Industry & Local 338 Welfare Fund

Medical Claims Audit
Services Proposal

July 23, 2019

SENECA CONSULTING GROUP

You can't manage what you can't measure.

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Table of Contents

INTRODUCTION

Seneca Consulting Group is pleased to submit a proposal for a ***Medical Claims Audit*** project to Industry & Local 338 Welfare Fund. The Industry & Local 338 Welfare Fund (Plan) provides health insurance coverage for members enrolled in a self-funded plan administered by Associated Administrators.

Seneca Consulting Group audit methods have been developed to maximize the audit recovery potential. As a result, Seneca Consulting Group will guarantee 100% of the audit fee will be offset by audit recovery potential, resulting in a budget neutral project.

MEDICAL CLAIMS AUDIT

A. PROJECT SCOPE & DESCRIPTION OF SERVICES

Scope of Project – An audit of 100% of the paid medical and prescription drug claims will be performed for all members, and their dependents, enrolled in the Plan administered by Associated Administrators for the period of claim payment history from January 1st 2018 - December 31st 2018 through the most recent month of claims data.

Project Description – The audit includes data mining of all paid claims for the Plan covering a wide variety of potential errors. The sample for the claims audit is selected from the results of this data mining process, so claims are reviewed based on their potential as errors as opposed to a random selection. This detailed focus on exceptions and errors allows for identification of plan improvement opportunities, clarification on plan interpretation, and root causes that can be corrected for future cost savings.

We are able to modify the scope of the audit to meet objectives that come to light during the initial planning phases of the project, including any targeted areas of concern for the Plan. Combining quality improvement available through an exceptional claims audit approach with direct recoveries from overpayment correction will offer Industry & Local 338 Welfare Fund an outstanding return on investment.

B. AUDIT PROCESS – MEDICAL CLAIMS

1. ***Data Gathering*** – The Audit Team will request the following information for the period from January 1st 2018 - December 31st 2018 through the most recent month of claims data:

   - ***Associated Administrators Data Request*** –
     - detailed historical claim data
     - member eligibility
     - banking file
     - coordination-of-benefit and other insurance information

   - ***Industry & Local 338 Welfare Fund Data Request*** –
     - plan documents
     - Associated Administrators Administrative Services Agreement
     - electronic eligibility rosters including employment status (active, terminated) and termination dates (and COBRA enrollment, if available)
     - information on reinsurance policies in force including reimbursements received if available

- summary of amounts funded to the claim account for the audit time period for comparison to the data set extracted from Associated Administrators claims system

2. ***Data Mining & Sample Selection*** – The Audit Team will query the medical claims data for a wide variety of potential errors, including but not limited to:

   - Duplicate claims
   - Eligibility confirmation
   - Coordination of Benefits and other Third Party Liability
   - Pricing of claims to network discounts, UCR (Usual, Customary and Reasonable) or other out-of-network limits
   - Modifier discounts such as multiple procedures, assistant surgeons
   - Medical edits such as unbundling of codes
   - Patient portions – deductible, copayments, coinsurance
   - Plan benefit limits and covered services
   - Timely filing
   - Turnaround time
   - Authorizations
   - Accurate data entry including member, provider, payee (tested on-site only)

   The Audit Team will review the output of these detailed queries and determine how best to construct the claim sample to maximize recoveries, resolve any high-dollar potential errors, and address all systemic concerns. We will request a sample size of 250 claims with Associated Administrators, though the audit can be accomplished with fewer site visit claims if required. The Audit Team will identify the maximum number of contract review selections to ensure that we test pricing and contractual terms on the highest paid facilities.

3. ***Site Visit*** – The project includes a one-week site visit at **ASSOCIATED ADMINISTRATORS**. The Audit Team will review the sample medical claims while on-site and will write-up all potential errors for review by **ASSOCIATED ADMINISTRATORS**. We would expect the majority if not all of the answers to these write-ups during the site visit week.

4. ***Reporting –*** Within one week of answers to write-ups, the Audit Team will provide the ***Draft Audit Report*** and out-of-sample claims to both **ASSOCIATED ADMINISTRATORS** and **INDUSTRY & LOCAL 338 WELFARE FUND**. We will incorporate the formal response from **ASSOCIATED ADMINISTRATORS** into a ***Final Audit Report***.

5. ***Remediation*** - The last stage of the audit process includes a meeting between **INDUSTRY & LOCAL 338 WELFARE FUND**, **ASSOCIATED ADMINISTRATORS** and the Audit Team to plan resolution of all findings including recovery and root cause correction where appropriate.

RESUMES

Daniel C. Opinante
President, Seneca Consulting Group

Having worked as a Senior Vice President for National Medical Healthcare Systems, Regional Sales Manager for Empire Blue Cross Blue Shield, as well as a large group representative for US Healthcare, Mr. Opinante is very knowledgeable both Medical and Pharmacy claims administration.

During his ten years working within the Pharmacy Benefit Management (PBM) industry, Mr. Opinante has had many notable accomplishments. His primary responsibility during his tenure in the PBM industry was Business Development for the eastern United States. His efforts contributed to his employer being named as the #1 fastest growing businesses in CRAINS, and the #4 fastest growing business in America. In addition to his business development responsibilities, Mr. Opinante was responsible for the conception and implementation of a PBM revenue forecasting model that is still in use today. The PBM revenue model Mr. Opinante created evaluates all PBM revenue sources, and is used in determining pricing offered to new clients, and existing clients upon renewal. It is this exceptional level of technical knowledge of the Pharmacy benefit industry that makes Mr. Opinante uniquely qualified as an auditor and consultant.

Publications:
Self-Funding Magazine:
Pharmacy Benefit Manager Contract Language that affects Plans Costs.

Traditional PBM Pricing Vs Pass-Through…Look Before you Leap!

Mr. Opinante has been very active in educational initiatives designed to help unveil the complexity of the pharmacy benefit industry. As the featured speaker of the national PBM educational series "Taming the Tiger", Mr. Opinante has had the opportunity to present his "PBM 101: Pricing and Revenue Models" throughout the Country. The PBM 101 presentation has been approved in New York State for Life and Health Licenses continuing education credits. Mr. Opinante has had the privilege of supporting education and awareness of PBM business models at many industry venues. As a speaker at the Health and Welfare Conference for Mid- Sized Employers, Made In America Taft Hartley Benefits Summit, the National Association of Police Officers (NAPO), and HCAA, Mr. Opinante is dedicated to offering his experience to provide industry colleagues with a unique understanding of the pharmacy benefit industry. Most importantly, Mr. Opinante provides valuable insight into how pharmacy benefits interface with the healthcare delivery system as a whole.

Prior to working within the PBM industry, Mr. Opinante worked at Empire Blue Cross Blue Shield as the Labor Sales manager, and supported all Taft-Hartley clients. Products included network leasing as well as administrative services only. Prior to Empire Blue Cross Blue Shield, Mr. Opinante was a large group representative for US Healthcare

John Hatala
Vice President

Mr. Hatala' experience includes over 20 years in the group insurance and managed health care industry. The most recent decade of his experience include VP and Director level positions specifically in the pharmacy benefit management (PBM) sector.

Mr. Hatala has extensive knowledge of multiple segments of the managed care industry and functions as the principal project manager and senior client service executive for Seneca Consulting. John is responsible for development of programs and strategies to deliver cost effective solutions and superior outcomes for clients. Mr. Hatala' areas of expertise include: Financial Analysis & Price Modeling, Contract Management,

Vendor Negotiations, Strategic Planning, Market Plan Development, Marketing Innovation, and Client Needs Assessment

Mr. Hatala' depth of professional experience includes positions with Coventry Health Care, Humana Inc., CVS Caremark and Novato Health. As a result of his work history, Mr. Hatala has a comprehensive understanding of the health care claims transaction that forms an excellent basis for claims auditing. Mr. Hatala has conducted PBM audits for clients across the country and has extensive knowledge of PBM and TPA business models.

Robert Allen
Data Analyst

Mr. Allen is responsible for data management for our pharmacy claims auditing program. Mr. Allen is a seasoned engineering professional with a Bachelor of Science in Industrial Engineering from Polytechnic Institute of New York. Mr. Allen is experience in the areas of pharmacy claims adjudication including the interface required between a pharmacy benefit manager and the Center of Medicare Services. Software proficiency includes but not limited to Agile environment supporting software including JIRA and Greenhopper, CAD/CAM Software, MS SQL, VBA, SAP and MRP Systems

Mindy Rogers, RN
Medical Management Supervisor

Ms. Rogers is responsible for coordinating member appeals and medical management services for our large self-funded clients. Ms Rogers overall experience includes claims processing with United Healthcare, Claims Manager with National Benefit Administrators, and a Cost Containment Coordinator with MediCompanies. In addition to Ms Rogers industry expertise, she also provides a background in medical care as registered nurse with Carolinas Medical Center.

John Graham,
Lead Auditor

John will serve as the Lead Auditor for both sample selections and the site visit. He will handle quality assurance review on all data work and will present all findings through the closing phases of the project. John has performed and managed claims audits for self-insured employers for fifteen years and has personally led the recovery of millions of dollars for clients in this time period. John has contributed to the development of the industry by significantly increasing acceptance of comprehensive claims audits over his career and developing unique arrangements for clients including negotiating more aggressive audit rights, enhanced provider contract audits, and higher frequency of claims audits. John's broad healthcare consulting experience also includes financial modeling for healthcare providers and payers, contract management system development and implementation, fee schedule analysis, and strategic planning. He has served as an expert for multiple litigation support projects focused on claims accuracy and testing. John graduated from Duke University with a Bachelor of Arts degree in Economics and earned the Group Benefits Associate designation through IFEBP.

Jeffrey Leegon
Advanced Analytics and Auditor

Jeffrey has over 10 years of experience working in healthcare including both operational and clinical data work related to quality improvement and public health. He served as an adjunct professor at Belmont University School of Pharmacy focusing on teaching foundational Pharmacy Informatics. He has also used his passion for ensuring access to healthcare for the uninsured in his position as Clinical Informatics and I.T.

Specialist at Siloam Family Health Center. There Jeffrey served in a lead data management function while moving analytics to SQL-based platforms and supporting the overall business with advanced analytics related to operational and clinical functions. Jeffrey graduated with Bachelor of Science in Computer Science from the University of Birmingham, England, then proceeded to earn a Masters of Science in Informatics/Artificial Intelligence specializing using Machine Learning from the University of Edinburgh, Scotland. Jeffrey finished his studies at Vanderbilt University with a Masters of Science in Biomedical Informatics with a Clinical focus. He brings a unique background in advanced analytics to J. Graham Inc. that is being used to further develop predictive modeling functions to allow for more efficient and effective audit results for our clients.

Guy Brooks
Claims Data Specialist and Auditor

Guy will handle all data functions on this project and will participate in all phases of the claims audit including the site visit. He will scrub data to our company standards, verify integrity of the data, run standard algorithms and write all custom queries including detailed benefits testing, peer review sample selections and audit claims on the site visit. Guy has over twenty years of experience in healthcare with focus in data processing, product development, business intelligence and quality improvement. He has worked in claims auditing over the last three years with direct experience serving multiple employer groups including Fortune 500 companies, municipalities, multi-employer groups, and union plans across various administrators and claims platforms. Guy graduated from Western Kentucky University with a Bachelor of Science degree in Computer Information Systems

REFERENCES

Contact	Group	Phone	Email
Mr. Michael Donovan, Fund Administrator	Uniformed Fire Officers	212-376-8400	mdonovan@ufoa.org
Mr. Noel DiGerolamo President	Suffolk County PBA	631-563-4200	noeld@suffolkpba.org
Ms Sheila MacFadyen, Chairperson	Suffolk School Employees Health Plan	770-575-0006	sheilamf@comcast.net
Mr. Frank Bayer, Internal Auditor	County of Suffolk	631-853-6040	Frank.bayer@suffolkcountyny.gov

DATA REQUESTS:

Medical Claims:

- ***Line item claims file*** covering the audit period per the minimum field specifications listed below. Please address any exceptions to this field list in advance of the data extract. This data should be provided in a delimited or fixed width text file with headers, a file layout, and a detailed data dictionary. The data dictionary should contain definitions for any values defined by the claims payer.
- ***Full historical eligibility file*** for the group(s) showing coverage and termination dates for every member present in the claims extract per the field list below. This file must link to the claims extract and must reflect actual coverage and not premium billing.
- ***Banking file*** showing the record of transactions from client account for each claim per the field specifications below to ensure that all voids, recoveries, unsolicited refunds and other accounting transactions are accurately reflected in the claim file.
- ***Benefit templates and account structure*** reflecting how the plans are loaded or implemented in the claims system. These are often the documents that customer service utilizes to quote benefits to members, or they may be documents used in the implementation process.
- ***Summary Plan Description*** for audit period to include any Material Modifications
- ***Administrative Services Only Contract*** for audit period
- ***Stop loss Contracts*** if applicable

Data Field List

Field	Description
Claim ID	Unique identifier for each claim line detail included in a single claim, should match the Claim ID in the banking file
Line Number	Number which represents a specific line of data on a claim
Claim Type	Reversal/adjustment, partial, original, replacement, supply list of descriptions for these codes as well
Check Number	Check number for payment made, should match the Check number in the banking file
Bill Type Code	3 digit bill type code identifying the facility, type of service, and frequency
Authorization Number	Denotes whether or not certain procedures or hospital stays were authorized by the health plan
Member ID	Identifier that allows for a member to be uniquely identified, must match the Member ID in the eligibility data
Employee ID	Members from the same family should have same employee ID, must match the employee ID in the eligibility data
Member's Last Name	Last name text format
Member's First Name	First name text format
Member's Gender	Male or female
Member's Date of Birth	Date of birth for the member, should link to eligibility file
Member's Relationship	Relationship to employee such as spouse or child, supply list of descriptions for these codes as well
Patient Account Number	Patient account number as reported on billing form
Benefit Plan	Identifies in which plan the member is enrolled for this date of

	service, supply list of descriptions for these codes as well
Group Number	Identifies in which group the member is enrolled for this date of service, supply list of descriptions for these codes as well
Network Indicator	An indicator of the specific fee schedule that was used for claims payment
Provider ID	Unique identifier for a given provider/supplier of healthcare
Tax Identification Number	Tax identification number for the healthcare provider or organization
Provider Name	Name of the provider performing/providing/rendering the service
Network Provider	Par/nonpar indicator or may include level of participation for specialized networks
Provider Address Line 1	Provider Billing Address Line #1
Provider Address Line 2	Provider Billing Address Line #2
Provider City	Provider Billing City
Provider State	Provider Billing State
Provider ZIP	Provider Billing Zip
Provider Specialty	Indication of the specialty of the provider, supply list of descriptions for these codes as well
Provider Type	Indication of the type of the provider, supply list of descriptions for these codes as well
Place of Service	Indication of the place of service where the healthcare services were provided, supply list of descriptions for these codes as well
Type of Service	An indicator that denotes the Types of Service being provided
Beginning Date of Service	For the individual claim line it is the first date the service was provider to a member
Ending Date of Service	For the individual claim line it is the last date the service was provider to a member
Paid Date	Date the Claim was paid on, all claim lines with the same Claim ID should have the same Paid Date
Received Date	Date the Claim was received from the provider, all claim lines with the same Claim ID should have the same Paid Date
DRG Code	For all inpatient claim lines this is the DRG that is used for pricing
ICD Type	Indication if this record has codes for ICD-9 or ICD-10
Primary ICD Diagnosis Code	Main diagnosis that a member had for this claim
Primary Diagnosis POA Flag	Present on Admission flag for the primary ICD Diagnosis code
Secondary ICD Diagnosis Codes	Secondary diagnosis codes for each claim, most data files have 5-9 secondary codes submitted
Secondary Diagnosis POA Flag	Present on Admission flag for each secondary ICD Diagnosis code
ICD Procedure Codes	All ICD Procedure codes for each claim, most data files have 6-9 ICD Procedure codes
Procedure Code	For the claim line this is the Procedure Code (CPT-4/HCPCS) code that was assigned
Procedure Code Modifier 1	First modifier code for the CPT-4/HCPCS
Procedure Code Modifier 2	Second modifier code for the CPT-4/HCPCS, include additional modifiers if available from data file
Revenue Code	Four digit UB revenue code used to assign a claim line to a revenue center in a facility

Discharge Status	Code used to specify patient discharge status, supply list of descriptions for these codes as well
Units	Units for the procedure code/revenue code for this claim line
Billed Amount	How much the provider billed for the services
Allowed Amount	Payer allowed for this service, typically this is the Billed amount minus the payer's agreed upon discount with the provider
Paid Amount	How much the payer paid for the claim line
Member Copay	Member fixed copay for this claim line
Member Deductible	Member deductible for this claim line
Member Coinsurance	Member coinsurance for this claim line
Other Insurance Indicator	Denotes existence of claimant other insurance for COB purposes
Coordination of Benefits Amount (COB)	Amount that the other insurance has paid for this claim line
Discount Amount	A negotiated discount is subtracted from the billed amount to determine the amount allowed
Non-Covered Amount	The amount of billed that is non-covered under the plan
Non-Covered Reason	An indicator to denote the reason why service was not covered, supply list of descriptions for these codes as well
ITS Serial Number	BCBS plans only
ITS Access Fee	BCBS plans only
Coverage Status	Indicates whether the plan code is active, retiree or COBRA

PROPOSED AUDIT FEES- INDUSTRY & LOCAL 338 WELFARE FUND

Audit Period:	January 1st 2018 - December 31st 2018 through
Medical TPA:	Associated Administrators

Guaranteed Fixed Fee

Seneca perform a comprehensive Medical claims audit, for a fee equal to:

Service	Fee
Comprehensive Medical Audit	$37,500.00

All of the claims audit services and expenses related to the claims audit, **including** one-week on-site analysis at Associated Administrators offices, travel costs and audit remediation are included in the project fee. Fees are payable in three equal installments; the first paid at contract signing, the second paid 60 (sixty) days after contract signing, and the balance paid upon completion of the ***Final Audit Report***.

*When comparing our price to other quotes received, pay particular attention to those that list expenses as an add-on to the fee quotes and those that break out audit remediation into a separate or undefined pricing. The Audit Team believes that claim audits are best quoted as a turnkey solution since most employer groups do not have the healthcare claims expertise to navigate these important final phases of the project without assistance. We price our services to include all necessary portions of the project so the client sees the exact cost for the **entire** project.*