Montgomery County, Maryland
Offices of the County Executive
Office of Internal Audit

United Healthcare Claims Audit

August 1, 2014

MCIA-15-3

Highlights

Why MCIA Did this Audit

Montgomery County Government (the County) provides healthcare benefits to its employees and retirees primarily using a self-funded, self-insured model. Under this model, the County, through its Office of Human resources (OHR), uses two third party claims administrators (TPAs), Blue Cross Blue Shield and United Healthcare (UHC) to pay claims on behalf of the County. This report covers UHC only. As part of the County-wide risk assessment completed by MCIA, performance of the health care claims administration process was considered high risk due to the nature of outsourcing claims processing and the annual amounts exposed to potential overpayment errors. The claims administration function has not previously been subject to an audit.

What MCIA Recommends

MCIA is making three (3) recommendations to the OHR regarding reducing exposure to certain costs subject to contract interpretation and in cases where the County's Summary Plan Description and Contact with UHC is silent or vague. OHR disagreed with the need for the recommendations. We continue to believe they should be considered as they have the potential to save the County significant funds.

August 2014

United Healthcare Claims Audit

What MCIA Found

United Healthcare has designed and implemented internal controls for financial payment and procedural accuracy in claims processing that meet or exceed the County's contracted performance guarantees and common industry performance standards. In a sample of 400 claims, we found four (4) errors related to procedural accuracy and one (1) error related to financial payment accuracy. The five (5) errors totaled $24,293 out of our claims payment sample of $6,860,112, representing less than 1% of the dollar value of the population of claims sampled, which we consider immaterial to the population of claims subject to our audit procedures and to the overall amount of claims processed annually by UHC on behalf of the County.

We also identified three areas where the County has the potential to significantly reduce costs. It involves considerations for amending the County's benefit plan and contract with UHC for the treatment of certain medical procedures.

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Objectives

This report summarizes the work performed by Cherry Bekaert LLP (Cherry Bekaert) during the internal audit of the medical benefits administered by United HealthCare (UHC or the Claims Administrator) on behalf of Montgomery County. The overall objectives of this internal audit are as follows:

1. Assess the propriety, accuracy and consistency of claims payments made on behalf of the County by UHC under their existing contract.

2. Provide assistance to the County (with the assistance of Dillabough & Associates) in resolving any potential disputes regarding specific claims tested.

More specific objectives concerning evaluation of claims payments, excluding pharmacy services, are to evaluate:

- The degree to which UHC is delivering quality effective results in the administration of the County's medical plan
- UHC's contract financial terms with the various providers
- UHC's performance and investigative procedures in such areas including, but not limited to:
    - Medical necessity
    - Application of discounts and Usual and Customary (U&C) limits
    - Adherence to plan provisions
    - Coordination of benefits (COB)
    - Medicare processing and coordination
    - Investigation of third party liability

The internal audit was performed in accordance with consulting standards established by the American Institute of Certified Public Accountants (AICPA). Our proposed procedures, developed to meet the objectives stated above, were reviewed and approved in advance by Montgomery County Internal Audit (MCIA). Interviews, documentation review and field work were conducted from August 26, 2013 to August 30, 2013. We worked with UHC to adequately resolve several disputed items identified in our audit in February through April of 2014.

Background

The County offered several medical benefit plan options, including United Exclusive Provider Organization (EPO) HealthCare medical plan, to active and retired workers during the audit period of January 1, 2012 to December 31, 2012. The County offered the same plans to retirees under age 65, or non-Medicare eligible, as active workers. The EPO or Health Maintenance Organization (HMO) option are self-insured and administered by UHC. Self-insured means the County self-funds and pays its plan participants' health claims rather than purchasing separate insurance through an insurance carrier. In FY2012 the County incurred approximately $52 million in self-insured medical insurance costs, of which $19.7 million was processed by UHC, covering 2,988 subscribers including 1,799 active employees and 1,189 retirees. The County has not previously had an independent claims audit performed for UHC's medical/benefit administrative services according to OHR officials.

Cherry Bekaert, in our role as an outsourced internal audit resource, was engaged to perform a limited scope audit of UHC's performance under the terms of its Administrative Contract (the Contract) with the County. Dillabough & Associates (the Auditor), a firm with specific subject

matter expertise related to healthcare claims processing, was engaged by Cherry Bekaert (with prior approval from MCIA) to perform the on-site portion of the audit of UHC in Florida.

Scope and Methodology

We reviewed the County's benefit summaries and plan documents before auditing the claims to familiarize ourselves with the documented benefit provisions. During the course of the audit, numerous questions were posed and answered regarding plan design and internal policies and procedures. The responses are documented in the "Results" section of this report.

The procedures performed in connection with the audit included:

1. Selection of a random stratified sample of claims (200 claims) and a selection of "focused" or targeted claims (200 claims) for a total sample of 400 claims as limited under the terms of the UHC Contract.
2. Confirmation of financial payment, overall accuracy and timeliness of the processed claims selected for testing. This included comparing the payment dollar amount, the payment incidence and the overall processing accuracy percentage against accepted standard measurements common for the industry.
3. Ensuring compliance with all processes and procedures affecting cost management. This included evaluating all processes and procedures for identification, investigation and follow-up claims processing. Areas under review included coordination of benefits, utilization management and other cost containment measures.
4. Determining whether claims payments reflect the provisions of the County's plan. We reviewed the detailed plan descriptions and administrative agreements prior to the audit. Each claim was audited against plan descriptions and contractual arrangements. As part of this step, we evaluated UHC's claims administration system to ensure that contract parameters were entered into the system correctly.
5. Identifying areas for potential improvement of the efficiency and effectiveness of claims administration. During the reporting process, we evaluated the errors found in the information obtained and from the observations made during the on-site audit.

In preparation of the claims audit, the Auditor received a claim data tape from UHC that contained all claims paid from January 1, 2012 to December 31, 2012. From the claims data, the Auditor made sample selections in accordance with the planned audit procedures.

Random ("Stratified") Sample of Audit-Fee-For-Service[1]

The purpose of the random audit sample is to evaluate the accuracy level of payments on fee-for-service claims. Like most claims audits, claims chosen for this sample are selected randomly and would not be expected to yield the same results as claims selected in a targeted audit sample. Claims were selected from the Claims Paid Report for the period of January 1, 2012 to December 31, 2012.

[1] Payment model where services are unbundled and paid for separately

Target ("Focus") Sample of Audit-Fee-For-Service

The purpose of the target audit sample selection is to evaluate the accuracy level of payments on fee-for-service claims. Unlike most claims audits, claims chosen for the target audit sample are not selected randomly and would not be expected to yield the same results of a random audit sample.

The selection of targeted claims included all claims with over $00.01 in payments (excluding claims previously selected by the random sample) that were identified during the initial screening of claims data based on the Auditor's judgment and experience as a subject matter expert with certain claim attributes such as those containing charges for an "assistant surgeon." Claims were selected from the Claims Paid Report for the period of January 1, 2012 to December 31, 2012.

Operational Assessment

The purpose of the Operational Assessment is to evaluate the process and level of payments against the plan document including but not limited to coordination of benefits, subrogation, pre-existing conditions, bundling/unbundling of procedures, denial of claims, ineligible claims, duplicate claims, and network contract compliance.

Results

During the audit process, claims are assessed for benefit payment accuracy (financial payment accuracy) with the Auditor looking at each claim as if it had been received for the first time. The claims are then tested against plan provisions and contracts (procedural accuracy).

- Financial payment accuracy — Claims were assigned a financial or payment error if the payment differed from the amount that should have been paid based on the terms of the plan, claims history and eligibility. Financial payment accuracy is defined as the release of an incorrect payment amount (over or under) for any reason, including but not limited to duplicate payments, miscalculation of patient liability (deductible, copays, coinsurance), Usual and Customary (U&C) or provider contract amounts, incorrect keying of total charge, misapplication of level of benefits exceeding benefit limits, and payments released to the incorrect payee, whether made to the wrong provider or made to the provider when the subscriber has prepaid or vice versa.

- Procedural accuracy — Other important areas related to the integrity of the individual claim data as well as the effects on claim history and eligibility were reviewed. Claims were assigned a procedural error if claims were not paid in accordance with plan provisions and contracts. Procedural accuracy is defined as non-financial claims processing inaccuracy, including but not limited to inaccurate coding of key claim data, not conducting appropriate investigations, and inaccurate recording and reporting of information pertinent to claim file history (i.e., eligibility, COB data, subrogation, referrals).

Each claim was audited for financial payment and procedural accuracy. Financial incidence is reported as a result of the errors identified for financial accuracy and the number of claims reviewed.

Results Overview

We found the following items with regard to the plans administered by UHC:

- Financial payment accuracy — UHC claims administration exceeds standards for financial accuracy in claims adjudication. The audit revealed 99.6% financial accuracy for the focused audit sample and 99.7% financial accuracy for the random stratified audit sample.

- Procedural accuracy — The audit revealed a 98% procedural accuracy for the random stratified audit sample and 99.5% procedural accuracy for the focused audit sample. Note that procedural errors resulting in a financial impact are included in the financial payment accuracy results.

- We identified a couple points of concern with claims processes and procedures:

    - The incorrect fee schedules were used to process claims in multiple situations. There are various instances in the application of fee schedules during claims processing where errors were identified and UHC agreed that the processing was incorrect. The likely root cause of these errors appears to be focused around UHC employees utilizing the incorrect fee schedule or applying the schedule incorrectly. The process resulted in overpaying the allowable amount. These errors are not indicative of a particular type of medical service.

    - There were claims that were priced incorrectly. The likely root cause is that UHC did not load the service provider's fees into the system on a timely basis. The claims were priced by UHC correctly at the time they priced the claims for payment. However, UHC did not timely update the healthcare provider's fee schedule into the UHC claims administration system thus causing fee payment differences between what was paid to the provider versus what should have been paid per the fee schedule in the UHC claims administration system, which is indicative of a procedural error.

During the audit, we submitted questions about processing and/or potential errors to UHC. UHC's responses gave us an opportunity to clarify processing errors and provide documentation to support claim decisions. A review of all errors was completed during the audit and in the days following the end of the audit. Conclusions to most of the claim errors identified were presented following the exit interview.

Testing Results

The total sample of 400 claims represented approximately $9,432,667 in total charges and $6,860,112 in paid claims. The sample pulled was from the individual claims line item. If a claim had multiple lines, then the Auditor selected one line item from the claim selected. The confirmed payment errors identified within the sample totaled $24,293 or 0.4% of the paid claims in the total sample population.

The following table details financial and procedural accuracy percentage results of the random and focused audit samples and compares them to United Healthcare's performance against the contract performance guarantees and common industry standards used by other large TPAs and Insurance carriers[2]. UHC's performance was found to meet or exceed performance guarantees and common industry performance standards.

COMPARISON OF RESULTS OF THE STRATIFIED SAMPLE			
CATEGORY	*UNITED HEALTHCARE AUDIT RESULTS*	*CONTACT PERFORMANCE GUARANTEES*	*COMMON INDUSTRY PERFORMANCE STANDARDS*
Stratified / (Random Sample)			
Financial Accuracy	99.7%	98%	99%
Procedural Accuracy	98.0%	97%	93%

COMPARISON OF RESULTS OF THE FOCUS SAMPLE			
CATEGORY	*UNITED HEALTHCARE AUDIT RESULTS*	*CONTACT PERFORMANCE GUARANTEES*	*COMMON INDUSTRY PERFORMANCE STANDARDS*
Focus / (Targeted Sample)			
Financial Accuracy	99.6%	98%	99%
Procedural Accuracy	99.5%	97%	93%

[2] United Healthcare's contractual performance guarantee with Montgomery County is 98% financial accuracy and 97% procedural accuracy (see contract between Montgomery County, Maryland and United Healthcare Insurance Company, Contract #8331000299 – AA, Attachment II, Exhibit B Performance Standards for Health Benefits). Common Industry Performance Standards are based on Subject Matter Expert's experience performing claims audits of other large TPAs/Insurance carriers, such as Aetna, CIGNA, United Healthcare, and Blue Cross Blue Shield.

Fee-For-Service Claim Errors Identified by Category

Number of Exceptions Found in Sample	Number of Items Sampled	Exception Rate	Dollar Value of Exceptions Found in Sample	Dollar Value of Claims Sample	Dollar Value of Exceptions Found to Value of Claims Sample
5	400	1.3%	$24,293	$6,860,112	0. 4%

The following table details the categories for which errors found could be classified.

No	Category	Amount	Error Details
1	Miscalculation of Charges	$2,306	Three (3) errors were identified with regard to the calculation of charges/payment. Includes sample claim numbers 246, 258, and 266. Calculation of charges is normally a function of the claims system.
2	Coordination Of Benefits (COB) Documentation	$4,890	There was one (1) error identified in claim sample number 261 due to a processing error where the claims processor did not correctly evaluate the AETNA EOB in the coordination of benefits. That is, we believe AETNA was the primary insurer and the County should have been considered secondary, which would have resulted in the County paying a lower amount.
3	Non-Par Physicians	$17,097	One (1) error was identified for a payment to a Non-Participating Physician in sample claim number 134. Based on research performed by UHC, it appears that the error was isolated to this claim.
Total		**$24,293**	

Other Matters

Amendments to Summary Plan Benefits Description and UHC Contract – During our audit we noted three areas where the County appears to be incurring unnecessary costs with regard to the application of self-insured coverage and treatment of certain medical procedures under the current benefit plan.

1. Treatment of Modifier Reductions – During our audit procedures we noted six (6) claims associated with anesthesia billings that could be considered overpaid by $4,214 if the County's SPD and related contract with UHC specifically addressed the treatment of modifier reductions. Health claim modifier reduction codes are used to process claims for surgical benefits regarding anesthesia charges, but can result in overpaying for anesthesia services if not specifically addressed. For example, to avoid overpaying for anesthesia services, we typically see language in the Summary Plan Description and TPA contact as follows:

   "Anesthesia Charges: Charges for the services of a Certified Registered Nurse Anesthetist (CRNA), in addition to an Anesthesiologist. If a Covered Person has authorized the services of a CRNA, charges are payable either to the supervising Anesthesiologist or the CRNA, but not both. If the CRNA and Anesthesiologist use certain code modifiers, specifically, health claim codes QX and QY modifiers, each would be paid at 50%, or two (2) bills paid at 50%, which equals full payment."

2. Treatment of Assistant Surgeons – During our audit procedures we noted that in 13 surgical assistant claims, the "surgeon" was a participating physician with UHC. The general rule is the physician supervises the Physician's Assistant (PA) or Nurse whether they are part of the surgeon's group or an extension of the group. The surgeon has the primary responsibility for overall direction and management of the surgical activities. Therefore, we would consider the Assistant to the Surgeon as part of the surgeon's team and their compensation should be tied to the team or participating provider's reimbursement. It is important to note that non-physician surgical assistants (nurses) do not have to be credentialed by insurance carriers, nor are they listed in a directory. As such, they are not considered participating or non-participating. Surgical assistants expect to be reimbursed a percentage of the surgeon's reimbursement.

   UHC's policy is designed to protect the member when services are performed by providers that may be outside the ability of the member to select, such as the assistant surgeon or co-surgeon. In response to our inquiries, UHC asserted that the facilities and the primary surgeons associated with these claims were IN Network (INN) with UHC. In addition, UHC asserted that the facilities' status drives the benefit level; therefore, INN benefits were awarded to the Out of Network (OON) assistant surgeons (including nurse practitioners) or co-surgeon, and so reductions did not apply to OON providers reimbursed at the INN level.

That said, assistant surgeons are there at the request of the participating provider who is performing the surgery. Most of the Assistant Surgeon claims were for nurse assistance. For 13 of claims we reviewed, UHC paid the assistant surgeons $22,620, or 120% of the surgeon fee of $18,876. The industry standard and Medicare is to pay the assistant surgeon 16% to 20% of the surgeon's fee. The County appears to be overpaying for assistant surgeon fees under its current plan design, unless the County considers this a required benefit to its subscribers consistent with UHC's response to our inquiry.

3. Treatment of Non-Participating Physicians/Providers – We noted during our audit there were twenty-three (23) claims that were paid to non-participating (non-par) providers, mainly laboratory (lab) vendors that UHC pays under its standard Radiology, Anesthesiology, Pathology and Lab (RAPL) policy.

   Per UHC, "The RAPL policy is designed to protect members when services are sent to an out of network (OON) provider without the member's knowledge. However, often an in-network *(*INN) physician refers a patient to an out of network (OON) independent laboratory. UHC's RAPL policy allows in-network processing of OON provider claims under certain circumstances and certain locations including the following:

   - ✓ The referring facility or physician is INN
   - ✓ The service is radiology, anesthesia, pathology, or laboratory
   - ✓ The service is radiology, anesthesia, pathology, or laboratory rendered during an emergency
   - ✓ The service was rendered in one of the following locations:
     - Outpatient Hospital (OH)
     - Inpatient Hospital (IH)
     - Ambulatory Surgical Center (AS)
     - Emergency Room (ER)
     - *Independent Laboratory*" (*emphasis added*)

   Of the total non-par paid claims we reviewed, $462,746 was associated with non-hospital place of service (offices or labs). We believe the majority of the non-par claims were not provided in the hospital setting and therefore should not be paid under a benefit plan if properly designed and administered by a third party claims processor such as UHC. The County appears to be overpaying for non-par provider services under its current plan design, unless the County considers this a required benefit to its subscribers consistent with UHC's response to our inquiry.

Recommendations

We are making three recommendations that we believe will improve internal controls over third party claims processing and reduce the annual cost of self-insured medical insurance incurred by the County. MCIA recommends that the Director, Office of Human Resources consider amending its Summary Plan Description (SPD) and related contract with UHC to explicitly describe the treatment of claims processed for the following medical procedure elements as discuss in "Other Matters" above:

1. Treatment of Modifier Reductions health claim codes involving surgical benefits regarding anesthesia charges.

2. Treatment of Assistant Surgeons health claims processing should follow Medicare guidelines.

3. Treatment of Non-Participating Providers (laboratories) – Stop paying non-participating providers unless certain prescribed specific conditions are met.

Comments and MCIA Evaluation

We provided OHR and UHC with a draft of this report for review and comment on July 3, 2014. OHR provided us with a written response on July 16, 2014 (see Appendix A). The Office of Human Resources indicated in their formal responses to our report that they disagree with our recommendations 1, 2, and 3 (formally designated as recommendations a, b, and c in a draft of this report).

OHR stated that their policy decision is to hold members harmless for medical treatment outside of the covered members' control, which is the reason the County's Summary Plan Description is silent regarding the treatment of the aforementioned medical procedures contained above in the section of our report titled "Other Matters".

However, we believe that the matters discussed above in the "Other Matters" section 1 and 2 of our report may be resolved with little to no impact to the covered member by amending the County's Summary Plan Description and its contract with UHC for the specific treatment of these procedures when it is in the control of the covered member and/or the "in network" Surgeon, such as, in the case of non-emergency surgery.

Also, regarding the treatment of non-participating provider laboratories (see "Other Matters" 3), we noted these services were not provided in hospital settings (mainly offices and labs). Based on our procedures, we could not find evidence to support that these out of network charges where emergency situations and therefore, beyond the covered members' control. Therefore, we believe the choice of service provider was likely within the members' control. Similar to fulfilling any prescription service, the member can choose which pharmacy, or in this case, which laboratory fills the prescription. It is common practice for members to inquire in the course of filling prescription type services whether the service provider is "in network" and covered by their medical benefits plan or risk not having the service covered and personally incur the cost for services obtained from the non-participating provider.

In the items selected for our audit, we identified the potential to save $485,804 in calendar year 2012 alone (see table below) if the specific treatment of these procedures in the County's Summary Plan Description and corresponding contract with UHC followed our recommendations above.

Items contained in "Other Matters"	Basis for Estimated Amount of Cost Savings	Estimated Amount of Cost Savings
1.	Costs incurred for the treatment of Modifier Reductions for health claim codes involving surgical benefits regarding anesthesia charges without amending the SPD as described in the Other Matters section above.	$4,214
2.	Difference in costs incurred for the treatment of Assistant Surgeons health claims processing if the SPD specifically followed Medicare guidelines at 16% - 20% of the Surgeon's fee. Calculated amount [($22,620 – ($18,876 *20% of Surgeon's fee)]	$18,844
3.	Costs incurred via Non-Participating Providers in non-hospital places of service (offices or labs).	$462,746
Total		**$485,804**

We believe our recommended changes to the County's Summary Plan Description and its contract with UHC have the potential to save the County significant amounts in the annual cost of self-insured medical health care benefits if applied to the universe of claims processed.

UHC provided us with a written response on July 7, 2014 (see Appendix B). UHC did not comment on recommendations 1-3.

Appendix A: Responses to Audit - OHR

OFFICE OF HUMAN RESOURCES

Isiah Leggett
County Executive

Joseph Adler
Director

MEMORANDUM

July 30, 2014

TO: Larry Dyckman, Manager, Office of Internal Audit

FROM: Joseph Adler, Director, Office of Human Resources

SUBJECT: Response to Recommendations from United Healthcare Claims Audit

The Office of Human Resources (OHR) is pleased with United Healthcare's (UHC) performance which meets or exceeds industry standards. Of the over $9M in total charges reviewed, procedural or financial errors from 5 claims resulted in $24,293 paid in error. Of the claims money not recoverable, UHC and OHR are working together to resolve any overpayment of claims to ensure the County was not billed for the claims associated with these errors.

Recommendations a, b and c, are contrary to the County's current policy to holding employees harmless where anesthetists', assistant surgeons', laboratories or other medical services used are outside the employees' control. OHR requests that these recommendations be removed from the report.

OHR has conferred with the County Attorney's Office regarding Recommendation d. Maryland statue 15-1005(1)-(3) applies to the contracts between UHC and their providers. This statue does not impact the contract between UHC and the County. OHR requests that this recommendation be removed from the report.

JA:bf

Appendix B: Responses to Audit – UHC

Christopher J. Mullins
Executive Director
UnitedHealthcare of the Mid-Atlantic
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Suite 400
Reston, VA 20191

July 18, 2014

Larry Dyckman
Manager
Office of Internal Audit
Montgomery County Government
101 Monroe Street, Room 626
Rockville, MD 20850

Dear Mr. Dyckman,

Thank you for the opportunity to review and provide formal comment to the draft report on the audit of health claims processed for Montgomery County, Maryland by UnitedHealthcare. We are committed to our partnership with the County and appreciate the work performed by Cherry Bekaert LLP on your behalf to provide a picture of the quality of claim processing in our transaction center.

The following constitutes UnitedHealthcare's official response to the auditor's recommendation appearing on page 11 of the audit report section (d) regarding the application of MD's Prompt Pay law. UnitedHealthcare's interpretation of the relevant Maryland statute, 15-1005(d)(2), is that the provider is afforded a minimum of 90 working days for appeal and, accordingly, a deadline that accommodates that minimum (such as, for example, 120 or 180 calendar days) would be permissible under MD law. We do not interpret the appeal provision as affording a mandatory minimum of 12 months for appeal. Under subsection (3), where the claim has been administratively processed in error, we are obligated to review the claim without requiring resubmission and denial for timely filing provided that the provider notifies us of the potential processing error within 12 months of the date the error was made. The provisions in the provider contracts generally include timelines that comply with the deadlines set forth in 15-1005(1)–(3) regarding: (a) the initial timely-filing; (b) appeal period; and, (c) processing error notifications.

UnitedHealthcare is committed to immediate and sustainable improvement in our overall administration of your medical benefit plan. We believe we have outlined an aggressive course of action, support by a remediation plan that includes all necessary enhancements to address the issues outlined in the draft report. Of the 5 claims resulted in $24,293 paid in error, recovery in full of $5,052 was completed by December 2013. Of the pertinent

issues related to our claims accuracy, and in benefit to our mutual client, we have worked aggressively to ensure that all corrections are made and all remediation completed.

The UnitedHealthcare team looks forward to a continued partnership as we strive to provide you with the best service in the industry.

Sincerely,

Christopher J. Mullins
Executive Director

cc: Scott McKay, CPA, CFE, CIA, CCSA
Partner
Practice Leader – Risk Advisory Services
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