



# **Internal Audit Committee of Brevard County, Florida**

## **Internal Audit Review of**

### **Self Insurance Claims**

**Prepared By:  
Internal Auditors of Brevard County  
February 28, 2006**

# Table of Contents

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Transmittal Letter ..... 1

Background ..... 2-3

Objectives and Approach ..... 4-5

TPA Summary ..... 6-12

Overall County Issue ..... 13-14

Attachments:

- Health First Claim Audit Results ..... A
- Aetna Claim Audit Results ..... B
- CIGNA Healthcare Claim Audit Results ..... C

February 28, 2006

The Audit Committee of  
Brevard County, Florida  
Viera, Florida 32940-6699

Pursuant to the approved 2005/2006 internal audit plan, we hereby submit our internal audit report covering Self Insurance Claims Audit. The Self Insurance Claims process is the responsibility of Brevard County Human Resources Department. We will be presenting this audit report to the Audit Committee at the next scheduled meeting on May 26, 2006.

Our report is organized in the following sections:

<b>Background</b>	This provides an overview of self-insurance and the related issues.
<b>Objectives and Approach</b>	The internal audit objectives and focus are expanded upon in this section as well as a review of the various phases of our approach.
<b>TPA Summary</b>	This section contains an overview and highlights of control system for each TPA.
<b>Overall County Issue</b>	This section gives a description of the issue as well as the recommended action.
<b>Attachments</b>	The attachments contain the claim audit summary worksheets for each TPA.

The follow-up process for the issues identified in this report will consist of County management follow-up with responsible personnel and reporting to the Audit Committee on a quarterly basis using the approved format.

We would like to thank all those involved in assisting the Internal Auditors in connection with our review of the Self Insurance Claims Audit.

Respectfully Submitted,

*INTERNAL AUDITORS*

# **Background**

# Background

On January 1, 2000 the Brevard County Government (“County”) adopted a self-insured health care plan with multiple options for employees and retirees. The plans and administrators were selected through the use of an outside consultant and a formal request for proposal (“RFP”) process. The RFP included requests for fully insured plans, and alternative funding arrangements. Only one fully insured plan was submitted and due to cost and benefit considerations the fully insured plans were not selected. The adoption process included a joint effort with the School Board of Brevard County (‘District’). By combining the groups for plan administration purposes, both entities received better benefits with cost reductions due to economies of scale. Third Party Administrators (“TPAs”) are utilized for plan administration, including claim payments.

Since the inception of the plan, the County and the District went through the RFP and selection process for the TPAs in 2003 are currently gearing up to go through this process again.

Generally, all salaried and hourly employees and retirees are eligible for coverage except: (1) part time employees, (2) temporary employees, (3) seasonal employees, or (4) substitute employees. The County subsidizes the premium for the employee and retirees, however premium costs for employee family members are borne by the employee. There are several options available to employees; this allows them to choose a plan and benefits, which most meet their needs. The options are summarized as follows:

## Brevard County 2004 Health Plan Comparison

Plan	HMO/EPO	CIGNA	
	Aetna, Health First, CIGNA	In-Network	Out-of-Network
<b>Benefits</b>	<b>In-Network Only</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Lifetime Max	\$1,000,000	\$1,000,000	
Coinsurance Levels	0%	15%	30% of R&C
Annual Deductible			
Individual	n/a	\$300	\$400
Family	n/a	\$600	\$800
Annual Out of Pocket Maximum			
Individual	\$1,500	\$2,000	\$4,000
Family	\$3,000	\$4,000	\$8,000
Inpatient Hospital Services	\$300 per admit	15% after deduct	30% after deduct
Outpatient Surgery	\$25	15% after deduct	30% after deduct
Major Outpatient Procedures	\$50	15% after deduct	30% after deduct
Office Visit			
PCP	\$15 per visit	\$30 per visit	30% after deduct
Specialist	\$20 per visit	\$30 per visit	30% after deduct
Diagnostic Services	100% coverage	15% after deduct	30% after deduct
Preventive Care	\$15 per visit	\$30 per visit	30% after deduct
Maternity Care	\$20 1 <sup>st</sup> visit only	15% after deduct	30% after deduct
Ambulance Services	100% coverage	15% after deduct	30% after deduct
Emergency Room	\$75	15% after deduct	30% after deduct
Urgent Care Facility	\$25	15% after deduct	30% after deduct
Pharmacy	Retail / Mail Order	Retail / Mail Order	Retail / Mail Order
Deductible	None	None	Not Covered
Out of Pocket Max	None	None	Not Covered
Generic	\$10 / \$20	\$10 / \$20	\$10/\$20
Preferred	\$20 / \$40	\$20 / \$40	\$20/\$40
Non-Preferred	\$35 / \$70	\$35 / \$70	\$35/\$70
Precertification Responsibility	Provider	Member	Member

Additional limitations may apply and some services are subject to prior authorization.

## Background - continued

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The financial position of the plan for calendar year 2004 is as follows:

Premiums*	\$ 31,831,169
Claims Paid	27,220,784
Administrative Expenses	2,710,885
Stop Loss Premiums	<u>519,270</u>
Total expenses	<u>30,450,939</u>
<b>Net Gain</b>	<b><u>\$ 1,380,230</u></b>

*\*Includes any reimbursements related to stop loss coverage.*

The plan maintains Stop Loss Insurance Coverage to pay any claims over \$200,000 per member per year up to the plan lifetime maximum of \$1,000,000 per member. The premium paid by the County for this coverage is \$4.74 per single member per month and \$14.00 per family per month.

Enrollment is outsourced to Benefit America and updated electronically by employees utilizing the County's web site during each open enrollment period. The TPAs receive a weekly wire of the membership list. Any changes of membership throughout the year are handled manually through the County's human resources department, and communicated to the TPAs via tape.

## **Objectives and Approach**

# Objectives and Approach

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## Objectives

<ul style="list-style-type: none"><li>▪ To develop an understanding of the contractual arrangement between the County, the District, and the TPAs.</li></ul>
<ul style="list-style-type: none"><li>▪ To examine the claims processing services for contractual performance standards.</li></ul>
<ul style="list-style-type: none"><li>▪ Evaluate the accuracy of claims administration being performed by the TPAs.</li></ul>

## Approach

Our audit approach consisted of three phases as follows:

### **Phase I: Understanding and Documentation of the Process**

We obtained an understanding of the process by meeting with the appropriate personnel of management and the TPAs to gain familiarity with systems and processes that are relevant to this project. We also reviewed aspects of the written agreements with the TPAs, hospitals and other providers that are pertinent to our testwork.

### **Phase II: Sample Determination and Testwork**

#### **Claims Sampling Methodology:**

To meet the objective for examining the claims processing services, we selected a sample of claim payments from each of the TPAs for the plan year 2004.

The initial claim population included all paid claims for sampling purposes. There was a total sample of 60 for each TPA which included paid claims and large claims for both the County and the District. The sample of denied and zero paid claims were judgmentally selected and tested.

To further develop our sample, we used audit software to filter the activity with the most risk in processing, and we further utilized sampling techniques to select specific claims for testing purposes. The sample size varied depending upon the population of items that were filtered for potential selection.

#### **Assessment of SAS 70 Reports:**

A SAS70 Review is the method by which an outsourced activity or service provider can communicate to the user organizations that their system of internal controls are effective and working as intended.

It should be noted that there are two types of SAS70's that an entity can engage an independent CPA firm to perform, a Level I and a Level II. The difference in the Levels is in the types of work being performed by the Audit firm. In a Level I, the Auditor will obtain from management a description of the internal controls in place with no testing performed to validate the controls. In a Level II, the Auditor obtains the description of controls from management and then will on a sample basis actually test the control environment and provide an opinion on the controls.

We requested SAS 70 reports from the TPA's and reviewed them for any issues identified.

# Objectives and Approach - continued

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## Phase II: Sample Determination and Testwork - continued

### Detailed Testing of Claims:

Within the sample, we determined the specific attributes to be tested for each claim selected. Testing included, but was not limited to, the following attributes:

1. The insured to whom the claim relates was traced to the eligibility system and to original enrollment documentation to ensure that the individual was covered under the plan on the date of service.
2. The type of procedure performed described on the claims submission was reviewed against the provisions of the plan for the period corresponding to the date of service to ensure the procedures were covered by the plan.
3. The provider was verified as an eligible provider for the plan or that benefits were paid pursuant to out-of-network coverage.
4. The TPA was able to provide sufficient documentation to support the claim and the data was reviewed for accuracy.
5. The amount of the claim was recalculated considering:
  - Amount submitted
  - Applicable fee schedule caps
  - Terms of provider agreements
  - Deductibles, coinsurance and annual/lifetime maximums imposed by the plan
6. We determined coordination of benefits source (auto insurance, workers' compensation or other) was properly reflected on the claims system through subrogation.
7. We verified amount of payment by examining cancelled checks or other bank documentation of cash disbursements.
8. For services requiring referral or pre-certification under the plan, we verified that proper documentation was submitted by the primary care provider.
9. We determined if coordination of benefits were pursued or, if not, verified that no available information indicates that coordination of benefits should have been pursued.
10. We reviewed the days to process were the correct dates of submission and the process date in the claims system was accurate.
11. We noted proper approval or denial of the submitted claim, based on benefits structure of the plan.
12. We reviewed the date of service date in the claims system was correct.

## Phase III: Report and Recommendations

We have summarized our detailed testing of claims and reviewed the results of our claims audit with the individual TPAs. We reviewed the results of our testing with the appropriate levels of management at the District and County and presented to the individual Audit Committees.

## **TPA Summary**

# TPA Summary

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The table below gives a comparison of certain operational statistics for the three TPAs as of December 31, 2004:

	<b>Brevard County</b>		
	<b>Health First</b>	<b>Aetna</b>	<b>CIGNA</b>
<b>Average Number of Members</b>	2,848	4,086	PPO - 836 EPO - 1,276
<b>Average Processing Time <sup>1</sup></b>	7.67	5.40	10.30
<b>Total Claim Cost per member per month (PMPM) <sup>2</sup></b>	\$163.51	\$184.68	\$227.69
<b>Administrative Cost per employee per month <sup>3</sup></b>	\$45.39	\$43.03	PPO - \$20.82 EPO - \$16.57

<sup>1</sup> Average processing time in days is for the tested sample only as consistent data from all providers for all claims was not provided.

<sup>2</sup> Calculation is from calendar year 2004 data provided by the TPAs on an incurred basis.

<sup>3</sup> Rates are per contract and do not include special requests etc. Health First's contractual terms are \$19.92/member per month, a cost per employee was calculated using 12/31/2004 enrollment data.

# TPA Summary - continued

# Health First

<i>On-site Fieldwork</i>	December 19, 2005
<i>Contact</i>	Cathynia Spence
<i>Random Sample</i>	60
<i>Large Claims</i>	3
<i>Cost Per Member Per Month</i>	\$163.51
<i>Average Number of Members for CY 2004</i>	2,848
<i>Claim Audit Summary Results</i>	Attachment A

## Overview

- Scope of Services** Health First Health Plans, Inc. ("Health First") is a subsidiary of Health First, Inc. Health First currently operates in Brevard County and the town of Sebastian in Indian River County. Health First offers fully insured HMO plans, Medicare Advantage Plans, as well as TPA services, which include provider contract negotiation, customer service, claims review and processing, and case management services.
- Claims Reimbursement** Health First reimburses their contracted providers based on the rates negotiated in their contracts. The majority of non-participating hospitals are reimbursed at 150% of the Medicare rate.
- Claims Processing** Health First receives approximately 80% of their claims electronically from contracted providers. The remaining 20%, while received in paper form are scanned and imaged through the Optical Character Recognition (OCR) process. The average time from receipt of claim to payment is 12 days.
- The County maintains a "Master Claims Paying Account" that both Health First and the County have signatory rights. Health First requests wire transfers throughout the month and sends a summary report at month end.
- Out-of-Area Providers** Health First utilizes Beech Street Network to negotiate with out-of-area providers. This results in approximately 20% savings from billed rates.
- Case Management** Case management is a process of assessment, planning, implementation, monitoring, evaluation, and coordination of medical services required to meet a member's healthcare needs across the continuum of care, through collaboration with members, care givers and providers to ensure quality, cost-effective care. Case managers work with Medical Directors to determine if the medical services proposed or rendered are medically necessary and/or performed at the appropriate place and provides the appropriate level of care. Authorizations include extensive notes from providers as well as medical necessity review criteria.
- Overall Operations** Health First is a local insurer that conducts business at a central location in Rockledge, FL. This provides a higher level of coordination of services from case management to claims processing. Health First handles several TPA accounts. TPA claims are processed according to state and federal guidelines for commercial HMOs.

## Highlights of Control System

<b>Audits</b>	Health First conducts monthly audits in accordance with their Annual Audit Work Plan which include reviewing their internal claims processing. Health First is also subject to several on-site reviews by regulatory agencies such as Agency for Healthcare Administration (AHCA), Office of Insurance Regulation (OIR) and Centers for Medicare and Medicaid Services (CMS).
<b>SAS70 Report</b>	Health First currently does not have a Level I or Level II SAS70 review.
<b>Coordination of Benefits</b>	For all lines of business, claims listing other insurers are pended for manual review. The COB Specialist investigates in order to determine the primary insurer. Depending on Health First status (primary or secondary) the claim is processed accordingly. In the event a determination can not be made, the member is notified via mail and has 30 days to respond.
<b>Subrogation</b>	Claims flagged with “other accident” or MVA accidents are pended for subrogation review. Subrogation Recovery specialists review and coordinate benefits with PIP carriers and any attorney involved.
<b>Membership Satisfaction</b>	A membership satisfaction survey is conducted annually.
<b>Stop Loss</b>	Health First notifies the County and the insurance company when the claim reaches 50% of the stop loss coverage floor.
<b>Contractual Performance Standards</b>	Per the contract there are no specific performance standards.

# TPA Summary - continued

Aetna

<i>On-site Fieldwork</i>	February 13 & 14, 2006
<i>Contact</i>	Jeanne Rogers
<i>Random Sample</i>	60
<i>Large Claims</i>	3
<i>Cost Per Member Per Month</i>	\$184.68
<i>Average Number of Members for CY 2004</i>	4.086
<i>Claim Audit Summary Results</i>	Attachment B

## Overview

- Scope of Services** Aetna is a national provider of health care services including both traditional plans and TPA administration. Aetna was contracted to provide full TPA services to the Brevard County School Board and Brevard County including: provider contract negotiation, claim processing, and case management. Claims processing for the School Board and Brevard County contract are performed in Tampa, Florida.
- Claims Reimbursement** We tested claims paid noting that the claims were paid at a reasonable percentage of Medicare. Aetna has a large network of providers resulting in fewer out of area claims paid at 100% of charges.
- Claims Processing** Aetna has a highly automated claims process. Electronic claims are a major source of claim information. All 'manual' claims information is optically scanned into their claims system, including the claims form and any supporting documentation. All data processing is performed at a separate data processing facility. Claims are batched by type of medical service (i.e., procedure codes). Claims processors specialize in types of claims and an individual processor will generally only process claims related to their specialty. Any claim follow-up is generally done electronically. Aetna requests wire transfers throughout the month and sends a summary report at month end. A separate ZBA is utilized for Aetna's claims payments.
- Out-of-Area Providers** Aetna network providers include not only Brevard County and Florida but a nationwide network.
- Case Management** Case management is done remotely by a group of nurses and doctors in Georgia. All case management information is entered electronically into the database and can be accessed online by case management specialists. The nurses utilize nationally published criteria (Milliman and Robertson) as a guide to determine medical necessity of procedures and to approve hospital stays. At one time Aetna has a nurse staffed in Brevard County to conduct on site hospital reviews however when she left they did not replace her. Therefore the case reviews are done via the telephone.

## Highlights of Control System

<b>Audits</b>	Aetna has several different regulatory audits that are performed throughout the year. In addition, Aetna has a Quality Review (QR) audit function. A varying percentage of claims are audited by the QR unit. The audit of claims over \$5,000 involves a complete review of the claim, while lesser claims are not reviewed as extensively.
<b>SAS70 Report</b>	Per review of the Level II SAS70 Report provided by Aetna, we noted no instances of material weakness or any potential for misstatement of the financial results.
<b>Coordination of Benefits</b>	Claims forms prepared by the providers and enrollment forms prepared by the member include sections for coordination of benefits information. Claims office personnel review claims submissions for evidence of another carrier's existence. If they find that the claim indicates the possibility of COB, they conduct a COB review. Letters are sent to the family and Aetna may also contact the other carrier to determine if the coverage is still in effect.
<b>Subrogation</b>	A feed of claim data, based on diagnosis, is provided monthly to the subrogation vendor, Rawlings, to perform a review. Letters are generated to assist them in determining if subrogation exists on a case and they will pursue reimbursement if a third party settlement is reached.
<b>Membership Satisfaction</b>	Aetna does conduct a membership satisfaction survey and those results are analyzed statewide and by Primary Care Provider.
<b>Stop Loss</b>	Stop Loss coverage is not provided through Aetna. Aetna provides monthly Stop Loss reports to the County's Stop Loss vendor using the selected threshold of \$50,000.
<b>Contractual Performance Standards</b>	Per review of the contract and our testing that has been completed through the date of this report, Aetna is in compliance with performance standards.

<i>On-site Fieldwork</i>	February 6 & 7, 2006
<i>Contact</i>	Christine Lewis
<i>Random Sample</i>	60
<i>Large Claims</i>	3
<i>Cost Per Member Per Month</i>	\$227.69
<i>Average Number of Members for CY 2004</i>	PPO - 836 EPO - 1,276
<i>Claim Audit Summary Results</i>	Attachment C

## Overview

- Scope of Services** CIGNA HealthCare is a business unit of CIGNA Corporation (CIGNA), which together with its subsidiaries, constitutes one of the largest healthcare and related benefits organizations in the United States. CIGNA offers a broad portfolio of group medical and specialty health care products and services. CIGNA provides certain group indemnity coverages, primarily medical and dental, through alternative funding programs under which the customer assumes all of a portion of the responsibility for funding claims, with CIGNA providing combinations administrative and claim processing services and insurance for a fee or premium charge.
- Claims Reimbursement** The majority of the non-hospital contracts we reviewed are based on two types of reimbursement policies: 1) the lower of usual and customary charges or 110% of the Medicare rate, and 2) capitated rates. The majority of hospital services in their network are capitated.
- Claims Processing** Personnel in multiple claim offices support claim processing which includes the receipt of claim information from various sources, loading of data into the claims systems and the adjudication of claims.
- Out-of-Area Providers** Third-Party Vendors (TPVs) supply provider networks to CIGNA members in areas where CIGNA does not have its own network. In many cases, providers within these TPV networks are required to submit their claims to the TPV for fee calculation (generally referred to as 'pre-pricing'). The TPV will pre-price these claims and then directly submit claim w/pre-pricing sheet, via paper or electronically, to CIGNA for processing. These pre-priced fees are the discounted amounts to be used during benefit determination.
- There is no client specific networks set-up for either of the Brevard accounts.
- Case Management** Case management assessment is designed as a comprehensive approach to problem solving. CIGNA incorporates an automated case management assessment tool in their Integrated Care Management System. To complete the assessment, information is collected from all relevant sources while maintaining confidentiality according to CIGNA and regulatory requirements.

## Highlights of Control System

<b>Audits</b>	<p>CIGNA operations are subject to a program of financial and operational audits performed by CIGNA's Corporate Audit Department (Corporate Audit). During the performance of its audits, Corporate Audit evaluates the soundness, adequacy and application of accounting, financial, and other operating controls; ascertains the extent of compliance with established policies, plans, procedures, and laws and regulations to which CIGNA is subject; verifies the accuracy and propriety of transactions processed; and ascertains the reliability of management information developed within the organization. Also covered by these audits are automated system application controls, customer service, and account administration.</p> <p>Formal reports of audit finding are provided to management after each audit and significant findings are summarized and reported quarterly to the Audit Committee of CIGNA's Board of Directors. In addition to the audit work performed by Corporate Audit, CIGNA HealthCare's Quality Assessment and Control Organization has a formal program of audits performed by Quality Assessment and Control staff. The results of these audits are summarized and reported to various levels of CIGNA's management, including senior management. CIGNA also has several different regulatory audits that are performed through out the year.</p>
<b>SAS70 Report</b>	<p>Per review of the Level II SAS70 Report provided by CIGNA, we noted no instances of material weakness or any potential for misstatement of the financial results.</p>
<b>Coordination of Benefits</b>	<p>The claim systems automatically prompt the claim processor to consider Coordination of Benefits (COB) if other insurance coverage has been previously indicated. The claim processor then determines which group health plan or payer is primary and which is secondary. If CIGNA is the secondary plan, necessary payment documentation from the primary plan, such as the Explanation of Benefits, will be requested. Once this information is received, the claim is processed. When other medical coverage is identified, COB information is recorded in the employee eligibility file for use in adjudicating future claim submissions.</p>
<b>Subrogation</b>	<p>CIGNA outsources third party liability/subrogation, to a company called Primax Recovery. On a monthly basis Primax receives an extract of paid claims data from the database. These claims are then processed through CIGNA's files to determine if the claims need to be re-examined and if there is money to be reclaimed. The two primary items that are looked at by Primax are:</p> <ul style="list-style-type: none"><li>• The diagnosis codes associated with the claims.</li><li>• The money threshold with the episode of care.</li></ul>
<b>Membership Satisfaction</b>	<p>CIGNA has not performed any satisfaction surveys on these accounts. No data is available.</p>
<b>Stop Loss</b>	<p>\$200,000.00 is the pooling point per individual for each account.</p>
<b>Contractual Performance Standards</b>	<p>There are no Contractual Performance Standards for either of these accounts.</p>

## **Overall County Issue**

<i>Issue</i>	<b>Plan Oversight</b>
	<p>The coordination of data, reconciliation, and financial analysis is critical in maintaining a self-insurance fund. There are many different parties involved, which means data is generated from a variety of sources. In addition, certain functions are handled in human resources and accounting and others are outsourced.</p> <p>During our audit we noted the following areas in which additional analysis and/or reconciliations would further strengthen internal controls.</p> <p><u>AETNA Claim Payments</u>  The County receives wire requests from Aetna on a regular basis (daily or every other day) to pay claims processed. At the time of the request the human resources department records the disbursement. The wire request does not contain backup which should be available to the County via Aetna's web site. At the time of our audit the County had not been provided access to the website to review the claims data in order to reconcile the wire requests to the source documentations.</p> <p><u>Enrollment Data</u>  The County outsourced the benefit enrollment process to Unum Provident Corporation via their web site: enrollment.com. This includes the open enrollment period as well as the transfer of this data to the TPA's. After open enrollment any changes to benefits (i.e. marriage, birth, and termination) is handled by human resources. The 'paperwork' is processed through HR and entered into enrollment.com and is then forwarded to the TPA's. During our audit we noted that a reconciliation of membership data between the TPA and enrollment.com is not performed. In addition, the County was not reconciling enrollments by participating employer agencies to TPA records.</p> <p><u>TPA Data</u>  The County receives monthly reports such as bank statements from the TPA's. This data includes paid claims. We found that these reports are not consistently reconciled to the books and records of the County.</p> <p><u>Reporting</u>  Monthly reporting of TPA data is critical in assessing the performance of each fund. Data, such as month-to-month changes in claims processed and average claim size, can be early indicators of TPA performance or medical related cost changes. This data can also assist in calculating proposed plan modifications.</p> <p>The audit found that each TPA provides information in a variety of formats, which focus on different statistics. There is no standardized reporting format.</p>

<b><i>Issue</i></b>	<b>Plan Oversight - continued</b>
	<b><i>Recommended Action</i></b>
	<ul style="list-style-type: none"> <li data-bbox="513 323 1417 443">❑ We recommend the County analyze and reconcile the data and utilize these reconciliations as control points within the self-insurance function. Additionally, management should utilize these analyses to improve budgeting, project premiums, assist in cost/benefit analysis and evaluate TPA's.</li> <li data-bbox="513 468 1417 617">❑ Management should monitor and set deliverables for these reconciliations. In this process current-staffing needs should be evaluated and the County may want to consider increasing the utilization of the current consultant. The County needs to resolve the issue of being granted access to the Aetna web site in order to properly reconcile the wire transfer requests being submitted by Aetna.</li> <li data-bbox="513 642 1417 699">❑ Consider the cost benefit of requiring TPA's to report critical data in a standard format. The reports should be submitted no less than 14 days after month end.</li> </ul>
	<b><i>Management Response and Action Plan</i></b>
<b>Response</b>	<p data-bbox="513 800 1417 1037">We agree that reconciliation of the financial and membership data is a critical function that requires further development. During the audit process, Aetna began to furnish the required backup documentation necessary for Employee Benefits to complete its financial reconciliation process. A membership reconciliation takes place weekly as a function of the enrollment benefit administrator with an electronic data feed sent to vendors with "fall out" reports as checks for errors/anomalies for all participating entities. Employee Benefits undertakes an annual membership reconciliation audit as back up to this process.</p> <p data-bbox="513 1073 1417 1344">Because of the disparity of responsibilities involved in this process, there is a need to re-establish co-ordination between Finance and Human Resources to balance bank statements and claim payments. Human Resources had previously conducted this evaluation, and disbanded the process due to resource constraints when findings consistently revealed no errors or discrepancies. Recent acquisition of ½ FTE dedicated to the financial aspect of the operation enables us to resume this function. The recently completed RFP for Health Plan Providers included provisions requiring standardized data formats. Theses data formats should become available to the County at the start of our next health plan year in First Quarter 2007.</p>
<b>Time Frame</b>	<p data-bbox="513 1415 1417 1503">We would estimate that the establishment of procedures, securing the cooperation of vendors and other departments, and refinement of the process (with the exception of standardized data formats) could be accomplished and implemented by 10/31/06.</p>
<b>Person Responsible</b>	<p data-bbox="513 1560 1243 1587">Jerry Visco, Brevard County Human Resources – Risk Management</p>

## **Attachments**

# Claim Audit Results

# Health First

## CLAIM AUDIT SUMMARY

TPA: HEALTH FIRST

FIELD AUDIT DATE:

12/19/2005

Sample Claim	Date Paid	Claim Amount Paid	Sufficient Documentation to Support Claim	Eligible Member	Applicable Deductibles Applied/ Co-Pay	Benefit Covered Under Plan Doc	Referral / Authorization	Agree to Contract Terms with Provider	Coordination of Benefits	Subrogation	Review Claim Form for Accuracy	Agree Check to Claim Form
1	06/18/2004	\$21.81	X	X	X	X	X	X	X	X	X	X
2	06/25/2004	\$155.22	X	X	X	X	X	X	X	X	X	X
3	06/18/2004	\$583.18	X	X	X	X	X	X	X	X	X	X
4	07/16/2004	\$22.34	X	X	X	X	X	X	X	X	X	X
5	07/16/2004	\$103.84	X	X	X	X	X	X	X	X	X	X
6	07/16/2004	\$15.10	X	X	X	X	X	X	X	X	X	X
7	07/23/2004	\$31.79	X	X	X	X	X	X	X	X	X	X
8	07/23/2004	\$71.73	X	X	X	X	X	X	X	X	X	X
9	07/30/2004	\$17.50	X	X	X	X	X	X	X	X	X	X
10	07/23/2004	\$68.97	X	X	X	X	X	X	X	X	X	X
11	08/06/2004	\$306.50	X	X	X	X	X	X	X	X	X	X
12	08/06/2004	\$35.53	X	X	X	X	X	X	X	X	X	X
13	09/17/2004	\$21.18	X	X	X	X	X	X	X	X	X	X
14	09/30/2004	\$40.83	X	X	X	X	X	X	X	X	X	X
15	09/30/2004	\$23.86	X	X	X	X	X	X	X	X	X	X
16	10/05/2004	\$21.81	X	X	X	X	X	X	X	X	X	X
17	10/26/2004	\$10.44	X	X	X	X	X	X	X	X	X	X
18	10/26/2004	\$91.58	A	X	X	X	X	X	X	X	X	X
19	10/26/2004	\$9.43	X	X	X	X	X	X	X	X	X	X
20	11/02/2004	\$81.53	X	X	X	X	X	X	X	X	X	X
21	11/09/2004	\$4.22	X	X	X	X	X	X	X	X	X	X
22	11/09/2004	\$3.27	X	X	X	X	X	X	X	X	X	X
23	11/09/2004	\$104.15	X	X	X	X	X	X	X	X	X	X
24	11/23/2004	\$3.27	X	X	X	X	X	X	X	X	X	X
25	12/07/2004	\$30.83	X	X	X	X	X	X	X	X	X	X
26	12/14/2004	\$22.50	X	X	X	X	X	X	X	X	X	X
27	12/14/2004	\$14.88	X	X	X	X	X	X	X	X	X	X
28	12/21/2004	\$81.53	X	X	X	X	X	X	X	X	X	X
29	12/21/2004	\$7.40	X	X	X	X	X	X	X	X	X	X
30	12/28/2004	\$60.43	X	X	X	X	X	X	X	X	X	X

Continued

## Claim Audit Results

Health First

## CLAIM AUDIT SUMMARY

TPA: HEALTH FIRST

FIELD AUDIT DATE:

12/19/2005

Sample Claim	Date Paid	Claim Amount Paid	Sufficient Documentation to Support Claim	Eligible Member	Applicable Deductibles Applied/ Co-Pay	Benefit Covered Under Plan Doc	Referral / Authorization	Agree to Contract Terms with Provider	Coordination of Benefits	Subrogation	Review Claim Form for Accuracy	Agree Check to Claim Form
31	06/18/2004	\$54.78	X	X	X	X	X	X	X	X	X	X
32	07/09/2004	\$30.56	X	X	X	X	X	X	X	X	X	X
33	07/09/2004	\$50.00	X	X	X	X	X	X	X	X	X	X
34	07/09/2004	\$9.70	X	X	X	X	X	X	X	X	X	X
35	07/23/2004	\$25.10	X	X	X	X	X	X	X	X	X	X
36	08/06/2004	\$23.38	X	X	X	X	X	X	X	X	X	X
37	08/06/2004	\$10.25	X	X	X	X	X	X	X	X	X	X
38	08/27/2004	\$86.63	X	X	X	X	X	X	X	X	X	X
39	08/27/2004	\$14.41	X	X	X	X	X	X	X	X	X	X
40	09/10/2004	\$2.64	X	X	X	X	X	X	X	X	X	X
41	09/17/2004	\$7.01	X	X	X	X	X	X	X	X	X	X
42	09/24/2004	\$34.40	X	X	X	X	X	X	X	X	X	X
43	10/05/2004	\$34.50	X	X	X	X	X	X	X	X	X	X
44	10/19/2004	\$3.50	X	X	X	X	X	X	X	X	X	X
45	10/19/2004	\$8.36	X	X	X	X	X	X	X	X	X	X
46	10/19/2004	\$85.16	X	X	X	X	X	X	X	X	X	X
47	10/26/2004	\$25.10	X	X	X	X	X	X	X	X	X	X
48	11/16/2004	\$29.42	X	X	X	X	X	X	X	X	X	X
49	11/30/2004	\$26.19	X	X	X	X	X	X	X	X	X	X
50	11/30/2004	\$221.28	X	X	X	X	X	X	X	X	X	X
51	01/04/2005	\$35.83	X	X	X	X	X	X	X	X	X	X
52	01/11/2005	\$22.52	X	X	X	X	X	X	X	X	X	X
53	02/01/2005	\$2.25	X	X	X	X	X	X	X	X	X	X
54	01/18/2005	\$3.41	X	X	X	X	X	X	X	X	X	X
55	02/01/2005	\$26.83	X	X	X	X	X	X	X	X	X	X
56	02/01/2005	\$72.52	X	X	X	X	X	X	X	X	X	X
57	02/01/2005	\$167.80	X	X	X	X	X	X	X	X	X	X
58*	11/23/2004	\$58,651.85	X	X	X	X	X	X	X	X	X	X
59*	12/07/2004	\$46,836.90	X	X	X	X	X	X	X	X	X	X
60*	12/07/2004	\$46,836.89	X	X	X	X	X	X	X	X	X	X

\* Represents large \$ claims

Continued

## Claim Audit Results

## Health First

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- A The process days to pay the provider were in excess of the requirement. The original claim that was submitted on 6/30/04 was missing the procedure code. The claim was resubmitted for payment on 10/14/04. Not an exception.

## Claim Audit Results

Aetna

## CLAIM AUDIT SUMMARY

TPA: AETNA

FIELD AUDIT DATE:

02/13/2006

Sample Claim	Date Paid	Claim Amount Paid	Sufficient Documentation to Support Claim	Eligible Member	Applicable Deductibles Applied/ Co-Pay	Benefit Covered Under Plan Doc	Referral / Authorization	Agree to Contract Terms with Provider	Coordination of Benefits	Subrogation	Review Claim Form for Accuracy	Agree Check to Claim Form
1	11/22/2004	\$34.49	X	X	X	X	X	X	X	X	X	X
2	10/26/2004	\$62.95	X	X	X	X	X	X	X	X	X	X
3	10/07/2004	\$50.25	X	X	X	X	X	X	X	X	X	X
4	01/06/2005	\$60.75	X	X	X	X	X	X	X	X	X	X
5	01/11/2005	\$8.59	X	X	X	X	X	X	X	X	X	X
6	10/28/2004	\$8.89	X	X	X	X	X	X	X	X	X	X
7	10/20/2004	\$120.87	X	X	X	X	X	X	X	X	X	X
8	09/28/2004	\$97.19	X	X	X	X	X	X	X	X	X	X
9	12/24/2004	\$1,716.56	A	X	X	X	X	X	X	X	X	X
10	09/09/2004	\$9.81	X	X	X	X	X	X	X	X	X	X
11	12/21/2004	\$27.58	X	X	X	X	X	X	X	X	X	X
12	01/28/2005	\$34.34	X	X	X	X	X	X	X	X	X	X
13	10/13/2004	\$663.60	X	X	X	X	X	X	X	X	X	X
14	09/24/2004	\$56.71	X	X	X	X	X	X	X	X	X	X
15	11/22/2004	\$55.71	X	X	X	X	X	X	X	X	X	X
16	08/26/2004	\$43.83	X	X	X	X	X	X	X	X	X	X
17	07/15/2004	\$3.19	X	X	X	X	X	X	X	X	X	X
18	01/07/2005	\$23.94	X	X	X	X	X	X	X	X	X	X
19	11/04/2004	\$13.33	X	X	X	X	X	X	X	X	X	X
20	06/24/2004	\$9.00	X	X	X	X	X	X	X	X	X	X
21	11/08/2004	\$2.48	X	X	X	X	X	X	X	X	X	X
22	08/30/2004	\$2.35	X	X	X	X	X	X	X	X	X	X
23	09/20/2004	\$864.00	X	X	X	X	X	X	X	X	X	X
24	03/22/2005	\$142.13	X	X	X	X	X	X	X	X	X	X
25	12/16/2004	\$206.46	X	X	X	X	X	X	X	X	X	X
26	01/18/2005	\$1,184.56	X	X	X	X	X	X	X	X	X	X
27	01/12/2005	\$9.81	X	X	X	X	X	X	X	X	X	X
28*	07/28/2005	\$149,090.33	X	X	X	X	X	X	X	X	X	X
29*	10/04/2004	\$91,621.93	X	X	X	X	X	X	X	X	X	X
30*	08/27/2004	\$80,793.35	X	X	X	X	X	X	X	X	X	X

\* Represents large \$ claims

Continued

## Claim Audit Results

Aetna

## CLAIM AUDIT SUMMARY

TPA: AETNA

FIELD AUDIT DATE:

02/13/2006

Sample Claim	Date Paid	Claim Amount Paid	Sufficient Documentation to Support Claim	Eligible Member	Applicable Deductibles Applied/ Co-Pay	Benefit Covered Under Plan Doc	Referral / Authorization	Agree to Contract Terms with Provider	Coordination of Benefits	Subrogation	Review Claim Form for Accuracy	Agree Check to Claim Form
31	11/12/2004	\$76.15	X	X	X	X	X	X	X	X	X	X
32	06/29/2004	\$13.00	X	X	X	X	X	X	X	X	X	B
33	08/31/2004	\$2.48	X	X	X	X	X	X	X	X	X	B
34	10/05/2004	\$30.72	X	X	X	X	X	X	X	X	X	B
35	09/20/2004	\$9.95	X	X	X	X	X	X	X	X	X	B
36	01/26/2005	\$7.24	X	X	X	X	X	X	X	X	X	X
37	02/01/2005	\$76.09	X	X	X	X	X	X	X	X	X	X
38	07/23/2004	\$2.48	X	X	X	X	X	X	X	X	X	B
39	07/05/2004	\$363.15	X	X	X	X	X	X	X	X	X	B
40	01/13/2005	\$11.13	X	X	X	X	X	X	X	X	X	X
41	08/26/2004	\$24.00	X	X	X	X	X	X	X	X	X	B
42	08/04/2004	\$61.35	X	X	X	X	X	X	X	X	X	B
43	12/23/2004	\$45.00	X	X	X	X	X	X	X	X	X	X
44	01/10/2005	\$143.40	X	X	X	X	X	X	X	X	X	X
45	09/17/2004	\$33.94	X	X	X	X	X	X	X	X	X	B
46	01/17/2005	\$61.35	X	X	X	X	X	X	X	X	X	X
47	12/29/2004	\$631.30	X	X	X	X	X	X	X	X	X	X
48	10/20/2004	\$32.25	X	X	X	X	X	X	X	X	X	B
49	12/06/2004	\$9.30	X	X	X	X	X	X	X	X	X	B
50	08/05/2004	\$38.62	X	X	X	X	X	X	X	X	X	B
51	08/17/2004	\$76.64	X	X	X	X	X	X	X	X	X	B
52	06/30/2004	\$125.00	X	X	X	X	X	X	X	X	X	B
53	12/20/2004	\$7.02	X	X	X	X	X	X	X	X	X	B
54	09/06/2004	\$28.94	X	X	X	X	X	X	X	X	X	B
55	12/23/2004	\$16.23	X	X	X	X	X	X	X	X	X	X
56	02/03/2005	\$61.35	X	X	X	X	X	X	X	X	X	X
57	02/04/2005	\$301.28	X	X	X	X	X	X	X	X	X	X
58	03/29/2005	\$356.40	X	X	X	X	X	X	X	X	X	X
59	04/11/2005	\$14.00	X	X	X	X	X	X	X	X	X	X
60	04/25/2005	\$141.58	X	X	X	X	X	X	X	X	X	X

Continued

## Claim Audit Results

**Aetna**

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- A** The process days to pay the provider were in excess of the requirement. Through inquiry of the system, we noted it was pended due to possible duplicate payment. Two claims from the same provider were submitted on the same date. Not an exception.
  
- B** The cleared checks and/or bank statements were not provided to us to complete our testing of payment verification. All of these claims were for Brevard County Government.

## Claim Audit Results

CIGNA

## CLAIM AUDIT SUMMARY

TPA: CIGNA

FIELD AUDIT DATE:

02/06/2006

Sample Claim	Date Paid	Claim Amount Paid	Sufficient Documentation to Support Claim	Eligible Member	Applicable Deductibles Applied/ Co-Pay	Benefit Covered Under Plan Doc	Referral / Authorization	Agree to Contract Terms with Provider	Coordination of Benefits	Subrogation	Review Claim Form for Accuracy	Check Agreed to Claim Form
1	06/24/2004	\$10.91	X	X	X	X	X	X	X	X	X	X
2	07/23/2004	\$10.33	X	X	X	X	X	X	X	X	X	X
3	09/08/2004	\$114.63	X	X	X	X	X	X	X	X	X	X
4	09/20/2004	\$14.66	X	X	X	X	X	X	X	X	X	X
5	10/22/2004	\$16.35	X	X	X	X	X	X	X	X	X	X
6	11/04/2004	\$46.55	X	X	X	X	X	X	X	X	X	X
7	11/30/2004	\$213.23	X	X	X	X	X	X	X	X	X	X
8	12/09/2004	\$16.92	X	X	X	X	X	X	X	X	X	X
9	01/05/2005	\$7.36	X	X	X	X	X	X	X	X	X	X
10	01/20/2005	\$7.23	X	X	X	X	X	X	X	X	X	X
11	04/13/2005	\$68.90	X	X	X	X	X	X	X	X	X	X
12	03/07/2005	\$9.20	X	X	X	X	X	X	X	X	X	X
13	04/05/2005	\$10.28	X	X	X	X	X	X	X	X	X	X
14	07/19/2005	\$20.82	A	X	X	X	X	X	X	X	X	X
15	05/19/2005	\$16.16	X	X	X	X	X	X	X	X	X	X
16	08/11/2004	\$104.88	X	X	X	X	X	X	X	X	X	X
17	07/10/2004	\$7.35	X	X	X	X	X	X	X	X	X	X
18	07/30/2004	\$32.14	X	X	X	X	X	X	X	X	X	X
19	08/25/2004	\$6.00	X	X	X	X	X	X	X	X	X	X
20	10/15/2004	\$3.99	X	X	X	X	X	X	X	X	X	X
21	10/26/2004	\$87.00	X	X	X	X	X	X	X	X	X	X
22	11/22/2004	\$54.84	X	X	X	X	X	X	X	X	X	X
23	12/20/2004	\$38.52	X	X	X	X	X	X	X	X	X	X
24	02/03/2005	\$6.00	X	X	X	X	X	X	X	X	X	X
25	02/17/2005	\$6.00	X	X	X	X	X	X	X	X	X	X
26	03/11/2005	\$61.27	X	X	X	X	X	X	X	X	X	X
27	03/30/2005	\$38.52	X	X	X	X	X	X	X	X	X	X
28	05/19/2005	\$144.44	X	X	X	X	X	X	X	X	X	X
29	06/10/2005	\$33.65	X	X	X	X	X	X	X	X	X	X
30*	02/23/2005	\$9,430.56	X	X	X	X	X	X	X	X	X	X

\* Represents large \$ claims

Continued

## Claim Audit Results

CIGNA

## CLAIM AUDIT SUMMARY

TPA: CIGNA

FIELD AUDIT DATE:

02/06/2006

Sample Claim	Date Paid	Claim Amount Paid	Sufficient Documentation to Support Claim	Eligible Member	Applicable Deductibles Applied/ Co-Pay	Benefit Covered Under Plan Doc	Referral / Authorization	Agree to Contract Terms with Provider	Coordination of Benefits	Subrogation	Review Claim Form for Accuracy	Agree Check to Claim Form
31	06/23/2004	\$25.39	X	X	X	X	X	X	X	X	X	X
32	07/16/2004	\$10.33	X	X	X	X	X	X	X	X	X	X
33	09/10/2004	\$7.16	X	X	X	X	X	X	X	X	X	X
34	09/24/2004	\$5.15	X	X	X	X	X	X	X	X	X	X
35	09/28/2004	\$2.18	X	X	X	X	X	X	X	X	X	X
36	10/21/2004	\$10.33	X	X	X	X	X	X	X	X	X	X
37	11/12/2004	\$5.75	X	X	X	X	X	X	X	X	X	X
38	03/18/2005	\$150.21	B	X	X	X	X	X	X	X	X	X
39	12/28/2004	\$16.11	X	X	X	X	X	X	X	X	X	X
40	12/28/2004	\$8.43	X	X	X	X	X	X	X	X	X	X
41	03/02/2005	\$10.33	C	X	X	X	X	X	X	X	X	X
42	02/07/2005	\$5.49	X	X	X	X	X	X	X	X	X	X
43	02/18/2005	\$56.46	X	X	X	X	X	X	X	X	X	X
44	03/14/2005	\$50.79	X	X	X	X	X	X	X	X	X	X
45	03/25/2005	\$4.75	X	X	X	X	X	X	X	X	X	X
46	04/15/2005	\$36.42	X	X	X	X	X	X	X	X	X	X
47	05/06/2005	\$7.00	X	X	X	X	X	X	X	X	X	X
48	05/25/2005	\$40.34	X	X	X	X	X	X	X	X	X	X
49	06/15/2004	\$213.16	X	X	X	X	X	X	X	X	X	X
50	07/26/2004	\$57.72	X	X	X	X	X	X	X	X	X	X
51	08/24/2004	\$60.08	X	X	X	X	X	X	X	X	X	X
52	09/29/2004	\$12.50	X	X	X	X	X	X	X	X	X	X
53	11/02/2004	\$2.41	X	X	X	X	X	X	X	X	X	X
54	12/03/2004	\$18.65	X	X	X	X	X	X	X	X	X	X
55	02/02/2005	\$1.92	X	X	X	X	X	X	X	X	X	X
56	02/10/2005	\$5.00	X	X	X	X	X	X	X	X	X	X
57	03/16/2005	\$16.78	X	X	X	X	X	X	X	X	X	X
58	04/19/2005	\$43.36	X	X	X	X	X	X	X	X	X	X
59*	03/29/2005	\$60,572.94	X	X	X	X	X	X	X	X	X	X
60*	03/10/2005	\$14,321.00	X	X	X	X	X	X	X	X	X	X

\* Represents large \$ claims

Continued

## Claim Audit Results

**CIGNA**

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- A** The claim was submitted electronically from Mutual of Omaha as this was a Medicare Crossover claim. The claim submission did not include the rendering provider's name. CIGNA followed protocol and requested the information prior to releasing payment. Claim was handled correctly. Not an exception.
- B** The procedure code billed required medical necessity review. CIGNA followed protocol and requested the information needed to review the claim. Claim was handled correctly. Not an exception.
- C** The procedure code billed required medical necessity review. CIGNA followed protocol and requested the information needed to review the claim. Claim was handled correctly. Not an exception.