Tempe
Internal Audit

Memorandum

TO:	Ken Jones, Deputy City Manager, Chief Financial Officer
FROM:	Bill Greene, City Auditor (X8982)
CC:	Andrew Ching, City Manager
	Steven Methvin, Deputy City Manager, Chief Operating Officer
	Tom Duensing, Deputy Internal Services Director - Finance
	Rebecca Strisko, Deputy Internal Services Director –HR
	Kathleen Broman, Manager, HR Benefits
DATE:	December 1, 2020
SUBJECT:	MEDICAL CLAIMS PROCESS

Purpose

On September 30, 2020 the IAO issued a memo providing the results of our review of the City's Healthcare Fund. This review prompted additional questions about controls surrounding the third-party administrator's review of medical claims and the necessity of a claims audit by an external party.

The IAO performed additional work at the request of the City Manager's Office:

1. Documented the healthcare claims payment process.
2. Conducted a risk assessment to identify medical claims overpayment risks and existing controls, including procedures conducted by the City's Third-Party Administrator (Allegiance).
3. Compared City of Tempe controls/procedures to other local jurisdictions with a similar structure (e.g. self-insured). Specifically, we verified if other jurisdictions employ periodic claims auditing/testing as part of their control structure and verified if other jurisdictions pay from summary claim information rather than detailed medical billings.
4. Identified relevant findings/support from the IAO's recent Healthcare Fund memo.

Scope and Methods

The objective of this consulting engagement was to identify City of Tempe medical claims processing procedures and related controls in place to mitigate risks of fraud and over-payment. We met this objective by performing the steps noted in the Purpose section above.

The work performed does not constitute an audit in accordance with *Government Auditing Standards*. An audit would have required additional steps such as the testing of relevant internal controls and a validation of data and information provided to IAO.

We employed the following methods to complete this engagement:

- Review of claims processing steps and controls with the City's third-party administrator;
- Survey of various metro-Phoenix cities;
- A matching of specific risk areas of concern with controls as described by the third-party administrator.

Results

1. ***Our survey of other cities showed that Tempe has medical claims review processes consistent with other cities surveyed. One area of differentiation is that half of the jurisdictions surveyed reported having an audit of claims performed by an entity not affiliated with the claims processing activities. As stated in our September 30, 2020 memo, we still recommend that HR-Benefits work with Procurement to contract for a periodic audit of medical claims by an independent firm not affiliated with the claims processing and payment functions.***

The IAO initiated a survey of metro-Phoenix cities relating to claims auditing and processing. The cities/towns of Phoenix, Mesa, Scottsdale, Surprise, Gilbert, and Glendale responded. Key findings were:

- 3 of 6 cities surveyed use independent claims audits performed by firms not affiliated with the city or its claims processing function. Recovery from such audits were reported to be "minimal" to less than 1%. Tempe does not execute an independent medical claims audit at this time. "Audits" of claims are solely performed by the city's third-party administrator for healthcare claims processing prior to payment.
- 4 of 6 cities surveyed work with TPA's to review, process and pay claims. This is the same arrangement Tempe has with Allegiance.
- 1 of 6 cities surveyed indicated that they reconcile detailed claims data to the billing summary prior to payment. Tempe pays claims weekly based on a summary report.

- 4 of 6 cities surveyed reported having processes in place aside from an annual audit to detect overpayments, fraud, or duplicate payments. Tempe's TPA reported that they use an automated claims processing system with built-in functions that are designed to detect indicators of fraud, overpayment, and duplicate payments and designate any claims flagged for review by a trained examiner.

See **Appendix 1** for the detailed summary of survey results.

2. Information provided by Allegiance adequately described medical claims processing procedures and specific controls established to address the primary risks to the City.

Allegiance provided a detailed description of the claims processing and payment functions. The IAO flowcharted the process to gain a better understanding of the steps. In addition, in consultation with Finance and HR, the IAO identified six primary risks to the City and corresponding potential negative outcomes associated with the medical claims processing and payment functions:

- Fraudulent medical claims are submitted and paid
- Duplicate medical claims are submitted and paid
- Detailed claims billing documentation does not match the summary billing
- Claims paid are not supported by adequate detailed claims documentation/invoices
- Claims are paid for ineligible participants
- Claims are paid in excess of the contracted amounts

Allegiance provided IAO staff information and documentation related to each of the six risks, which we used to determine whether controls exist to address and mitigate each risk. We did not conduct control testing as this was not the purpose of our work. However, we received the necessary information and supporting documentation that, if accurate, should provide the necessary controls to protect the City's interests. As mentioned in result #1 above, claims processing performed by the TPA has not been audited by a firm other than Allegiance itself.

See **Appendix 2** for the detailed risk/control matrix.

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Summary of Survey of Other Cities
Claims Processing/Audits
APPENDIX 1

City	1. Is your City self-insured for medical benefit expenses?	2. Who is your 3rd party administrator (TPA)?	3. Does your TPA have the responsibility to review and pay medical claim billings?	4. Do you reconcile detailed claims data to the summary billing prior to payment?	5. Are claims paid from summary billings and does the TPA receive detailed invoices?	6. What other steps are taken by you or your TPA to identify overpayments, fraud, and/or duplicate payments?	7. Is an audit of medical claims performed?	8. If claims audit is performed: by whom? How often?	9. Does your contract with your TPA contain a requirement to perform periodic claims audits?	10. What % of claim costs have been recovered due to audits?
TEMPE	**Yes**	**Allegiance**	**Yes**	**No; only a summary report is supplied weekly by Allegiance**	**Tempe pays claims based on a summary billing request but TPA receives detailed claims data**	**Allegiance has automated processes built into its claims processing system designed to identify duplicates, potential fraud, and overpayments.**	**Not by independent party-Allegiance performs internal audits on 3-6% of claims**	**See #7**	**Specific Audit services can be requested for additional charge**	**N/A**
Phoenix	Yes	N/A -no TPA	N/A	Carrier provides performance guarantees on all medical management and administrative and clinical services in adherence to plan description processes and operational procedures.	N/A	Audit performed by third-party auditor, annually.	Yes	External Auditor, annually	N/A	N/A
Mesa	Yes	Cigna	Yes	No, but we do cross reference 3 different reporting mechanisms by division, plan and dollars to reconcile to the overall	Not answered	several medical management processes including case management, disease management and pre-certification and concurrent review processes; bill review/cost containment processes including large claims over $250,000 medical director review, specifically designated fraud and abuse team, complex claim review, overpayment recovery processes, bill negotiation services etc.	implementation audit (upon new contract installation – discretionary) and/or stratified medical claims audits available up to annually (discretionary).	third party benefits consulting audit practice	as part of performance guarantees to support financial accuracy measures	significantly less than 1%

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Summary of Survey of Other Cities
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				banking funding request						
Scottsdale	Yes	Cigna	Yes	Yes	Yes	They have a pretty extensive process, they re-cover and reimburse fraud payments a couple times a month, payments vary; any claims over $10,000 go over a couple of reviews.	Yes	Wolcott (Claims Audit firm), typically every 3 years	It gives us the ability to perform audits at their claims processing location – 600 claims.	Minimal, they have been pretty accurate.
Surprise	Yes	We do not work with a TPA	The individual carriers are responsible for reviewing and paying claims.	No	N/A	N/A; however, BCBS has processes and audits in place that they perform as part of their contracted services. They have several established criteria for claims audits based on factors such as total claims cost and stop loss thresholds, diagnosis codes, subrogation potential, etc. Further, accuracy in claims processing and audit processes is monitored by the City and our broker as part of annual performance guarantees. In addition, our broker can solicit additional information about claims or request an audit of particular claims if there is a specific question or concern.	See #6	See #6	N/A	That's great question but not something we have asked BCBS to provide.
Gilbert	Yes	Banner/Aetna	Yes	No	No	Annual Audits	Yes	KPMG, annually	Yes	0.025%
Glendale	Yes	BCBSAZ	Yes	No	Claims are paid directly from an establish checking account. Funding occurs based on the summary billing and reconciliation. The detailed claims report is provided to the City for review.	We do a monthly eligibility reconciliation and quarterly will spot check claims to ensure none have been paid out of terminated employees/dependents.	No	N/A	No- our contract states that we have a right to audit- but have not done an audit	N/A

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Appendix 2
RISK ASSESSMENT / INTERNAL CONTROLS

#	RISK/POTENTIAL ERROR	POSSIBLE NEGATIVE RESULTS (including FRAUD)	CONTROL IN PLACE PER ALLEGIANCE
1	Fraudulent medical claims are submitted and paid	FRAUD; negative effect on Healthcare funds balance	Allegiance's claims processing system, LuminX, has the ability to perform a multitude of edits to review claims for coding accuracy, fraud and duplication. System edits automatically flag the claim for an examiner for review. Examples of edits in our system include: • Age/sex procedural codes • Workers compensation • Auto/medical • Fraudulent providers • Suspect addresses • Limits on age for covered services • Verification of the accuracy of coding • Matches claims to pre-certifications • Follow-up questionnaires for information to identify third party liability and work-related claims. All claims examiners are required to complete an extensive fraud training course that provides them with the skills and expertise to identify potentially fraudulent claims or providers.
2	Duplicate medical claims are submitted and paid	Overpayment of claims; negative effect on Healthcare fund balance	Allegiance's core administrative system automatically compares key components of a claim, such as date of service, name of provider, and type of charge, against our claims history files to prevent duplicate payments. If the system finds an exact match in our history file, we automatically deny payment. If several, but not all, key items match a claim on the history file, a claims examiner reviews, investigates and determines whether the claim is a duplicate.
3	Detailed claims billing documentation does not match the summary billing	Paying for unsupported costs; paying for procedures/services not performed	Claims funding requests are generated from actual medical claims data. Claims are fully processed when they are selected for funding.
4	Claims paid are not supported by adequate detailed claims documentation/invoices	Potential overcharging	Claims funding is requested weekly. A summary request is provided listing the total disbursements, voids, and refunds as well as the claims detail in a csv format. Claims are reviewed by Allegiance at the line-item level, not just at summary/total level.
5	Claims are paid for ineligible participants	Unnecessary payments; negative effect on Healthcare fund balance	Client eligibility is loaded directly to the same system used to pay claims. During the processing of each claim the system is queried for current eligibility prior to adjudication. Eligibility and enrollment are accepted from client in many formats, and clients also have direct access to a dedicated Enrollment Specialist to make urgent updates to enrollment data. Eligibility data is updated weekly.
6	Claims are paid in excess of the contracted amounts	Overpayment of claims; negative effect on Healthcare fund balance	1. Claims are received pre-priced from Cigna who reviews the claims and prices according to provider contracts. Allegiance has a dedicated contact to review any claims where the pricing is disputed from the provider. During the implementation process, they conduct a thorough review of the client's benefit plan in ensure that the intent behind all plan language is understood fully. The claims system, LuminX, operates around a group plan building module that completely defines and stores the intricacies of your plan. Because everything is programmed according to

#	RISK/POTENTIAL ERROR	POSSIBLE NEGATIVE RESULTS (including FRAUD)	CONTROL IN PLACE PER ALLEGIANCE
			the individual plan document, they are able to process claims quickly, accurately and consistently. They conduct a number of claim edits and reviews on a pre-payment basis, reducing the number of overpayment requests necessary. 2. Allegiance has implemented innovative processes to proactively monitor and prevent potential overpayments. They regularly report processing accuracy rates greater than 99%. They identify overpayments from multiple sources including, but not limited to, the providers, the group, the members, payment audits, and a contracted hospital auditing firm. When an overpayment is identified, a refund request is submitted to the recipient of the payment. If no refund is received in a specified period, a second request is submitted. If no payment is received subsequently, a telephone call is made to the recipient of the payment. If no payment is received subsequent to the call and the refund meets criteria the case is forwarded to their in-house counsel for follow-up and recovery.