Price
CMS	Centers For Medicare and Medicaid Services
EGWP	Employer Group Waiver Plan
J-Codes	Procedure Codes for Specialty Medications
MAC	Maximum Allowable Cost
PDE	Prescription Drug Event
U&C	Usual and Customary

OBJECTIVES AND SCOPE

Audit Objectives

The objectives of the PillarRx audit of Navitus' pharmacy benefit management were to determine if:

- Navitus adhered to the contractual and pricing terms outlined in the agreement with the State of Montana.
- Navitus accurately administered benefit provisions for both commercial and Employer Group Waiver (EGWP) plans.
- Navitus appropriately generated and submitted Prescription Drug Event (PDE) records to the Centers for Medicare and Medicaid Services (CMS).

Audit Scope

PillarRx's audit encompassed the contract in force and the pharmacy benefit claims administered by Navitus for the audit period of January 1, 2018 through December 31, 2019. The State's population of claims and the total net plan paid (equals total payment less member copayment) during this period:

Audit Period January 1, 2018 through December 31, 2019	
Commercial Plan	
Number Prescription Drug Claims Paid	530,290
Net Plan Paid	$61,827,934
EGWP Plan	
Number Prescription Drug Claims Paid	278,257
Net Plan Paid	$36,211,083

The audit included the following components:

1. **Pricing and Fees Audit**
2. **Benefit Payment Accuracy Review - Commercial and EGWP**
3. **Prescription Drug Event (PDE) Review – EGWP**

Auditor's Conclusion

The audit PillarRx performed was a comprehensive assessment of Navitus as they pertain to the State's Prescription Drug Plan. The audit entailed significant exchange of information and data between PillarRx and Navitus. Based on our findings, and in our opinion, Navitus:

- Filled the claims in accordance with the benefit design, except those noted in the report
- Did meet the contract discount rates at retail for various categories of drugs
- Produced Prescription Drug Event (PDE) according to CMS guidance

Specific objectives, findings and recommendations for each of the three components of this audit can be found in this report.

KEY FINDINGS AND RECOMMENDATIONS

Pricing and Fees Audit

The Pricing and Fees Audit verified if prescription drugs were processed according to the discounts and fees specified in Navitus' contract with its network pharmacies. After a thorough forensic verification of the electronic claim data provided by Navitus, PillarRx systematically re-priced 100% of paid prescription drug claims to determine that:

- Discounts were applied correctly based on the lessor of Maximum Allowable Cost (MAC), Average Wholesale Price (AWP) and Usual and Customary (U&C); and
- Pharmacy dispensing and administrative fees were applied correctly.

Any errors identified in pricing or fees were shared with Navitus. Details of the discussion of those errors between PillarRx and Navitus can be found under separate cover in the ***Specific Finding Report***.

Findings and Recommendations

PillarRx has assessed discounts and dispensing fees against a standard template PBM contract for a client of this size with the understanding that Navitus is passing through all discounts to the State.

PillarRx concludes that Navitus is performing as expected on discounts and dispensing fees. PillarRx reviews national contracts on a regular basis, pricing parameters compare favorably with the size and scope expected in the market place for the time period analyzed.

Benefit Payment Accuracy Review

The objective of the Benefit Payment Accuracy Review is to identify potential opportunities for recovery and/or cost savings associated with incorrect adjudication of plan design provisions.

PillarRx created an exact model of the benefit plan parameters of the State's pharmacy plan in AccuCAST and systematically re-adjudicated 100% of paid prescription drugs. Benefit plan parameters analyzed included, but were not limited to:

- Age and gender
- Copay/coinsurance
- Day supply maximums
- Excluded drugs
- Prior authorizations
- Quantity limits
- Refill limits
- Zero balance claims

Exceptions that were identified but could not be explained by PillarRx's benefit analysts were provided to Navitus for explanation. If adequate documentation was provided to support that the exceptions were adjudicated correctly, AccuCAST was reset to represent the revised plan parameters and the claims were electronically re-adjudicated again to ensure consistency.

Findings and Recommendations

Our Benefit Payment Accuracy Review confirmed that prescription drug claims paid by Navitus under the State's benefit plan were paid correctly and in accord with the provisions in the plan sponsor's summary plan description and plan documents with the exception of 2 claims (STELARA) that took incorrect copays on the Commercial line. The variance reported ($9,966) is owed to the client.

Prescription Drug Event (PDE) Review

Medicare Part D is a federal program to subsidize the costs of prescription drugs for Medicare-eligible active employees and retirees. Part D plan sponsors typically rely on their PBM to submit Prescription Drug Event (PDE) files to the Centers for Medicare and Medicaid Services (CMS). PDE files are the basis for all federal Part D subsidies.

PillarRx audited 100% of the PDE records processed from January 1, 2018 through December 31, 2019. PillarRx identified 37 claims that matched to a Rejected or Deleted PDE in 2019 and 9 claims that matched a Rejected or Deleted PDE in 2018. All claims have been provided to Navitus for review and response.

Findings and Recommendations

Navitus provided responses to all claims. For 2019, PDEs were either accepted at the end of 2019 or claims were reversed in 2019 and never reprocessed- 3 claims were noted to be associated with members that had been retro-termed. For 2018, PDEs were determined to have been accepted. Based on Navitus' responses, PillarRx agrees all PDEs were processed correctly.

J-CODE ANALYSIS

PillarRx's Integrated Medical / Rx Specialty Analysis is performed in conjunction with clinical overview and financial analysis. Utilizing J-Code comparative analysis, the end results allow PillarRx to provide our clients recommendations on best benefit coverage (medical and pharmacy), assuring the appropriate drug is being dosed and administered at an optimal site of care, potentially facilitate the recovery of double payments, reduce drug costs, and gain additional savings through increased rebates.

For the State of Montana, PillarRx loaded 80,307 medical J-Code transactions and 807,344 pharmacy claims. A crosswalk between the medical and pharmacy claim was created by matching the employee ID and social security number along with the relationship code to the subscriber, the gender, and date of birth. Over 1,000 medications were reviewed. PillarRx used a filtering method to exclude claims that did not meet the parameters of the analysis.

PillarRx reviewed and compared all specialty claims within each patient's profile and included an Implied Diagnosis for each medication filled. Within each Implied Diagnosis, medications were sorted by the specific place of service at which they were filled and summarized. Some of the places of service included the office, pharmacy, independent clinic, outpatient hospital, federally qualified health center, and the emergency room. PillarRx reviewed the Average Charge, Average Cost per Utilizer, and Average Unit Cost for each category with the optimal price identified. In some cases, the claims filled at the pharmacy had the price advantage.

KEY FINDINGS AND RECOMMENDATIONS

Drug Pricing Channel Benchmarks: Medical Vs. Pharmacy

A comparative analysis between the actual medical claims and pharmacy claim data for the same GPI was completed to demonstrate the advantage of moving drugs from the medical benefit to the pharmacy benefit assuming a 30 day supply and 100% of the claims moving to the pharmacy program.

There can be an advantage to moving these drugs to the pharmacy program based on the rebate guarantees outlined in the PBM contract but rebates can also be obtained through medical coverages.

Duplicative Reimbursement

PillarRx analyzes claims to determine whether or not the medical and a pharmacy benefits were being provided simultaneously. Duplicate therapy (a wasteful practice that allows a subscriber and/or provider to be paid simultaneously) is a prevalent and costly issue. This analysis is designed to help you avoid double payments and any potential associated waste.

PillarRx identified one (1) member who received the same specialty medication from both the medical benefit and the pharmacy benefit at the same time. Our analysis compared the fill date on the pharmacy claim to the incurred date on the medical claim for the same drug. If the difference between those dates was less than 15 days it was considered a potential situation of double-dipping. PillarRx reviewed the claims and concluded that there is overlap between the medical and pharmacy claims. The medical claim had a total plan paid amount of $857 and the pharmacy claim had a total plan paid amount of $909. This could be a case of double billing, or inaccurate billing of administration fees by the medical provider.

To determine if duplicate therapy truly occurred, we recommend that the client reach out to the medical providers to confirm whether or not the provider used its own supply of the medication or whether the claim was billed in error.

It is of interest to note that the diagnosis of the patient is predictive of the use of specialty medications. In general, the state of the distribution model is being administered appropriately. A potential process improvement would be to ensure that patients with the identified diagnoses who receive their specialty medications under the medical benefit are encouraged to obtain the medications through the pharmacy benefit to lower costs.

CONCLUSION

We understand you will need to review these findings and recommendations to determine your priorities for action. Should the State desire additional assistance with this, our contract offers eight hours of post-audit time to help you create an implementation plan.

We consider it a privilege to have worked for, and with, your staff and we welcome any opportunity to assist you in the future. Thank you again for choosing CTI and PillarRx.

APPENDIX – ADMINISTRATOR'S RESPONSE TO DRAFT REPORT

The Navitus team has reviewed the Findings Reports and agree with the results.

A total of 197 Commercial claims were identified as potential exceptions to the copay requirements. The Navitus team reviewed all of the claims and provided an explanation as to why the claims paid as they did. There were two specialty drug claims in Q1-2018 that paid incorrectly due to the Prior Authorization being entered with an incorrect tier. This caused the member to pay a lower copayment amount which caused the State of Montana to overpay. The Manager of the Prior Authorization team reviewed the two claims and prior authorization and agreed the authorization was entered incorrectly due to a Navitus error. As noted on Page 11 for the 'Retail Tier 4' Copayment Rule, the Navitus Response outlines what steps were taken to correct the prior authorization and to ensure all other Prior Authorizations were entered correctly. The Navitus response also includes four additional steps that were implemented to prevent this error from occurring in the future.

A total of 92 EGWP claims were identified as potential exceptions to the copay requirements. The Navitus team reviewed all of the claims and provided an explanation as to why the claims paid as they did. As noted in the report, there were no variances found.

The current Performance Guarantee for Electronic Claims Processing Accuracy is 99.5% or higher for all claims. The Member Copay collected variance percentage is 0.073%. When calculating the variance percentage of the Net Plan Paid amount on page 1, the overall variance percentage is 0.016%. Navitus will defer to the State of Montana for any next steps regarding the variance amount noted in the report.

CLAIM TECHNOLOGIES
INCORPORATED

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

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

Claim Administration Audit

SPECIFIC FINDINGS REPORT

State of Montana Medical Plan
Administered by Allegiance Benefit Plan Management, Inc.

Audit Period: January 1, 2018 through December 31, 2019

Presented to

Montana Legislative Audit Division

March 31, 2020

Presented by

CLAIM TECHNOLOGIES INCORPORATED

TABLE OF CONTENTS

INTRODUCTION

This ***Specific Findings Report*** contains information, findings, and conclusions from CTI's audit of Allegiance Benefit Plan Management, Inc.'s (Allegiance) claim administration of the State of Montana's plans. 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 report to the State of Montana, the plan sponsor, and Allegiance, the claim administrator. A copy of Allegiance's response to these findings appears in Appendix B of this report.

CTI conducted the audit according to current, accepted standards and procedures for claim audits in the health insurance industry. We base our audit findings on the data and information provided by the State of Montana and Allegiance. Their validity is reliant upon the accuracy and completeness of that information. While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind.

We planned and performed the audit to obtain a reasonable assurance claims were adjudicated according to the terms of the contract between Allegiance and the State of Montana as well as all approved plan documents and communications.

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 policies, procedures, and systems Allegiance used to pay the State of Montana's claims during the audit period.

Audit Objectives

CTI's objectives for Allegiance's claim administration audit were to determine whether:

- Allegiance followed the terms of the services agreement;
- Allegiance paid claims according to the provisions of the plan documents and if those provisions were clear and consistent;
- Members were eligible and covered by the State of Montana's plans at the time a service paid by Allegiance was incurred; and
- Any claim administration or eligibility maintenance systems or processes need improvement.

Audit Scope

CTI audited Allegiance's claim administration of the State of Montana medical plans for the period of January 1, 2018 through December 31, 2019. The population of claims and amount paid during that period were:

Total Paid Amount	$255,079,037
Total Number of Claims Paid/Denied/Adjusted	831,355

The audit included the following components:

1. **Operational Review and 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
   - Identify missing provisions, ambiguities, and inconsistencies

3. **100% Electronic Screening with 30 Targeted Samples**
   - Systematic analysis of 100% of paid claims
   - Eligibility verification
   - Problem identification and quantification

4. **Random Sample Audit of 180 Claims**
   - Statistical confidence at 95% +/- 3%
   - Key Indicator performance levels
   - Benchmarking
   - Identify and prioritize problems
   - Recommendations

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

OPERATIONAL REVIEW

Objective

CTI's Operational Review evaluates Allegiance's claim administration systems, staffing, and procedures to identify any deficiencies that might materially affect its ability to control risk and pay claims accurately on behalf of the plans.

Scope

The scope of the Operational Review included:

- Claim administrator information:
  - Insurance and bonding
  - Conflicts of interest
  - Internal audit
  - Financial reporting
  - Business continuity planning
  - Claim payment system and coding protocols
  - Data and systems security
  - Staffing
- Claim funding:
  - Claim funding mechanism
  - Check processing and security
  - COBRA/direct pay premium collections
- Claim adjudication, customer service, and eligibility maintenance procedures:
  - Exception claim 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 used an Operational Review Questionnaire to gather information from Allegiance. We modeled our questionnaire after the audit tool used by certified public accounting firms when conducting an SSAE 16 or SSAE 18 audit of a service administrator. We modified that tool to elicit information specific to the administration of your plans.

We reviewed Allegiance's responses and any supporting documentation supplied to gain an understanding of the procedures, staffing, and systems used to administer the State of Montana's plan. This allowed us to conduct the audit more effectively.

In addition to the questionnaire, we used our proprietary Electronic Screening and Analysis (ESAS®) software to identify the best cases to test operational processes. We selected a targeted sample of 30 cases and provided a substantive testing questionnaire to Allegiance to collect information for each. We used the responses provided to validate that Allegiance followed procedures to control risk and accurately pay claims.

Following is a list of sample screening categories used to identify candidate cases for operational 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
Dependent Child Eligibility
Large Claim Review
Case Management
Provider Discounts and Fees

Findings

Claim Administrator Information

CTI reviewed information about Allegiance including:

- Background information
- Financial reports
- Insurance protection types and levels
- Dedicated staffing
- Systems and software
- Fee and commission disclosure
- Performance standards
- Internal audit practices

Allegiance reported the following:

- Allegiance has served State of Montana for over five years and processes medical claims for more than 50 clients.
- Allegiance provided copies of declaration pages for fidelity bond, errors and omissions, and cyber liability coverage. The pages showed fidelity bond coverage of $2 million with a $25,000 retention, errors and omissions coverage with an aggregate of $5 million with a $50,000 retention, and commercial general liability coverage with a $2 million aggregate.
- Allegiance and the State of Montana have a performance agreement with measure categories of Claim Quality, Claim Timeliness, and Customer Service. Allegiance provided performance

reports for 2018 and 2019 showing that it met or exceeded all measures. Allegiance reports on a client-specific basis, a best practice.

- Allegiance indicated that it had been audited for compliance 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. 18, reporting on controls at a service organization. Under SSAE 18, the administrator is required to provide its own description of its system, which the service auditor validates. CTI has a copy of Allegiance's SOC 1 Type 2 audit report and we can confirm that Allegiance's external auditor did not note any deviations in the installation and maintenance of customer benefits, enrollment information, and healthcare provider agreements control, or in the claim adjudication and claim payment and customer funding controls.
- Since 1999, Allegiance has used LuminX claim administration software. Allegiance also contracts with Zelis to detect claim unbundling. Allegiance has adopted most NCCI edits but some are turned off because they are incompatible with provider contracts.
- Allegiance has redundant systems at a failover location. Data is backed-up nightly and also stored at a secondary location. System file backups are maintained and rotated daily/weekly/monthly/quarterly and annually. End of year backup tapes are retained indefinitely.
- Allegiance has a dedicated account executive and two health operations managers for the State of Montana.
- Allegiance reported that it does not subcontract with vendors for any claim processing, member, or provider service functions for the State of Montana's account.

Claim Funding

CTI reviewed Allegiance's claim check controls and procedures for:

- Claim funding
- Fund reconciliation
- Refund and returned check handling
- Large check approval
- Security
- Stale check disposition
- Audit trail reports
- COBRA and retiree/direct pay premium collection

We observed the following:

- Allegiance issues claim checks from its own account which is also used for administrative fees. Refunds and returned checks reduce the amount of funding requests to the State of Montana.
- Allegiance has Examiner Payment/Denial Authority Levels starting for paid or denied claims of $30,000 or more. Claims of $30,000 to $59,999 must also be reviewed by an Intermediate Examiner. Claims of $60,000 to $99,999 must also be reviewed by a Senior Intermediate Examiner. Claims of $100,000 to $199,999 are reviewed by the Director of Technical Claims Services and claims of $200,000 and above are reviewed by the Vice President of Technical Claims Services.

- Allegiance uses appropriate levels of security and control within its claim funding and checks issuance procedures to protect the plan's interest and ensure all transactions are performed by authorized personnel only.
- All Allegiance's claim system users maintain unique access passwords. Employees' system access and override authority is based on their job descriptions.

Claim Adjudication, Customer Service, and Eligibility Maintenance Procedures

CTI reviewed Allegiance's enrollment, eligibility maintenance, and claim processing controls and procedures. We observed the following:

- Allegiance had adequately documented training, workflow, procedures, and systems to provide consistently high levels of accuracy in the processing of claims and enrollment.
- Allegiance has enrollment specialists assigned to the State of Montana who update eligibility changes on a daily basis.
- Allegiance performs Coordination of Benefits (COB) as outlined in the State of Montana's summary plan description.
- Allegiance provided COB savings reports for 2018 and 2019 showing $19,000,217 and $19,944,278 in savings, respectively.
- 95.2% of the State of Montana's claims were submitted electronically, decreasing administrative costs and reducing the potential for manual data entry errors. However, only 53.9% of the State of Montana's claims auto-adjudicate.
- Allegiance performs overpayment recovery for amounts over $50. Allegiance tracks the reasons for overpayment, a best practice. Allegiance provided a report for dates of service from 2017 to 2019 showing total overpayments of $851,257.52, total recoveries of $649, 656.70 (76%), and $201,600.82 outstanding.
- Allegiance performs subrogation on a pursue and pay basis when $1,000 in claims has been paid. Montana law requires plan participants to be made whole prior to the plan being reimbursed. As such, the State of Montana is very rarely, if ever, reimbursed through the subrogation process when member claims were caused by or contributed to by third-party liability. The State of Montana must approve any lien waivers or reductions, a best practice.
- Allegiance identifies potential Workers' Compensation claims through ICD-10 codes, provider notes, and member notification. These claims are held until an accident claim form has been completed. There must be at least $1,000 in claim payments before an investigation is undertaken.
- Allegiance's sister company, Allegiance Care Management, performs precertification and large claim management. Disease management is performed by American Health Holding.
- Allegiance keeps an internal log to track appeal timeframes and resolution. Allegiance provided 2018 and 2019 summary reports. For 2018, there were 160 appeals, 69% of which were upheld, 30% overturned, and 1% partially upheld/overturned. 91% of appeals were handled in a timely fashion in 2018. For 2019, there were 146 appeals, 73% of which were upheld, 21% overturned, and 6% partially upheld/overturned. 96% of appeals were handled in a timely fashion in 2019. Allegiance also provided detailed lists of the reasons appeals were not handled timely.

- Allegiance's claim system does not track the date adjustments are identified; it defaults to the original claim receipt date. As a result, adjustments are excluded from claim turnaround time calculations and the corresponding performance guarantee.
- Allegiance does not have staff dedicated to detecting and investigating fraud, waste, and abuse. Allegiance's credentialing team researches past fraud and sanctions as it is credentialing providers. Zelis's code editing service provides fraud detection, as well.
- Allegiance provided a Network Savings report showing discounts of 26.5% and 27.1% for 2018 and 2019, respectively. Network utilization was high at 96% in 2018 and 98% in 2019. State of Montana members traveling or domiciled outside of Montana can access Cigna's OAP network which helps drive network savings.
- Allegiance compensates out-of-network providers using a fee schedule based on the percentage of Medicare used for all service reimbursements. The State of Montana's reference-based pricing network is the primary driver of network savings.

HIPAA Compliance

CTI reviewed information about the systems and processes Allegiance had in place to maintain compliance with HIPAA regulations. The objective 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 has appropriate levels of security and controls in place to protect the plan sponsor's medical plan records and data and was compliant with HIPAA requirements at the time of the audit.
- Allegiance's Privacy Officer oversees HIPAA compliance at Allegiance.
- Allegiance employees receive online HIPAA training on an annual basis and occasionally more often.
- During the audit period, Allegiance reported it did not have any breaches triggering notification requirements for the State of Montana.

Electronic Screening and Analysis System (ESAS®) and Targeted Samples of Administrative Procedures
We used ESAS to test Allegiance's controls and procedures by selecting specific claim cases processed during the audit period. We prepared testing questionnaires (QID) for each and sent them to the administrator for completion. A CTI auditor reviewed the responses and supporting documentation.

The following detail report shows, by category, the number of line items or claimants with process improvement opportunities remaining after our analysis and removal of verified false positives.

A recommendation and explanation for each process improvement opportunity follows the report.

ESAS Operational Review Summary Report				
Client: State of Montana **Screening Period:** January 1, 2018 through December 31, 2019				
Category	**Lines**	**Claimants**	**Charge**	**Allowed**
UCR Provider Specialty – Assistant Surgeon	24	24	$65,896	$41,195

Fraud, Waste, and Abuse (FWA) Detail

Electronic screening of all service lines processed revealed the potential for incorrectly paid claims. Analysis confirmed the opportunity for process improvement and further testing is warranted. We sent QID numbers 14 - 16 to Allegiance for written response. After review of the response and additional information provided, CTI confirmed the potential for process improvement.

ESAS Operational Review Detail Report			
QID	**Under/Over Payment**	**Administrator Response**	**CTI Conclusion**
15	$5,000.32	Agree. Unfortunately, this was a manual entry error at time of processing resulting in an overpayment.	A procedural deficiency and $5,000.32 overpayment are cited. Claim was allowed in excess of the 90th percentile of usual, customary and reasonable.

PLAN DOCUMENTATION ANALYSIS

Objective

CTI's Plan Documentation Analysis evaluates the documents governing administration of State of Montana's medical plans and identifies inconsistencies, ambiguities, or missing provisions that might negatively impact accurate claim administration. Through this evaluation, we gained an understanding of Allegiance's administrative service responsibilities for State of Montana's medical plans. This understanding allowed us to audit more effectively.

Scope

Our auditors evaluated:

- Plan documents, descriptions, and any amendments
- Administrative services agreement

Methodology

CTI obtained a copy of the plan documentation from State of Montana and/or Allegiance. Our auditors reviewed the applicable documents to better understand the provisions Allegiance should have used to adjudicate all medical claims. We used a benefit matrix to help us understand your plan provisions. 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 allowed us to identify inconsistencies, ambiguities, or missing provisions.

CTI obtained clarification from State of Montana about any inconsistencies in the plan documents. Our auditors then used the benefit matrix as a cross-reference tool as they audited claims.

Findings

Plan Documentation and Administrative Services Agreement

The following inconsistencies, ambiguities, or missing provisions were found in your plan documents or administrative service agreement:

- The State of Montana should determine its benefit intent for genetic counseling and update the plan documentation accordingly to ensure member understanding. Note that genetic counseling is covered under the Affordable Care Act in some circumstances.

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

CTI's 100% Electronic Screening with Targeted Sample Analysis identified and quantified potential claim administration payment errors. State of Montana and Allegiance should talk about any verified under or overpayments to determine the appropriate actions to correct the errors.

Scope

CTI electronically screened 100% of the service lines processed by Allegiance during the audit period. The accuracy and completeness of Allegiance's data directly impacted the screening categories we completed 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 exclusions and limitations
- Multiple surgical procedures

Methodology

We followed these procedures to complete our ESAS process:

- *Electronic Screening Parameters Set* – We used your plan document provisions to set the parameters in ESAS.
- *Data Conversion* – We converted and validated your claim data, reconciled it against control totals, and checked it for reasonableness.
- *Electronic Screening* – We systematically screened 100% of the service lines processed and flagged claims not administered according to plan parameters.
- *Auditor Analysis* – If claims within an ESAS screening category represented a material amount, our auditors analyzed the findings to confirm results were valid. When using ESAS to identify payment errors, note that incomplete claim data could lead to false positives. CTI auditors made every effort to identify and remove false positives.
- *Targeted Sample Analysis* – From the categories identified with material amounts at risk, we selected the best examples of potential under or overpayments to test. As cases were not randomly selected, we cannot extrapolate results. We selected a total of 30 cases and sent your administrator a questionnaire for each. Targeted samples verified if the claim data supported our finding and if our understanding of plan provisions matched Allegiance's administration.
- *Audit of Administrator Response and Documentation* – We reviewed the responses and redacted the responses to eliminate personal health information. Based on the responses and further analysis of the findings we removed false positives identified from the potential amounts at risk.
- *Eligibility Verification of Every Claim by Date of Service* – We used ESAS to compare service dates against the eligibility periods provided to us to look for claims paid for ineligible members.

Findings

While we are confident in the accuracy of our ESAS results, note the dollar amounts associated with the results represent ***potential*** payment errors and process improvement opportunities. We would have to perform additional testing to substantiate the findings that could then 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 results with findings for all screening categories where, in our opinion, process improvement, recovery or savings opportunities exist.

ESAS Targeted Sample Categories for Potential Amount At Risk					
Client: State of Montana **Screening Period:** January 1, 2018 through December 31, 2019					
Category	**Lines**	**Claimants**	**Charge**	**Benefit**	**Potential at Risk**
Duplicate Payments					
Duplicate Payments	94	465	123	$254,835	$197,404
Plan Exclusions					
Custodial Care	4	16	5	$2,882	$2,496
Elastic Support	29	109	69	$20,568	$16,503
Impotency	229	621	289	$298,692	$182,145
Routine Foot Care	45	240	86	$17,064	$5,727

Duplicate Payments

Our electronic screening of all service lines processed revealed some services were paid more than once. This resulted in a benefit total (accumulation of payment, deductible, coinsurance applied to out-of-pocket accumulation) greater than the allowed amount for that service. Our analysis confirmed the opportunity for process improvement and findings proved to be sufficiently material to warrant further testing. We sent QID numbers 9 - 12 to Allegiance for written response. After review of the response and additional information provided, we confirmed the potential for process improvement.

ESAS Targeted Sample Audit Detail Report			
QID	**Under/Over Payment**	**Administrator Response**	**CTI Conclusion**
9	$2,689.91	Agree. Refund of $2,689.91 requested.	Procedural deficiency and $2,689.91 overpayment remain.

Plan Exclusions

Electronic screening of all service lines processed revealed that some services were potentially overpaid as a result of paying for excluded services. Analysis confirmed the opportunity for process improvement and findings proved to be sufficiently material to warrant further testing. We sent QID numbers 17 - 30 to Allegiance for written response. After review of the response and additional information provided, we confirmed the potential for process improvement.

ESAS Targeted Sample Audit Detail Report				
QID	**Category**	**Under/Over Payment**	**Administrator Response**	**CTI Conclusion**
23	Custodial Care	$470.48	Agree. Claim was received from Medicaid; however custodial care is excluded from the plan. Other claims for this service denied correctly.	Procedural deficiency and $470.48 overpayment remain.
24	Elastic Support	$0.00	Billing error confirmed; Corrected claim has been received and diagnosis will be corrected. No change to processing so no refund or additional payment needed.	A procedural deficiency is cited.
26	Routine Foot Care	$152.61	Agree. Claim auto-released. Revenue code 360 for nail debridement. $152.61 refund requested.	Procedural deficiency and $152.61 overpayment remain.
27	Impotency	$1,364.00	Claim not eligible. Medicare is primary and allowed for the services; however primary diagnosis is N52.8; other male erectile dysfunction. Surgery code is 54401; insertion of penile prosthesis.	Procedural deficiency and $1,364.00 overpayment remain.

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 to prioritize areas of administrative deficiency for further review and remediation.

Scope

CTI's Random Sample Audit included a stratified random sample of 180 paid or denied claims. 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 the sample is in Appendix A.

Allegiance's performance was measured using the following key performance indicators:

- Financial Accuracy
- Accurate Payment
- Accurate Processing

We also measured claim turnaround time, a commonly relied upon performance measure.

Methodology

Our 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. Our auditors reviewed each sample claim selected to ensure it conformed to plan specifications, agreements, and negotiated discounts. We recorded our findings in our proprietary audit system.

When applicable, we cited claim payment and processing errors identified by comparing the way a selected claim was paid and the information Allegiance had available at the time the transaction was processed. **It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so you can discuss how to reduce errors and re-work in the future with your administrator.**

CTI communicated with Allegiance in writing about any errors or observations using system generated response forms. We sent Allegiance a preliminary report for its review and written response. We considered Allegiance's written response, as found in Appendix B, when producing our final reports.

Findings

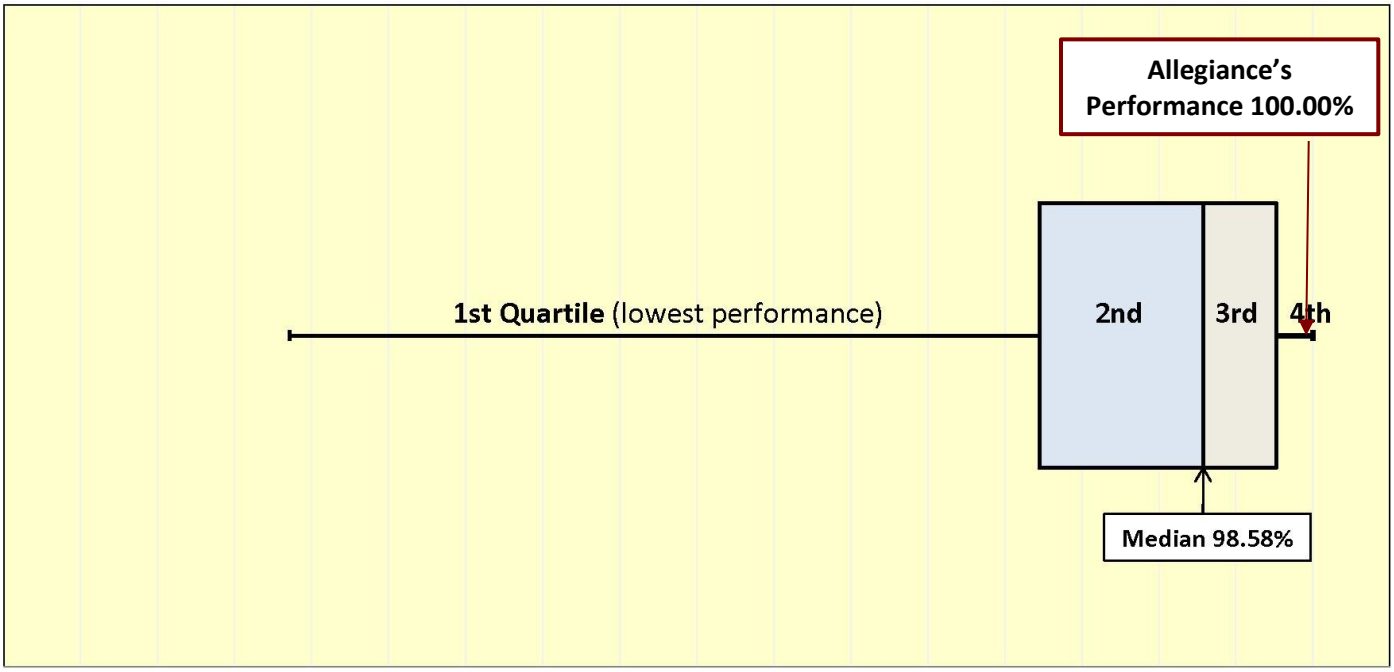
The following box and whiskers charts demonstrate Allegiance's performance as compared to the last 100 medical audits performed by CTI. The fourth quartile represents the 25 highest performing plans, and the first quartile represents the lowest 25. The Median is the point at which 50 plans audited were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

Financial Accuracy

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 $0.00 in underpayments and $2.30 in overpayments, for a combined variance of $2.30. The correct payment total for the adequately documented claims in the audit sample should have been $552,829.73.

The weighted Financial Accuracy rate for the claims sampled was **100.00%**.



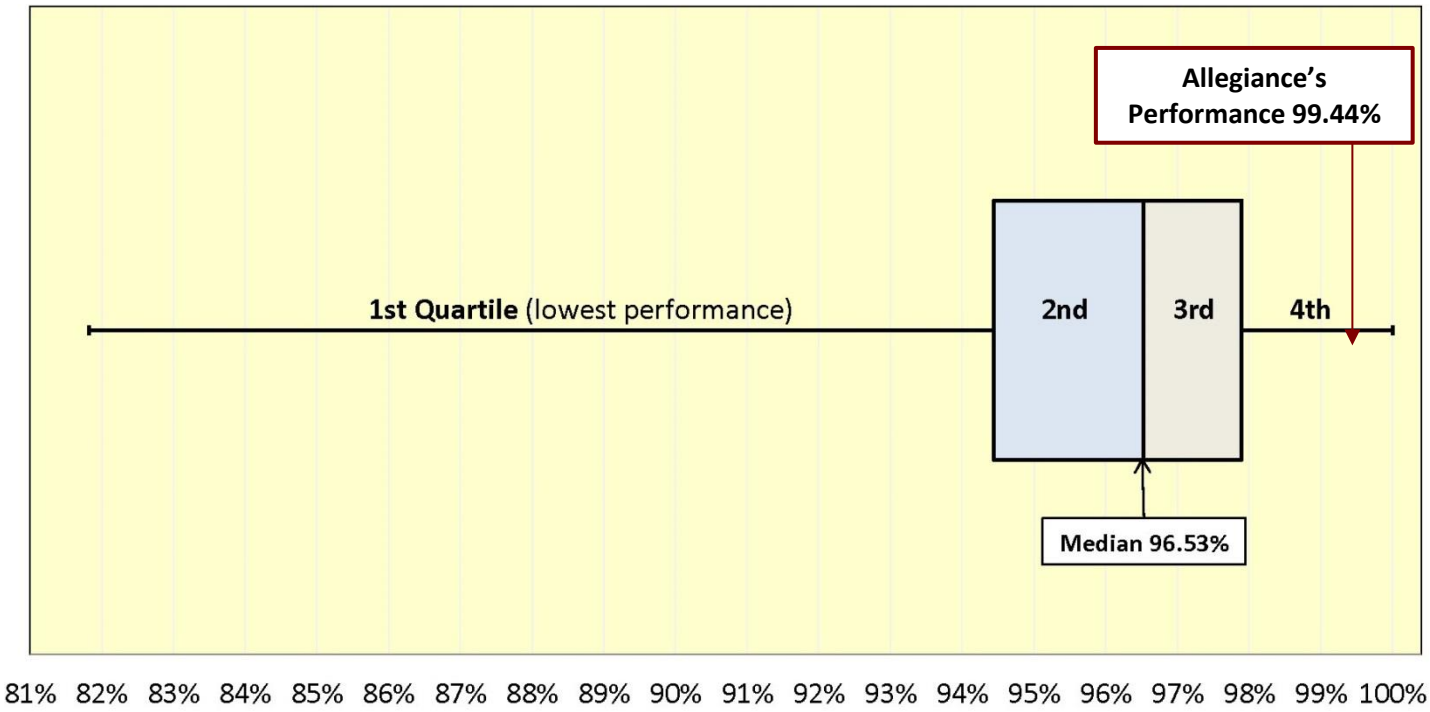
Random Sample Audit Financial Accuracy and Accurate Payment Detail Report						
Error Description	**Audit No.**	**Under/ Over Paid**	**Administrator Response**	**CTI Response**	**Manual or System**	
Incorrect COB with Medicare	1059	$2.30	Agree. A9270 Non-covered item or service paid $2.30 in error on this claim. Refund not requested, as the payment is less than the $50.00 refund threshold.	An adjudication error and $2.30 overpayment cited.	Manual	
Subtotal	**1**					
TOTALS	**1**	**VARIANCE $2.30**			**M: 1**	**S:0**

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 1 incorrectly paid claim and 179 correctly paid claims. Note: CTI only uses adequately documented claims for this calculation.

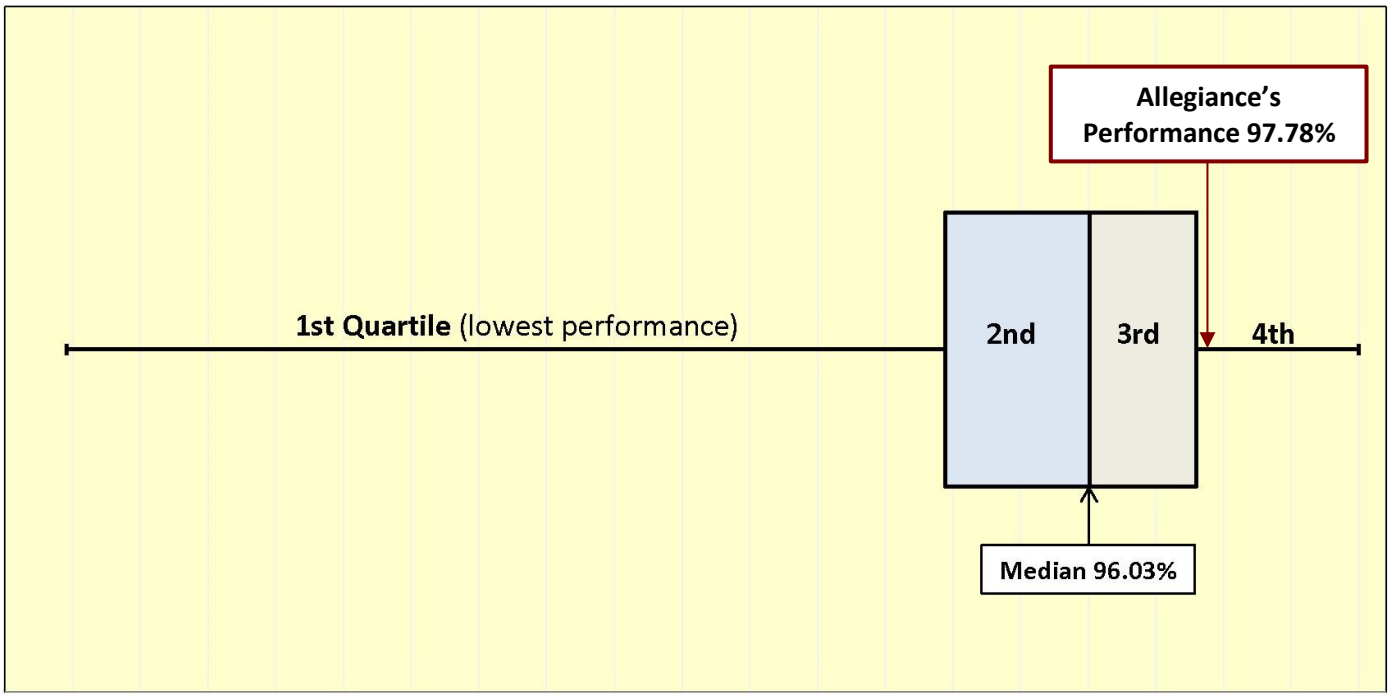
Random Sample Audit			
Total Claims	**Incorrectly Paid Claims**		**Frequency**
	Underpaid Claims	**Overpaid Claims**	
180	0	1	99.44%



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.

Random Sample Audit			
Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
176	0	4	97.78%



Random Sample Audit Accurate Processing Detail Report				
Error Description	**Audit No.**	**Administrator Response**	**CTI Response**	**Manual or System**
Coordination of Benefits				
Incorrect COB with Medicare	1059	Agree. A9270 non-covered item or service paid $2.30 in error on this claim. Refund not requested as it is less than the $50.00 refund threshold.	An adjudication error and $2.30 overpayment cited.	Manual
Other insurance not investigated	1096	Agree. Annual COB questionnaire to go out in February 2020. Initial COB questionnaire was sent out 1/29/2020.	Adjudication error cited. The other parent's birthday is unknown and may be prior to the employee's for this dependent.	Manual
Other insurance not investigated	1097	Agree. Annual COB questionnaire to go out in February 2020. Initial COB questionnaire was sent out 1/23/2020.	Adjudication error cited. The other parent's birthday is unknown and may be prior to the employee's for this dependent.	Manual
Other insurance indicator overlooked	1178	Agree. Claim processed AUTOMED prior to set up of COB record. When COB information was received and review completed, COB record was set up and examiner notified to review claim that was released by AUTOMED. Reversal of claim 20191028ALFA of amount applied to the DED has been completed and reprocessing occurred on the claim.	Adjudication error cited. The initial processing missed the indicator of other insurance (birthday rule).	Manual

Claim Turnaround

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

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

Random Sample Audit		
Median	**Mean**	**+45 Days to Process**
4	8	4

DATA ANALYTICS

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

- Network Provider Utilization and Discount Savings;
- Sanctioned Provider Identification;
- Patient Protection and Affordable Care Act (PPACA) Preventive Services Payment Compliance;
- National Correct Coding Initiative (NCCI) Editing Compliance; and
- Global Surgery Prohibited Fee Period Analysis.

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

Network Provider Utilization and Discount Savings

The **Network Provider Utilization and Discount Savings** 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 of our clients will allow for more 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 these subsets was further delineated into four subgroups:

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

Report

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

Provider Discount Review
State of Montana - Allegiance
Paid Dates 1/1/2018 through 12/31/2019

Total of All Claims

Claim Type	Eligible Charge	Provider Discount		Paid
Ancillary	$13,541,537	$4,050,512	29.9%	$7,857,206
Non-Facility	$137,806,958	$41,596,955	30.2%	$75,096,892
Facility Inpatient	$85,086,793	$20,367,192	23.9%	$61,643,606
Facility Outpatient	$138,334,908	$38,113,030	27.6%	$82,662,703
Total	**$374,770,195**	**$104,127,689**	**27.8%**	**$227,260,406**

In-Network

Claim Type	Eligible Charge	Provider Discount		Paid
Ancillary	$12,918,797	$4,050,512	31.4%	$7,323,005
Non-Facility	$136,100,137	$41,595,709	30.6%	$74,180,746
Facility Inpatient	$84,790,645	$20,367,192	24.0%	$61,387,301
Facility Outpatient	$137,819,961	$38,112,356	27.7%	$82,293,542
Total In-Network	**$371,629,540**	**$104,125,768**	**28.0%**	**$225,184,594**
% of Eligible Charge -	99.2%	% Claim Frequency -	92.2%	

Out of Network

Claim Type	Eligible Charge	Provider Discount		Paid
Ancillary	$622,740	$0	0.0%	$534,201
Non-Facility	$1,706,821	$1,247	0.1%	$916,146
Facility Inpatient	$296,148	$0	0.0%	$256,305
Facility Outpatient	$514,947	$674	0.1%	$369,161
Total Out of Network	**$3,140,656**	**$1,921**	**0.1%**	**$2,075,813**
% of Eligible Charge -	0.8%	% Claim Frequency -	7.8%	

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%	

Report excludes individuals age 65 or older
Eligible Charge *- Provider Discount + Deductible + Copayment + Coinsurance + Paid Amount*
Facility Inpatient *- Room and Board Revenue Codes (100-219) or Inpatient bill types*
Facility Outpatient *- Revenue Codes not Flagged as Inpatient or non-inpatient bill types*
Non-Facility *- CPT Codes: 00100 - 99999*
Ancillary *- All other claims not flagged in Inpatient, Outpatient and Non-Facility*

The State of Montana's members had utilization of network or secondary network providers at 99.2% of all allowed charges and 92.2% 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 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 about 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 physician and other medical professional claims.

Report

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

PPACA Preventive Services Coverage Compliance

The **Preventive Services Coverage Compliance** report confirms that the 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) requires that certain preventive services, if performed by a network provider, must be covered at 100% without copayment, coinsurance, or deductible. Our review analyzed 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 for the definition of preventive services is somewhat vague, leaving it up to individual health plans to define their own 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; or
- 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 for which we identified non-compliance (if any) are listed first and the percentage of allowed charge paid is in the last column. To demonstrate full compliance with PPACA's requirements, the last column of this report should show 100% of services performed by network providers were paid and that no deductible, coinsurance, or copayment was applied.

Because services may be denied for reasons 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). We electronically screened 78 categories of preventive services that match the preventive care services specified by HHS including immunizations, women's health, tobacco use counseling, cholesterol and cancer screenings, and wellness examinations. This review either confirms compliance with PPACA or highlights areas for improvement.

CTI's analysis also found that 90.13% of the procedure codes identified as preventive services were paid by Allegiance at 100% when provided in-network. A detailed list of the other 9.87% is available upon request**.**

The following report provides an outline for discussion between the State of Montana and Allegiance.

Preventive Care Services Compliance Review

State of Montana - Allegiance

Audit Period 1/1/2018 - 12/31/2019

Plans: All

Filters: Exclude - out of network, adjustments, edits with frequency limits, claimants 65 or older

		Claim Lines Submitted	Denied	Applied Deductible		Applied Copay		Applied Coinsurance		Paid @100%		
Edit Guideline	Preventive Service Benefit	#	#	#	Amount	#	Amount	#	Amount	#	Amount	%
Bright Futures	Hearing Screening 0-21 yrs	309	4	270	$3,217	0	$0	20	$58	15	$158	4.85%
HHS	Gestational Diabetes Mellitus screening - women	1,322	14	547	$10,000	0	$0	654	$4,012	107	$3,217	8.09%
USPSTF-A	Hepatis B screening - women	384	10	179	$4,469	0	$0	98	$886	97	$2,733	25.26%
USPSTF-A,B	Rh incompatibility screening - pregnant women	500	15	183	$5,748	0	$0	172	$1,606	130	$4,284	26.00%
USPSTF-A	HIV screening - pregnant women	371	9	181	$6,800	0	$0	66	$749	115	$3,551	31.00%
USPSTF-A	Urinary tract infection screening - pregnant women	549	12	200	$6,515	0	$0	140	$1,358	197	$4,468	35.88%
USPSTF-A	Syphilis screening - pregnant women	262	5	97	$2,265	0	$0	59	$542	101	$1,963	38.55%
USPSTF-B	BRCA screening counseling - women	343	15	25	$4,717	112	$3,180	16	$2,839	175	$73,961	51.02%
USPSTF-B	Depression screening - >18	155	0	49	$468	0	$0	23	$56	83	$1,733	53.55%
USPSTF-B	Vision screening - 3- 5	252	9	87	$753	0	$0	7	$16	149	$1,451	59.13%
USPSTF-B	Depression screening - 12-18	37	6	7	$74	0	$0	1	$3	23	$317	62.16%
USPSTF-B	Breast cancer chemoprevention counseling- >17	189	4	3	$420	58	$1,640	2	$64	122	$25,327	64.55%
USPSTF-A	Hemoglobinopathies or sickle cell screening 0-90 days	23	0	7	$156	0	$0	1	$6	15	$487	65.22%
USPSTF-A	Phenylketonuria (PKU) screening 0-90 days	101	0	25	$953	0	$0	6	$42	70	$2,571	69.31%
Bright Futures	Dyslipidemia screening - 2-20	403	122	0	$0	0	$0	0	$0	281	$6,746	69.73%
USPSTF-B	Hepatitis C Virus (HCV) Screening	646	20	92	$4,118	0	$0	57	$821	477	$20,761	73.84%
USPSTF-A	Hypothyroidism screening - 0-90 days	20	0	4	$74	0	$0	1	$3	15	$433	75.00%
Bright Futures	Iron Supplement - <21	613	145	5	$64	0	$0	0	$0	463	$2,280	75.53%
Bright Futures	Lead screening - <21	334	68	9	$153	0	$0	4	$31	253	$5,945	75.75%
USPSTF-B	Gonorrhea screening - female	1,287	28	141	$13,046	0	$0	123	$2,973	995	$69,832	77.31%
USPSTF-B	Cholesterol abnormalities screening - men 20-34	9	0	2	$128	0	$0	0	$0	7	$289	77.78%
USPSTF-B	Hearing loss screening - 0 - 90 days	64	2	9	$1,315	0	$0	3	$70	50	$6,641	78.13%
HHS	Breastfeeding support and counseling - women	172	11	0	$0	19	$515	7	$48	135	$26,383	78.49%
USPSTF-A,B	Chlamydia infection screening - women	1,415	31	154	$14,426	0	$0	119	$2,859	1,111	$77,588	78.52%
USPSTF-B	Tobacco use counseling - <19	5	0	0	$0	0	$0	1	$17	4	$112	80.00%
USPSTF-B	Diabetes screening	114	8	9	$466	0	$0	5	$49	92	$2,765	80.70%
HHS	Wellness Examinations - women	7,986	112	65	$10,054	1,047	$27,053	168	$7,079	6,594	$1,378,648	82.57%
AMA	Modifier 33	2,533	239	127	$8,445	6	$150	35	$3,062	2,126	$647,500	83.93%
USPSTF-A	Syphillis screening	41	1	4	$74	0	$0	1	$11	35	$598	85.37%
USPSTF-A	HIV screening - >14	519	13	39	$2,378	0	$0	19	$289	448	$16,806	86.32%
ACIP	Immunizations - Hepatitis B >18	155	16	2	$191	0	$0	3	$151	134	$11,499	86.45%
USPSTF-B	Healthy diet counseling	241	26	2	$116	0	$0	2	$81	211	$24,352	87.55%
ACIP	Immunizations - Pneumococcal >18	233	10	4	$640	0	$0	13	$493	206	$24,465	88.41%
ACIP	Immunizations - DTP >18	1,566	37	87	$8,328	0	$0	56	$1,603	1,386	$56,689	88.51%
USPSTF-A	Tobacco use counseling - >18	156	11	1	$4	0	$0	4	$63	140	$3,713	89.74%
USPSTF-A	Colorectal cancer screening - 50-75	2,832	222	28	$4,700	0	$0	19	$6,546	2,563	$1,918,665	90.50%
HHS	Wellness Examinations - >18	2,480	58	83	$12,861	55	$1,455	35	$1,255	2,249	$458,358	90.69%
HHS	Contraceptive methods - women	2,811	49	155	$6,845	0	$0	44	$2,676	2,563	$842,909	91.18%
USPSTF-B	Alcohol misuse - screening and counseling	53	1	3	$190	0	$0	0	$0	49	$1,837	92.45%
ACIP	Immunizations - Varicella <19	599	35	2	$250	0	$0	1	$31	561	$59,748	93.66%
USPSTF-A	Cholesterol abnormalities screening - men 35-75	1,363	22	43	$1,862	0	$0	11	$126	1,287	$43,850	94.42%
ACIP	Immunization Administration - >18	7,290	147	100	$4,397	0	$0	136	$2,072	6,907	$228,485	94.75%
USPSTF-A,B	Cholesterol abnormalities screening - women >19	953	13	28	$1,230	0	$0	9	$177	903	$40,708	94.75%
USPSTF-A	Cervical Cancer Screening (Pap) - women	3,688	103	45	$2,628	0	$0	16	$308	3,524	$196,774	95.55%
ACIP	Immunizations - Influenza Age >18	3,523	38	36	$1,290	0	$0	75	$659	3,374	$75,114	95.77%
ACIP	Immunizations - Inactivated Poliovirus <19	80	3	0	$0	0	$0	0	$0	77	$2,877	96.25%
HHS	Cervical Cancer Screening (HPV DNA) - women >29	1,612	33	16	$1,735	0	$0	8	$198	1,555	$119,736	96.46%
ACIP	Immunizations - Herpes Zoster >59	291	1	2	$276	0	$0	7	$364	281	$46,640	96.56%
ACIP	Immunizations - Hepatitis A <19	1,071	28	5	$347	0	$0	1	$18	1,037	$43,538	96.83%
ACIP	Immunizations - DTP <19	2,005	44	4	$434	0	$0	3	$96	1,954	$150,498	97.46%
ACIP	Immunizations - Rotavirus <19	984	20	2	$175	0	$0	2	$44	960	$103,461	97.56%
HRSA/HHS	Wellness Examinations - <19	7,758	127	30	$2,034	20	$505	5	$44	7,576	$1,334,956	97.65%
Bright Futures	Developmental Autism screening - <3	727	7	8	$138	0	$0	0	$0	712	$12,831	97.94%
ACIP	Immunization Administration - <19	11,183	201	11	$367	0	$0	9	$143	10,962	$475,910	98.02%
ACIP	Immunizations - Hepatitis B <19	114	1	1	$31	0	$0	0	$0	112	$3,261	98.25%
ACIP	Immunizations - Meningococcal >18	377	5	1	$325	0	$0	0	$0	371	$74,140	98.41%
ACIP	Immunizations - Hepatitis A >18	271	3	1	$59	0	$0	0	$0	267	$21,500	98.52%
ACIP	Immunizations - Meningococcal <19	693	7	2	$724	0	$0	0	$0	684	$87,482	98.70%
Bright Futures	Tuberculin testing - <21	83	1	0	$0	0	$0	0	$0	82	$1,196	98.80%
ACIP	Immunizations - Human papillomavirus	1,015	8	1	$206	0	$0	1	$60	1,005	$230,734	99.01%
ACIP	Immunizations - Influenza <19	4,035	25	6	$172	0	$0	5	$35	3,999	$86,626	99.11%
USPSTF-B	Breast cancer mammography screening - >39	10,068	22	2	$163	0	$0	0	$0	10,044	$1,388,078	99.76%
ACIP	Immunizations - Measles, Mumps, Rubella <19	396	0	0	$0	0	$0	0	$0	396	$78,294	100.00%
ACIP	Immunizations - Varicella >18	13	0	0	$0	0	$0	0	$0	13	$1,676	100.00%
ACIP	Immunizations adult - Influenza Age (FluMist) 19-49	8	0	0	$0	0	$0	0	$0	8	$195	100.00%
ACIP	Immunizations - Pneumococcal <19	4	0	0	$0	0	$0	0	$0	4	$336	100.00%
ACIP	Immunizations - Human Papillomavirus 19-26	2	0	0	$0	0	$0	0	$0	2	$368	100.00%
ACIP	Immunizations - Measles, Mumps, Rubella >18	1	0	0	$0	0	$0	0	$0	1	$225	100.00%
	Totals	**91,692**	**2,227**	**3,231**	**$154,014**	**1,317**	**$34,498**	**2,273**	**$46,793**	**82,644**	**$10,641,273**	**90.13%**

NCCI Editing Compliance

While there are no universally accepted correct coding guidelines among private insurers and administrators, the Centers for Medicare & Medicaid Services (CMS), the nation's largest payer for health care, took the initiative to provide valuable guidance for medical benefit plans. Implementation of NCCI mandated several initiatives to prevent improperly billed claims from being paid under Medicare and Medicaid.

Scope

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

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

Our claim system code editing analysis identified services submitted to the plan and paid by Allegiance that Medicare and Medicaid would have denied. Since Allegiance paid the billed charges, the payments represent a potential savings opportunity to the State of Montana.

It is difficult to establish the extent to which administrators and carriers use NCCI edits; however, CTI recommends these reports be discussed with administrators to determine the extent they could incorporate CMS edits. Using these edits typically reduces claim expenses for employers and their employees, as well as furthering efforts toward achieving standardized code-editing systems for all payers.

PTP Edits Report

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

Procedure to Procedure Edits								
State of Montana - Allegiance								
Based on Paid Dates 1/1/2018 through 12/31/2019								
Outpatient Hospital Services (facility claims with codes not designated inpatient)								
Primary		**Secondary**		**Mod**	**Primary Description**	**Secondary Description**	**Line**	**Secondary**
Code	**Mod**	**Code**	**Mod**	**Use**			**Count**	**Allowable**
74177		96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	94	$12,437
					Standards of medical / surgical practice			
97140	GP	97530	GP	YES	Manual therapy 1/> regions	THERAPEUTIC ACTIVITIES	147	$11,412
					Mutually exclusive procedures			
31276	SG,50	31255	SG,50,51	YES	SINUS ENDOSCOPY SURGICAL	REMOVAL OF ETHMOID SINUS	2	$11,339
					CPT Manual or CMS manual coding instructions			
45385	PT	45380	PT	YES	LESION REMOVAL COLONOSCOPY	COLONOSCOPY AND BIOPSY	28	$10,155
					More extensive procedure			
94640		99284		YES	AIRWAY INHALATION TREATMENT	EMERGENCY DEPT VISIT	9	$9,824
					CPT Manual or CMS manual coding instructions			
70553		70544		YES	Mri brain stem w/o & w/dye	MR ANGIOGRAPHY HEAD W/O DYE	9	$8,929
					Misuse of column two code with column one code			
92928		93454		YES	Prq card stent w/angio 1 vsl	CORONARY ARTERY ANGIO S&I	1	$7,245
					CPT Manual or CMS manual coding instructions			
97597	GP	29581	GP	YES	RMVL DEVITAL TIS 20 CM/<	APPLY MULTLAY COMPRS LWR LEG	37	$7,035
					CPT Manual or CMS manual coding instructions			
36415		99211		YES	ROUTINE VENIPUNCTURE	OFFICE/OUTPATIENT VISIT EST	59	$6,928
					Misuse of column two code with column one code			
36247		36245		YES	INS CATH ABD/L-EXT ART 3RD	INS CATH ABD/L-EXT ART 1ST	1	$6,802
					More extensive procedure			
						Top 10 TOTAL	**387**	**$92,107**
						GRAND TOTAL	**3,350**	**$565,390**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)								
Primary		**Secondary**		**Mod**	**Primary Description**	**Secondary Description**	**Line**	**Secondary**
Code	**Mod**	**Code**	**Mod**	**Use**			**Count**	**Allowable**
43245		43239		YES	UPPR GI SCOPE DILATE STRICTR	UPPER GI ENDOSCOPY BIOPSY	11	$2,499
					Misuse of column two code with column one code			
31276	50	31255	50,51	YES	SINUS ENDOSCOPY SURGICAL	REMOVAL OF ETHMOID SINUS	3	$2,004
					CPT Manual or CMS manual coding instructions			
43239		99152		YES	UPPER GI ENDOSCOPY BIOPSY	MOD SED SAME PHYS/QHP INITIAL 15 MINS 5/> YRS	70	$1,721
					CPT Manual or CMS manual coding instructions			
00400	AA	64461	50	YES	ANESTH SKIN EXT/PER/ATRUNK	Paravertebral block (PVB) (paraspinous block), thoracic; single injection site (includes imaging gui	1	$1,714
					Standard preparation / monitoring services for anesthesia			
31256	50	31000	50	YES	EXPLORATION MAXILLARY SINUS	IRRIGATION MAXILLARY SINUS	1	$1,627
					More extensive procedure			
19371	50	11970	50	YES	REMOVAL OF BREAST CAPSULE	REPLACE TISSUE EXPANDER	1	$1,531
					Misuse of column two code with column one code			
90471		99213		YES	IMMUNIZATION ADMIN	OFFICE/OUTPATIENT VISIT EST	14	$1,531
					CPT Manual or CMS manual coding instructions			
97140	GP	97530	GP	YES	Manual therapy 1/> regions	THERAPEUTIC ACTIVITIES	30	$1,368
					Mutually exclusive procedures			
31255	50,51	31288	50,51	YES	REMOVAL OF ETHMOID SINUS	NASAL/SINUS ENDOSCOPY SURG	3	$1,348
					CPT Manual or CMS manual coding instructions			
22633		22612	59	NO	LUMBAR SPINE FUSION COMBINED	LUMBAR SPINE FUSION	1	$1,346
					HCPCS/CPT procedure code definition			
						Top 10 TOTAL	**135**	**$16,689**
						GRAND TOTAL	**1,441**	**$108,894**

Additional Observation

During the Data Analytics review, our auditor observed the following situation that may not have caused an error on the claim but may impact future claims or overall quality of service. We have summarized these additional observations below.

Observation	QID Number
Cigna's contract with the Mayo Clinic of Arizona, which Allegiance accesses, prohibits application of claim edit. As such, claims from this provider may allow payment for inappropriately coded items.	2

MUE Report

An 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. MUE errors could be caused by 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.

CTI's MUE analyses are grouped into three separate reports:

- Outpatient hospital
- Non-facility
- Ancillary

NCCI MUE Edits				
State of Montana - Allegiance Based on Paid Dates 1/1/2018 through 12/31/2019				
Outpatient Hospital Services (facility claims with codes not designated inpatient)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line count Exceeding Limit**	**Gross Benefit Allowed**
J2796	150	ROMIPLOSTIM INJECTION	7	$185,516
		Rationale: Clinical: Data		
J9299	480	Injection, nivolumab, 1 mg	6	$151,392
		Rationale: Prescribing Information		
J2425	125	PALIFERMIN INJECTION	5	$77,550
		Rationale: Clinical: Data		
93653	1	Ep & ablate supravent arrhyt	1	$46,229
		Rationale: Nature of Service/Procedure		
80307	1	DRUG TEST PRSMV INSTRMNT CHEMISTRY ANALYZERS	107	$20,504
		Rationale: Code Descriptor / CPT Instruction		
92998	2	PUL ART BALLOON REPR PERCUT	2	$20,423
		Rationale: Clinical: Data		
99070	1	Special supplies phys/qhp	60	$16,081
		Rationale: Code Descriptor / CPT Instruction		
99217	1	OBSERVATION CARE DISCHARGE	112	$15,276
		Rationale: Code Descriptor / CPT Instruction		
50590	1	FRAGMENTING OF KIDNEY STONE	2	$15,258
		Rationale: Anatomic Consideration		
99220	1	INITIAL OBSERVATION CARE	71	$13,688
		Rationale: Code Descriptor / CPT Instruction		
		Top 10 TOTAL	**373**	**$561,918**
		GRAND TOTAL	**1,169**	**$845,036**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)				
Procedure Code	Service Unit Limit	Procedure Description	Line count Exceeding Limit	Gross Benefit Allowed
0365T	15	Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient;	77	$44,089
		Rationale: Clinical: Society Comment		
J1602	300	Injection, golimumab, 1 mg, for intravenous use	4	$32,852
		Rationale: Prescribing Information		
95165	30	ANTIGEN THERAPY SERVICES	29	$27,637
		Rationale: Clinical: Data		
36224	1	Place cath carotd art	2	$10,199
		Rationale: CMS Policy		
11045	12	DEB SUBQ TISSUE ADD-ON	2	$9,917
		Rationale: Clinical: Data		
11043	1	DEB MUSC/FASCIA 20 SQ CM/<	1	$9,499
		Rationale: Code Descriptor / CPT Instruction		
59426	1	ANTEPARTUM CARE ONLY	5	$9,212
		Rationale: Code Descriptor / CPT Instruction		
88332	13	PATH CONSULT INTRAOP ADDL	2	$6,639
		Rationale: Clinical: Data		
P9047	20	ALBUMIN (HUMAN), 25%, 50ML	1	$6,477
		Rationale: Clinical: Data		
17312	6	MOHS ADDL STAGE	2	$6,220
		Rationale: Clinical: Data		
		Top 10 TOTAL	**125**	**$162,742**
		GRAND TOTAL	**588**	**$284,469**

Global Surgery Prohibited Fee Period Analysis

CMS created the definition of *global surgical package* to make payments 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 and 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 inpatient hospital, outpatient hospital, ambulatory surgical center (ASC), and physician's office. Claims for surgeon visits in intensive care or critical care units are also included in the global surgical package. Our analysis encompasses the three types of procedures with global surgical packages: simple, minor, and major. Each type 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. When this occurs, the provider can add a modifier 24, 25, or 57 to the E/M service procedure code but must submit supporting documentation with the claim.

Ancillary (All other claims not flagged Inpatient, Outpatient Hospital, or non-facility)				
Procedure Code	Service Unit Limit	Procedure Description	Line count Exceeding Limit	Gross Benefit Allowed
B4035	1	ENTERAL FEED SUPP PUMP PER D	77	$29,506
		Rationale: Code Descriptor / CPT Instruction		
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	775	$23,758
		Rationale: Nature of Equipment		
K0553	1	COMBINATION ORAL/NASAL MASK	20	$22,458
		Rationale: Code Descriptor / CPT Instruction		
E0443	1	PORTABLE 02 CONTENTS, GAS	27	$3,634
		Rationale: Code Descriptor / CPT Instruction		
B4034	1	ENTER FEED SUPKIT SYR BY DAY	26	$2,486
		Rationale: Code Descriptor / CPT Instruction		
E0486	1	ORAL DEVICE/APPLIANCE CUSFAB	1	$2,250
		Rationale: Nature of Equipment		
A7020	1	INTERFACE, COUGH STIM DEVICE	12	$1,513
		Rationale: Nature of Equipment		
E0601	1	CONT AIRWAY PRESSURE DEVICE	2	$1,475
		Rationale: Nature of Equipment		
L3002	2	FOOT INSERT PLASTAZOTE OR EQ	1	$1,118
		Rationale: Anatomic Consideration		
L7520	12	REPAIR PROSTHESIS PER 15 MIN	1	$704
		Rationale: Clinical: Data		
		Top 10 TOTAL	**942**	**$88,903**
		GRAND TOTAL	**1,056**	**$94,164**

Report

The following 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 24, 25, or 57 when Medicare would have required supporting documentation before payment; and
3. Analysis of the same providers' surgeries without modifier 24, 25, or 57 when Medicare would have denied payment.

Payment of unbundled, post-surgical E/M services during the global fee period increases the cost of a claim. While there are no universally accepted guidelines for global surgery fee periods with 24, 25, or 57 modifiers, some states and groups mandate providers accept assignment of benefits on those claims. This mitigates the financial impact of unbundling and improper coding. When we discuss our findings, we will help you identify strategies to monitor and eliminate unbundling within your plan.

State of Montana - Allegiance									
Audit Period 1/1/2018 - 12/31/2019									
Provider Id	Surgeries with 'CMS Defined' Prohibited 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 24, 25, or 57		E/M Procedure Codes without Modifier 24, 25, or 57	
	Count	Allowed Charge	Count	% Surgeries with E/M Charges during Prohibited Global Fee Periods	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge
810515695001	135	$22,191	27	16.7%	$4,679	16	$2,076	13	$2,157
301058754001	161	$29,243	40	19.9%	$6,004	26	$4,263	12	$2,089
042970129003	0	$0	3	100.0%	$13,526	0	$0	1	$639
474147401001	410	$194,260	258	38.6%	$74,431	248	$56,142	6	$593
611744940025	12	$1,810	38	76.0%	$2,552	34	$4,580	4	$589
810141660526	10	$8,548	7	41.2%	$8,310	3	$411	4	$541
273193107183	67	$42,995	12	15.2%	$5,583	7	$892	4	$494
841411721008	170	$104,767	28	14.1%	$9,434	26	$3,921	3	$467
464056262332	1	$661	2	66.7%	$3,122	0	$0	2	$451
416011702AwC	0	$0	1	100.0%	$14,754	0	$0	2	$450
Top 10 TOTAL	**966**	**$404,475**	**416**	**30.1%**	**$142,395**	**360**	**$72,286**	**51**	**$8,471**
Overall Total	**22,542**	**$8,324,250**	**4,864**	**17.7%**	**$1,204,933**	**4,484**	**$587,835**	**212**	**$29,213**

CONCLUSION

We consider it a privilege to have worked for, and with, your staff and administrator. Our contract offers 8 hours of post-audit time to help you develop an implementation plan should the State of Montana desire additional assistance in that regard.

Thank you again for choosing CTI.

APPENDIX A – SAMPLE CONSTRUCTION AND WEIGHTING METHODOLOGY

Client: MTAllegiance19
Audit Period: January 01, 2018 - December 31, 2019

Claim Universe (as converted)

Stratum*	Claim Count	Total Charge Amount	Total Paid Amount
1	691,221	$105,837,077	$47,849,098
2	120,243	$161,614,882	$58,910,928
3	19,891	$395,895,378	$148,319,111
Total	831,355	$663,347,338	$255,079,137

Audit Stratification

Stratum	Audit Universe (# Claims)	Proportion (Weight by Count)	Sample
1	691,221	83.14%	60
2	120,243	14.46%	60
3	19,891	2.39%	60
Total	831,355	100.00%	180

Audit Sample Overview

Category	Count	Paid
Claims requested for audit	180	$552,832.03
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	$552,832.03
Audit sample if all claims paid correctly	180	$552,829.73
Claims with inadequate documentation	0	$0.00
Total claim payments remaining in audit sample	180	$552,829.73

**CTI's sampling methodology stratifies claims according to size and selects the same number of claims from each stratum using random sampling. Disproportionate (or non-proportionate) random sampling employs strata, but does not allocate sample observations by shares. CTI uses disproportionate random sampling within strata. This approach allows for oversampling small subpopulations (e.g. high dollar claims, which tend to occur less frequently than do other claims). The weighting process helps re-establish the balance in observations found in the original data.*

APPENDIX B – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Your administrator's response to the draft report follows.

CLAIM TECHNOLOGIES INCORPORATED

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

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

Claim Administration Audit

SPECIFIC FINDINGS REPORT

State of Montana Dental Plan
Administered by Delta Dental Insurance Company

Audit Period: January 1, 2018 through December 31, 2019

Presented to

Montana Legislative Audit Division

April 7, 2020

Presented by

CLAIM TECHNOLOGIES INCORPORATED

TABLE OF CONTENTS

INTRODUCTION

This ***Specific Findings Report*** contains information, findings, and conclusions from CTI's audit of Delta Dental Insurance Company's (Delta Dental) claim administration of the State of Montana's plan. 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 report to the State of Montana, the plan sponsor, and to Delta Dental, the claim administrator. We have included Delta Dental's response to these findings in Appendix B of this report.

CTI conducted the audit according to current, accepted standards and procedures for claim audits in the health insurance industry. We base our audit findings on the data and information provided by the State of Montana and Delta Dental. Their validity is reliant upon the accuracy and completeness of that information. While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind.

CTI planned and performed the audit to obtain a reasonable assurance claims were adjudicated according to the terms of the contract between Delta Dental and the State of Montana as well as the approved plan documents and other approved communications.

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 Delta Dental's claim payment policies, processes, and systems during the audit period.

Audit Objectives

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

- Delta Dental followed the terms of the services agreement;
- Delta Dental paid claims according to the provisions of the plan documents and if those provisions were clear and consistent;
- Members were eligible and covered by the State of Montana's plan at the time Delta Dental paid for an incurred service;
- Any claim administration or eligibility maintenance systems or processes need improvement.

Audit Scope

CTI audited Delta Dental's claim administration of the State of Montana dental plan for the period of January 1, 2018 through December 31, 2019. The number of claims and amount paid during that period were:

Total Paid Amount	$14,548,794
Total Number of Claims Paid/Denied/Adjusted	104,422

The audit included the following components:

1. **Operational Review and 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
   - Identify missing provisions, ambiguities, and inconsistencies

3. **100% Electronic Screening with 15 Targeted Samples**
   - Systematic analysis of 100% of paid claims
   - Problem identification and quantification

4. **Random Sample Audit of 110 Claims**
   - Statistical confidence at 95% +/- 3%
   - Determine the performance level for Key Indicators
   - Benchmarking
   - Problem identification and prioritization
   - Recommendations

5. **Data Analytics**
   - Provider Discounts
   - Sanctioned Provider Identification

OPERATIONAL REVIEW

Objective

CTI's Operational Review evaluates Delta Dental's claim administration systems, staffing, and procedures to identify any deficiencies that might materially affect its ability to control risk and to pay claims accurately on behalf of the plans.

Scope

The scope of the Operational Review included:

- Claim administrator information:
  - Delta Dental's insurance and bonding
  - Conflicts of interest
  - Internal audit
  - Financial reporting
  - Business continuity planning
  - Claim payment system and coding protocols
  - Data and systems security
  - Staffing
- Claim funding:
  - Claim funding mechanism
  - Check processing and security
  - COBRA/direct pay premium collections
- Claim adjudication, customer service, and eligibility maintenance procedures:
  - Exception claim 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 used an Operational Review Questionnaire to gather information from Delta Dental. We model our questionnaire after the audit tool used by certified public accounting firms when conducting an SSAE 18 audit of a service administrator. We modified that tool to elicit information specific to the administration of your plans.

We reviewed Delta Dental's responses and any supporting documentation supplied to gain an understanding of the procedures, staffing, and systems used to administer the State of Montana's plans. This allowed us to conduct the audit more effectively.

Findings

Claim Administrator Information

CTI reviewed information about Delta Dental including:

- Background information
- Financial reports
- Insurance protection types and levels
- Dedicated staffing
- Systems and software
- Fee and commission disclosure
- Performance standards
- Internal audit practices

We offer the following observations:

- Delta Dental provided a copy of its fidelity bond declaration page that showed a $15 million aggregate and $200,000 deductible. A copy of its cyber liability policy declaration page showed a $5 million aggregate with a deductible of $1 million. Delta Dental also provided a copy of its errors and omissions insurance declaration page showing a $10 million aggregate and $1 million deductible.

- Delta Dental and the State of Montana had a performance agreement in place for each year of the audit period with targets in the following categories:
  - Claims Turnaround Time
  - Overall Claims Accuracy
  - Customer Service Response Time
  - Customer Service Response
  - Account Management
  - Provider Monitoring
  - Timely Reporting

  All measures with the exception of Account Management and Timely Reporting are measured globally for Delta Dental's entire client pool. Delta Dental's self-reported results for 2018 and 2019 showed that all targets had been met or exceeded.

- Delta Dental indicated it had been audited for compliance 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. 18, reporting on controls at a service organization. Under SSAE 18, the administrator is required to provide a description of its system, which the service auditor validates. CTI has a copy of Delta Dental's SSAE 18 Bridge Letter and we can confirm that Delta Dental's external auditor did not note any deviations in the installation and maintenance of customer benefits, enrollment information, and healthcare provider agreements control, or in the claim adjudication and claim payment and customer funding controls.

- Delta Dental processes all claims on the MetaVance system, which was first deployed in 2007. Delta Dental uses self-developed software in conjunction with MetaVance to help detect unbundling.

- Delta Dental maintains a comprehensive Business Continuity and Disaster Recovery program designed to ensure the continuation of all vital corporate and business functions in the event of a disaster.
- Delta Dental has an account executive and account manager assigned to the State of Montana. Both have worked on the account for many years.

Claim Funding

CTI reviewed Delta Dental's claim check controls and procedures for:

- Claim funding
- Fund reconciliation
- Refund and returned check handling
- Security
- Stale check disposition
- Audit trail reports
- COBRA and retiree/direct pay premium collection

We observed the following:

- Delta Dental issued claim checks from its own checking account, which is designated solely for claim payment.
- In addition, Delta Dental indicated that it performs reconciliation and stale check handling for the State of Montana.
- Delta Dental appeared to have appropriate levels of security and control within its check issuance procedures to protect the State of Montana's interest and ensure all transactions were performed by authorized personnel only.
- Delta Dental provided documentation of claim system controls that include secure log-on passwords, separation of duties and access, and limitations on system override authority.
- Delta Dental honors assignment of benefits for non-network providers but also has a system of controls in place for checks issued directly to members.

Claim Adjudication, Customer Service, and Eligibility Maintenance Procedures

CTI reviewed Delta Dental's enrollment, eligibility maintenance, and claim processing controls and procedures. We observed the following:

- Delta Dental has adequately documented training, workflow, procedures, and systems.
- The State of Montana submits electronic employee and dependent eligibility data to Delta Dental on a weekly basis. Delta Dental updates its eligibility data on a daily basis.
- Delta Dental sends State of Montana members' notification letters each month up to a dependent's termination date beginning 120 days prior to the over age birthday. The letters instruct the primary enrollee to update his or her dependent's eligibility status. Dependent children are eligible to remain on the plan until they reach age 26.
- Delta Dental follows the standard industry process for coordination of benefits (COB) to ensure that combined benefits from all payers do not exceed 100% of its covered amount.
- Delta Dental does not report COB savings separately for the State of Montana.

- Delta Dental reported the State of Montana's electronic claim submission rate is 77%.
- Delta Dental stated that 93.4% of the State of Montana'a claims auto-adjudicate.
- Delta Dental pursues overpayment recovery on all amounts either by requesting repayment or withholding from future checks. Delta Dental does not typically seek to recover overpayments made to enrollees; those amounts are not charged back to the client. If Delta Dental is responsible for an overpayment and the funds are irretrievable, Delta Dental credits the client's account at its own expense. Delta Dental tracks reasons for overpayments but does not provide reports to clients.
- Delta Dental has a Network Oversight and Compliance department that conducts on-site examinations of dental offices to ensure member dentists are abiding by the terms of the agreements and to investigate allegations of fraud. All staff members have either a bachelor's degree in criminal justice or a related field and several years' dental claim audit experience or over 10 years of dental claim auditing. Delta Dental is a member of the National Health Care Anti-Fraud Association (NHCAA) and also monitors OIG and SAM reports to help detect potential fraud and abuse. In addition, it uses Business Objects to build models to identify suspect billing and utilization patterns.

Provider Contract and Reimbursement

- Delta Dental indicated that 91.3% of the State of Montana's claims came from in-network providers in 2019.
- CTI requested and Delta Dental declined to provide reports showing provider savings and discount amounts.

Dental Consultant/Utilization Review

- Delta Dental employs a full-time staff of dental consultants for claim review, pre-treatment estimate review, and quality assessment. Consultants are DDS/DMDs, have active licenses, and at least five years of experience.
- Services requiring consultant review include all procedures that require professional judgment for adjudication, miscellaneous procedures, procedures that are not otherwise adequately described by an existing CDT code, and claims submitted by dentists on review for exceptional utilization.
- Approximately 1% of all claims processed is forwarded for review and policies recommended by reviewers achieve over 3% savings off all submitted charges.

HIPAA Compliance

CTI reviewed information about the systems and processes Delta Dental had in place to maintain compliance with HIPAA regulations. The objective was to determine if the administrator was aware of the HIPAA regulations and was compliant at the time of the audit.

We observed the following:

- Delta Dental had appropriate levels of security and controls in place to protect the plan sponsor's dental plan records and data and was compliant with HIPAA requirements at the time of the audit.
- Company-wide HIPAA compliance is overseen by Delta Dental's Department of Risk, Ethics, and Compliance.

- Delta Dental employees receive HIPAA training within 90 days of hire and annually thereafter.
- Delta Dental indicated it did not have any breaches triggering notification requirements for the State of Montana.

PLAN DOCUMENTATION ANALYSIS

Objective

The objective of the Plan Documentation Analysis was to evaluate the documents governing the administration of the State of Montana's dental plans and identify inconsistencies, ambiguities, or missing provisions that might negatively impact accurate claim administration. Through this evaluation, we gained an understanding of Delta Dental's administrative service responsibilities for the State of Montana's dental plan. This understanding allowed us to audit more effectively.

Scope

Our auditors evaluated:

- Plan documents, descriptions, and any amendments
- Administrative services agreement

Methodology

CTI obtained a copy of the plan documentation from the State of Montana and/or Delta Dental. Our auditors reviewed the applicable documents to better understand the provisions Delta Dental should use to adjudicate the State's claims. We used a benefit matrix to help us understand your plan provisions. 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 the State of Montana about any inconsistencies in the plan documents. Our auditors then used the benefit matrix as a cross-reference tool as they audited claims.

Findings

Our auditors did not identify any inconsistencies, ambiguities, or missing provisions in our Plan Document Analysis.

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

CTI's 100% Electronic Screening with Targeted Sample Analysis identified and quantified potential claim administration payment errors. The State of Montana and Delta Dental should talk about any verified under or overpayments to determine the appropriate actions to correct the errors.

Scope

CTI electronically screened 100% of the service lines processed by Delta Dental during the audit period. The accuracy and completeness of Delta Dental's data directly impacted the screening categories we completed 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 exclusions
- Plan limitations

Methodology

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

- *Electronic Screening Parameters Set* – We used your plan document provisions to set the parameters in ESAS.
- *Data Conversion* – We converted and validated your claim data, reconciled it against control totals, and checked it for reasonableness.
- *Electronic Screening* – We systematically screened 100% of the service lines processed and flagged claims not administered according to plan parameters.
- *Auditor Analysis* – If claims within an ESAS screening category represented a material amount, our auditors analyzed the findings to confirm results were valid. When using ESAS to identify payment errors, note that incomplete claim data could lead to false positives. CTI auditors made every effort to identify and remove false positives.
- *Targeted Sample Analysis* – From the categories identified with material amounts at risk, we selected the best examples of potential under or overpayments to test. As cases were not randomly selected, we cannot extrapolate results. We selected a total of 15 cases and sent your administrator a questionnaire for each. Targeted samples verified if the claim data supported our finding and if our understanding of plan provisions matched Delta Dental's administration.
- *Audit of Administrator Response and Documentation* – We reviewed the responses and redacted them to eliminate personal health information. Based on the responses and further analysis of the findings we removed false positives identified from the potential amounts at risk.

Findings

After review of Delta Dental's responses to the substantive testing questionnaires we sent for each of the 15 targeted samples, we did not identify any potential payment errors or process improvement opportunities.

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 to prioritize areas of administrative deficiency for further review and remediation.

Scope

CTI's Random Sample Audit included a stratified random sample of 110 paid or denied claims. 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 the sample is in Appendix A.

Delta Dental's performance was measured using the following key performance indicators:

- Financial Accuracy
- Accurate Payment
- Accurate Processing

We also measured claim turnaround time, a commonly relied upon performance measure.

Methodology

CTI's Random Sample Audit employs a consistent methodology. While it is rooted in the principles of statistical process control, our Random Sample Audit goes beyond because its intended outcome is continuous quality improvement. Our auditors reviewed each sample claim selected to ensure it conformed to plan specifications, agreements, and negotiated discounts. We recorded our findings in our proprietary audit system.

When applicable, we cited claim payment or processing errors. We observed payment errors by comparing the way a selected claim was paid and the information Delta Dental 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 Delta Dental how to reduce errors and re-work in the future.

CTI communicated in writing with Delta Dental about any errors or observations using system generated observation response forms. We sent Delta Dental a preliminary report for its review and written response. We considered Delta Dental's response, as found in Appendix A, when producing the final reports.

Findings

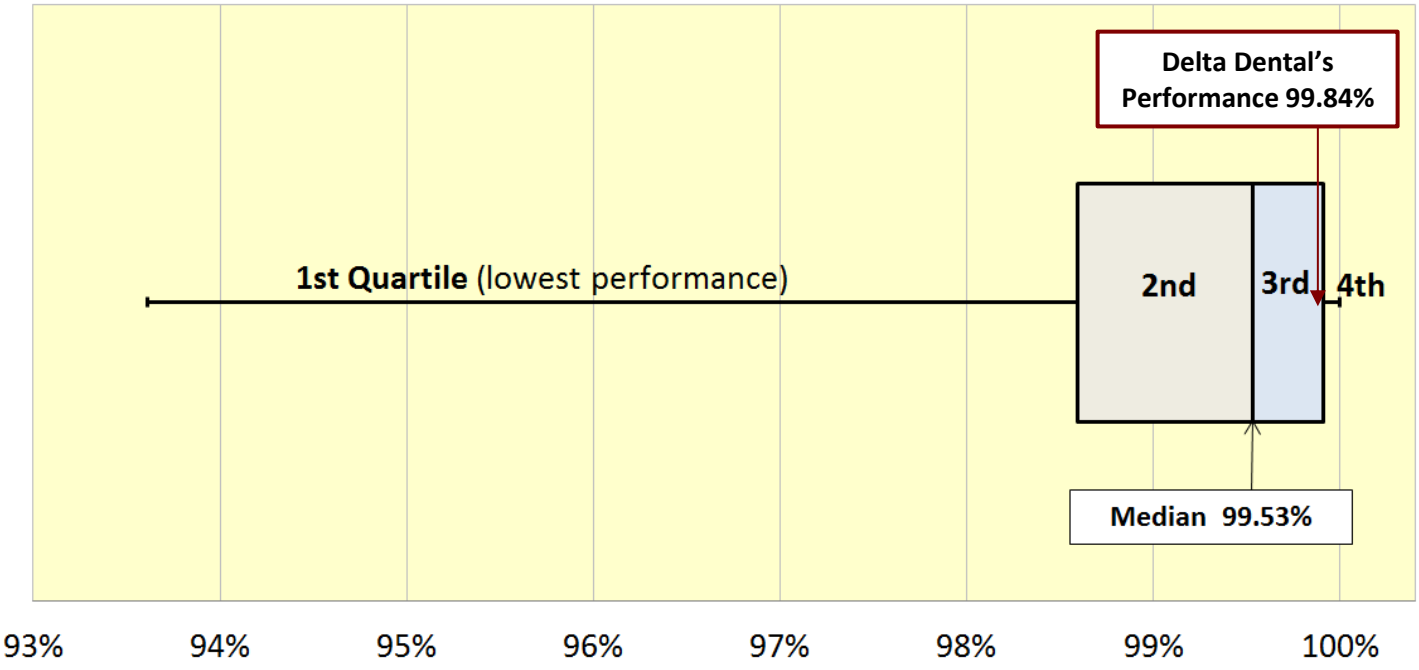
The following box and whiskers charts demonstrate Delta Dental's performance as compared to the last 40 dental audits performed by CTI. The fourth quartile represents the 10 highest performing plans, and the first quartile represents the lowest 10. The Median is the point at which 20 plans audited were above, and 20 plans were below.

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 $107.00 in underpayments and $0.00 in overpayments, for a combined variance of $107.00. The correct payment total for the adequately documented claims in the audit sample should have been $25,016.20.

The weighted Financial Accuracy rate for the claims sampled was **99.84%**.



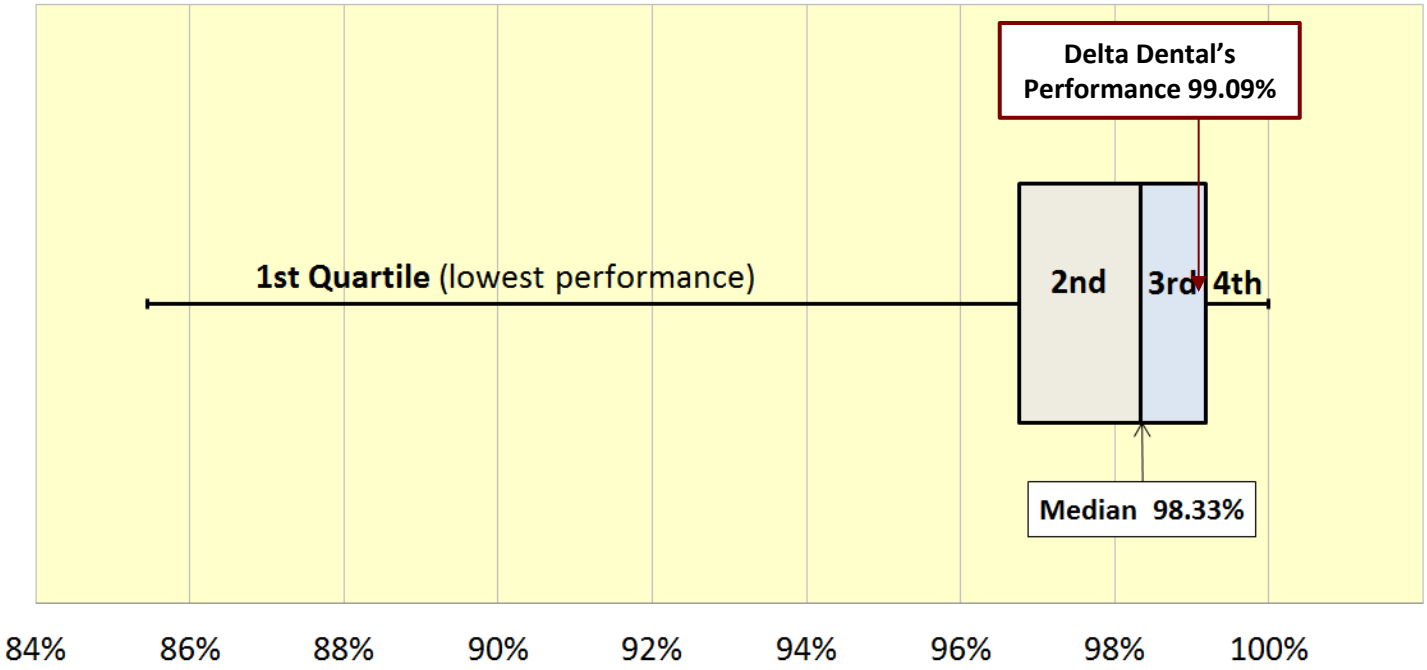
Financial Accuracy and Accurate Payment Detail Report						
Error Description	**Audit No.**	**Under/ Over Paid**	**Admin Response**	**CTI Response**	**Manual or System**	
Denied Eligible Procedure	1096	$107.00	Agree. The mailroom team member did not follow all desk level procedures and failed to separate the claims forms for the sibling. We apologize for the error. The claim has since been processed under the other claimant's account. Payment along with interest will go to the provider.	An adjudication error and underpayment are cited. Eligible expenses for the second claimant were denied.	System	
TOTALS	**1**	**VARIANCE $107.00**			**M: 0**	**S1**

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 1 incorrectly paid claims and 109 correctly paid claims. Note CTI only uses adequately documented claims for this calculation.

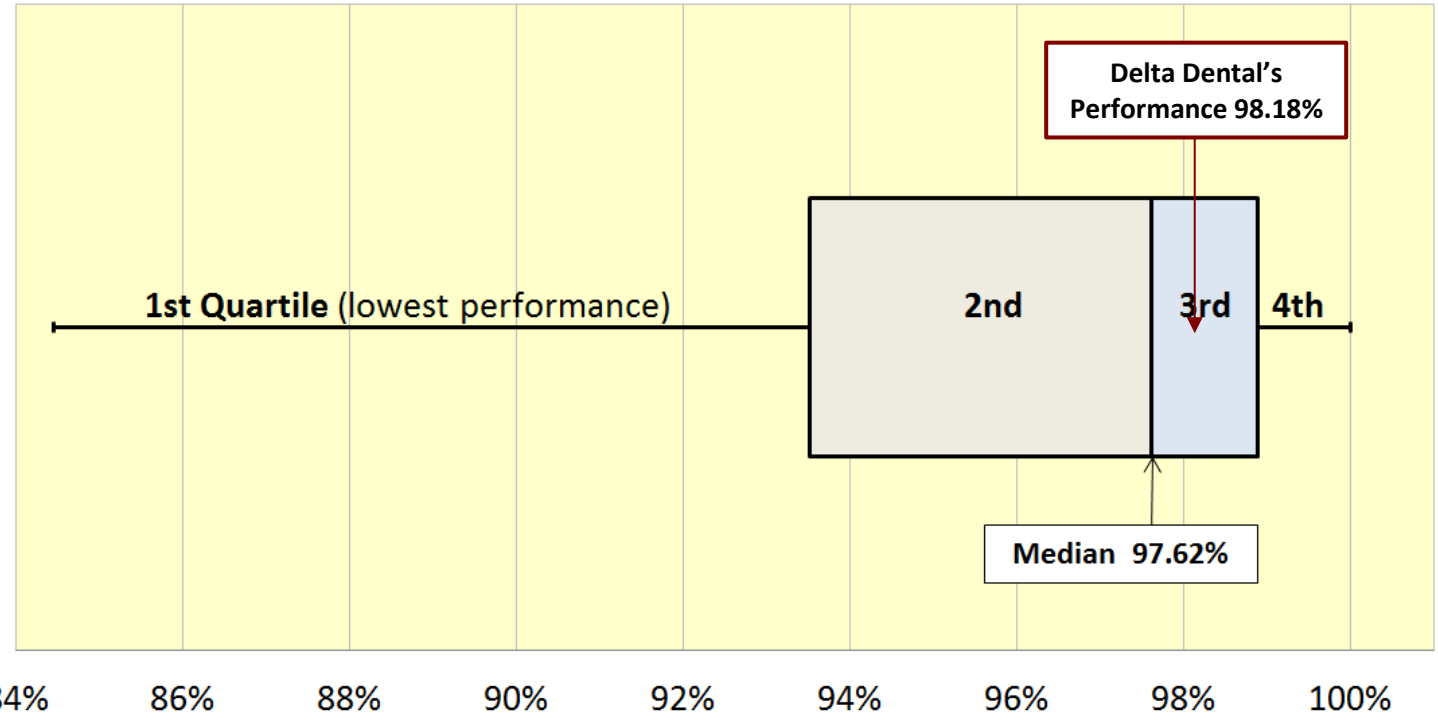
Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid Claims	Overpaid Claims	
110	1	0	99.09%



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	
108	2	0	98.18%



Accurate Processing Detail Report				
Error Description	**Audit No.**	**Admin Response**	**CTI Response**	**Manual or System**
Coordination of Benefits Investigation				
Other Insurance Not Investigated	1092	Agree. The claims examiner did not follow all desk level procedures when the claim pended for examiner review. The examiner incorrectly entered COB information. However, the claim ultimately denied, and no overpayments were made. The claim examiner was coached, and additional training was provided.	An adjudication error is cited. The billing provider on this claim is Medicaid. The claim was denied for tooth numbers not listed when Delta Dental should have also requested other insurance information. With the way Delta Dental's system processes claims, once the tooth numbers are provided, the system will then request the other insurance information and processing will be delayed. Ideally, the system should ask for all needed information in one comprehensive request.	System
Policy Provisions				
Denied Eligible Procedure	1096	Agree. The mailroom team member did not follow all desk level procedures and failed to separate the claims forms for the sibling. We apologize for the error. The claim has since been processed under other claimant's account. Payment along with interest will go to the provider.	An adjudication error is cited. Eligible expenses for the second claimant were denied.	System

Claim Turnaround

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

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

Median	Mean	+45 Days to Process
1	2	0

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:

- Provider Discount Validation
- Sanctioned Provider Identification

The following pages provide the objectives, scope, and report of each data analytic to enable more-informed decisions about ways the State of Montana 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 of our clients will provide a more meaningful comparison.

Report

We were unable to calculate provider discounts for the State of Montana because Delta Dental considers its contracted discounts confidential information and does not provide them in electronic format.

Sanctioned Provider Identification

The Sanctioned Provider Identification report identifies services rendered by providers 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 about 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 physician and other medical professional claims.

Report

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

CONCLUSION

We consider it a privilege to have worked for, and with, your staff and administrator. Should the State of Montana decide that additional assistance in implementing or performing any of the required tasks would be beneficial, our contract offers eight hours of post-audit time to provide you with further assistance.

Thank you again for choosing CTI.

APPENDIX A – SAMPLE CONSTRUCTION AND WEIGHTING METHODOLOGY

Client: State of Montana
Audit Period: January 01, 2018 - December 31, 2019

Claim Universe (as converted)

Stratum*	Claim Count	Total Charge Amount	Total Paid Amount
1	76,597	$11,047,438	$6,734,012
2	13,538	$4,488,018	$1,945,369
3	14,287	$19,057,593	$5,869,413
Total	104,422	$34,593,049	$14,548,794

Audit Stratification

Stratum	Audit Universe (# Claims)	Proportion (Weight by Count)	Sample
1	76,597	73.35%	36
2	13,538	12.96%	53
3	14,287	13.68%	21
Total	104,422	100.00%	110

Audit Sample Overview

Category	Count	Paid
Claims requested for audit	110	$24,909.20
Claims for which records not received	0	$0.00
Claims outside scope of audit	0	$0.00
Claims as entered included in audit sample	110	$24,909.20
Audit sample if all claims paid correctly	110	$25,002.00
Claims with inadequate documentation	0	$0.00
Total claim payments remaining in audit sample	110	$25,002.00

**CTI's sampling methodology stratifies claims according to size and selects the same number of claims from each stratum using random sampling. Disproportionate (or non-proportionate) random sampling employs strata, but does not allocate sample observations by shares. CTI uses disproportionate random sampling within strata. This approach allows for oversampling small subpopulations (e.g. high dollar claims, which tend to occur less frequently than do other claims). The weighting process helps re-establish the balance in observations found in the original data.*

APPENDIX B – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Your administrator's response to the draft report follows.

DELTA DENTAL®

deltadentalins.com

March 30, 2020

Ms. Vivian Hayashi
Claims Technologies Incorporated
100 Court Abe, Suite 306
Des Moines, IA 50309

Re: State of Montana Audit of Delta Dental

Dear Vivian:

Thank you for providing the audit findings for our mutual customer, State of Montana.

State of Montana is a valued customer of Delta Dental. We are committed to administering their benefits accurately and according to contract.

We have thoroughly reviewed the findings and have provided a response to each in the grid below.

Audit Finding	Page Number	sample Number	Delta Dental Response	Delta Dental Supporting Detail
Coverage for this service is currently being paid at 100%, however, this code is a periodontal code. Plan reflects that periodontics is covered under the Basic Benefits and payable at 80%. An adjudication error is cited with an overpayment of $14.20.	16	1085	Disagree with auditors finding.	As a standard Delta Dental allows the D4346-(scaling in presence of generalized moderate or severe gingival inflammation – full mouth) is treated as preventative procedure because it is more similar to a D1110

Response to observation:

Audit Finding	Page Number	Item Number	Delta Dental Response	Delta Dental Supporting Detail
The billing provider was Medicaid. Other insurance payment amounts were entered on the BCBS system. However, the claim billed did	16	1092	Agree with auditors' findings	The claims examiner did not follow all desk level procedures when the claim pended for examiner review. The examiner incorrectly entered COB information. However, the

Delta Dental Insurance Company
55 West 14th Street
Suite 101
Helena, MT 59601

Telephone: 406-449-0255
800-547-1986
Facsimile: 406-495-0322

not contain this information. The claim was denied for tooth numbers not being listed on the bill when BCBS would also need the other insurance information in order to process this claim				claim ultimately denied, and no overpayments were made. The claim examiner was coached, and additional training was provided.
A. The charge amount was entered as $69.00 and should have been entered as $89.00. A data coding error is cited. B. Eligible expenses for Nikayla were denied on this claim. This should have been covered under her policy. An adjudication error is cited with an underpayment of $107.00.	16	1096	Agree with auditors' findings	The mailroom team member did not follow all desk level procedures and failed to separate the claims forms for the sibling. We apologize for the error. The claim has since been processed under the Nikayla account. Payment along with interest will go to the provider.

We look forward to jointly discussing the results of this audit at a future meeting with the State of Montana. Once again, thank you for your partnership.

Sincerely,

Jeffrey Almonte

Audit Project Manager

Account Manager

CLAIM TECHNOLOGIES INCORPORATED

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

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

Prescription Benefit Management Audit

SPECIFIC FINDINGS REPORT

State of Montana
Administered by Navitus Health Solutions, LLC

Audit Period: January 1, 2018 – December 31, 2019

Presented to

State of Montana
April 10, 2020

Prepared by

PillarRx
Consulting

Subcontractor to

CLAIM TECHNOLOGIES
INCORPORATED

PREFACE

This ***Specific Findings Report*** contains detailed information, findings, and conclusions that the PillarRx Consulting, LLC (PillarRx) audit team has drawn from their Prescription Benefit Management Audit of Navitus Health Solutions, LLC's (Navitus) administration of the State of Montana pharmacy plan. This ***Specific Findings Report*** is provided to the State of Montana, the plan sponsor, and Navitus, the pharmacy benefit manager.

The findings in this report were based on data and information the State of Montana, as the plan sponsor, and Navitus, as the pharmacy benefit manager (PBM) provided to PillarRx and their validity relies upon the accuracy and completeness of that information.

The audit was planned and performed to obtain a reasonable assurance that prescription drug claims were adjudicated according to the terms of the contract between Navitus and the plan sponsor, as well as the benefit descriptions (summary plan descriptions, plan documents or other communications) approved by the State of Montana.

PillarRx is a firm specializing in audit and control of pharmacy benefit plan administration. The statements made by PillarRx in this report relate narrowly and specifically to the overall efficacy of Navitus' policies, processes and systems relative to the State of Montana's paid claims during the audit period.

PillarRx Consulting, LLC

TABLE OF CONTENTS

PREFACE

This ***Specific Findings Report*** contains detailed information, findings, and conclusions that the PillarRx Consulting, LLC (PillarRx) audit team has drawn from their Prescription Benefit Management Audit of Navitus Health Solutions, LLC's (Navitus) administration of the State of Montana pharmacy 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***. This ***Specific Findings Report*** is provided to the State of Montana, the plan sponsor, and Navitus, the pharmacy benefit manager.

The findings in this report were based on data and information the State of Montana, as the plan sponsor, and Navitus, as the pharmacy benefit manager (PBM) provided to PillarRx and their validity relies upon the accuracy and completeness of that information.

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

PillarRx is a firm specializing in audit and control of pharmacy benefit plan administration. The statements made by PillarRx in this report and the ***Specific Findings Report*** relate narrowly and specifically to the overall efficacy of Navitus' policies, processes and systems relative to the State of Montana's paid claims during the audit period.

PillarRx Consulting, LLC

ACRONYMS USED IN THIS REPORT

Acronym	Definition
AWP	Average Wholesale Price
CMS	Centers For Medicare and Medicaid Services
DS	Day Supply
EGWP	Employer Group Waiver Plan
HCPCS	Healthcare Common Procedure Coding System
J-Codes	Procedure Codes for Specialty Medications
MAC	Maximum Allowable Cost
MOOP	Maximum Out-of-Pocket
MPA	Member Prior Authorization
NC	Non-Covered
NDC	National Drug Code
NONPAR	Non-Participating
NPI	National Provider Identifier
PA	Prior Authorization
PBM	Pharmacy Benefit Manager
PDE	Prescription Drug Event
U&C	Usual and Customary

INTRODUCTION

Audit Objectives

The objectives of the PillarRx audit of Navitus' pharmacy benefit management were to determine if:

- Navitus adhered to the contractual and pricing terms outlined in the agreement with the State of Montana.
- Navitus accurately administered benefit provisions for both commercial and Employer Group Waiver Plans (EGWP).
- Navitus appropriately generated and submitted Prescription Drug Event (PDE) records to the Centers for Medicare and Medicaid Services (CMS).

Audit Scope

PillarRx's audit encompassed the contract in force and the pharmacy benefit claims administered by Navitus for the audit period of January 1, 2018 through December 31, 2019. The State of Montana's population of claims and the total net plan paid (equals total payment less member copayment) during this period:

Audit Period January 1, 2018 through December 31, 2019	
Commercial Plan	
Number Prescription Drug Claims Paid	530,290
Net Plan Paid	$61,827,934
Employer Group Waiver Plan (EGWP)	
Number Prescription Drug Claims Paid	278,257
Net Plan Paid	$36,211,083

The audit included the following three components.

1. **Pricing and Fees Audit**
2. **Benefit Payment Accuracy Review - Commercial and EGWP**
3. **Prescription Drug Event (PDE) Review - EGWP**

Key findings for each component are discussed in the following sections of this report.

PRICING AND FEES AUDIT

Pricing and Fees Audit Objective

The Pricing and Fees Audit verified that claims were processed according to the discounts and fees specified in Navitus' contract with the State of Montana.

Pricing and Fees Audit Scope

After a thorough forensic verification of the electronic claim data provided by Navitus, PillarRx systematically re-priced 100% of prescription drug claims paid during the audit period to determine:

- Discounts were applied correctly based on the lesser of Maximum Allowable Cost (MAC), Average Wholesale Price (AWP), and Usual and Customary (U&C); and
- Pharmacy dispensing and administrative fees were applied correctly.

Pricing and Fees Audit Methodology

Contract Document Review

PillarRx requested and received from the State of Montana and Navitus all contracts, amendments, formulary drug lists, and reconciliation documents for the audit period.

Claim Validation

We mapped and validated the raw claim data provided by Navitus to PillarRx's standard layout. Raw claim data represented the successive pharmacy claim transactions that included both paid and reversed claims and was critical to our understanding of Navitus' processing and adjudication rules. Once mapped, the data was reconciled against control totals and put through a rigorous process referred as PillarRx's data forensics – or the verification of claim data by assessing appropriate patterns and relationships. The data forensics included comparing the mapped data to the following benchmarks:

- Prior authorizations
- Rejections
- Reversals
- National Provider Identifier (NPI)
- National Drug Code (NDC)

To complete the claim validation, we provided our forensic report to Navitus to verify that the:

- Pharmacy benefit claims data provided for this audit was complete and accurate;
- Claims were loaded correctly into the PillarRx system; and
- Claim counts and total paid claim amounts were accurate.

Pricing and Fees Analysis

Drug discount rates are calculated based on the AWP and evaluated by brand and generic then applied to the delivery channels of mail, retail and specialty pharmacy claims. The discount portion of the pricing audit compares the contractually agreed upon discount rates to the discount rates that were actually achieved. The State of Montana's contract with Navitus is considered a pass-through contract, in which all discounts and billing are passed on to the State of Montana. The discount guarantees are outlined in the Request For Proposal (RFP), which is considered a part of the contract.

PillarRx has assessed discounts and dispensing fees against a standard template PBM contract for a client of this size with the understanding that Navitus is passing through all discounts to the State of Montana.

PillarRx concludes that Navitus is performing as expected on discounts and dispensing fees. PillarRx reviews national contracts on a regular basis, and the State's pricing parameters compare favorably with the size and scope expected in the marketplace for the time period analyzed.

2018-2019 Discounts		**PillarRx BENCHMARKS**
Mail	**Achieved Discounts**	**Benchmark Discounts**
Brand	AWP – 22.74%	AWP – 23.00%
Generic	AWP – 89.40%	AWP – 80.25%
Specialty	AWP – 21.03%	AWP – 17.75%

Retail	**Achieved Discounts**	**Benchmark Discounts**
Brand	AWP – 19.33%	AWP – 16.00%
Generic	AWP – 88.64%	AWP – 78.50%

Dispensing Fees Collected
$312,043

BENEFIT PAYMENT ACCURACY REVIEW

Benefit Payment Accuracy Review Objective

The objective of the Benefit Payment Accuracy Review was to verify correct adjudication of plan design provisions and quantify potential opportunities for recovery and/or cost savings.

Benefit Payment Accuracy Review Scope

PillarRx created an exact model of the benefit plan parameters of the State of Montana's pharmacy plan in AccuCAST and systematically re-adjudicated 100% of paid prescription drugs. Benefit plan parameters analyzed included but were not limited to:

- Age and gender
- Copay/coinsurance
- Day supply maximums
- Excluded drugs
- Prior authorizations
- Quantity limits
- Refill limits
- Zero balance claims

Exceptions that were identified but could not be explained by PillarRx's benefit analysts were provided to Navitus for explanation. If adequate documentation was provided to support the exceptions were adjudicated correctly, AccuCAST was reset to represent the revised plan parameters and the claims were electronically re-adjudicated again to ensure consistency.

Benefit Payment Accuracy Review Methodology

After receiving the plan documentation from the State of Montana and Navitus, including copayment and coverage rules, summary plan description and/or plan documents, PillarRx programmed the State of Montana's plan design in AccuCAST. Each claim was re-adjudicated and exceptions were identified. The exceptions were aggregated by category and analyzed by our benefit analysts. Exceptions that could not be explained were submitted to Navitus for review.

PillarRx provided 1,465 claims to Navitus for review and response. Our audit results were based upon those responses.

Benefit Payment Accuracy Review Findings

Commercial Plan

Copayments

Copayments represented the dollar amount required to be paid by the member when a prescription drug was purchased. Our observations and conclusions relative to copayments follow.

Commercial - Copayment Plan Analysis (1/1/2018 – 12/31/2019)				
Total Claims	**Copays per Plan**	**Copays Collected**	**Variance**	**Variance Percent**
530,290	$13,610,364	$13,600,398	$9,966	0.073%

PillarRx submitted 197 commercial claims to Navitus that represented potential exceptions to the copayment requirements.

PillarRx's findings with Navitus' responses below:

Commercial - Retail and Mail Prescription Drugs			
Copayment Rule	**PillarRx Initial Findings**	**Navitus Responses**	**PillarRx's Final Conclusion**
Tier 1 – Pref Generics	Various copay amounts are being charged outside of what is in the plan documents of $15. There are many Prior Authorizations for these claims.	• Member Prior Authorization (MPA) overriding copay to $0. • This is COB claim where Navitus is paying secondary. • Out of Pocket Met.	Based on additional information provided by Navitus, PillarRx agrees claims adjudicated appropriately.
Tier 1 – 90 Day Supply	Various copay amounts are being charged outside of what is in the plan documents of $30. There are many Prior Authorizations for these claims.	• MPA overriding copay to $0 • MPA overriding copay to 100% • This member has met their smoking max benefit and is now at 100% copay. • Not a 90DS. It's 150DS which pays according to regular retail benefits, not Extended Supply benefits. • NONPAR claim. They should be limited to a 10-day supply and a copay of $15 for T1. But MPA for this claim overrode that. The claim was a Government/Military claim for an active duty member. • Pharmacy submitted a negative amount for other insurance payment.	Based on additional information provided by Navitus, PillarRx agrees claims adjudicated appropriately.
Retail Specialty-No Tier	Various copay amounts are being charged outside of what is in the plan documents of $200. There are many Prior Authorizations for these claims.	• Coupon applied to claim and is supposed to take $0. • Specialty coupon claim, paying correctly at 30% • This is a specialty claim for a 56-day supply and drug is not on the limited to 30-day supply list. So, it is taking 2-month copay. • This is a specialty claim for an 84 day supply and drug is not on the limited to 30 day supply list. So it is taking 3 month copay.	Based on additional information provided by Navitus, PillarRx agrees claims adjudicated appropriately.

Commercial - Retail and Mail Prescription Drugs			
Copayment Rule	**PillarRx Initial Findings**	**Navitus Responses**	**PillarRx's Final Conclusion**
Retail Tier 4	$50 copay being charged, per plan design claims should take 50%; specialty claim not filled at a preferred specialty pharmacy. There Prior Authorizations for these claims.	• The MPA that was used on the claim incorrectly set the Tier to 4. The Tier needs to be set to S in order to take the non pref specialty copay. This MPA/override was entered back in March of 2018 by an agent that is no longer with Navitus. After this time, the Prior Authorization team pulled all MPA/overrides on file for not covered (NC) specialty medications that were entered as of May 2018 and updated them if they were entered incorrectly. • We increased our auditing processes and changed the timeliness of the delivery of the audits to provide more direct and immediate feedback and to allow for more timely corrections. • We revamped how all of our MPA references were worded/displayed for not covered specialty medications to better call out how to correctly enter these overrides. • Notification was sent to the team when the updates to those references were made so that any agents on the floor were made aware of the changes and new agents are trained on the correct processes for these approvals. • We also changed how the Clinical team indicates they are approving a NC specialty medication to call attention to the need for new/different references from traditional NC approvals.	Based on additional information provided by Navitus, PillarRx finds this to be an error: these 2 STELARA claims were set up incorrectly and should have taken the 50% coinsurance vs. $50 flat copay; Billings Clinic is not a preferred specialty pharmacy so the claims should have taken the non-preferred specialty copay. The variance being reported ($9,966) is owed to the client.

Commercial Plan - Drug Exclusions/Prior Authorizations

Exclusions specify the drugs and products that a plan did not or would not cover unless there was a Prior Authorization (PA). Based on documentation provided by Navitus, PillarRx created an

exclusion drug list and PA drug list and then re-adjudicated the claims for these non-covered and prior authorized medications.

Navitus provided PillarRx with a drug list which included NDCs that were not covered or that required a PA. After entering this into our system, there are 597 claims that require a PA that didn't have a PA on the file.

Navitus responded to a sample of 50 claims and identified that the majority of claims (EPIDUO and TRETINOIN) that require a PA were processed appropriately because members were under the age restriction required for a PA and the remaining claims were for TRUVADA which upon further research does not require a PA.

Based on Navitus' responses, PillarRx agrees claims adjudicated appropriately.

Commercial Plan - Administration of Quantity Limits

The quantity limit is the maximum quantity that can be dispensed over a given period of time. Examples would include inhalers, injectables and patches.

PillarRx's quantity limit analysis examines the State of Montana's plan design and dosage rules, compares these to the pharmacy claims and identifies any discrepancies or trends.

PillarRx's analysis didn't find any claims outside the quantity limits.

EGWP Plan

Copayments

Copayments represented the dollar amount required to be paid by the member when a prescription drug was purchased. Our observations and conclusions relative to copayments follow.

EGWP - Copayment Plan Analysis (1/1/2018 – 12/31/2019)				
Total Claims	**Copays per Plan**	**Copays Collected**	**Variance**	**Variance Percent**
278,257	$7,959,663	$7,959,663	$0	0%

PillarRx submitted 92 EGWP claims to Navitus that represented potential exceptions to the copayment requirements.

PillarRx's findings with Navitus' responses below:

EGWP- Retail and Mail Prescription Drugs			
Copayment Rule	**PillarRx Initial Findings**	**Navitus Responses**	**PillarRx's Final Conclusion**
Mail Tier 1	Claims not charging the expected copay of $30	• Unbreakable Package Logic (creams, lotions, eye drops, etc). Day supplies were less than 90 days. • MOOP was met	Based on additional information provided by Navitus, PillarRx agrees claims adjudicated appropriately.
Mail Tier 2	Claims not charging the expected copay of $100	• MOOP was met.	Based on Navitus' responses, PillarRx agrees claims are adjudicating appropriately.
Mail Tier 3	Claims not charging the expected 50% coinsurance however they all do have a PA. Verify the PA is for the copay and provide a screen print.	• Copay lowering was approved through MPA for various members treating claims as Tier 2- transition fills.	Based on additional information provided by Navitus, PillarRx agrees claims adjudicated appropriately.
Retail Tier 3 (1-34 ds)	Claims in question are charging a $50 copay instead of 50% however they all do have a PA. Verify the PA is for the copay and provide a screen print.	• Copay lowering was approved through MPA for various members treating claims as Tier 2- transition fills. • MOOP was met.	Based on additional information provided by Navitus, PillarRx agrees claims adjudicated appropriately.
Retail Tier 4 (1-34 ds)	Claims not charging the expected coinsurance of 50%. Review and provide reason and screen shots if necessary to explain why.	• MPA is not setting a tier so it is taking the Tier 1 copay. • MPA is setting claim to $50 copay. • MOOP was met.	Based on additional information provided by Navitus, PillarRx agrees claims adjudicated appropriately.

EGWP - Drug Exclusions/Prior Authorizations

Exclusions specify the drugs and products that a plan did not or would not cover unless there was a Prior Authorization (PA). Based on documentation provided by Navitus, PillarRx created an exclusion drug list and PA drug list and then re-adjudicated the claims for these non-covered and prior authorized medications.

Navitus provided PillarRx with a drug list which included NDC's that required a PA. After entering this into our system, there are only two claims that require a PA that didn't have a PA on the file.

Navitus provided claim level responses for all the claims that should have a PA according to plan design documentation. Navitus indicated that claims paid correctly because claims paid under

Transition and PA was not required. Based on Navitus' responses PillarRx agrees claims are adjudicating appropriately.

EGWP - Administration of Quantity Limits

The quantity limit is the maximum quantity that can be dispensed over a given period of time. Examples would include inhalers, injectables and patches.

PillarRx's quantity limit analysis examines the State of Montana's plan design and dosage rules, compares these to the pharmacy claims and identifies any discrepancies or trends.

PillarRx's analysis didn't find any claims outside the quantity limits.

Prescription Drug Event (PDE) Analysis

PillarRx audited 100% of the PDE records processed from January 1, 2018 through December 31, 2019. PillarRx identified 37 claims that matched to a Rejected or Deleted PDE in 2019 and nine claims that matched a Rejected or Deleted PDE in 2018. All claims were provided to Navitus for review and response.

Navitus provided responses to all claims. For 2019, PDEs were either accepted at the end of 2019 or claims were reversed in 2019 and never reprocessed- 3 claims were noted to be associated with members that had been retro-termed. For 2018, PDEs were determined to have been accepted. Based on Navitus' responses, PillarRx agrees all PDEs were processed correctly.

J-CODE ANALYSIS

As healthcare continues to evolve with new treatments and cures for complex, chronic diseases, providers are moving towards managing therapies and identifying cost-containment strategies. Specialty drug treatments are driving this initiative within the pharmacy and medical benefit. It's estimated within the next few years specialty medications will represent 55% of overall pharmacy costs. Specialty medications are also growing in absolute dollars within the medical benefit.

PillarRx's Integrated Medical / Rx Specialty Analysis is performed in conjunction with clinical overview and financial analysis. Utilizing J-Code comparative analysis, the end results allow PillarRx to provide our clients recommendations on best benefit coverage (medical and pharmacy), assuring the appropriate drug is being dosed and administered at an optimal site of care, potentially facilitate the recovery of double payments, reduce drug costs, and gain additional savings through increased rebates.

Data Loading and Integration

The first portion of the analysis, PillarRx loads and analyzes the integration of data to verify the data is accurately and correctly supports the analysis. The PillarRx software and analytics tool reviews 100% of both medical and pharmacy claims and delivered a thorough analysis of:

- Medical/Rx claims overlap and duplication of payment – we look for any concurrent 30-day period for the medical and prescription claim for the same pharmaceutical.
- Financial understanding of the various delivery silos – a comparative analysis of J-Codes Medical vs NDC pharmacy including provider type and rebate potential, relative to net cost.
- Correct policies/procedures for benefit coverage – we look to ensure payments meet specific prior authorization coverage criteria for medical and pharmacy claims.
- Optimization of Specialty Spend and Management by site of care – following data analysis, if applicable, PillarRx will provide recommendations for optimizing your specialty program.

Medical Data Analysis: J-Codes are part of the Healthcare Common Procedure Coding System (HCPCS) Level II set of procedure codes. J-Codes are used by the medical claim payor to price and process, including the pharmaceutical and potentially associated fees.

Pharmacy Data Analysis: PillarRx's specialty drug analysis employs proprietary benchmarks and algorithms. The benchmarks and algorithms utilize implied dose and duration to identify potential waste and inefficiencies. We compare medications paid for and delivered in the medical benefit to the medication paid for and delivered in the pharmacy benefit. Performed in conjunction with a cross-disciplinary mix, clinical overview, and financial analysis, the results of the specialty drug analysis enabled us to make recommendations and potentially facilitate a long-term solution for managing pharmacy spend.

The analysis includes:

- Payments within the Medical Benefit
- Payments made within the Pharmacy Benefit (Mail Order, Specialty, Pharmacy Network)

For the State of Montana, PillarRx loaded 80,307 medical J-Code transactions and 807,344 pharmacy claims. A crosswalk between the medical and pharmacy claim was created by matching the employee ID and social security number along with the relationship code to the subscriber, the gender, and date of birth. Over 1,000 medications were reviewed. PillarRx used a filtering method to exclude claims that did not meet the parameters of the analysis.

Drug Pricing Channel Benchmarks: Medical vs. Pharmacy

Next, PillarRx benchmarks pricing and determines the optimal pricing channel for the specialty medications. This includes:

- Conducting an analysis of medical and pharmacy claim submission
- Identifying differences in systems, pricing (per unit), and coding
- Specifically analyze the plan utilizing NDC codes
- Conducting an analysis of medical claims submission
  - Differences in pricing/coding
  - Conduct an analysis of Medical vs. Rx claims
- Identifying the most appropriate delivery channel or point of access for categories of drugs
- Clinical assessment of application of medical necessity guidelines, business rules, and site of care delivery on both the medical and pharmacy side

PillarRx reviewed and compared all specialty claims within each patient's profile and included an Implied Diagnosis for each medication filled. Within each Implied Diagnosis, medications were sorted by the specific place of service at which they were filled and summarized. PillarRx included the Average Charge and Average Cost per Utilizer for each category. We included the average unit cost for each category. In the chart below, the optimal pricing is highlighted in yellow. In some cases, the claims filled at the pharmacy had the price advantage.

Specialty Claim Utilization

Diagnosis / Indication	Medication	Place of Service	Total Allowed Amount	Sum of Claim Count	Utilizing Members	Average Allowed / Claim	Average Allowed / Utilizing Members
Asthma	Benralizumab	Office	$ 28,894.43	8	2	$ 3,611.80	$ 14,447.22
		On Campus-Outpatient Hospital	$ 12,778.70	3	1	$ 4,259.57	$ 12,778.70
	Omalizumab	Office	$ 857,380.15	295	18	$ 2,906.37	$ 47,632.23
		On Campus-Outpatient Hospital	$ 351,692.93	93	7	$ 3,781.64	$ 50,241.85
Blood Cell Deficiency	Darbepoetin Alfa	Office	$ 37,280.04	45	2	$ 828.45	$ 18,640.02
		On Campus-Outpatient Hospital	$ 244,568.35	431	22	$ 567.44	$ 11,116.74
	Pegfilgrastim	Unknown	$ 6,768.83	2	1	$ 3,384.42	$ 6,768.83
		Office	$ 15,664.47	3	1	$ 5,221.49	$ 15,664.47
		On Campus-Outpatient Hospital	$ 1,008,388.07	130	39	$ 7,756.83	$ 25,856.10
Contraception	Copper (IUD)	Office	$ 35,022.62	51	49	$ 686.72	$ 714.75
		On Campus-Outpatient Hospital	$ 2,035.20	5	1	$ 407.04	$ 2,035.20
		Pharmacy	$ 1,602.64	2	3	$ 801.32	$ 534.21
	Etonogestrel	Federally Qualified Health Center	$ 425.00	1	1	$ 425.00	$ 425.00
		Office	$ 128,134.14	187	177	$ 685.21	$ 723.92
		On Campus-Outpatient Hospital	$ 1,400.56	1	1	$ 1,400.56	$ 1,400.56
		Pharmacy	$ 8,213.25	9	13	$ 912.58	$ 631.79
		Rural Health Clinic	$ 966.87	1	1	$ 966.87	$ 966.87
	Levonorgestrel (IUD)	Federally Qualified Health Center	$ 125.00	1	1	$ 125.00	$ 125.00
		Office	$ 403,424.39	434	392	$ 929.55	$ 1,029.14
		On Campus-Outpatient Hospital	$ 8,863.85	10	9	$ 886.39	$ 984.87
		Pharmacy	$ 24,470.89	27	32	$ 906.33	$ 764.72
		Rural Health Clinic	$ 1,458.87	1	1	$ 1,458.87	$ 1,458.87
Endocrine Disorder	Degarelix Acetate	Office	$ 1,508.00	2	1	$ 754.00	$ 1,508.00
		On Campus-Outpatient Hospital	$ 11,330.82	10	1	$ 1,133.08	$ 11,330.82
	Leuprolide Acetate	Home	$ 9,055.39	1	1	$ 9,055.39	$ 9,055.39
		Independent Clinic	$ 858.74	1	1	$ 858.74	$ 858.74
		Office	$ 111,654.84	83	22	$ 1,345.24	$ 5,075.22
		On Campus-Outpatient Hospital	$ 160,546.20	71	22	$ 2,261.21	$ 7,297.55
	Octreotide Acetate	On Campus-Outpatient Hospital	$ 399,696.39	82	6	$ 4,874.35	$ 66,616.07
		Pharmacy	$ 549,769.79	134	10	$ 4,102.76	$ 54,976.98
Hemophilia	Antihemophilic Factor/von Willebrand Factor Co	Emergency Room – Hospital	$ 28,903.51	4	1	$ 7,225.88	$ 28,903.51
		On Campus-Outpatient Hospital	$ 15,847.41	2	2	$ 7,923.71	$ 7,923.71
	Desmopressin Acetate	Emergency Room – Hospital	$ 746.37	1	1	$ 746.37	$ 746.37
		On Campus-Outpatient Hospital	$ 1,528.05	2	1	$ 764.03	$ 1,528.05
		Pharmacy	$ 3,212.18	77	15	$ 41.72	$ 214.15
	Tenecteplase	Emergency Room – Hospital	$ 30,897.02	4	3	$ 7,724.26	$ 10,299.01
		On Campus-Outpatient Hospital	$ 7,097.68	2	1	$ 3,548.84	$ 7,097.68
Immune Deficiency	Immune Globulin (Human) IV	Emergency Room – Hospital	$ 15,748.97	1	1	$ 15,748.97	$ 15,748.97
		Office	$ 734,950.26	164	7	$ 4,481.40	$ 104,992.89
		On Campus-Outpatient Hospital	$ 1,172,730.42	239	17	$ 4,906.82	$ 68,984.14
	Immune Globulin (Human) IV or Subcutaneous	Office	$ 9,538.26	7	2	$ 1,362.61	$ 4,769.13
		On Campus-Outpatient Hospital	$ 66,002.24	15	4	$ 4,400.15	$ 16,500.56
		Pharmacy	$ 481,619.98	50	2	$ 9,632.40	$ 240,809.99
	Immune Globulin (Human) Subcutaneous	Home	$ 167,828.18	84	4	$ 1,997.95	$ 41,957.05
		Office	$ 56,691.78	13	4	$ 4,360.91	$ 14,172.95
		On Campus-Outpatient Hospital	$ 27,850.62	11	5	$ 2,531.87	$ 5,570.12
		Pharmacy	$ 112,565.88	60	3	$ 1,876.10	$ 37,521.96
Infection	Daptomycin	Emergency Room – Hospital	$ 384.72	1	1	$ 384.72	$ 384.72
		Home	$ 55,300.00	13	2	$ 4,253.85	$ 27,650.00
		Office	$ 27,625.00	40	3	$ 690.63	$ 9,208.33
		On Campus-Outpatient Hospital	$ 26,854.97	81	7	$ 331.54	$ 3,836.42
Inflammatory Bowel Disease (IBD)	Vedolizumab	Office	$ 131,632.26	23	4	$ 5,723.14	$ 32,908.07
		On Campus-Outpatient Hospital	$ 329,448.05	40	4	$ 8,236.20	$ 82,362.01

Diagnosis / Indication	Medication	Place of Service	Total Allowed Amount	Sum of Claim Count	Utilizing Members	Average Allowed / Claim	Average Allowed / Utilizing Members
Inflammatory Conditions	Abatacept	Office	$ 7,788.88	3	1	$ 2,596.29	$ 7,788.88
		On Campus-Outpatient Hospital	$ 209,324.87	41	4	$ 5,105.48	$ 52,331.22
		Pharmacy	$ 1,077,987.78	263	14	$ 4,098.81	$ 76,999.13
	Belimumab	Office	$ 215,636.18	119	3	$ 1,812.07	$ 71,878.73
		On Campus-Outpatient Hospital	$ 57,795.57	3	1	$ 19,265.19	$ 57,795.57
		Pharmacy	$ 41,042.64	11	2	$ 3,731.15	$ 20,521.32
	Certolizumab Pegol	On Campus-Outpatient Hospital	$ 259,256.71	91	6	$ 2,848.97	$ 43,209.45
		Pharmacy	$ 797,892.65	182	14	$ 4,384.03	$ 56,992.33
	Golimumab	Office	$ 85,397.28	33	4	$ 2,587.80	$ 21,349.32
		On Campus-Outpatient Hospital	$ 131,029.12	42	6	$ 3,119.74	$ 21,838.19
		Pharmacy	$ 238,863.62	52	1	$ 4,593.53	$ 238,863.62
	Infliximab	Office	$ 319,150.62	97	18	$ 3,290.21	$ 17,730.59
		On Campus-Outpatient Hospital	$ 1,181,651.13	189	26	$ 6,252.12	$ 45,448.12
		Pharmacy	$ 21,214.08	8	1	$ 2,651.76	$ 21,214.08
	Tocilizumab	Office	$ 67,836.00	20	2	$ 3,391.80	$ 33,918.00
		On Campus-Outpatient Hospital	$ 236,862.38	132	6	$ 1,794.41	$ 39,477.06
		Pharmacy	$ 771,524.92	214	13	$ 3,605.26	$ 59,348.07
	Ustekinumab	Office	$ 291,431.70	15	3	$ 19,428.78	$ 97,143.90
		On Campus-Outpatient Hospital	$ 277,240.42	13	2	$ 21,326.19	$ 138,620.21
		Pharmacy	$ 2,183,589.03	211	14	$ 10,348.76	$ 155,970.65
	Ustekinumab (IV)	Office	$ 24,489.09	5	4	$ 4,897.82	$ 6,122.27
		On Campus-Outpatient Hospital	$ 28,682.58	2	2	$ 14,341.29	$ 14,341.29
Lipid Disorder	Agalsidase beta	Home	$ 479,302.40	32	1	$ 14,978.20	$ 479,302.40
		Office	$ 16,037.60	1	1	$ 16,037.60	$ 16,037.60
Miscellaneous Specialty Condition	Collagenase Clostridium Histolyticum	Office	$ 31,141.96	9	6	$ 3,460.22	$ 5,190.33
		On Campus-Outpatient Hospital	$ 4,255.20	1	1	$ 4,255.20	$ 4,255.20
	OnabotulinumtoxinA	Ambulatory Surgical Center	$ 10,396.00	21	3	$ 495.05	$ 3,465.33
		Office	$ 464,404.50	439	91	$ 1,057.87	$ 5,103.35
		On Campus-Outpatient Hospital	$ 105,592.04	70	23	$ 1,508.46	$ 4,590.96
Multiple Sclerosis (MS)	Natalizumab	Office	$ 318,825.00	47	4	$ 6,783.51	$ 79,706.25
		On Campus-Outpatient Hospital	$ 718,320.40	76	4	$ 9,451.58	$ 179,580.10
	Ocrelizumab	Home	$ 38,122.50	1	1	$ 38,122.50	$ 38,122.50
		Office	$ 1,537,932.05	54	16	$ 28,480.22	$ 96,120.75
		On Campus-Outpatient Hospital	$ 1,031,896.93	13	4	$ 79,376.69	$ 257,974.23
Ophthalmic Conditions	Aflibercept	Office	$ 849,946.00	451	49	$ 1,884.58	$ 17,345.84
		On Campus-Outpatient Hospital	$ 11,051.66	8	3	$ 1,381.46	$ 3,683.89
	Dexamethasone (Ophth)	Office	$ 7,175.00	5	1	$ 1,435.00	$ 7,175.00
		On Campus-Outpatient Hospital	$ 4,408.65	2	1	$ 2,204.33	$ 4,408.65
		Pharmacy	$ 222.40	3	5	$ 74.13	$ 44.48
Osteoarthritis	Cross-Linked Hyaluronate	Office	$ 6,820.46	16	10	$ 426.28	$ 682.05
		On Campus-Outpatient Hospital	$ 1,057.88	1	1	$ 1,057.88	$ 1,057.88
	Hyaluronan	Office	$ 29,322.08	84	26	$ 349.07	$ 1,127.77
		On Campus-Outpatient Hospital	$ 45,767.10	45	13	$ 1,017.05	$ 3,520.55
		Rural Health Clinic	$ 1,415.31	9	2	$ 157.26	$ 707.66
	Hylan	Office	$ 64,903.02	110	53	$ 590.03	$ 1,224.59
		On Campus-Outpatient Hospital	$ 6,733.47	14	8	$ 480.96	$ 841.68
Thrombolytic	Alteplase	Emergency Room – Hospital	$ 17,363.26	6	5	$ 2,893.88	$ 3,472.65
		Home	$ 1,945.49	19	4	$ 102.39	$ 486.37
		Office	$ 10,257.11	13	1	$ 789.01	$ 10,257.11
		On Campus-Outpatient Hospital	$ 21,619.96	68	25	$ 317.94	$ 864.80
Transplant	Cyclophosphamide	Home	$ 339.53	1	1	$ 339.53	$ 339.53
		On Campus-Outpatient Hospital	$ 158,589.30	118	21	$ 1,343.98	$ 7,551.87
		Pharmacy	$ 29,156.38	51	3	$ 571.69	$ 9,718.79
	Mycophenolate Sodium	Home	$ 20,928.18	33	3	$ 634.19	$ 6,976.06
		Unknown	$ 1,392.40	2	1	$ 696.20	$ 1,392.40
		Pharmacy	$ 90,152.63	186	16	$ 484.69	$ 5,634.54
		* Place of Service with the most Optimal Pricing highlighted inYellow					

Assumptions
Excluded - All Oncology Indications
Claim Count based on 30 day supply. (If filled for 90 days, claim count = 3)
Only included medications that were filled at 2 or more silos
Excluded Medication/Place of Service categories where all averages were less than $500

A comparative analysis between the actual medical claims and pharmacy claim data for the same GPI was completed to demonstrate the advantage of moving drugs from the medical benefit to the pharmacy benefit. The following assumptions were made:

- For the medical claims we are assuming a 30 day supply to compare to pharmacy claims with a 30 day supply.
- The analysis is calculated based on 100% of these claims moving to the pharmacy, however we understand this is not a true reflection of what will actually happen.

There can be an advantage to moving these drugs to the pharmacy program based on the rebate guarantees outlined in the PBM contract but rebates can also be obtained through medical coverages.

Indication	Short Description	Medical Claim Count	Average Medical Allowed Amount	Total Allowed Amount	Average Pharmacy Claim Amount **
Allergic Asthma	Mepolizumab	44	$ 3,033.81	$ 133,487.85	$ 2,497.34
Alpha-1 Deficiency	Alpha1-Proteinase Inhibitor (Human)	16	$ 9,121.20	$ 145,939.20	$ 10,546.30
Asthma	Benralizumab	11	$ 3,788.47	$ 41,673.13	$ 5,023.53
Asthma	Omalizumab	389	$ 3,108.34	$ 1,209,145.99	$ 2,020.23
Blood Cell Deficiency	Darbepoetin Alfa	499	$ 564.83	$ 281,848.39	$ 1,586.54
Blood Cell Deficiency	Pegfilgrastim	135	$ 7,635.71	$ 1,030,821.37	$ 6,574.80
Blood Cell Deficiency	Romiplostim	23	$ 13,164.32	$ 302,779.43	$ 12,478.11
Blood Cell Deficiency	Tbo-Filgrastim	1	$ 774.37	$ 774.37	$ 2,704.32
Contraception	Copper (IUD)	56	$ 661.75	$ 37,057.82	$ 802.81
Contraception	Etonogestrel	190	$ 689.09	$ 130,926.57	$ 886.26
Contraception	Levonorgestrel (IUD)	446	$ 927.96	$ 413,872.11	$ 880.96
Cryopyrin-Associated Periodic Syndromes	Canakinumab	6	$ 18,782.00	$ 112,692.00	$ 20,096.28
Endocrine Disorder	Lanreotide Acetate	75	$ 4,673.23	$ 350,491.96	$ 5,679.83
Endocrine Disorder	Leuprolide Acetate	156	$ 1,808.43	$ 282,115.17	$ 708.42
Endocrine Disorder	Octreotide Acetate	91	$ 4,392.27	$ 399,696.39	$ 2,184.97
Hemophilia	Antihemophilic Factor (Recombinant)	27	$ 25,213.35	$ 680,760.47	$ 9,282.69
Hemophilia	Antihemophilic Factor (Recombinant) Peg	6	$ 51,206.04	$ 307,236.24	$ 42,224.16
Hemophilia	Antihemophilic Factor/von Willebrand Fac	6	$ 7,458.49	$ 44,750.92	$ 7,289.95
Hemophilia	Emicizumab-kxwh	10	$ 10,729.00	$ 107,290.04	$ 5,804.04
Immune Deficiency	Immune Globulin (Human) IV	404	$ 4,760.96	$ 1,923,429.65	$ 4,443.62
Immune Deficiency	Immune Globulin (Human) IV or Subcutan	22	$ 3,433.66	$ 75,540.50	$ 5,819.29
Immune Deficiency	Immune Globulin (Human) Subcutaneous	109	$ 2,316.41	$ 252,488.40	$ 3,799.21
Inflammatory Bowel Disease (IBD)	Vedolizumab	63	$ 7,318.74	$ 461,080.31	$ 5,338.88
Inflammatory Conditions	Abatacept	44	$ 4,934.40	$ 217,113.75	$ 3,985.42
Inflammatory Conditions	Belimumab	122	$ 2,241.24	$ 273,431.75	$ 3,120.47
Inflammatory Conditions	Certolizumab Pegol	91	$ 2,848.97	$ 259,256.71	$ 3,943.97
Inflammatory Conditions	Golimumab	75	$ 2,885.69	$ 216,426.40	$ 3,707.86
Inflammatory Conditions	Infliximab	286	$ 5,247.56	$ 1,500,801.75	$ 1,941.07
Inflammatory Conditions	Tocilizumab	152	$ 2,004.59	$ 304,698.38	$ 2,931.14
Inflammatory Conditions	Ustekinumab	28	$ 20,309.72	$ 568,672.12	$ 10,435.56
Inflammatory Conditions	Ustekinumab (IV)	7	$ 7,595.95	$ 53,171.67	$ 1,370.74
Lipid Disorder	Agalsidase beta	33	$ 15,010.30	$ 495,340.00	$ 18,425.67
Lipid Disorder	Methylnaltrexone Bromide	4	$ 543.10	$ 2,172.40	$ 1,762.51
Miscellaneous Specialty Condition	AbobotulinumtoxinA	1	$ 1,261.79	$ 1,261.79	$ 686.23
Miscellaneous Specialty Condition	Collagenase Clostridium Histolyticum	10	$ 3,539.72	$ 35,397.16	$ 7,519.39
Miscellaneous Specialty Condition	Hydroxyprogesterone Caproate	21	$ 1,058.78	$ 22,234.39	$ 2,734.01
Miscellaneous Specialty Condition	OnabotulinumtoxinA	530	$ 1,095.08	$ 580,392.54	$ 498.76
Multiple Sclerosis (MS)	Natalizumab	123	$ 8,432.08	$ 1,037,145.40	$ 6,072.35
Multiple Sclerosis (MS)	Ocrelizumab	68	$ 38,352.23	$ 2,607,951.48	$ 20,837.14
Ophthalmic Conditions	Dexamethasone (Ophth)	7	$ 1,654.81	$ 11,583.65	$ 91.23
Osteoarthritis	Cross-Linked Hyaluronate	17	$ 463.43	$ 7,878.34	$ 79.74
Osteoarthritis	Hyaluronan	138	$ 554.38	$ 76,504.49	$ 1,757.66
Osteoarthritis	Hylan	124	$ 577.71	$ 71,636.49	$ 873.67
Thrombolytic	Alteplase	106	$ 482.89	$ 51,185.82	$ 282.81
		4,772	$ 17,120,154.76		$ 13,885,306.45
	Potential Savings (Rebates of $450/Prescription)				$ 2,147,400.00
	Potential Savings w/Rebates if filled at Pharmacy				$ 5,382,248.31

**Average Pharmacy Claim Amount is an average based on PillarRx Pharmacy claims.

Duplicative Reimbursement

PillarRx analyzes claims to determine whether or not the medical and a pharmacy benefits were being provided simultaneously. Duplicate therapy (a wasteful practice that allows a subscriber and/or provider to be paid simultaneously) is a prevalent and costly issue. This analysis is designed to help you avoid double payments and any potential associated waste.

PillarRx assesses specialty pharmacy from the point of distribution as it dramatically impacts the cost of reimbursement. Medical claims that include specialty medications with a HCPCs code of J, S, Q or C (requires capability of identifying drug/quantities through J, S, Q or C codes) are assessed along with an identification of where the care was delivered.

PillarRx identified one (1) member who received the same specialty medication from both the medical benefit and the pharmacy benefit at the same time. Our analysis compared the fill date on the pharmacy claim to the incurred date on the medical claim for the same drug. If the difference between those dates was less than 15 days it was considered a potential situation of double-dipping. PillarRx reviewed the claims and concluded that there is overlap between the medical and pharmacy claims. The medical claim had a total plan paid amount of $857 and the pharmacy claim had a total plan paid amount of $909. This could be a case of double billing, or inaccurate billing of administration fees by the medical provider.

To determine if duplicate therapy truly occurred, we recommend that the client reach out to the medical providers to confirm whether or not the provider used its own supply of the medication or whether the claim was billed in error.

Summary and Conclusion

Analyzing the integrated medical and pharmacy claims was complex and thorough. It is of interest to note that the diagnosis of the patient is predictive of the use of specialty medications. In general, the state of the distribution model is being administered appropriately. A potential process improvement would be to ensure that patients with the identified diagnoses who receive their specialty medications under the medical benefit are encouraged to obtain the medications through the pharmacy benefit to lower costs.

APPENDIX A - NAVITUS' RESPONSE TO DRAFT REPORT

The Navitus team has reviewed the Findings Reports and agree with the results.

A total of 197 Commercial claims were identified as potential exceptions to the copay requirements. The Navitus team reviewed all of the claims and provided an explanation as to why the claims paid as they did. There were two specialty drug claims in Q1-2018 that paid incorrectly due to the Prior Authorization being entered with an incorrect tier. This caused the member to pay a lower copayment amount which caused the State of Montana to overpay. The Manager of the Prior Authorization team reviewed the two claims and prior authorization and agreed the authorization was entered incorrectly due to a Navitus error. As noted on Page 11 for the 'Retail Tier 4' Copayment Rule, the Navitus Response outlines what steps were taken to correct the prior authorization and to ensure all other Prior Authorizations were entered correctly. The Navitus response also includes four additional steps that were implemented to prevent this error from occurring in the future.

A total of 92 EGWP claims were identified as potential exceptions to the copay requirements. The Navitus team reviewed all of the claims and provided an explanation as to why the claims paid as they did. As noted in the report, there were no variances found.

The current Performance Guarantee for Electronic Claims Processing Accuracy is 99.5% or higher for all claims. The Member Copay collected variance percentage is 0.073%. When calculating the variance percentage of the Net Plan Paid amount on page 1, the overall variance percentage is 0.016%. Navitus will defer to the State of Montana for any next steps regarding the variance amount noted in the report.

CLAIM TECHNOLOGIES INCORPORATED

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

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