Comprehensive Claim Administration Audit

SPECIFIC FINDINGS REPORT

Kansas State Employee Medical Plan

Administered by Blue Cross Blue Shield of Kansas

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

Presented to

Kansas State Employee Health Plan

August 31, 2020

CLAIM TECHNOLOGIES
INCORPORATED

TABLE OF CONTENTS

INTRODUCTION

This ***Specific Findings Report*** contains CTI's findings and recommendations from our audit of Blue Cross Blue Shield of Kansas's (BCBSKS) administration of the Kansas State Employee Health Plan (the State) plans.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and information provided by the State and BCBSKS. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to obtain a reasonable assurance claims were adjudicated according to the terms of the contract between BCBSKS and the State 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 BCBSKS used to pay the State's claims during the audit period. 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 other than agreed upon audit fees.

OBJECTIVES AND SCOPE

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

- BCBSKS followed the terms of its contract with the State;
- BCBSKS 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's plans at the time a service paid by BCBSKS was incurred; and
- Any claim administration or eligibility maintenance systems or processes need improvement.

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

Total Paid Amount	$259,014,762
Total Number of Claims Paid/Denied/Adjusted	872,563

The audit included the following components which are described in greater detail on the following pages:

- Operational Review and Questionnaire
- Plan Documentation Analysis
- 100% Electronic Screening with 50 Targeted Samples
- Random Sample Audit of 180 Claims
- 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 BCBSKS 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.

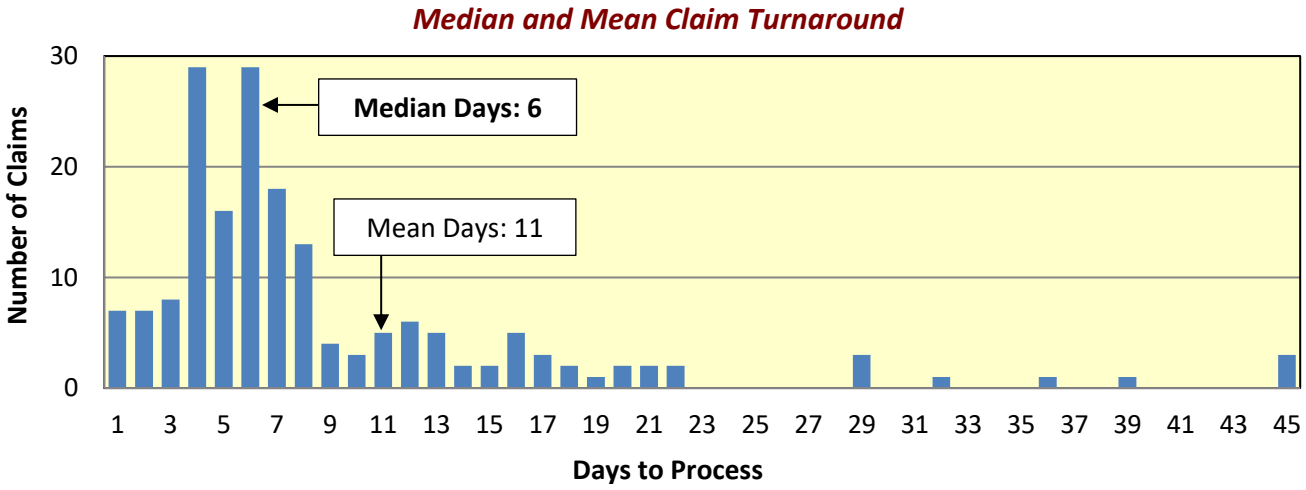
CTI's Random Sample Audit categorizes errors into key performance indicators. We use this systematic labeling of errors and calculation of performance as the basis for the benchmarks generated using results from our most recent 100 medical claim audits.

The following table illustrates BCBSKS's performance was 100% in all 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%**
Accurate Payment: Compares number of correctly paid claims to total number of claims paid.			**96.53%**		**100%**
Accurate Processing: Compares number of claims processed without any type of error (financial or non-financial) to total number of claims processed.			**96.03%**		**100%**

Claim Turnaround Time

A final measure of claim administration performance is claim turnaround time. Through the audit sample, BCBSKS demonstrated its median turnaround time on a complete claim submission was 6 days from the date it received a complete claim to the date the claim was paid or denied.



Random Sample Recommendation

The random sample audit did not identify any financial or procedural deficiencies. We recommend the State continue to monitor BCBSKS's administration through performance goal reporting and periodic audits to verify BCBSKS continues to perform at a high level and to identify emerging processing issues.

100% Electronic Screening with Targeted Samples Findings

We used our proprietary Electronic Screening and Analysis System (ESAS) software to further analyze claim payment and eligibility maintenance accuracy as well as and opportunities for system and process improvement. Using the data file provided by BCBSKS, we readjudicated each line on every claim the plan paid or denied during the audit period against the plan's benefits. Our Technical Lead Auditor tested a targeted sample of 50 claims to provide insight into BCBSKS's claim administration as well as operational policies and procedures.

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
Incorrect Copayment	**$34,151**
Office Visit - Telemedicine	$13,200
Urgent Care	$20,951
Fraud, Waste and Abuse – Spinal Region Upcoding	**$1,001,029**
Employee Eligibility Screening – Claims Paid*	**$554,534.11**

**CTI notes that only .002% of the State' total medical spend processed by BCBSKS was identified as paid for members who may not have been eligible for coverage. These results are low compared to the 1 – 2% CTI generally reports.*

100% Electronic Screening with Targeted Samples Recommendations

The State should talk to BCBSKS about conducting a focused analysis of the items identified through ESAS of BCBSKS's administrative procedures. Specifically, we recommend the State talk to BCBSKS about:

- Telemedicine consultation and if the $10 copayment applies just to Amwell or to all providers;
- The system update and report BCBSKS ran to identify urgent care claims in which a $60 copayment was mistakenly applied instead of $50; and
- If there are discussions or plans underway to set claim system edits to verify the number of regions in the procedure codes and diagnosis codes for spinal manipulation claims match.
- Review of the claimants flagged in the eligibility screening and perform causal analysis to identify any workflow and/or system improvements that could reduce or eliminate paying claims for ineligible claimants.

The State, CTI and BCBSKS discussed the ESAS results to determine if overpayment recovery and/or system improvements were possible and to reduce or eliminate similar errors going forward. Where any research or impact analyses were requested by the State, BCBSKS completed it and reported its findings to the State.

The State asked BCBSKS to review a sample of high dollar claimants who were flagged in the eligibility screening to determine if they were eligible on their dates of service. BCBSKS shared their research with CTI and the screening was updated.

Operational Review Findings

BCBSKS completed our Operational Review Questionnaire and 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 review include:

- BCBSKS provided copies of declaration pages for its fidelity bond, several errors and omissions policies, and its cyber insurance policy. The fidelity bond has an aggregate of $10 million, the errors and omissions policies have aggregates of $5 million, and the cyber insurance policy has an aggregate of $20 million.
- BCBSKS and the State have an extensive performance agreement in place with standards for 23 different measures. All measures are tracked at a client-specific level using a random sampling technique. BCBSKS reported paying $2,500.00 to the State for not meeting the Claims Processing Timeliness guarantee in the second quarter of 2019 and SEHP verified receipt of the payment.
- BCBSKS 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 a description of its system, which the service auditor validates. CTI has a copy of the audit report and bridge letter and we can confirm that BCBSKS'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.
- BCBSKS indicated its open systems (Windows, AIX, Linux, VMware) and Mainframe are backed up nightly and a replication process is in place for recovery at the IBM Business Continuity and Resiliency Service center in Boulder, Colorado.
- BCBSKS handles claim checking account reconciliation and refunds for the State. Returned checks are credited to the client after claims have been adjusted. BCBSKS turns over uncashed checks to the Kansas State Treasurer after the dormancy period has been met.
- BCBSKS has high dollar claim payment review thresholds as follows:
    - Inpatient Institutional – $150,000.00
    - Outpatient Institutional – $100,000.00
    - Professional/Shield – $50,000.00
    - Pay Member - $5,000.00

  High dollar claims are reviewed by assistant supervisors, supervisors, and managers prior to final adjudication. Prior to checks being written, assistant supervisors perform a final quality check.

- BCBSKS provided documentation of claim system security controls that included secure log-on passwords and system authorization, authorized check signatures, separation of duties, and limited ability to override system edits and limitations.
- BCBSKS follows NAIC guidelines to determine order of benefits. BCBSKS calculates COB savings as the amount paid by the primary carrier. For example, if the primary payment for a procedure would have been $100.00 and the primary carrier has paid $60.00, BCBSKS would show savings of $60.00 and a payment of $40.00. The $60.00 savings can then be used to make additional payments on claims that were not paid in full between the primary carrier payment and its secondary payment. BCBSKS reported COB reports aren't available by group.
- BCBSKS indicated approximately 78.83% of the State's claims auto-adjudicated during the audit period.
- BCBSKS pursues overpayment recovery on amounts over $25.00 and has the ability to auto-recoup overpayments to in-network providers. BCBSKS contracts with RMS/IQ to assist with overpayment recovery. RMS/IQ's commission is 25%. BCBSKS indicated that it tracks reasons for overpayments, including whether they were solicited or unsolicited.
- For pursuit of work-related claims, the State's case creation threshold is $1,000 unless BCBSKS receives something on the claim or from other sources that indicates workers compensation, then the dollar threshold is not involved. If workers compensation is already known, there is no dollar threshold.
- BCBSKS reported 273 appeals in 2019 with 178 upheld (65%), 81 overturned (30%), and 14 (5%) partially overturned. Only one appeal was not completed within 60 days. 266 of the appeals were closed in 2019 with seven being closed in January of 2020.
- BCBSKS indicated that 99.74% of the State's claims came from in-network providers.
- BCBSKS indicated that it received rebates for processing specialty drugs under the medical coverage and applied them to reduce plan administrative fees.
- BCBSKS did not have any data breaches during the audit period.

Operational Review Recommendations

- BCBSKS tracks reasons for overpayments and contracts with RMS to assist with overpayment recovery. If not already provided, we recommend review of periodic overpayment reports to see the volume of overpayments made on the State's behalf, the causes, the amounts recovered, and associated fees to ensure the State isn't paying recovery fees for overpayments due to BCBSKS's administration.
- BCBSKS reported COB reports aren't split out by group but we recommend asking if a report can be generated for the State on an ad hoc basis. The report would allow the State to see the savings to the plan from participants' other coverages and estimate what the State's liability would be if these other coverage were to end.

The State, CTI and BCBSKS discussed the operational review recommendations. BCBSKS verified it's unable to provide group-level overpayment and coordination of benefits reports at this time. If that should change, the State will be notified. In addition, the State discussed the rebates BCBSKS received for processing specialty medications and their application toward reducing administrative fees.

Plan Documentation Analysis Findings and Recommendations

Plan Documentation

Our Plan Documentation Analysis indicated the State plan documents were silent on whether marriage counseling is a covered benefit. We recommend the State consider updating its plan documents to include this as a covered benefit or to list it as a plan exclusion.

Data Analytics Findings

CTI used electronic claim data provided by BCBSKS 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 BCBSKS 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	$18,087,165	$9,087,122	50.2%	$7,005,506
Non-Facility	$195,991,070	$86,387,561	44.1%	$73,540,634
Facility Inpatient	$166,962,549	$94,753,251	56.8%	$65,334,199
Facility Outpatient	$274,579,948	$169,514,883	61.7%	$80,764,955
Total	**$655,620,732**	**$359,742,817**	**54.9%**	**$226,645,294**

The State's members had network utilization with 99.1% of all allowed charges and 99.3% of all claims.

Sanctioned Provider Identification

CTI screened 100% of non-facility provider claims from BCBSKS 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

Federal healthcare reform (PPACA) mandates that all health plans (unless grandfathered) cover certain preventive services at 100% without cost-share if the service is performed by a network provider. During the last audit, BCBSKS reported preventive services have to have the preventive diagnosis in the first position so this screening only looked at the diagnoses in the first position and not any others submitted on the claim.

CTI's analysis found 94.91% of the procedure codes were identified as preventive services from in-network providers. CTI can provide a detailed list of the other 5.09% upon request.

NCCI Editing Capability

CTI analyzed BCBSKS'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 the State and paid by BCBSKS that CMS would have denied using the NCCI edits. Since BCBSKS paid the billed charges, the payments represent a potential savings opportunity to the State.

Claim System Code Editing Capability Analysis by CMS NCCI Initiative		
	Procedure-to-Procedure Edits	**Medically Unlikely Edits**
Facility	$1,025,423	$2,462,661
Non-Facility	$1,433,031	$1,075,356
Ancillary	N/A	$6,952

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 BCBSKS that CMS would have denied using its defined global surgery fees. Payment of post-surgery E/M (office visits) 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 BCBSKS paid allowed charges, those payments represent a potential savings opportunity to the State.

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**
8,843	$754,757	1,017	$139,367

Data Analytics Recommendations

The State, CTI and BCBSKS discussed the Data Analytics findings and the potential for additional cost savings to the plan. CTI found $6,142,790 in claims that would have been denied by CMS. BCBSKS is unable to adopt all of CMS's NCCI edits and global fee period edits due to member contracts, medical policies, and provider policies. If that should change, the State will be notified.

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.

CTI also suggests that the State perform a follow-up audit to verify that BCBSKS continues to perform above benchmarks, 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.

CLAIM TECHNOLOGIES INCORPORATED

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

(515) 244-7322 • claimtechnologies.com