500 North Brand Boulevard
Suite 1400
Glendale, CA 91203-3338
T 818.956.6700
F 818.956.6790
segalco.com

Memorandum

To: Industry & Local 338 Welfare Fund

From: Amber M. Turner, MBA, PMP

Date: June 15, 2021

Re: Calendar Years 2018 and 2019 : Target Medical Claims Audit

This report summarizes Segal's review of the claims processing and payment procedures utilized by Empire BlueCross BlueShield (Empire) and Associated Administrators in their administration of the Industry & Local 338 Welfare Fund's (the Fund's) group medical benefits. Amber Turner of Segal's Benefit Audit Solutions Practice conducted the remote audit. The audit was conducted utilizing Empire's network pricing and Associated Administrators' adjudication of claims and issuance of claim payments. The audit encompassed a total sample of 100 claims for the 24-month audit period.

Scope of Services

Associated Administrators provided an electronic data file of all medical claims processed and paid during the 24-month period of January 1, 2018 through December 31, 2019. The objective of the review was to ensure that claims were paid in accordance with the Fund's plan provisions. Segal's audit included the following remote review components:

1. An Adjudication Procedures review to assess day-to-day processing guidelines and claim control measures;

2. A sample of 100 target claims (50 claims from 2018 and 50 claims from 2019) identified through an electronic analyses of all claims designed to explore potential duplicate payments and/or sample various benefit applications (i.e. deductibles, employee cost-shares, limitations, and exclusions).

The auditor completed a form for each sampled claim serving as the primary documentation on which the report is based. To maintain patient confidentiality, claims addressed within this report are referred to as "Worksheets" (1-100). The auditor reviewed each claim from receipt to release of check disbursement to identify any variances in procedures and benefit determination.

Performance Results – Time-to-Process

Overall, there were no concerns with the Time-to-Process / turnaround time achievements. Results from the electronic analysis of all claims processed during the audit period revealed:

- During 2018, Associated Administrators processed 99.30% claims within 14 calendar days and 99.81% within 30 calendar days; and,
- In 2019, Associated Administrators processed 99.89% of claims within 14 calendar days and 100.00 % within 30 calendar days.

Time-to-process for individual claims is measured from the date a claim is first received to the initial date processed for payment or denial; subsequent adjustments were measured from receipt of the new information to the benefit determination date with processing measured as the longest interval. Measurements included routing delays due to internal review (i.e. documentation review, quality audit).

Industry standards indicate 95% of all claims should be processed within 14 calendar days. Best practice, which follows Department of Labor (DOL) regulations, requires 100% within 30 calendar days.

Target Claim Sampling

Segal performed an electronic review of all claims processed and paid during the audit period of January 1, 2018 through December 31, 2019. The electronic review was designed to identify potential deficiencies in the benefit delivery system; however, our analysis was not intended to identify data entry errors (i.e. incorrect patient, date of service, or provider) or creative billing practices of the provider.

- The data file contained $1,640,879.24 paid in calendar year 2018. The claims sample in 2018 equaled to $625,562.94 (38%).
- The data file contained $1,643,798.58 paid in calendar year 2019. The claims sample in 2019 equaled to $662,396.90 (40%).

The electronic analyses included exploration of scenarios that could suggest an error in programing and/or administrative procedures with focus given to patterns suggesting a greater financial impact to the Fund. Our query process was defined by the following categories:

- High dollar paid claims.
- Potential duplicate payments.
- Reimbursement of Plan exclusions, limitations, and prior authorizations.
- Patient out-of-pocket expenses (i.e. deductible, copay and coinsurance).

The Summary Plan Description (SPD) document and Summary Benefit Coverages (SBCs) served as our references for the electronic analyses. Electronic reports provided a list of suspected errors that required the auditor's manual review to refine the analysis and identify any patterns of concern; a selection of claims was chosen to confirm suspected errors and identify appropriate query revisions.

The remote review of target claims focused on the attribute(s) selected to gain confidence and to understand how a change in query programs could present more accurate results (e.g., minimize the number of false-positives evidenced in such electronic reviews).

Review Process

Associated Administrators provided a copy of the sampled claim submissions and supporting documentation. Empire provided Segal with remote access into their pricing documentation for review. The auditor recalculated and reviewed each claim manually from initial receipt to final benefit determination seeking evidence of compliance with established adjudication procedures and benefit provisions; each patient's claim history was reviewed to confirm proper application of plan deductibles and benefit maximums. In addition to verifying the amount paid, evidence of the following processing tasks was explored.

- Claims were paid only on behalf of eligible individuals based on records contained in the claims system.
- Documentation (i.e. provider bills, physician statements, utilization review decisions or penalty findings, surgical reports, etc.) is on file for claims paid and verified when necessary.
- Coordination of benefits (COB) and subrogation provisions were enforced, where applicable.
- Amounts paid were within the network discount fees or designated non-contracted allowances.
- Proper medical necessity was investigated as defined by the Plan.
- Benefits were paid under the proper classification, diagnostic, and procedure codes as an incorrect entry may affect payment accuracy or future benefit determinations.
- Appropriate benefit limitations, deductibles, copayments, coinsurance, and out-of-pocket maximums were applied.
- As appropriate, high-dollar claims were considered for care management and applicable stop-loss notifications were filed timely.
- Claims system logic for examiner edits and auto-adjudication capabilities.
- Arithmetic calculations were correct.
- Duplicate submissions were properly denied.

- Payment was made to the proper party (i.e. the provider of service if benefits were assigned; claimant is benefits were not assigned).

- Time-to-Process achievements for processing of claims was within industry standards.

All questions and potential errors were presented to Empire's and Associated Administrators' representatives daily; additional supporting documentation was provided by the vendors through April 26, 2021.

Of the 100 claims targeted through electronic analyses, 83 were supported by claim documentation, confirmation of Plan intent, and/or explanation of established administrative procedures.

Key Findings and Recommendations

The following bullet points summarize the primary findings identified by Segal's auditor during the claims review. Associated Administrators' and Empire's responses to the findings from the remote review are summarized and italicized throughout the memorandum. Associated Administrators and Empire were presented with a draft memorandum on May 19, 2021 for their review and comment. Empire's formal response, which was provided to Segal on May 26, 2021, can be located in the Attachment of the report (A). Associated Administrators' formal response, which was provided to Segal on June 4, 2021, can be located in the Attachment section of this report (B).

- A total of 17 claims were found in error (16 claims totaling the overpayment of: $4,789.87 and one (1) claim totaling the underpayment amount of -$3,829.00) through Segal's review. Segal recommended that Associated Administrators provide financial impact reports, where indicated.

  Associated Administrators notes that a 1% financial or "other" error ratio is generally considered satisfactory. The Trustees may wish to discuss this metric with Segal. We pride ourselves on accurate and efficient claims processing and look forward to answering any additional questions the Board may have.

  – Nine (9) of the claims were found to have no prior authorization and no penalty applied. Per the plan document, if no authorization is obtained, there is a penalty applied to the payment of 50% up to $500.00. (Samples: 3, 9, 11, 28, 64, 65, 68, 89, & 91, Total Overpayment: $3,614.00)

    Associated Administrators agreed to these errors during the remote review but later revised their decisions on five (5) of the nine (9) claims.

    Segal recommended that Associated Administrators run a financial impact report for the claims where prior authorization penalty was not applied and provide corrective actions regarding changes to the process of reviewing authorization penalties going forward. Associated Administrators should discuss overpayment recovery options with the Fund.

- ***Associated Administrators Response:*** *Associated Administrators noted that they agree to the following as no prior authorization was achieved for these services and a penalty was not applied:*

  - *Samples 68 and 89 - Authorization for MRIs*

  - *Sample 9 - C-section stay for 5 day inpatient stay*

  - *Sample 3 - 8-day inpatient hospital stay with authorization occurring after the admission date.*

- ***Associated Administrators Response:*** *Associated Administrators noted that they do not agree to the following non-authorization errors assessed by Segal.*

  - **Inpatient Hospital Partial Approval - *Associated Administrators Response:*** *Associated Administrators noted that they do not agree to Sample 11's error even though no prior authorization was achieved for these services and a penalty was not applied:*

    Sample 11 - The full inpatient stay was not authorized. Associated Administrators noted that due to this claim paying with a DRG, the dates cannot be split out as it relates to charges for what was approved versus what was not.

    Segal disagrees with Associated Administrators and notes that the penalty should still apply as the full stay was not approved. Segal recommends that the Fund discuss with Associated Administrators regarding the authorization requirements for DRG claims.

  - **Inpatient Hospital - *Associated Administrators Response:*** *Sample 28 - Associated Administrators noted that the patient was admitted through the emergency room and was authorized within 48 hours of the admission.*

    Segal upholds the error as proof of the emergency room charges were not provided.

  - **Durable Medical Equipment - *Associated Administrators Response:*** *Samples 64 and 65 - Associated Administrators noted that the DME supply for wrist hand orthosis, wrist extension control cock-up, non-molded, prefabricated, off-the-shelf appliances is not listed as requiring prior authorization from Healthlink. As of January 1, 2021 Healthlink only requires orthotic equipment to obtain an authorization when in excess of $1,000 purchase price.*

    Segal upholds the error as page 86 of the SPD under Empire's Medical Management program section notes that members must call to pre-certify before one may rent, purchase or replace prosthetics orthotics, or durable medical equipment (DME). This section does not denote a purchase amount or specified piece of equipment.

    Segal recommends that the Fund discuss this prior certification guideline with Associated Administrators.

- **Eye Related Procedure - Associated Administrators Response:** Sample 91 - Associated Administrators noted that the outpatient surgical procedure (code 66984-Cataract Removal with insertion of intraocular lens prosthesis) is not noted through Healthlink as requiring a prior authorization.

  Segal upholds the error as page 86 of the SPD under Empire's Medical Management program section notes that members must call to pre-certify before one receive same-day surgery for medically necessary cosmetic/reconstructive surgery, outpatient transplants, and ophthalmological or eye related procedures.

  Segal recommends that the Fund discuss this prior certification guideline with Associated Administrators.

- One (1) claim was missing the copayment for physical therapy. (Sample: 61, Amount: $20.00)

  Associated Administrators agreed to this error during the remote review.

  Segal recommends that Associated Administrators run a financial impact report for claims where the physical therapy copayments were not applied.

- One (1) claim had incorrect pricing due to a provider rate change in the system. (Sample: 25, Amount: -$3,829.00)

  Empire agreed with the error during the remote review, but noted they cannot adjust the claim as it is from 2018.

  Segal recommends that the Fund discuss provider contract update reimbursement timelines with Empire. If Empire has limitations on the provider reimbursements Segal recommends an annual audit review to ensure the Fund is being made whole.

- Four (4) claims are noted as paying routine hearing exams. Per the SPD, Page 48, routine hearing exams are not covered. (Samples: 62, 63, 84, 85, Amount: $80.92)

  Associated Administrators stated hearing exams are noted under well child visits per the Preventive Health Guidelines based on AAFP, AAP, ACIP, ACOG, ACS, CDC, & USPSTF, and hearing exams are noted under the USPSTF recommendations for adults over the age of 50.

  Segal recommends that the Fund review hearing benefits coverage and update or amend the plan document(s), as applicable.

- Two (2) claims were noted as not having the proper surgery payment reduction for multiple surgeries. "According to page 42 of the SPD, for a second procedure performed during an authorized surgery through the same incision, Empire pays for the procedure with the higher allowed amount. For a second procedure done through a separate incision, Empire will pay the allowed amount for the procedure with the higher allowance and up to 50% of the allowed amount for the other procedure." (Samples: 66 & 67, Amount: $1,074.95)

Empire disagreed with these errors during the remote review noting ClaimsXten (Empire's coding editing software) allowed the service in full.

Empire's Response- *Claims submitted directly to Empire for reimbursement go through ClaimsXten, a McKesson product that is widely used within the industry today. This coding logic tests for the appropriateness of procedure codes and modifiers when billed together or separately. ClaimsXten utilizes both the NCCI code combinations, along with the McKesson proprietary bundling code combinations. The combination of both would lead to many more edits firing than NCCI alone. NCCI has approximately 700,000 code combinations. The combination of NCCI and McKesson proprietary rules has approximately 1.5 million code combinations. NCCI is just one (1) of approximately 90 rules incorporated in ClaimsXten.*

Both claims went through ClaimsXten review. Sample 66 reported two separate procedures, based on the combination and services reported, both services were allowed in full. Sample 67 billed eight (8) separate procedures reported on the same day. Based upon the combination of codes and modifiers reported, three services were considered inclusive to others on claim and were not reimbursed; one service was cutback to 50% based upon Empire's editing tools in place.

Segal recommends that the Fund discuss with Empire the Fund's intent of the multiple surgery reduction as it relates to claims adjudication.

- Currently, Associated Administrators does not auto-adjudicate the Fund's claims.

  Segal recommended that Associated Administrators discuss their auto-adjudication capabilities with the Fund in order to avoid human error in the adjudication of claims.

  Associated Administrators Response: *Associated Administrators believes auto-adjudication is effective only for simple, unchanging claims and prefers to assign processing to claims adjusters. Our staff are Union employees, highly trained, and highly professional.*

  Segal's recommendation stands.

- Segal reviewed the total annual claim payment amounts for individual members to identify high-dollar accumulations. Two (2) members were identified as potentially meeting or exceeding the stop-loss insurance attachment point.

  – One (1) member is receiving ongoing dialysis services, which started in 2018. Benefit payments from this member's file indicate that $136,550.75 was paid in 2018 and $182,980.60 was paid in 2019. This member was confirmed to be under the elimination period for Medicare coordination as dialysis started in 2018.

  Claim benefit payments for the diagnosis of End Stage Renal Failure is under the stop-loss attachment amount of $175,000. Segal recommended that Associated Administrators flag this member for future stop-loss insurance coverage review.

Associated Administrators Response: *The Stoploss carrier was properly notified and the participant's file was reviewed on a monthly basis for claim reimbursement eligibility in accordance with the contract between HHC and the Fund.*

- One (1) member started cancer treatments in 2019. Throughout the year, this member accumulated $174,223.97 in total benefit payments.

  Claim benefit payments for the diagnosis of Cancer is under the stop-loss attachment amount of $175,000. Segal recommended that Associated Administrators flag this member for future stop-loss insurance coverage review.

  Associated Administrators Response: *The Stoploss carrier was properly notified and the participant's file was reviewed on a monthly basis for claim reimbursement eligibility in accordance with the contract between HHC and the Fund.*

Attachment -

A) Empire's Formal Response to the Memorandum Report

www.empireblue.com
Empire Blue Cross Blue Shield
Customer Audit Services
85 Crystal Run Road
Middletown, NY 10940

May 25, 2021 ***Via email only***

Amber Turner Segal Consulting
500 North Brand Boulevard Suite 1400
Glendale, California 91203

RE: Local 338– Medical Claim Target Audit

Dear Ms. Turner:

Empire BlueCross BlueShield (Empire) reviewed the audit report prepared by Segal Consulting on behalf of the Industry and Local 338 Welfare Fund (Fund). The Empire audit portion was conducted remotely during the week of March 15, 2021. The audit conducted utilizing Empire's pricing access and Associated Administrators adjudication of claims payments. The audit encompassed a total sample of 100 claims for the 2018 & 2019 audit period. Empire's response to each audit finding is presented in *italics* below.

Key Findings and Recommendations

One (1) claim had incorrect pricing due to a provider rate change in the system. (Sample: 25, Amount: -$3,829.00). Empire agreed with the error during the remote review but noted they cannot adjust the claim as it is from 2018.

Empire's Response*- Empire noted during the audit, NYPHS Lawrence Hospital became a* campus of New York Presbyterian Columbia, due to contract negotiations DRG rates were retro- actively loaded and updated with an effective date of 04/01/2018. Sample claim for date of service 06/16/18- 06/18/18 initially paid based on the DRG rate on file at the time of initial processing, which was $7,046. Due to contract negotiations, previous rates were terminated

effective 03/31/18 and new rates were updated with an effective date of 04/01/18. The sample claim should have been adjusted to pay at the new DRG rate of $10,875 in 2019 when the rate updates occurred. Unfortunately, this claim was not adjusted. Due to timing, claim is no longer eligible for an adjustment. Failure for timely adjustment resulted in an underpayment of $3,829.Two (2) claims had no pricing on file to support the claims. Empire noted they did not price these claims and Associated Administrators noted Empire passed the pricing to them as in- network claims. Both claims were paid as billed. (Samples: 29 & 98, Amount: $40,134.70).

Segal recommends that Associated Administrators confirm with Empire if pricing was provided for these claims. Amounts of any identified overpayments should be reported to the Fund.

Empire's Response- *Empire noted it was not able to provide payment support because they were* not Empire direct claims and did not utilize Empire's pricing. The two claims referenced were priced by non-Empire Host Plans. Empire will utilize the pricing passed by the Host Plan since the provider is contracted with the Host Plan in the reporting location. Both providers are contracted PPO providers with each individual plan. The pricing for each claim was available in the Blue2 system. Empire could not supply pricing support other than refer to Blue2 system for pricing detail. Sample 29 was priced as a DRG, with a DRG rate of $34,200.00. The total billed charge on this claim was $35,759.70. This claim was not reimbursed at billed charges. The claim reimbursed at $33,670.55 (DRG rate $34,200.00 - $529.45 coins = $33,670.55). Under sample 98, the Host Plan passed a pricing method of 20, per diem, an all-inclusive daily reimbursement rate of $625. The claim reported seven (7) dates of service, each with a daily charge of $625. The daily charge matched the daily per diem rate.

Two (2) claims were noted as not having the proper surgery payment reduction for multiple surgeries. "According to page 42 of the Summary Plan Document, for a second procedure performed during an authorized surgery through the same incision, Empire pays for the procedure with the higher allowed amount. For a second procedure done through a separate incision, Empire will pay the allowed amount for the procedure with the higher allowance and up to 50% of the allowed amount for the other procedure." (Samples: 66 & 67, Amount: $1,074.95) Empire disagreed with these errors during the remote review noting ClaimsXten (Empire's coding editing software) allowed the service in full.

Segal Recommends that the Fund discuss with Empire the intention of the multiple surgery reduction as it relates to claims adjudication

Empire's Response- *Claims submitted directly to Empire for reimbursement go through* ClaimsXten, a McKesson product that is widely used within the industry today. This coding logic tests for the appropriateness of procedure codes and modifiers when billed together or separately. ClaimsXten utilizes both the NCCI code combinations, along with the McKesson proprietary bundling code combinations. The combination of both would lead to many more edits firing than NCCI alone. NCCI has approximately 700,000 code combinations. The combination of NCCI and McKesson proprietary rules has approximately 1.5 million code combinations. NCCI is just one (1) of approximately 90 rules incorporated in ClaimsXten.

Both claims went through ClaimsXten review. Sample 66 reported two separate procedures, based on the combination and services reported, both services were allowed in full. Sample 67 billed eight (8) separate procedures reported on the same day. Based upon the combination of codes and modifiers reported, three services were considered inclusive to others on claim and were not reimbursed; one service was cutback to 50% based upon Empire's editing tools in place.

We look forward to discussing any of the above responses with you. If you have any questions concerning the audit, you may contact me at 845-695-4118 or Marijane Gadbury, Director, Customer Audit Services at (317) 771-9729.

Sincerely,

Toni Angelo

Toni Angelo
External Audit Manager
Senior Customer Audit
Services

cc: Diana Brooks, Anthem
Joseph Bruzzo, Anthem
Marijane Gadbury, Anthem

B) Associated Administrators' Formal Response to the Memorandum Report

Associated Administrators' comments are noted in Red.

– Nine (9) claims were found to have no prior authorization and no penalty applied. Per plan document, if no authorization is obtained there is a penalty applied to the payment of 50% up to $500.00. (Samples: 3, 9, 11, 28, 64, 65, 68, 89, & 9, Amount: $3,614.00)

Associated Administrators agreed to these errors during the remote review.

Segal recommends that Associated Administrators run a financial impact report for the claims where prior authorization penalty was not applied and provide corrective actions regarding changes to the process of reviewing authorization penalties going forward. Associated Administrators should discuss overpayment recovery options with the Fund.

Each year Healthlink Medical Management supplies Associated Administrators with a list of services requiring pre-certification. Healthlink sends Associated Administrators a daily spreadsheet containing authorizations of procedures/services they have made. The adjuster consults the spreadsheet, and if Healthlink has authorized the procedure the adjuster processes the claim.

Included among the claims identified by Segal (68 and 89) are two MRIs which the adjuster released without authorization; the penalty would have been $500 each, sample 9 was a 5 day hospital stay for a C-section delivery of child which was released for payment without prior authorization, the penalty would have been $500, and sample 3 which is an 8 day hospital stay where the authorization was established after the admission date.

Sample 11 was for a 2 day inpatient hospitalization. Healthlink authorized the initial date of admission. Because this claim was a DRG claim, or case rate, it is not possible to split out charges for the second day. The claim would have needed to be paid or denied in its entirety. The claim was released for payment since there was an authorization that covered charges within the DRG service dates.

Sample 28 was for a 5 day inpatient hospitalization. The participant was admitted through the emergency room. The hospital did contact Healthlink within 48 hours according to documentation received from Healthlink. No penalty should apply.

Two claims identified by Segal (64 and 65) are for wrist hand orthosis, wrist extension control cock-up, non-molded, prefabricated, off-the-shelf appliances. The DME supply is not listed on the publication of procedures requiring authorization supplied by Healthlink. As of 1/1/2021; Healthlink requires Orthotic equipment in excess of $1,000 purchase price to be pre-authorized. No penalty should apply.

Sample 91 is for an outpatient surgical procedure released without a Healthlink authorization on file. The procedure code billed is not a procedure listed on Healthlink's publication that requires pre-certification. No penalty should apply.

Associated Administrators believes Healthlink may be able to include additional information on the spreadsheet to facilitate processing; if the Board so desires, Associated Administrators will work with Healthlink to address.

- Two (2) claims had no pricing on file to support the claims. Anthem noted they did not price these claims and Associated Administrators noted Anthem passed the pricing to them as in-network claims. Both claims were paid as billed. (Samples: 29 & 98, Amount: $40,134.70)

  Segal recommends that Associated Administrators confirm with Anthem if pricing was provided for these claims. Amounts of any identified overpayments should be reported to the Fund.

  The data supplied on the 837 claim file from Anthem was reviewed against what was loaded into the basys system. The 837 file confirmed Loop 2400, HCP14 and HCP15 segments contained a value of 1 which indicates the provider was in-network and payment was assigned to be issued to the provider. Loop 2300, HCP01 segment contained a value of 10 which indicates Participating Provider, Priced.

  For sample 98, the in-network and out-of-network out-of-pocket was satisfied therefore payment was issued at 100% of the allowed amount.

- Currently, Associated Administrators do not auto-adjudicate the Funds claims.

  Segal recommends that Associated Administrators discuss their auto-adjudication capabilities with the Fund in order to avoid human error in the adjudication of claims.

  Associated Administrators believes auto-adjudication is effective only for simple, unchanging claims and prefers to assign processing to claims adjusters. Our staff are Union employees, highly trained, and highly professional.

- Segal did not identify any deviation from the Empire pricing system (excluding Sample 25). From reviewing the top 5 claims paid in each 2018 and 2019 year, Segal identified:

  - 2018-2 Back Surgery claims for $145,604.96
  - 2018-2 Coronary Care claims for $98,983.68
  - 2018-1 Sepsis admission claim for $43,498.15
  - 2019 3 Heart related inpatient hospital admissions for $108,419.20
  - 2019 1 Hip surgery claim for $33,670.55
  - 2019 1 Cesarean birth for $32,267.14

- Segal reviewed the overall claim payment for individual members to identify high dollar accumulations.

  – One member is completing ongoing dialysis starting in 2018. Benefit payments from this member's file indicate $136,550.75 paid in 2018 and $182,980.60 in 2019. This member was confirmed to be under the elimination period for Medicare coordination as dialysis started in 2018.

    The diagnosis of End Stage Renal Failure is under the stoploss attachment amount of $175,000. Segal recommends that Associated Administrators flag this member for future stoploss opportunities.

    The Stoploss carrier was properly notified and the participant's file was reviewed on a monthly basis for claim reimbursement eligibility in accordance with the contract between HHC and the Fund.

  – One member started cancer treatments in 2019. Throughout the year this member accumulated $174,223.97 in benefit payments.

    The diagnosis of Cancer is under the stoploss attachment amount of $175,000. Segal recommends that Associated Administrators flag this member for future stoploss opportunities.

    The Stoploss carrier was properly notified and the participant's file was reviewed on a monthly basis for claim reimbursement eligibility in accordance with the contract between HHC and the Fund.

    Associated Administrators notes that a 1% financial or "other" error ratio is generally considered satisfactory. The Trustees may wish to discuss this metric with Segal. We pride ourselves on accurate and efficient claims processing and look forward to answering any additional questions the Board may have.