

**Third Party Administrator Claim Audit Report
Final Report of Findings**

May 12, 2005

Onsite Audit

Conducted By:

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Insurance Compliance Consulting Services, Inc. (ICCS)

Requested By:

Joe Patton
General Counsel
CRS Solutions Group

Date of Onsite Audit:

January 25 -2 7, 2005

Location:

Benefit Management Inc.
Great Bend, Kansas

BMI Contacts:

Chad Somers, Vice President
Chris Clasen, Manager, Pool Unit

Objective:

The overall purpose of the audit is to ensure compliance with the Administrative Service Agreement and to measure the administrator's performance.

Attachments:

Audit Detail Spreadsheet

I. General Information

The Washington State Health Insurance Pool (WSHIP) provides health benefits to approximately 2,800 enrollees. Benefit Management Inc. (BMI) is the new contracted Third Party Administrator (TPA) that provided the claim administration for the period audited. BMI has 65 full-time employees; 12 of those employees are involved in the WSHIP program. For the onsite audit, BMI provided hard copies of the actual claims and explanation of benefits. System access was also provided that allowed inquiry to system notes, accumulators, and eligibility information.

BMI did not provide any documentation for pending items with the exception of some pre-certification information that had been received from Health Integrated via fax. Chris Clasen, Manager answered questions and provided additional documentation during the onsite audit as well as follow-up documentation post onsite review.

II. Scope of Audit

In preparation for the audit a total of 200 claims were selected from a claim data dump produced by BMI. Based on the sample size and selection pool, this audit carries a 95% confidence level at 4% sample precision. The data included all claims processed by BMI from April 1, 2004 through September 30, 2004. The claims were randomly selected by claim type (professional and facility) and payment category (\$0 and up) to ensure an adequate audit sample. The majority of the claims selected for this audit were run-in claims that had been originally received by the prior TPA.

The Washington State Health Insurance Pool offers three health insurance plans to its enrollees. Plan 1 is a major medical plan with deductible options ranging from

\$500-\$1,500, Plan 2 is available to enrollees that are covered by Medicare Part A and Part B and does not have a deductible; Plan 3 is a PPO plan with deductible options of \$500 or \$1,000 and a variable coinsurance for par vs. non-par provider claims. WSHIP pays benefits secondary to all other coverage except Medicaid.

Medical case management, pre-certifications and concurrent reviews are handled by Health Integrated. The Preferred Provider Organization is First Choice Health Network.

Claims are submitted to First Choice Health Network, which forwards the claims with repricing sheets to the TPA for processing. Member ID cards list the First Choice Health address for this purpose. Claim checks are issued to the members and providers daily.

III. Audit Findings

Member Eligibility

Member eligibility was verified by accessing the TPA claim system. This included effective and termination dates as well as plan types selected for each member. WSHIP policies do not provide benefits for pre-existing conditions during the first six months of coverage. Upon request, BMI produced some additional information for enrollees that were subject to this provision, such as system documentation that indicated premium discounts because of continuous prior coverage.

BMI policies and procedures indicate that annual requests are made to update other coverage, and that inquiries are made if the standard billing forms include an indicator that other coverage may be in force.

Claim Adjudication

BMI informed the auditors that currently all claims are received by mail or fax as they are not yet prepared to accept any data via Electronic Data Interface (EDI). According to BMI policies and procedures, the mail is date-stamped upon receipt and delivered to the pre-registration department. Pre-registration staff assigns an internal control number to each claim which is stamped on the claim and then the claim is entered into the claims system within two working days of actual receipt. Claims are batched by date of receipt for processing. The claims examiners process the claim batches according to date of receipt. Benefit codes are assigned by the claim examiners and they enter all applicable information for adjudication. At the end of each business day, a check list is created and matched against all processed claims. Checks are issued on a daily basis. All claims and related documentation are digitally archived in alpha order (last name) and by check date.

Claim pending procedures are in place for accidents, subrogation, and pre-existing conditions. Letters for additional information in those cases are addressed to the member with a copy to the provider. If no response is received within seven days, another letter is issued. If no response is made within 14 days from the initial request, the claim will be denied. All claims will be pended if the member has not paid the premium for the month in which the claim has been incurred. The claim examiner will review the claim weekly to determine if premium has been received or if a termination date was entered into the claims system by the billing department.

The BMI claims system does not provide a tracking record on pending claims. According to BMI the pending dates are stored in the database; however, they were not

visible or accessible during the onsite audit while reviewing the various claims on the system. The system only shows the last date the claim was handled by an examiner or supervisor prior to payment. It is our understanding that that date is used to calculate the turnaround time as well.

Ingenix data base is utilized to determine UCR for non-par claims.

Other coverage inquiries are made annually by BMI for all members.

There are no procedures in place to obtain itemized bills for any claims.

BMI does not maintain a refund/overpayment log. They indicated that those claims are maintained in a file and reviewed periodically.

BMI indicated that it has not identified any claims involving potential subrogation or third party liability, therefore, no log was available for review.

BMI informed the auditors that the back-log claims that were received from the prior administrator were all pended for duplicate checking using pending code "WR". Since the pending documentation was not available at the onsite audit, the pending codes and dates were checked post audit from data dump that was previously provided to the auditors by BMI. BMI reports that its internal pend code of "WR" (for claims received from ACS) is removed by the examiner allowing the adjudication process to be completed. Once the pend code is removed, BMI loses the ability to see the pend code in its system.

BMI reports that part of the 11,000+ claims in back log that it received from ACS had previously been processed by ACS, even though BMI requested to receive separately the unprocessed claims. In September of 2004, BMI investigated the accuracy of claims

with incurred dates prior to April 1, 2004 that BMI had processed in order to attempt to find the overpayments.

Procedures for duplicate claim checking were provided which indicate that the claims examiner must manually check for potential duplicates. BMI reports that its duplicate check against ACS information was a manual process for examiners against a text file that ACS had originally provided. BMI subsequently received an Access database with ACS' claims history which allowed BMI to cross reference its database of claims processed with a date of service prior to April 1, 2004 in order to ascertain which claims BMI had been paid in duplicate.

While many duplicate claims were found that were recovered by BMI prior to the audit, several of the claims audited were actually corrected billings of previously adjudicated claims. These were processed by BMI for full payment resulting in overpayments as well. While many of the refunds/credits could be identified during the audit process, it is suggested that BMI complete a full audit of all claims received during the run-in period to ensure accurate accounting of all overpayments, refunds, and outstanding refunds.

Deficiencies noted

1. Duplicate claim checking. As noted above, many duplicate payments were discovered in the audit process that were previously processed by ACS, unknown to and subsequently overpaid by BMI. BMI was able to substantiate that many of these overpayments were discovered as part of the recovery process described above and were successfully recovered by BMI prior to the audit. All of these "prior-ACS" claims are

noted on the attached spreadsheet; however, they are not counted as deficiencies in this report.

The claims noted below are duplicates that BMI did not substantiate as having been yet recovered, or that were missed during the recovery efforts described above.

Claim 20040122731 - \$5,850.81

Corrected billing; not originally checked for duplicate; \$5,077.31 was paid by ACS, thus \$5,077.31 overpayment. BMI notes that the total charge on this claim was \$6,883.30 and that during the search for duplicates, this overpayment was *not discovered*. The refund of the BMI overpayment and the corrected claim charges was eventually found and received by BMI.

Claim 20040102338 - \$19.07

This claim was pended for duplicate checking; appears to be a duplicate previously paid by ACS. BMI did not substantiate that this claim had been recovered.

Claim 20040192213 – \$87,936.74

This claim was paid twice *by BMI*. Paid 100% of billed charges twice. BMI did discover this overpayment prior to audit, but was still a duplicate error. BMI agreed with this finding of error at the time of audit.

BMI requests that the issue of duplicate checking be eliminated from consideration due to the “ACS transition being essentially complete.” BMI suggests reinforcing current procedures, and indicates that it is implementing a 30-day Duplicate Report to identify any duplicate payments made in the future. The auditors recommend that this issue continue to be monitored, and that BMI and WSHIP discuss whether procedures can be strengthened.

2. Incomplete claim investigations –Accidents

Claim 20040127354 - \$143,752.59

Claim 20040196080 - \$8,256.27

These two claims are accident-related and the response to the accident inquiry is dated 6/28/04 (via fax), which indicates a fall from a balcony into lake. The address where the accident occurred is different from the member's residence address that is on file. Although the letter states that there is no other insurance carrier liable, it seems that further investigation is necessary for this large claim due to the potential for other liability and possible subrogation. The auditors recommend that BMI perform a thorough investigation regarding this accident.

BMI contends that per its policies and procedures, the policyholder's "NO" response to whether other liability insurance was available was sufficient to stop further investigation. However, due to the circumstances (different address, accident details) and size of the loss, standard claims practice warranted pursuit of this claim for other liability and/or possible subrogation.

Claim 20040089657 - \$13,278.50

This claim is accident related and no accident information was available at the time of audit. The hospital bill is clearly coded to reflect E881.0 Accidental fall from ladder; 807.4 and 807.5 open fractures and the primary diagnosis is 860.0 traumatic pneumothorax. This claim was paid at 100% of billed charges. The hospital bill attached to the explanation of benefits as well as the ACS report show that a payment of \$8,867.63 was previously made in January 2004. Further, the hospital bill shows that an adjustment

for the balance of \$4,410.87 was made by "accent". BMI has responded that they did not perform any accident investigation as they do not consider "Pneumothorax without mention of open wound into thorax" an "accident" diagnosis. BMI also notes that ACS came to the same conclusion as BMI with respect to paying this claim.

It appears that BMI staff, at least in this case, relied upon one single diagnosis/procedure code rather than evaluating all diagnoses and procedures to make a payment decision on the status of the claim. Additionally, BMI contends that the \$8,867.63 was a PPO discount even though this is a non-First Choice provider (claim incurred in Portland, Oregon).

The auditors recommend that BMI perform a complete investigation regarding this accident and the payments previously made on this claim to determine the correct WSHIP liability. BMI should also confirm to WSHIP that as a matter of overall procedure, the claims examiner reviews all diagnoses and procedures incurred to make decisions on the proper status of claims, as opposed to reviewing a single diagnosis / procedure code which may not properly reflect the overall claims status.

BMI suggests expanding its policies and procedures to encompass a broader range of primary diagnosis codes in which to investigate for possible accident situations, and also suggests consideration of secondary diagnosis codes in determining possible accident situations. Both suggestions are warranted, along with recognition of overall standard industry claims practices with respect to evaluating the context of such claims based on the available information.

3. Incomplete claim investigations – Pre-existing conditions

Claims incurred within the first 6 month of coverage require pre-existing condition investigation or documentation of prior coverage. BMI has recently (post-audit) provided information confirming that two claims (20040206765 and 20040218665) were eligible for waiver of the pre-existing condition provision due to having prior coverage in place prior to WSHIP coverage. The following claim was not pursued for pre-existing condition investigation:

Claim 20040190837 - \$415.76

With respect to this claim, BMI indicates that if a pre-existing waiting period check had been done by the prior administrator, BMI did not perform the same exercise. This was apparently done in an effort to expedite the processing of the ACS backlog. BMI defined a pre-existing check as having been done by ACS if ACS had processed same diagnosis code claims already. This claim was considered a deficiency; however, WSHIP may decide that BMI's processing based on prior payment by ACS to be sufficient as confirmation of pre-existing condition investigation.

4. Incomplete claim investigations – other coverage, including Medicare

Claim 20040212717 - \$30,374.00.

This claim is for renal failure, dialysis and Medicare is primary payer. BMI response: *WSHIP was not aware that insured has Medicare (which was effective 7/1/04) until September 28, 2004. This claim was processed prior to this date (on 9/9/04). Refund will be requested.* Despite the BMI response, this claim was paid in error as Medicare

was listed on the billing, and the claim was for a condition that triggers Medicare eligibility and at minimum should have warranted investigation.

BMI states that other claims processed for this insured did not indicate other coverage and that BMI relied on prior ACS data. However, BMI acknowledges that this claim did show Medicare as other coverage.

BMI states that its examiners are aware that ESRD is a trigger for Medicare coverage but BMI indicates that its Medicare guidelines indicate that Medicare coverage usually doesn't start until the 4th month of dialysis treatment, so it is not necessarily definitive of Medicare coverage for each claim. BMI was advised that in this situation, Medicare would only pay as secondary for the first 30 months of the Coordination Period since the insured had other coverage. BMI is disputing Medicare's decision.

Claim 20040091276 - \$76,569.08.

Date of service 5/7/03 – Paid at 100% of billed charges. This member is shown on Medicare Plan; however no inquiries as to Medicare coverage were documented. BMI advised that they completely rely upon ACS history file which indicates that member was not covered by Medicare until October 2003. The recommendation for this claim is that BMI should investigate Medicare coverage dates, prior claim history and eligibility to ensure that this claim is paid correctly.

Claim 20040067115 - \$6,812.13

Date of service is 1/1-1/29/04 – for hemodialysis due to renal failure. This member was effective with WSHIP 12/1/03. There was no investigation into Medicare coverage performed. BMI advised that the member was covered under a PPO plan from 12/1/03-3/31/04 and on 4/1/04 became covered under Medicare plan option. The

insured also qualified for a discount because prior coverage, thus no pre-existing condition investigation was warranted. It is recommended that members on dialysis for renal failure/end stage renal be investigated and files documented regarding their Medicare eligibility status and dates.

BMI states that this claim with the date of service in January 2004 was prior to the date in which the insured became eligible for Medicare. He was covered under the PPO plan by ACS at that time. BMI again states that it felt it prudent to be able to put confidence in ACS having enrolled insureds in the correct plan design.

BMI also provides that it conducted an eligibility determination at the time of the takeover from ACS, by first mailing out an eligibility verification form indicating which plan design the insured was enrolled in and to verify address, status of other coverage, etc. BMI then followed up with a second request mailing for those in which it did not get an initial response. BMI states that it performed a complete (“100%”) verification in order to discover as many of these issues of other coverage as possible prior to claims adjudication.

BMI feels that its policies and procedures are adequate to handle Medicare eligibility determinations, coupled with annual verification of eligibility, monthly invoice questioning of other coverage, and processor awareness of identifying other coverage listings on claims. BMI’s primary contention on this issue is that it relied on prior ACS data and that expediency of processing the transitional backlog necessitated reliance on prior ACS classifications.

BMI suggests education of processing staff to not make the assumption that Medicare will not pay as primary in the first 3 months of dialysis for ESRD, but will require a denial Explanation of Medicare Benefits each time.

BMI also suggests educating the processing staff to not make the assumption that Medicare will not pay as primary in the 30 month Conversion Period for any case.

BMI also suggests that its in-house trainer and in-house Utilization Management nurse will perform continuous training on this issue.

All of these suggestions are recommended.

5. Incomplete review of claims during adjudication – transplants, high dollar claims, multiple surgical procedures, etc.

The followings claims within the audit sample were for organ transplants but were not coded as such on the claims system and therefore not accumulating toward the policy lifetime maximum benefit for transplants.

Claim 20040146724 – \$131,534.26

This claim is for a bone-marrow transplant (allogenic) as indicated on the hospital billing including coding and stamps placed on the bill: "BMT 87% Reimbursement" & "BMT". BMI responded: *“Diagnosis on claim is 238.7 = neoplasm of uncertain behavior of other and unspecified sites and tissues, other lymphatic and hematopoietic tissues. This diagnosis is not a transplant diagnosis thus transplant benefit not used. Typical transplant diagnosis code would begin with a ‘V’.”* A copy of the

precertification for the bone marrow transplant was provided to the auditors while onsite. On February 18, 2005.¹

The hospital bill for this member included several diagnoses, including that of aplastic anemia which is considered a covered condition for allogenic bone marrow transplants (i.e. Coverage Issues Manual – Medicare). Further, according to ICD9 Volume 1,V Code is a supplementary classification of factors influencing health status and contact with health services (V01-V82).

BMI states that the benefit code for Transplant was not used; rather, that the claim was assigned the benefit code of Hospital Room and Board. Regardless of cause, this claim was processed incorrectly and the amount paid should be applied to the lifetime maximum.

Claim 20040153321 – \$115,181.10

This claim is for bilateral lung transplant as indicated on the hospital billing by coding and by billing for "CADAVER DONOR". In fact, the hospital bill indicates: principal procedure on 4/16/04 as ICD9, Volume I code 33.52 –Bilateral lung transplantation. BMI responded: *“Diagnosis on claim is 277.02 = with pulmonary manifestations, cystic fibrosis with pulmonary exacerbation. This diagnosis is not a transplant diagnosis thus transplant benefit not used.”* However, BMI provided the auditors with a copy of the case management vendor’s approval letter for the transplant.

¹ While the applied benefit on this claim exceeded the lifetime maximum benefit of \$100,000, BMI provided a copy of a Policy Endorsement to the policy reflecting a \$250,000 lifetime maximum benefit effective 4/1/04 and further stated that the new maximum was actually retroactively in effect as of 1/1/04. WSHIP confirms this retroactive application of the maximum benefit change to apply the \$250,000 lifetime benefit effective 1/1/04.

This claim was not processed correctly, regardless of cause, and the amount paid should be applied toward the lifetime maximum benefit. It should also be noted for future reference that double lung transplants are generally deemed medically necessary for the diagnosis of cystic fibrosis in cases such as this.

Claim 20040196733 - \$10,373.78

This claim spans dates of service from 4/7-5/31/04. This member had a Bone Marrow Transplant on 4/14/04. BMI did not obtain an itemization for this claim; therefore the auditors unable to determine what amount actually should be applied toward the lifetime maximum transplant benefit. BMI states that the prior transplant claim did not detail any donor or transplant charges in the line items, thus the benefit code for “Transplant” was not used and the payable amount was not applied to the lifetime transplant maximum benefit.

Claim 20040115855 – \$74,954.24.

Cadaveric Kidney Transplant on 1/8/04. Member effective date is 9/19/03. No documentation was available to confirm that pre-existing does not apply, nor was any documentation available to confirm that no other coverage was in force for this transplant.. There is a note on the BMI claim system indicating that this member had also coverage with Premera from 1/1/04-9/30/04; it is not clear what type of coverage this was. As Premera was a contracted Medicare Part A intermediary in Washington prior to 10/1/04, it would appear that this insured had Medicare coverage due to her end stage renal disease that apparently led to the transplant. Again, BMI stated that they relied on ACS history information for this.

At this time this claim is overpaid by an unknown amount. BMI indicates that refunds have been requested. This claim is considered a processing error that resulted in a financial error. Since Medicare entitlement for End Stage Renal Disease (ESRD) is triggered by first date of hemodialysis or kidney transplant, it is generally the responsibility of the claims administrator to properly investigate claims for such treatments.

Claim 20040063740 – \$39,425.00

This claim is for surgery performed at the University of Wisconsin Medical Foundation in Milwaukee, Wisconsin. There are six surgical procedures billed and paid at 100% of billed charges. This member is enrolled in the PPO plan and the University of Wisconsin is not a participating provider. BMI has responded that Health Integrated negotiated 100% payment of billed charges for this claim. Therefore, BMI did not apply any coinsurance, UCR, or deductions for multiple surgical procedures performed during the same operative session. The claim states: “Commercial/GE –Commercial/MIS.”, which indicates potential other coverage. No investigation was made to determine if in fact such other coverage nor was any investigation done to ensure member continues to meet residency requirements.

BMI states that BMI did not arbitrarily waive deductible and coinsurance responsibility for the insured and that the balances for contract year 2003 were satisfied at the time the claim was processed. BMI further states that since HI pre-negotiated the claim, it was already discounted when BMI received it and BMI processed it as an In-Network claim by allowing the charges at 100%.

With respect to this claims category, BMI states that it is willing to modify its policies and procedures to expand the check for other coverage prior to processing transplant claims, if WSHIP wants BMI to do so. This is recommended.

BMI states that it will re-process these transplant claims above to properly apply them to the transplant plan lifetime maximum.

BMI states that its in-house trainer and in-house Utilization Management nurse will perform continuous training.

6. File documentation; validation of system notes

The system notes that were reviewed during the audit were found to be incomplete in many instances, as evidenced in many of the above-described claim scenarios. File document in many cases did not contain any dates or names of the staff members that entered the notes. For example, generally there was no indication how the information was obtained i.e. by phone, fax, letter, etc., the date the information was entered, the staff member entering the information, etc..

7. Adjustments

The audit sample included several claims or adjustments to claims that were not properly documented to validate accuracy.

Claim 20040134143 - \$18,025.24

This claim consisted of a total charge of \$40,497.55, allowable of \$19,657.24 and a payment of \$18,025.24. The check for \$18,025.24 is dated 7/13/04, #37586. The hospital bill is noted to be a corrected claim. It was noted that a prior claim for the same date and

service had been received and paid in June 2004, specifically a check for \$11,157.76 was issued on 6/17/04, # 32478. In addition to the check copy of \$18,025.24 and \$11,157.76, the auditors were also provided with a check copy for \$6,867.48, dated 7//13/04, #37586 (same as the \$18,025.24). BMI has advised the auditors that the total paid on their system is only \$18,025.24 and that the \$11,157.76 was deducted.

BMI states that the original and adjusted EOB's are available; however, the auditors recommended that BMI should provide documentation to WSHIP, including the voided checks, to validate the transactions for this claim.

8. Pending dates

The BMI system does not appear to track pending dates. The staff can manually update the received date when a change to a claim is made, for example a high dollar claim that requires authorization. Once this change in the received date is made, however, the original received date is no longer shown on the system.

9. Premium Paid-To

There were 13 claims pended for premium paid-to dates. According to the policy and BMI's procedures, coverage terminates if premiums are not paid within the 31 day grace period. The majority of these claims were pended for premium more than 30 days after the dates of service. It is recommended that BMI provide complete documentation regarding the premium payments for those members to determine that terminations for non-payment of premiums are handled according WSHIP's policies.

BMI states that all corrections of prior ACS errors have been made.

10. Pre-certification

The WHSIP policies state that the Utilization review panel must be notified of hospital admissions at least seven days prior to a scheduled admission. Further, the Utilization review panel must be notified of emergency admissions on the first business day following the admission. None of the claims audited had copies of actual pre-certification letters or other documentation to validate the dates that the pre-certs were requested or obtained.

BMI explained that their staff called HI for the pre-certification and made a “circle” to indicate covered days or wrote pre-cert dates on the claims. In a few circumstances there were copies of faxes provided that listed various members’ pre-certified claims. However, this did not include the dates when the requests were made. In light of this, the auditors were unable to confirm that certifications were timely obtained according to policy provisions.

BMI states that recently it has been able to gather precertifications electronically, which should make tracking more effective. BMI also contends that in accordance with the WSHIP plan document, “no days of inpatient care or home health care have been processed by BMI that did not have an authorization to cover them.” Further, BMI states that its understanding is that WSHIP prefers a retrospective review of claims processed without a precertification, rather than denying coverage outright.

11. No review process for large out-of-network claims

The audit sample included 12 claims incurred by non-par providers, each totaling in excess of \$10,000. These claims were paid in full without requiring an itemized bill for

review to ensure that all charges made are actually medically necessary and appropriate and covered expenses under the policy.

BMI states that WSHIP retained BMI with an understanding (via BMI's response to RFP) that BMI did not have unbundling software. BMI is willing to contract with another firm to unbundle claims or to audit any large claim over \$10,000. One or both of these approaches is recommended.

Claim Standards

Internal quality assurance audits are performed on 0.50% of the production. In addition, claims examiners have payment authority levels and claims in excess of these limits are reviewed by supervisory staff and released. The authority levels for claim examiners range from \$2,000 to \$20,000; the account manager has a \$35,000 limit and claims above that must be approved at the executive level.

Financial Accuracy

200 claim transactions were audited totaling \$1,996,609.99. Payment errors identified by the auditors total \$138,182.03. This represents an error percentage of 6.9%, and an accuracy percentage of 93.1%. The payment errors are identified on the attached spreadsheet and most are described in the sections above. Based on the audit findings, financial accuracy of 98% was not technically satisfied; however it should be noted that many of the errors are disputed by BMI due to the circumstances described above with respect to issues related to handling of ACS backlog, existing policies and procedures,

and the other described issues. The accuracy percentage should be reevaluated at a future audit once the recommendations contained in this report are implemented.

Procedural Accuracy

Clerical/data entry was found to be 100% accurate for the audit sample. However, there were 20 claims identified that were incurred prior to BMI's takeover that resulted in duplicate payments (see section above addressing duplicate checking). The duplicated payments are noted on the attached claims listing.

Turnaround Time

The average overall turnaround time for the audit sample is 40 days. The audit sample included a total of 114 pended claims. These can be categorized as follows:

Duplicate checking: 29

Medical (precert): 41 (3 of these were also pended for duplicate checking;
10 of these did not require precerts)

W9 Forms: 3

Premium Paid –To: 13

Accident Info: 1

Internal process: 30 (Processor limits, system problems, etc.)

As noted, the BMI system does not provide pend date information.

Refunds

BMI stated that it does not currently maintain a refund log. Claims subject to refunds are kept in a file folder for periodic follow-up.

Subrogation

BMI stated that no subrogation log currently exists as they have not identified any claims subject to subrogation.

Grievances

BMI produced a copy of the *WSHIP Grievances* log and two of the four cases listed were reviewed while onsite. BMI's policies and procedures were also reviewed and it was found that those procedures correspond with the WSHIPs policies. The grievance log did not include information regarding the first appeal to WSHIP's Administrator. The log included the following information: Name, ID#, Plan Type, Date Received, Description of Grievance, Date to Board, Resolution, Further Actions, and Date Notified.

BMI states that it did not provide the Appeal log or IRO log to the auditors for the grievances because only the grievance log was requested. The auditors were not aware that BMI kept the appeal and IRO portion of the grievance in separate logs.

The following cases were reviewed:

Grievance I:

The Request submitted to Committee within 2 business days; committee review and decision was made and member notified within 30 days. Member requested an external review within days of the committee's decision; Administrator forwarded the

request for external review to an Independent Review Organization (IRO) within 3 business days. An IRO response was received the following day indicating that the IRO does not review this type of grievance. This appeal was not based on a benefit denial.

However, the insured's actual grievance was because of the new Administrator's explanation of benefits not containing any preferred provider discounts for non-covered charges. The IRO response was received on January 13, 2005 and there was no further correspondence available for review by the auditors (in the "Grievance" log) at the time of audit (1/27/05).

BMI has since provided information that the legal council and the OIC opinions concurred that this insured had exhausted their appeal rights. BMI prepared a letter to the enrollee explaining that the IRO had declined to review the case based upon it not being within their purview and therefore the enrollee's appeal rights under their contract with WSHIP had been exhausted. On February 7, 2005, the completed draft letter for signature and mailing by the Executive Director was mailed to the insured.

This grievance appears to have been handled properly.

Grievance 2

The Request submitted to Committee within 2 business days; committee review and decision was made and member notified within 30 days. Member requested an external review within days of the committee's decision; Administrator forwarded the request to the IRO within 2 business days (Jan 12, 2005). An IRO response had not yet been received as of the audit date.

This grievance appears to have been handled properly.

IV. Recommendations

Implement or revise policies and procedures in the following areas:

In addition to the responsive suggestions made by BMI in each claims category above, the recommendations below are offered for discussion between WSHIP and BMI. Some of these recommendations may ultimately be decided by WSHIP not to be warranted, based on issues related to handling of transitional items from ACS to BMI. In other words, some of these issues may have already been handled through the completion of the transition from ACS to BMI.

- Require detailed itemized bills for out-of-network facility claims in excess of a pre-specified amount (i.e. \$10,000). Review the details bills for billing accuracy, medical necessity, appropriateness, non-covered items, etc.
- Review out-of-network claims in excess of a pre-specified amount (i.e. \$5,000) for potential discounts.
- Conduct pre-existing conditions investigations and maintain related documentation, train staff as necessary. .
- Maintain pre-certification information received from Health Integrated with the claims or online to ensure timely processing of claims requiring certification. The pre-cert information should include the date on which authorization was requested and authorized.
- Duplicate checking – Continue to check for duplicates in ACS claim history for dates of service prior to the takeover.

- Increase current internal audits to a minimum of 2-5% of production, which is the claims industry standard.
- Pending claims – BMI should identify those claims requiring additional external information for processing vs. claims that are pended for internal processes (such as over limits, audits, system problems) to ensure accurate reporting of turnaround time for clean claims. It is the auditors' understanding that currently, the received dates are manually updated by claims staff when a claim is updated regardless of the pend reason.
- Maintain accurate accumulators for deductibles, out-of-pocket amounts, limited benefits, including transplants
- Properly pursue accident investigation details, train staff as necessary.
- Properly pursue third party liability investigations/subrogation, train staff as necessary.
- Utilize industry standard medical coding used on provider billings, train staff as necessary.
- Properly identify and investigate potential other coverage, including Medicare, train staff as necessary.
- Properly identify potential catastrophic claims, including transplants, train staff as necessary.
- Develop and maintain a refund / outstanding overpayment log.
- BMI data system should be upgraded to track dates claims are pended and dates that the additional information was received. Distinctions should be made between

external pend reasons and internal pend reasons, in order to properly calculated turnaround processing time.

- WSHIP should have all transplant files audited to ensure accurate benefit payments and accumulators.
- BMI should provide necessary documentation to determine premiums were received within the grace period for the claims identified in this audit.
- Ongoing future auditing is warranted to confirm improvement in the foregoing areas.