

**PUBLIC SCHOOL EMPLOYEES'
RETIREMENT SYSTEM**

HOP

HEALTH OPTIONS PROGRAM



WWW.HOPBENEFITS.COM

CORESOURCE

ELECTRONIC CLAIMS ANALYSIS

FOR THE PERIOD
JANUARY 1 THROUGH DECEMBER 31, 2008

THE SEGAL COMPANY
CLAIMS AUDIT DIVISION
1230 W. WASHINGTON STREET
SUITE 501
TEMPE, AZ 85281-1248
866-872-6995

J. RICHARD JOHNSON
1920 N STREET, NW
SUITE 400
WASHINGTON, D.C. 20036-1659
202-833-6400

REPORT DATED

JUNE 19, 2009

CONFIDENTIALITY STATEMENT

Release of electronic and hardcopy information for this analysis required execution of an agreement by The Segal Company and CoreSource.

All audit information and findings prepared and presented in this report are considered confidential and proprietary. Sharing of contents with any other party or the copying of information herein is expressly prohibited without the written consent of the agreeing parties.

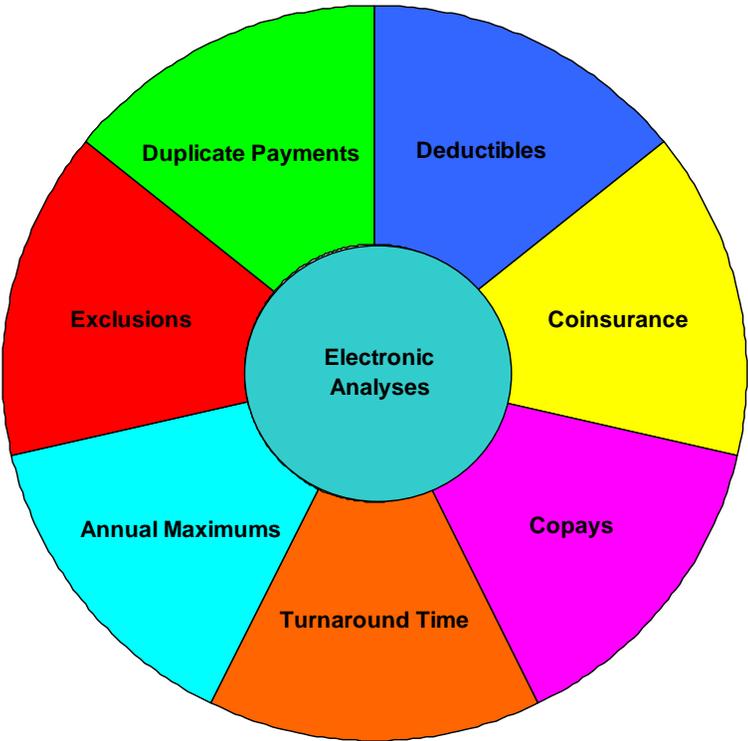
TABLE OF CONTENTS

SECTION I – EXECUTIVE SUMMARY	1
SCOPE OF SERVICES	1
SUMMARY FINDINGS.....	2
OVERALL ACHIEVEMENT	2
SECTION II – ELECTRONIC REVIEWS	5
CLAIMS DATA VALIDATION.....	5
ANNUAL DEDUCTIBLES.....	5
COPAYMENT APPLICATION	6
ANNUAL COINSURANCE.....	7
ANNUAL MAXIMUMS	7
PLAN EXCLUSIONS.....	8
DUPLICATE PAYMENTS	9
PROCESSING TURNAROUND TIME	10
SECTION III – CORESOURCE’S RESPONSE	12

SECTION I – EXECUTIVE SUMMARY

SCOPE OF SERVICES

Segal was retained to conduct a review of 2008 medical claims on behalf of the Public School Employees’ Retirement System Health Options Program (PSERS). While the objective of our current review mirrors prior year onsite projects, our electronic review of 100% of all claims included the following components with a focus on plan changes effective January 1, 2008. Our review included claims processed January 1 through December 31, 2008 for eligible retirees and dependents under the Traditional (High and Standard), Pre-65, and 65-Special Plans. Our electronic review process allows us to provide extra value through a duplicate claim analysis of all payments over \$100.

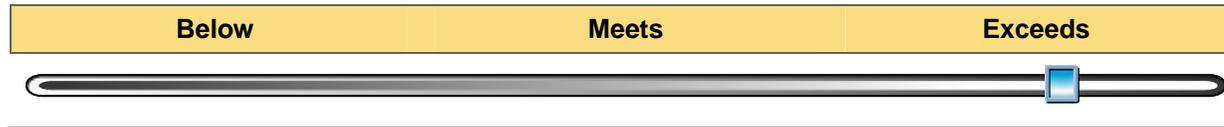


Paid Claims:	1,207,578
Benefits Paid:	\$67,940,129.47
Zero Pay Claims:	250,789
Percent of Total:	20.77%

SUMMARY FINDINGS

- **Annual Deductibles:** One underpayment (\$9.04) and one non-payment error. Limits for each plan are accurately programmed.
- **Copayment Application:** No errors related to office visit or hospital admission copays/deductibles.
- **Annual Coinsurance:** One overpayment (\$24.90). Appropriate coinsurance (*i.e.*, 60%, 75%, or 80%) up to the plan limit was noted.
- **Annual Maximums:** One overpayment (\$95 under wellness benefits) and one non-payment error were identified.
- **Plan Exclusions:** Results revealed denial or no claims for quantifiable exclusions (acupuncture, hearing aids, non-surgical treatment of obesity, spinal manipulations, non-emergency treatment at an emergency room, or temporomandibular joint disorder).
- **Duplicate Payments:** CoreSource confirmed total duplicate payments totaling \$3,621.10 for 14 claims (\$100 per service threshold).

OVERALL ACHIEVEMENT



Our quantitative analysis of primary plan provisions for 100% of claims verified that CoreSource’s performance far exceeded industry standards.

- **Financial, Payment, and Procedural Accuracy = 99.99%** (each category)
- **Time to Pay = 97.06%** (non-adjustment claim transactions processed within 14 calendar days); a single claim may be reported more than once if separate services were processed on different days.

	Financial Accuracy (dollar value)	Payment Accuracy (Incidents of financial error)	Procedural Accuracy (Non-payment errors)	Time to Pay (14 calendar days)
Industry Standards	99.00%	97.00%	95.00%	90.00% - 95.00%

Industry standards (provided for comparison) are developed through ongoing review of measures utilized by major carriers and third party administrators nationwide for administration of fully-insured and self-insured corporate, public, and multi-employer plan benefits.

Assumptions/Comments

- By design, our electronic analyses may not identify human error (*i.e.*, incorrect data entry, lack of documentation, benefit interpretation, processing judgment).
- Lifetime maximums were not included in our analysis due to the self-limiting audit period of claims processed in 2008.
- Eligibility was accepted as correct based on CoreSource’s system record at the time claims were processed; a separate eligibility audit was not included in the scope of our review.
- Pre-certification for “plan primary” hospital confinements was accepted based on CoreSource’s record of excluded amounts and corresponding message codes; compliance indicators were not included in the data file.
- Network pricing under the Pre-65 Plan was accepted as reported; the scope of our review did not include source file comparison.
- Queries were generated for each individual plan (Traditional, Pre-65, and 65-Special); detailed results are noted as applicable in Section II.
- Errors were confirmed through CoreSource’s validation of query exception results; non-payment (procedural) errors were due to claims processed under incorrect patients.
- CoreSource states that corrective action was initiated during the query validation process for all errors, including duplicate payments, identified through our electronic review.

Recommendations

Details of each recommendation are provided in Section II. CoreSource was presented with a draft report for their review and comment; their responses are paraphrased in italics below, with the entire response provided as Section III.

- The 65-Special Summary Plan Description (SPD) should be revised to stipulate application of the \$10 office visit copay toward the annual deductible up to \$140 or the current Medicare Part B deductible limit.

CoreSource has reviewed this with PSERS and the language will be added to the next revision/reprinting of the 65-Special Summary Plan Description (SPD) document.

- CoreSource should provide PSERS with proof of refund for overpayments identified through this audit; amounts unrecovered after 60 days should be credited back to the Plan.

Collection procedures have been initiated and refunds will be credited back to the plan once they are received.

- CoreSource should provide an explanation of processing procedures that affected claims where turnaround time exceeding 30 days; our review identified an average of 500 per month during the audit period.

CoreSource challenges the finding of the 500 claims per month paid past 30 days, requesting an additional opportunity to review a greater number of claims in this category. Based on review of six Segal sample claims, three were paid in less than 10 days. This raises a concern regarding the criteria used to determine Segal's findings.

Segal confirms the six samples included claims processed in less than 10 days. CoreSource reviewed an additional 60 claims provided by Segal; however, the information returned was an independent internal query of claims processed in excess of 30 days. While Segal's query excluded adjustments to claims processed prior to the current audit period, it is possible that a small number of claims reported as exceeding 30 days includes some internal corrections as identified by CoreSource. A claim-by-claim comparison, with processing time verification, would be required to provide an exact validation of the different reports. The potential value does not warrant the time and expense required for further review given the extremely low percent of claims processed in excess of 30 days compared to the total population.

Segal further notes that CoreSource's excellent processing time achievement (97.02% within 14 calendar days with only .44% exceeding 30 calendar days) reflects strong internal claim control measures to insure superior processing timeliness.

This report would be incomplete without recognition of the professionalism and cooperation extended to us by CoreSource during the preparation phase of this project and throughout the data validation process of our electronic claims review.

SECTION II – ELECTRONIC REVIEWS

CLAIMS DATA VALIDATION

A data file of all claims processed January 1 through December 31, 2008 was provided by CoreSource for our electronic review process with accompanying control totals of 2,364,145 data records and \$68,082,247.93 in paid amounts. Our data validation process revealed:

- Actual file payment total was \$68,002,396.48; difference due to last digit dropped on some number fields when CoreSource extracted data for the claims file. Total file variance (0.12%) was determined to be within acceptable limits for the purpose of our review.
- Non-benefit payments for 312 audit and medical record fees, totaling \$62,267.01 (removed prior to our claims analyses).
- Number of data records and paid amount used for performing our reviews totaled 2,363,833 and \$67,940,129.47.

Comments/Observations

- Individual variances (\$.01 to \$.20) were reconciled during the review of claims identified in the results of each query process.

ANNUAL DEDUCTIBLES

- Query parameters were developed to identify:
 - » excess deductible applied
 - » payments with coinsurance applied before deductible was met

Services* with deductible applied = 21,262 Number of deductible errors = 2 * Multiple services on a single claim may have been applied to deductible.

The following two errors were identified:

- **\$9.04 underpayment.** Excess deductible was applied when the retiree transitioned from the Pre-65 to 65-Special Plan.
- **\$110 deductible application.** A claim was applied to deductible a second time under an incorrect retiree history. No payment error occurred; the correct patient was not charged excess deductible, and the incorrect patient had no other deductible. (65-Special Plan)

Comments/Observations

- Queries were based on plan deductible limits.
 - » Traditional: \$350 (High) and \$600 (Standard)
 - » Pre-65: \$1,500 (in and out-of-network combined)
 - » 65-Special: \$250 (\$10 office visit copays apply to a \$140 maximum)
 - Services payable at 100% (*i.e.*, preventative care or Medicare secondary liability) were excluded from our analysis.
 - Amounts included deductible applied under two plans for claimants who transitioned from a non-Medicare to the 65-Special Plan.
 - Traditional and Pre-65: Results identified three individuals with claim payments where the 2008 deductible was not met; supporting documentation by CoreSource validated that this was 2007 fourth quarter carry-over.
 - 65-Special: 85 exception results were identified for deductible not met. Segal provided CoreSource with 30% (27 claimants) for review; proof of fourth quarter carry-over was provided. Based on those findings, review of the remaining results was not indicated.
-

COPAYMENT APPLICATION

- Hospital copays/deductibles were verified for medical and mental health confinements based on each plan requirement.
- A \$10 copay was applied to the Medicare liability for physician services in an office, clinic, or skilled nursing facility.

Number of copays applied = 390,759 Number of copay errors = 0
--

Comments/Observations

- If the Medicare liability was less than \$10 for an office visit, copay for the entire amount was noted (*i.e.*, \$7 vs. \$10).
 - Office visits by a Veterans Administration provider were subject to deductible and coinsurance as there was no Medicare liability.
 - Our review of the data file revealed office copays applied during the audit period totaled \$3,728,207.70.
-

ANNUAL COINSURANCE

- Query parameters were developed to identify:
 - » excess coinsurance applied
 - » payments at 100% before required coinsurance was satisfied

Services* with coinsurance applied = 1,156,742

Number of coinsurance errors = 1

* Multiple services on a single claim may have coinsurance applied.

The following error was identified:

- **\$24.90 overpayment.** An out-of-network facility was paid at the network coinsurance level (100%) for a wellness service due to manual exception. Network wellness exceptions apply to laboratory and x-ray service providers only.

Comments/Observations

- Queries were based on plan coinsurance limits (total out-of-pocket minus deductible).
 - » Traditional: \$500 (High) and \$1,500 (Standard)
 - » Pre-65: \$3,500 (in and out-of-network combined)
 - » 65-Special: \$500 (office visit copays do not apply)
- Services payable at 100% were excluded from our analysis.
- Amounts included coinsurance applied under two plans for claimants who transitioned from a non-Medicare to the 65-Special Plan.
- Two potential errors for coinsurance not met were referred to CoreSource for validation. The above error was verified; the second was documented with amounts applied under both the Pre-65 and 65-Special Plans.

ANNUAL MAXIMUMS

Queries were developed to verify day or dollar maximums for:

- Inpatient and outpatient mental health and substance abuse benefits (10 or 30 days)
- Skilled nursing facility, home health care (90 days), or inpatient hospice (10 days)

- Advanced life support as stand-alone services by ambulance provider (\$150)
- Routine or wellness services (annual frequency or \$300 maximum)
- \$250,000 maximum benefit payment under the Pre-65 Plan

Number of claims: 9,102*
 Number of errors: 2
 * Does not include Medicare primary claims.

The following errors were identified:

- **\$95 overpayment.** Non-routine services were reimbursed under the wellness benefit. (Pre-65 Plan)
- One nursing home visit was paid under the incorrect retiree history. (Traditional Plan)

Comments/Observations

- Documentation of medical review was obtained for skilled nursing facility confinements exceeding 100 days under the 65-Special Plan. One stay was originally denied, then reconsidered based on independent medical review through the appeal process.
- Payments exceeding \$150 for advanced life support were allowed in conjunction with patient transport services.
- One retiree received approval on appeal for 90 mental health visits based on incorrect information in the annual personal statement.
- No individual under the Pre-65 exceeded \$200,000 in benefit payments.

PLAN EXCLUSIONS

Queries were developed to identify treatment of the following verifiable plan exclusions.

Number of claims: 167*
 Number of errors: 0
 * Does not include Medicare primary claims.

- | | |
|---|---|
| <ul style="list-style-type: none"> » Acupuncture » Hearing aids, fittings, or exams » Non-surgical obesity treatment | <ul style="list-style-type: none"> » Spinal manipulation » Non-emergency treatment at an emergency room » Temporomandibular Joint Disorder (TMJ) |
|---|---|

Comments/Observations

- Identification of non-emergency treatment was limited to observation of benefit adjudication subject to CoreSource's internal guidelines and determination. No services were denied as non-emergency based on review of the assigned system benefit code.
-

DUPLICATE PAYMENTS

Data was queried to identify potential duplicate claims with payments of \$100 or more that had an exact match on:

- » Social security number
 - » Claimant identifier
 - » Provider
 - » Total charge
 - » Date of service
 - » Procedure code
- The preliminary results identified 530 matches on individual services (one or more on a single claim). CoreSource's validation of sample results allowed us to refine our analysis; our revised findings totaled \$11,393.60 for 56 claims.
 - CoreSource confirmed duplicate payments totaling \$4,645.10 for 14 claims, all due to manual intervention. CoreSource advises a refund was received January 22, 2009 for one duplicate paid under the incorrect patient; 13 outstanding overpayments total \$3,621.10.
 - The remaining 42 potential duplicate payments were documented as multiple procedures (technical and professional), Medicare adjustments, or billing error (refund received).

Number of matches: 530
Number of errors: 13

Comments/Observations

- Based on the limited number and value of identified duplicate payments, we do not recommend extending the review to payments under \$100.
-

PROCESSING TURNAROUND TIME

The following table reflects our findings relative to the *original processing transaction* for all claims processed within the audit period. Results exceed industry standards, which state 90% - 95% of claims should be processed within 14 calendar days.

CALENDAR DAYS	NUMBER OF CLAIMS	INDIVIDUAL PERCENT	CUMULATIVE PERCENT
0	15,787	1.08%	1.08%
1	8,815	0.60%	1.68%
2	7,374	0.51%	2.19%
3	11,489	0.79%	2.98%
4	23,624	1.62%	4.60%
5	30,205	2.07%	6.67%
6	94,624	6.48%	13.15%
7	222,084	15.22%	28.37%
8	207,764	14.24%	42.61%
9	159,809	10.95%	53.56%
10	142,366	9.76%	63.32%
11	128,104	8.78%	72.10%
12	171,425	11.75%	83.85%
13	136,636	9.36%	93.21%
14	56,154	3.85%	97.06%
15	24,477	1.68%	98.74%
16-20	9,286	0.64%	99.38%
21-25	1,752	0.12%	99.50%
26-30	1,182	0.08%	99.58%
31 or greater	6,405	0.44%	100.00%
Total	1,459,362	100.00%	* May not add due to rounding

Comments/Observations

- Adjustments to claims processed prior to January 1, 2008 were excluded from our turnaround time analysis.
- Claims may have been counted more than once if some services were processed on different days (*i.e.*, at three and six days).
- Electronic resubmissions (primarily from Medicare) document the new transmission dates, which were used to calculate turnaround time independently for each processing transaction.
- Adjustments to hard copy (scanned) claims retain the original received date; turnaround time for 12,975 subsequent processing transactions was calculated separately to avoid skewing the overall results. Results revealed 30.59% exceeded 30 days; however, this is calculated without the actual provider or retiree resubmission date.
- CoreSource's internal procedures include priority routing of all claim correspondence and customer service referrals (including written or verbal adjustment requests) to claims examiners for handling within two business days; compliance is monitored through supervisory reports.
- Quarterly reports did not reveal any significant trends between periods throughout the year.

In excess of 97% of all claims were originally processed within 14 calendar days. Less than 0.05% were over 30 calendar days.
--

Section III – CoreSource’s Response

CoreSource's Response to the 2008 PSERS HOP claims Audit by Segal Company which was performed in 2009:

CoreSource agrees with the payment findings on the processed claims reviewed by the Segal claims auditors. CoreSource appreciates the comparison to Industry standards which highlights our statistical achievement and Performance Guarantees.

Recommendation responses:

- \$10 physician copay applicable to Major Medical Deduction: We have reviewed this with the client and we are in agreement the language will be added to the next revision/reprinting of the 65 Special Summary Plan Description (SPD) document.
- Refunds for overpayments identified through this audit process has been initiated. Collection procedures have been started and refunds will be credited back to the plan once they are received.
- We challenge the finding of the 500 claims per month paid past the 30-day turnaround time. We are requesting an additional opportunity to review a greater number of claims in this category. At our request, six claims were provided to us on 06-04-09, three were past the 30 days and three were paid under 10 days. Based on our review of these six claims, a concern is raised on the criteria used to determine your findings.

**Commonwealth of Pennsylvania
Public School Employees' Retirement System
Donald J. Halke, Internal Auditor
Phone: 720-4610 /// FAX: 717-783-8760
e-mail dhalke@state.pa.us**

TO: Audit/Budget Committee
FROM: Donald J. Halke II
DATE: September 18, 2009
RE: Segal Group's Evaluation of Claim Payments

As part of PSERS' ongoing monitoring of the Health Options Program, the Segal Group Inc. (Segal) was hired to analyze and evaluate the medical claims processing and payment procedures utilized by CoreSource, Inc.

At the Audit Budget Committee meeting scheduled for October 1, 2009, Rick Johnson, from Segal will provide an overview of the claims audit process, as well as the results and findings of the audit conducted for the 2008 plan year. A copy of the claims audit follows for your review.

We are also providing copies of both the proposed Committee and Board resolutions accepting the audit report.

Please contact me if you have any questions.