Electric Reliability Council of Texas

FINAL REPORT

Claims Administration Audit and

Electronic Claims Testing of

Connecticut General Life Insurance Company

November 2008

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Project Overview

Sagebrush Solutions LLC (Sagebrush) was engaged by Electric Reliability Council of Texas (ERCOT) to review and evaluate the claims processing services provided on behalf of the ERCOT employee benefit plan by Connecticut General Life Insurance Company (CIGNA). Sagebrush also reviewed some operational aspects at CIGNA consisting of the completion of a detailed administrative questionnaire and review of related documentation including but not limited to operating policies and procedures, SAS 70 reports, HIPAA compliance, and business continuity / disaster recovery. The objectives of the audit were to determine the degree of accuracy with which ERCOT medical and pharmacy claims are processed and provide an overview of CIGNA claims operations. The overall purpose of this review was to provide an independent assessment of CIGNA Healthcare's performance relative to the administration of the ERCOT benefit plan and to identify potential claim overpayments.

Sagebrush conducted an onsite review of claims at the CIGNA location in Denison, Texas starting on August 18, 2008 and ending on August 21, 2008. Additional follow-up audit work was conducted September 19, 2008. During this review, the audit team tested a sample of 200 medical claims for financial and processing accuracy. The claims were tested for eligibility, timeliness, payment accuracy and adherence to plan benefits and administration procedures. The sample was selected from the population of ERCOT medical claims processed between July 1, 2007 and May 31, 2008. A sample of 200 pharmacy claims was also tested for payment and processing accuracy. The pharmacy claims sample was selected from the population of ERCOT pharmacy claims processed between July 1, 2007 and May 31, 2008.

In addition to the statistical claim review, Sagebrush conducted focused reviews on the claims reinsurance process (stop loss), eligibility, standard clinical edits, claims funding review, and duplicate payments.

The following summary provides an overview of the audit findings along with our observations and recommendations. The complete audit results are discussed in the body of the report.

Medical Claim Audit Results

Medical Claims Adjudication Accuracy

The medical claim review identified ten (10) payment errors, Six (6) overpayments totaling $3,225.25 and four (4) underpayments totaling $139.07. The net value of the identified medical payment errors is an overpayment of $3,086.18. Two (2) procedural (non-payment) errors were identified in the sample. CIGNA agreed with eleven (11) of the errors.

- Based on the distribution of the ten (10) financial errors identified in the medical sample, the projected gross financial (dollar) accuracy within the medical claim population is 99.4%. The standard commonly found in the industry for financial accuracy is 99.0%. The reported standard for financial accuracy for CIGNA benefit examiners is 99.0%. The

performance guarantee for financial accuracy is 97.0% and above. There is no performance guarantee for financial accuracy for ERCOT.

- From the extrapolation of the identified payment errors to the medical claim population, our best estimate of the total absolute financial (dollar) error in the population is $21,196.11.

- Ten (10) payment errors were identified in the medical sample. Based on the distribution of the errors, the projected payment accuracy of the medical claim population is 95.0%. Payment accuracy refers to the incidence of correct claim payments. The common industry standard for this measure is 95% - 97%. The reported standard for payment accuracy for CIGNA benefit examiners is 97.0%. There is no performance guarantee for payment accuracy.

- Two (2) procedural errors were assessed during the audit. Based on this result, the projected procedural accuracy of the claim population is 99.0%. The common industry standard for this measure is 95%. The reported standard for non-payment processing accuracy is 95.0%. CIGNA does not have a performance guarantee for procedural accuracy.

The audited results indicate that CIGNA Healthcare's performance for financial accuracy meets the standard for its benefit examiners, the industry standard and the ERCOT performance guarantee.

For payment accuracy and processing accuracy, the audit results are consistent with or exceed industry standards.

Turnaround Time

Turnaround time (TAT) is defined as the total number of days needed to process a claim. Turnaround time is significant from several perspectives. Claims that do not receive prompt consideration when they are submitted can potentially cause member and provider relation difficulties. Secondly, when claim adjudication does not occur promptly, claims are re-submitted by members and providers, increasing claim volume as well as the probability that duplicate claim payments will occur.

Most claim administrators strive to process 85% - 90% of all claims within 14 calendar days and 99% within 30 calendar days. The reported CIGNA office target for TAT is 90% of clean claims within 14 calendar days and 98% within 30 calendar days, excluding adjustments. We were unable to separate clean claims in the data sets provided by CIGNA; therefore, the statistics provided include all claims processed during the period.

- Our testing of the claim population indicates that 91% of all claims were processed within 14 calendar days, and 95% were processed within 30 days.

Based on industry standards, we conclude that CIGNA did not perform adequately with respect to claim turnaround time during the period tested.

Pharmacy Claim Audit Results

Pharmacy Claims Adjudication Accuracy

Sagebrush did not identify any assessable claim exceptions in the three categories tested: financial accuracy, payment accuracy, and procedural accuracy.

Focused Reviews

Sagebrush conducted focused reviews of: potential duplicate payments; stop loss claims; claim payments involving clinical edits; claims funding, and member eligibility. Briefly, our testing revealed:

- Sagebrush conducted a test of potential stop loss claims incurred by member. We found that four (4) members with expenses exceeding the stop loss limit during the audit period. Sagebrush reviewed the stop loss information provided.
- A total of $918.11 in duplicate claim payments were identified and validated during the onsite review.
- Sagebrush conducted an analysis of claim payments involving clinical edits: multiple surgical procedures, incidental procedures and mutually exclusive procedures. Our testing did identify several payment errors but did not reveal a high incidence or significant issues.
- Sagebrush compared the eligibility file provided by ERCOT to eligibility on the CIGNA claims system on several members that appeared to have claims paid after the coverage termination date.
- Sagebrush reviewed claims funding documents against claims payment activity to assess whether the numbers balance.

Observations and Recommendations

The project results indicate that CIGNA Healthcare's performance relative to claims accuracy and timeliness and operational efficiency is generally within acceptable standards and guidelines. Our overall conclusion based on the results of the claim reviews, our observations during the onsite review and the analysis of the administrative questionnaire is that CIGNA claims operations appear to be appropriate and efficient. Based on the results of the claim review there is room for improvement, especially in the area of ineligible members.

The claims operation effectively utilizes technological solutions as evidenced by: the largely paperless environment and efficient claims processing system. The following information provides a summary of our general observations and recommendations relative to the claims and operational review and electronic testing. Additional information is provided in the corresponding sections of this report.

- In review of the claims Turnaround Time (TAT), Sagebrush tested the length of time CIGNA took to process claims and determined that 94.5% of claims were processed within 30 days. This fell short of the industry standard of 99% processed within 30 days.

Recommendation: CIGNA should take necessary measures to ensure timely processing of claims that do not auto adjudicate. The monthly claim volume for ERCOT members is not prohibitively high.

- Sagebrush identified instances in the random sample review and the focused review where multiple surgery cutbacks were not appropriately applied. Errors attributed to clinical editing software issues can be costly in the long run if they go un-checked.

Recommendation: CIGNA should periodically test the clinical editing software to ensure it is accurately applying the appropriate cutbacks for secondary procedures. Overpayments recovered by CIGNA overpayment vendor could be used to train individuals or as a tool to assist with system configuration going forward.

- Sagebrush identified net overpayments amounting to $10,704 during the random sample review and focused tests.

Recommendation: CIGNA should take steps to recover on the identified overpaid claims on behalf of ERCOT.

Medical Sample Selection and Testing

Sagebrush used a stratified random sampling technique to select the medical sample. This technique was selected because it permits the financial results to be extrapolated to the entire population of claims with statistical significance. The estimated sample size for the overall sample was intended to achieve a 95% confidence level with a 3% precision if the payment error rate was 5%. The actual precision rate varies based on the tested error rate.

A sample of 200 medical claims totaling $1,048,908.50 in benefits paid was selected from a population of 14,179 claims paid at $3,344,875.18 for claims incurred and paid during the period of July 1, 2007 through May 31, 2008. The sample was selected from the claim data files provided by CIGNA. For adjusted claims, only the most recent iteration was eligible for selection.

Using a stratified random sampling technique, the claims were selected randomly within each of five payment bands listed below. The strata were selected using an optimal allocation formula that takes into account the actual distribution of the population sampled.

Strata number	Payment range	
1	$0.00	$199.99
2	$200.00	$849.99
3	$850.00	$3249.99
4	$3,250.00	$21,999.99
5	$22,000.00	+

Sample Tests

Each claim in the selected sample was tested for payment and coding accuracy, adherence to plan benefits and administration procedures, and timeliness. Each claim was tested ("re-adjudicated") on the CIGNA claim adjudication system, Proclaim, for financial and procedural accuracy. Claims were compared to system information, original claim documentation (imaged and electronic), plan provisions and written CIGNA policies and procedures. The following elements were tested for each claim:

- Was the paper submission an unaltered original? Did it contain all required information to process the claim?
- Was the claimant eligible for medical benefits on the date(s) of service?
- Was the claim submitted within the specified time as defined by the plan?
- Were managed care discounts and contractual provisions applied correctly?
- Were the procedures covered, billed and paid, and were procedures medically necessary and appropriate according to CIGNA medical review?
- Were claims for multiple procedures, bilateral procedures, unbundled services, and experimental prescription drugs/services submitted to the appropriate levels for review and adjudicated correctly?
- Were benefit coordination and subrogation accurately determined if the claimant had other coverage available?
- Did the correct claimant or assignee receive payment?
- Did the claim contain all required information and was it coded properly in the claim processing system?
- Were benefits applied in accordance with plan requirements?
- Were the mathematical computations and the application of co-payments, out-of-pocket limits, and deductibles accurate?
- Were allowable charge limitations of the plan correctly applied?
- Were preauthorization, second surgical opinion, and ambulatory procedures followed and documented when appropriate?
- Was the claim paid only once?
- Did claim payment response time meet contractual provisions and generally accepted industry standards?

Medical Audit Results

Definition of Accuracy Measures

All claims were tested for accuracy in three areas:

- Financial Accuracy
- Payment Accuracy
- Procedural (non-payment) Accuracy

Descriptions of the accuracy measures are outlined below. Our experience has shown that these measures are commonly found within the industry.

Since the tested medical sample was selected using stratification, the mathematical formulas described below for payment and procedural (non-payment) accuracy are first applied to each stratum. Then a composite rate is developed for the medical population by weighting each stratum based on the relative proportion of the given population stratum to the total population.

Summing the projected absolute dollar error for each claim stratum, and comparing the result to the total paid dollars in the population derive the estimated financial accuracy for the medical claim population. The projected absolute dollar error is based on the average tested dollar error times the number of claims in each stratum.

The sample items were tested for accuracy using the following accuracy measures and formulas:

$$\textbf{Financial Accuracy} = 1 - \frac{\text{Total Projected Absolute Dollar Error for all Claim Strata}}{\text{Total Population Dollars Paid}}$$

For purposes of a claim administration audit, financial accuracy reflects the financial implication of payment errors identified in the audit. The standard commonly found in the industry for financial accuracy is 99%.

$$\textbf{Payment Accuracy} = \frac{\text{Number of Claims Paid Correctly}}{\text{Number of Claims Paid}}$$

Payment accuracy reflects the percentage of claims that result in the correct payment of benefits. The common industry standard for this measure is 95% - 97%.

$$\textbf{Procedural Accuracy} = \frac{\text{Number of Claims without Procedural Errors}}{\text{Number of Claims Paid}}$$

Procedural accuracy reflects the percentage of claims that do not contain coding, data entry, or other errors not resulting in the incorrect payment of the claim. The common industry standard for this measure is 95%.

While procedural errors do not directly have a financial impact, they are noteworthy because procedural errors often lead to future payment errors. An example is when a procedure code on a given claim is keyed incorrectly. A subsequent duplicate payment could occur since the examiner or system logic will not be able to identify the duplicate procedure.

Claims Adjudication Accuracy

In claims with more than one error, one error per claim was counted. If a claim had a financial and procedural error, we counted the financial error. Each identified potential error or question was submitted to CIGNA in writing for review and written response.

A total of ten (10) payment errors were assessed. CIGNA agreed with all ten (10) errors. There were two (2) procedural errors and CIGNA agreed one (1) error and disagreed with one (1) error.

The results of the claim testing are outlined in the following tables. Table 1 provides a summary of the audited accuracy rates, along with CIGNA internal targets and commonly seen industry standards.

Table 2 shows the payment and procedural accuracy rates by medical claim stratum. Composite accuracy rates are derived by weighting the tested error rate for each claim stratum based on the relative proportion of the given population stratum to the total population. The composite rates are included in Table 1.

Table 3 shows the estimated financial accuracy of the medical claim population. Totaling the projected absolute dollar error for each claim stratum and comparing the result to the total paid dollars in the population derive the estimated financial accuracy for the claim population. The projected absolute dollar error is based on the average tested dollar error times the number of claims in each stratum.

Table 1: Summary of Accuracy Rates

Measure	Claim Accuracy	CIGNA Stated Goals	Common Industry Standards
Financial Accuracy	99.4%	99.0%	99%
Payment Accuracy	95%	97%	95% - 97%
Procedural Accuracy	99%	95%	95%

Table 2: Medical Payment and Procedural Accuracy Rates by Claim Strata

Claim Strata	# Of Claims	Sample Size	# Pmt. Errors	Payment Accuracy	# Proc. Errors	Procedural Accuracy
$0 - $199.99	11,922	40	5	87.5%	1	97.5%
$200 - $849.99	1,693	40	0	100%	0	100.0%
$850 – $3249.99	439	40	2	95%	0	100.0%
$3,250 – $21,999.99	115	40	3	92.5%	1	97.5%
$22,000 +	10	40	0	100.00%	0	100.00%
Total/Weighted	**14,179**	**200**	**10**	**95.0%**	**2**	**99.0%**

Table 3: Estimated Financial Accuracy of the Medical Claim Population

Claim Strata	Sample Absolute $ Error	Sample Size	Avg. $ Error	# Of Claims	Projected Absolute $ Error	Paid Population	Financial Accuracy
$0 - $199.99	27.57	40	$0.69	11,922	$8,217.24	$655,188.01	98.7%
$200 - $849.99	$0	40	$0	1,693	$0	$663,736.02	100%
$850 – $3,249.99	417.99	40	$10.45	439	$4,587.44	$680,673.08	99.3%
$3,250 – $21,999.99	$2,918.76	40	$72.97	115	$8,391.44	$684,912.89	98.8%
$22,000 +	$0	40	$0	10	$0	$660,365.18	100%
Total/ Weighted	**$3,364.32**	**200**	**$84.11**	**14,179**	**$21,196.11**	**$3,344,875.18**	**99.4%**

Financial Accuracy

The stratified random sampling method permits projection of the audited financial accuracy rate to the entire population. The auditor's ability to statistically project the audit findings in this manner depends on the sampling technique used.

The tested gross financial error in the medical sample is $3,364.32. Based on the distribution of the errors within the claim strata; our best estimate of the absolute (gross) financial error is $21,196.11 in the paid claim population of $3,344,875.18, resulting in a projected gross financial (dollar) accuracy within the claim population of 99.4%. The standard commonly observed in the industry is 99.0%.

Classification of Errors

The following tables provide a breakdown of the errors identified in the audited samples.

Error Classification	# Of Errors	$ Error
Overpayments	6	$3,225.25
Underpayments	4	($139.07)
Total/Net Error	10	3,086.18

Error Type	#	% Of Total	Absolute $ Error	% Of Total $
Allowable amounts	4	33.3%	$39.50	1.17%
Benefit Type	3	25.0%	$141.83	4.22%
Multiple Surgery Cutback/Assistant Surgeon Cutback	2	16.7%	$3,175.75	94.4%
Charge Previously Considered	1	8.3%	$0.00	0.0%
Incorrect Provider Suffix Chosen	2	16.7%	$7.24	.21%
Total	**12**	**100%**	**$3,364.32**	**100%**

* This list includes two procedural errors.

The medical claim review identified 12 errors. CIGNA agreed with eleven (11) errors and disagreed with one (1) error.

Allowable amounts: Two (2) overpayments totaling $2.00 were identified because the fee schedule was not updated. (Sample Numbers: 7, 39) Two (2) overpayments were assessed because claim did not pay at the proper default percentage in absence of a fee schedule. (Sample Numbers: 38, 121)

Benefit Type: One (1) claim underpaid $.83 because the claim applied a $20.00 co-pay and paid at 90% instead of paying at 100% for lab work. One (1) claim underpaid $111.00 for Emergency Room services because a $250 deductible was taken instead of the $50 Emergency Room co-pay and paying at a 90% coinsurance rate. One (1) overpayment was assessed for a $30 due to an office visit co-pay was not taken. (Sample Numbers: 18, 120, 142)

Multiple Surgery Cutback/Assistant Surgeon: One (1) claim overpaid $2,868.76 because services for Assistant Surgeon were not cutback. One (1) overpayment for $306.99 was assessed for a multiple surgery cutback that was not taken. (Sample Numbers: 98, 153)

Charge Previously Considered: A procedural error was assessed on Sample 26, as a charge was considered twice for the same rendering physician.

Incorrect Provider Suffix: One (1) underpayment of $7.24 was assessed on sample 28 because the out of network provider suffix was chosen for a provider that is in network. A procedural error was assessed on Sample 137, as the provider name on the claim did not match the remit to provider.

Medical Turnaround Time

Turnaround time (TAT) is defined as the total number of days needed to process a claim. The calculation covers the period from the day the claim is received to the day the claim payment is processed, suspended, or denied.

Turnaround time is significant from several perspectives. Claims that do not receive prompt consideration when they are submitted can potentially cause member and provider relation difficulties. Secondly, when claim adjudication does not occur promptly, claims are re-submitted by claimants and providers, increasing claim volume as well as the probability that duplicate claim payments will occur. In addition, delays in processing claims can have an adverse impact on Incurred But Not Reported (IBNR) claims calculations, experience rating and projected loss ratios.

Most claim administrators strive to process 85% - 90% of all claims within 14 calendar days and 99% within 30 calendar days. The reported CIGNA office target for TAT is 90% of all clean claims within 14 calendar days, excluding adjustments.

The following tables represent the TAT statistics for the CIGNA claim population for claims incurred and processed during the period July 1, 2007 through May 31, 2008. We were unable to differentiate clean from non-clean claims in the data sets provided by CIGNA; therefore, the statistics provided include all claims processed during the period. For adjusted claims, the final disposition is included.

Claim Population Turnaround Time

Calendar Days	Number of Claims	Percentage of Pop.	Cumulative Calendar Days	Cumulative Number of Claims	Cumulative Percentage Of Pop.
0 – 7 days	12,413	83.54%	7 days	12,413	83.54%
8 – 14 days	1090	7.34%	14 days	13,503	90.88%
15 – 21 days	332	2.23%	21 days	13,835	93.11%
22 – 30 days	214	1.44%	30 days	14,049	94.55%
31 – 60 days	353	2.37%	60 days	14,402	96.92%
Over 60 days	457	3.08%	Over 60 days	14,859	100.00%

Our analysis indicates that CIGNA processed 91% of all claims within 14 calendar days of receipt. CIGNA processed 95% of all claims within 30 calendar days.

The TAT does not meet the industry standard of 99% of all claims in 30 days.

Pharmacy Audit Results

Sample Selection

A random sample of 200 pharmacy claims totaling $15,144.75 in paid dollars were selected and tested from the population of ERCOT pharmacy claims processed by CIGNA Pharmacy Management. CIGNA provided Sagebrush with claim screen prints to review the pharmacy payments.

Sample Tests

Each ERCOT pharmacy claim in the selected sample was tested for payment and dispensing accuracy and adherence to plan benefits and administration procedures.

CIGNA uses the Average Wholesale Price (AWP) minus a discount and Maximum Allowable Cost (MAC) to determine reimbursement rates.

The following elements were tested for each claim:

- Was the claimant eligible for benefits on the date(s) of service?
- Did the correct claimant or assignee receive payment?
- Were benefits applied in accordance with plan requirements?
- Were the claims accurately priced using the appropriate and most current AWP, MAC, U&C, or submitted charge allowances?
- Were the mathematical computations, discounts, the application of co-payments, and professional fees accurate?

Results

Financial Accuracy: The tested financial accuracy rate of the sample is 100 percent. This accuracy exceeds the CIGNA internal goal of 99.3 percent and the generally observed industry standard of 99.0 percent.

Payment Accuracy: The payment accuracy rate for the audit sample is 100 percent. This accuracy exceeds the CIGNA internal goal of 98.0 percent and the generally observed industry standard of 95.0 to 97.0 percent.

Procedural Accuracy: The procedural accuracy rate for the audit sample is 100 percent. We did not identify any procedural errors. This accuracy exceeds the CIGNA internal goal of 95.0 percent. This accuracy rate exceeds the generally accepted industry standard of 95.0 percent.

The table below outlines the results of the audit sample.

	ERCOT Pharmacy
Number of Claims Sampled	200
Dollar value of Sample	$15,144.75
Dollar value of Overpayments	$0
Dollar Value of Underpayments	$0
Number of Payment Errors	0
Number of Procedural Errors	0
Financial Accuracy Rate	100%
Payment Accuracy Rate	100%
Procedural Accuracy Rate	100%

Focused Review Results

In addition to the statistical claim review, Sagebrush conducted four (4) focused reviews. We electronically tested the claims data to identify potential duplicate claim payments. We tested the population to identify members above the individual stop loss level of $125,000. We analyzed medical claim payments utilizing Clinical Editing Software. We tested a sample of claims for eligibility. During the onsite claim review, Sagebrush validated those claims identified as potential errors.

Stop Loss Review

ERCOT reinsured with CIGNA on losses over $105,000. Sagebrush conducted a test of claims processed between July 1, 2007 and May 31, 2008 for individuals that accumulated claims that exceeded $100,000 to determine whether the claims paid in excess of the stop loss threshold were properly sent for re-insurance. Sagebrush identified four individuals that incurred claims in excess of $100,000 and all four episodes properly triggered the re-insurance mechanism at the proper attachment point.

Duplicate Payment Review

Sagebrush tested the claims processed between July 1, 2007 and May 31, 2008 for potential duplicate payments. In a preliminary diagnostic test, we identified potential duplicate payments. The actual duplicates can only be verified with an onsite assessment of each individual claim.

During the onsite visit, we validated a sample of 40 sets of payments that had been identified as potential duplicates. Each set had two or more payments. The validation process determined which claims were duplicate payments, contained a related error, or were paid correctly.

Sagebrush reviewed the claims and the member's history applying the rule that the most recent payment is considered the duplicate payment unless the available information indicates otherwise. Sagebrush tested the sample and provided CIGNA with the listing of claims that were identified as potential errors. CIGNA reviewed the claims and provided Sagebrush with their findings.

Results

In the 40 sets Sagebrush identified nine (9) duplicate payments, totaling $2,318.43. CIGNA agreed to seven (7) of the overpayments for $918.11.

Clinical Edits

Sagebrush conducted an analysis of claim payments involving standard clinical edits for: age, gender, cosmetic procedures, mutually exclusive procedures, multiple surgical procedures, global fees, and unbundling procedures. Sagebrush reviewed the claims history against our Clinical Editing Software. This software is widely used by payers in the industry to perform clinical editing on claims during processing. The results provide a comparison of CIGNA's multiple surgery edits against those programmed within Proclaim. Sagebrush does not customize the multiple surgery edits within the software; therefore, our test results are often more aggressive (cutbacks are more frequent) than those seen at payers whom customize the program or use other coding packages.

Our testing did not reveal a high incidence of claims that were not reduced according to multiple surgery guidelines. The testing identified a rather small population of claims with potential multiple surgery processing issues as defined by the Clinical Editing Software edits. A sample was reviewed onsite. The majority of the claims reviewed were false positives that either had been reduced or reduction was not required as the procedures were in separate surgical sites. For those claims reviewed that had not been reduced per Clinical Editing guidelines, it appeared the absence of a reduction was due to differences in the edits between the Sagebrush Clinical Editing Software and the CIGNA software.

Results

- Sagebrush reviewed eighty (80) claims with potential mutually exclusive services. Five (5) claims were submitted to CIGNA with overpayments for $302.37. CIGNA agreed with four (4) for $281.07.
- Sagebrush identified twenty-five (25) potential multiple surgery episodes to determine whether the proper multiple procedure cutback was applied. Fifteen (15) claims were identified not taking the multiple surgery reduction for $6,305.18. CIGNA agreed with ten (10) errors for $4,892.71
- Sagebrush reviewed fifty-seven (57) claims with procedures that may be incidental to another billed procedure on the same date of service. Seventeen (17) claims were submitted to CIGNA to review for $4,801.14. CIGNA agreed with one (1) overpayment for $681.67.

Based on the outcomes of all other claims in our analysis and the lack of clinical edit errors in the medical sample, it appears that the CIGNA clinical editor is performing appropriately.

Eligibility Test

ERCOT provided Sagebrush with the eligibility files for the audit period July 1, 2007 – May 31, 2008. Sagebrush electronically compared the eligibility files to the dates of services for claim payments in the CIGNA claims payment file.

We compared the ERCOT eligibility files to each claim in our sample and identified potential overpayments.

We selected a sample of claims from an electronic audit of payments to members who had a change in coverage and were potentially ineligible.

Results

Sagebrush identified eleven (11) members, based on the eligibility file provided by ERCOT, that had claims paid after the policy termination date. Eligibility information later verified on the CIGNA claims system revealed that ten (10) members had COBRA that extended coverage beyond the date noted in the ERCOT eligibility file. One (1) member had matching termination dates between ERCOT and CIGNA with overpayments totaling $190.26.

Claims Funding Test

Sagebrush conducted a review of claims funding transfers made by ERCOT against the claims data to ensure the funding reports matched the value of claims paid by CIGNA. ERCOT provided Electronic Funds Transfer data and claims data for review and CIGNA presented check log documents. Our analysis determined that the ERCOT funding matched the claim expenditures within 2.7 percent. ERCOT wired $4.6 million to CIGNA for claims paid during

the audit period and CIGNA paid $4.7 million in claims. The difference is attributable to claim adjustments and to some extent the timing.

Medical Claim Administrator Questionnaire

Prior to conducting the onsite review, CIGNA provided Sagebrush with a completed copy Operational Questionnaire. The administrative questionnaire addressed issues such as system capabilities, claim adjudication procedures, member services, mail processing, quality assurance, training and staffing.

The following topics were touched on the Operational Questionnaire:

Eligibility and Enrollment

Prior to January 2008 eligibility maintenance was maintained by ERCOT on the CIGNA access website. Starting in January 2008, ERCOT began providing an automated file with eligibility updates on a weekly basis. An eligibility determination is made for paper claims submitted during the indexing process performed at the mail center. The processor matches the claim to a member on file based on the employer group, name, address and/or SSN. If a match is not found, the claim is returned to the sender. An electronic claim is rejected at the gateway.

Active eligibility information is generally not archived. It remains on the system for seven (7) years.

Retroactive terminations are the responsibility of the Eligibility Department. In case of retroactive terminations, the claims history is reviewed for claims that were processed after the termination date. Overpayment requests are sent on overpaid claims that result from retroactive terminations and are pursued by CIGNA's overpayment recovery vendor.

CIGNA verifies dependent student status by sending student verification letters on August 1st. If CIGNA does not receive a response by October 15th or the dependent is no longer a student, the dependent is terminated effective September 30th.

CIGNA investigates coordination of benefits on a rolling 14-month basis. Claim Processors request COB information by utilizing a message on EOB's or correspondence letter. CIGNA accepts response by mail or by telephone.

Claims Processing

CIGNA notes that 83.7% of received claims are by electronic submissions and the auto-adjudication rate for ERCOT claims is 80.7%. Claims that are not auto-adjudicated are routed to

claim processors by iTrack, CIGNA Healthcare's workflow application that electronically routes pended claims and correspondence.

CIGNA processes ERCOT claims on the Proclaim claims system. Based on our observations, the system seems to perform adequately. The system appears to have sufficient edits and accumulators as evidenced by the low incidence of accumulator errors. It is reported that the system utilizes ClaimCheck clinical editing and unbundling software package.

The computer disaster recovery and business continuity plans described by CIGNA are appropriate and adequate. These plans are reviewed and tested routinely to ensure accuracy and completeness and to ensure that recovery time is well within standard parameters. CIGNA also conducts a routine backup of claims data for disaster recover purposes.

CIGNA indicates that in 2008 there are 52 management/supervisory staff, 294 examiner/processor staff members and 2 technical staff in the Denison office claims department. There are 5 claims processors dedicated to the ERCOT account.

Customer Service

CIGNA has a service unit separate from claims processing to handle member service phone calls. A designated call unit handles ERCOT inquiries. The average call wait time is 15 seconds.

The primary responsibility of the Customer Service Representative is to handle phone calls from members and providers. CSR's access the processing system and claims history using a desktop tool called iCare. The eTalk call monitoring system has two components that allow review of the audio portion of the call as well computer movements, keyboard strokes and, mouse movements. Ten calls a month are reviewed. Customer Service Representatives average 65-75 calls a day
The CSR is authorized to make simple claim adjustment while the caller is on the line. All other adjustments are documented in iCare and sent high priority electronically to the adjustment team.

Quality Assurance

CIGNA has an internal quality assessment (QA) program at the Denison office and at the corporate level. The QA department has several components of quality review that include pre-disbursement reviews as well as post disbursement reviews. Random sample reviews are conducted on 2-3% of claims for each processor. In addition, high dollar claims receive multiple levels of review to ensure accuracy before payment is released.

Each claim is reviewed for system applications, eligibility, provider information, claims processing. The assessment measures financial accuracy, but there is no internal tracking for payment accuracy and procedural accuracy. Errors identified are captured and reported to the Claims Managers. The examiner is given the opportunity to provide additional information to substantiate their actions, as appropriate.

The Quality results are used to identify and track specific issues and trends. Results are utilized to provide ongoing education and training and to identify situations where focused audits would be appropriate.

Corporate quality standards are also measured tracking claims processors for financial accuracy, payment accuracy and procedural accuracy. Claims Processors are promoted and receive salary increases based on these performance reviews.

Training

Claims Processing

CIGNA maintains a formal training program. All processors are not required to have prior health claim processing experience. The initial training program consists of three months of formal claims processing training conducted in classroom, along with computer-based and one-on-one settings.

New benefit examiners take a series of tests that determine areas where additional training is needed. Each trainee is under 100% review and must meet appropriate quality standards prior to release. CIGNA has specific training modules that can be customized to meet the individual needs of an examiner based on ongoing assessments.

Ongoing training needs are identified through the internal quality program and supervisor feedback. Refresher training and instruction on new procedures is provided to all employees on an as needed basis.

Utilization Review and Case Management

CIGNA maintains an in house Utilization Review (UR) Department. The Utilization Review Program is designed to manage the utilization of resources provided to members and allows providers to discuss concerns with CIGNA representatives. UR activities are conducted in accordance with standards developed by the CIGNA Medical Advisory Committees, specialty panels, and internal medical staff.

Inpatient Preauthorization

ERCOT has selected the PHS medical management model. Preauthorization is required for all inpatient hospital stays under this model. CIGNA posts its current review list requiring preauthorization on their website and updates any changes on an ongoing basis.

The member's network provider is responsible for preauthorizing in-network care.

For other out-of-network and out-of-area care, the provider typically secures authorization of charges. Patients are encouraged to work with providers on out of network stays to ensure authorization is secured to avoid penalties.

Preauthorization standards are based on clinical screening criteria to ensure eligibility of services, cost efficiency, medical necessity, and appropriateness. Nurses determine medical necessity and length of stay with the help of Intracorp Care Facilitation Center. Claim Nurse Reviewers (CNR) and the Care Facilitation Centers enter all certifications into the ICMS utilization management system. ICMS interfaces with eligibility, the provider module, and the claims system to support auto adjudication of claims. Authorizations are reviewed according the following criteria:

- Appropriateness of procedure
- Location and level of care
- Length of stay
- Appropriateness of pre-operative days
- Assignment of next review date

ICMS is also an automated tool that empowers staff to identify potential candidates for case management. It is used to identify risk factors such as diagnosis of chronic conditions, sudden catastrophic occurrences, abnormal utilization patterns, and specialty referrals.

Fraud and Abuse Program

CIGNA has internally developed a fraud detection program. This program is designed to detect aberrant utilization and/or billing patterns through the analysis of claims information, anti-fraud education of CIGNA staff and standardized policies and procedures.

CIGNA Healthcare's Internal Audit Department Special Investigations (SI) is responsible for minimizing CIGNA Healthcare's risk to healthcare fraud. The SI team partners with Claims Operations to identify suspicious claims and patterns of potential fraud. The SI team also works with federal and state law enforcement agencies and regulatory agencies to detect, prevent, and prosecute healthcare fraud.

Claim processors and customer service representatives are trained to identify potential fraud. Claims that meet criteria for potential fraud are referred to the SI unit for investigation and supporting documentation.

CIGNA Healthcare utilizes claim system controls to reduce the risk of fraud and abuse. This includes software that rebundles fragmented claims, reasonable and customary guidelines, duplicate edits and hospital bill audit indicators.

HIPAA Compliance

CIGNA provided a copy of their HIPAA overview and guidelines as. The overview outlines CIGNA Healthcare's commitment to protecting members' privacy and confidentiality in accordance with HIPAA privacy regulations.

Sagebrush observed that confidential information is contained in their secure internal operating system and access to such information is limited to those individuals who need access to perform their specific job functions.

CIGNA protects private health information through physical and system security measures, including passwords, filing documents and limited system access to the individuals who perform the functions. CIGNA enforces a strict policy that restricts the exchange of PHI to secure e-mail server when communicating externally. CIGNA employees are trained on HIPAA privacy rules and CIGNA privacy policy and procedures. CIGNA Healthcare has moved away from using the member's SSN as an identification number and currently creates a unique alpha - numeric 9-digit identifier.

Refund Recovery

Overpayments are refunded to CIGNA and credited to ERCOT through either the normal refund recovery process or a provider settlement. Once a refund is posted to a member's account it cannot be removed. As a refund is posted to the claims system, the refunded amount flows into the group's bank account.

Normal Refund Recovery Process

CIGNA Healthcare has several methods by which overpayments can be identified and recovered. An internal department is in place that identifies and recovers potential overpayments. CIGNA contracts with an overpayment vendor to identify and recover overpayments. CIGNA also utilizes a vendor that specializes in COB overpayment identification and recovery. Vendor recoveries are received through weekly reports and recoveries are processed on the claims system within 7-10 days.

In the event an overpayment is identified, CIGNA generates a refund request letter that is mailed to the provider requesting return of the overpayment. In an instance where the provider has disputed the amount overpaid or a settlement was made to obtain the refund, the amount recovered will be posted to the member's claim history and the client's bank account. In the rare instance that a refund cannot be processed to the member's account, CIGNA will credit ERCOT's bank account.

Provider Settlements

CIGNA does not have guidelines or corporate policy related to provider settlements.

Stop Payments / Voided Checks

CIGNA Healthcare issues, voids, stops, and refunds checks using CIGNA Healthcare's Issuance and Repository Processing System (CHIRPS).

Medicare Coordination and Medicare Secondary Payor

Each claim is verified for Medicare status against the membership file. CIGNA identifies Medicare as potentially the primary plan using the member's age, end stage renal disease (ESRD) status, disability and employment status. CIGNA will also identify a Medicare member if a Medicare EOB is received in the mail, or if information is received from a Medicare Secondary Payor (MSP).

Once documentation is received that shows Medicare coverage, the eligibility system and the claims system are updated to reflect the changed status and whether Medicare is the primary or secondary coverage. Additionally, CIGNA is contracted with a COB vendor that specializes in COB identification.

Claims for Medicare eligible members who are enrolled in the ERCOT plan and are not enrolled in Medicare are processed with ERCOT as the primary responsibility.

Pharmacy Administrator Questionnaire

CIGNA provided Sagebrush with a completed copy of the Pharmacy Operational Questionnaire after the onsite review was completed. The administrative questionnaire addressed issues such as system capabilities, claim adjudication procedures, member services, mail processing, quality assurance, training and staffing.

The following topics were touched on the Operational Questionnaire:

Pharmacy Eligibility and Enrollment

Prior to January 2008 eligibility maintenance was maintained by ERCOT on the CIGNA access website. Starting in January 2008, ERCOT began providing an automated file with eligibility

updates on a weekly basis. Discrepancies identified by CIGNA are returned to ERCOT for research and clarification.

Active eligibility information is generally not archived. Eligibility information does not purge from the Central Eligibility Database (CED).

Retroactive terminations are the responsibility of the Eligibility Department. In case of retroactive terminations, the claims history is reviewed for claims that were processed after the termination date. CIGNA will review the file for potential overpayments if ERCOT places a request to do so.

Pharmacy Claims Processing

CIGNA notes that 99 % of pharmacy claims are received by electronic submissions and the auto-adjudication rate for ERCOT claims is 100 %. Manual intervention is limited to keying paper claim submissions. When paper claims are received they process through the regional mail center where they are imaged and prepped for procession using iTrack. ITrack is a mail management system designed as an online mail repository and claims monitoring module.

ERCOT pharmacy claims are processed on the ARGUS system. Sagebrush is unable provide an evaluation of ARGUS as the system was not made available. CIGNA provided screen prints for the claims review.

CIGNA indicates that in 2008 there are 45 management/supervisory staff, 154 pharmacists, 118 pharmacy technicians, and 18 claims processors.

Pharmacy Customer Service

Pharmacy claims customer service is part of a combined unit with pharmacy claims processing. The average call wait time is 25 seconds and the call unit answered over a half million calls during the audit period.

The primary responsibility of the Customer Service Representative is to handle phone calls from members and providers. CSR's have online access to eligibility, benefits, and 13 months of claims history. Claims history older than 13 months can be requested from archives as needed. CIGNA randomly monitors calls for accuracy, tone and, responsiveness using a tool called eTalk. The eTalk call monitoring system has two components that allow review of the audio portion of the call as well computer movements, keyboard strokes and, mouse movements. Ten calls a month are reviewed. Customer Service Representatives average 80 calls a day.
The CSR does not have the authority to adjust claims and routes requests for claim adjustments to the adjustment team.

Pharmacy Quality Assurance

CIGNA performs random audits of claims processed chosen from the processor productivity reports. Each month 30 claims are randomly selected for each processor from the processor productivity reports. Claims are tested for payment accuracy, financial accuracy, and non-payment accuracy.

Pharmacy Training

Claims Processing

CIGNA maintains a formal training program. All processors are not required to have prior health claim processing experience. New claim processors undergo a two to three month training program in a classroom setting. Processors learn core basics in coding and terminology and build on those skills until they master more complex skill development and claims scenarios. CIGNA utilizes modules called Just in Time Delivery that match to the new hires skill level.

New pharmacy examiners take a series of tests to certify levels of mastery. . Each trainee is under 100% review and must meet appropriate quality standards prior to release.

Ongoing training is provided to all employees to keep up with changes to benefit plans, internal procedures, legislation, and system enhancements.

Pharmacy Fraud and Abuse

CIGNA Pharmacy Management has an audit program that is administered in partnership with CIGNA Healthcare’s audit vendor. CIGNA Pharmacy Management and the audit vendor review 100 percent of all pharmacy network claims.

CIGNA also administers a Desk Top audit program performed by pharmacy professionals utilizing monthly analysis of claims data with the purpose of reviewing trends and inconsistencies.

An On-Site review can be administered by CIGNA as well. On-Site reviews are performed by pharmacy professionals and are designed to build program compliance and to deter fraudulent behavior. CIGNA identifies pharmacies that deviate from normal plan percentages through statistical analysis and identifies potential candidates for an on-site review.

Overall Conclusions

Our review of the CIGNA systems encompassed the on-line testing of each claim in the statistical sample. Our on-line testing consisted of "re-adjudicating" each of the claims sampled, just as a CIGNA examiner would have paid the claim using the CIGNA system. Our review did not include the application of CIGNA systems to functions beyond the scope of claims processing, such as member services, utilization management or general financial functions.

Based on the responses provided in the questionnaire, our understanding of CIGNA operations, and our testing of claims in the statistical claim audit, we conclude that CIGNA has appropriate and adequate guidelines and processes for each of the areas discussed above.

Random Sample Errors

Ref #	Payment	Correct Payment	Payment Error	Financial Error (Y/N)	Procedural Error (Y/N)	Error Description	Status
7	$37.00	$36.00	$1.00	Y	N	Incorrect fee schedule or old fee schedule	Agree
18	$44.64	$45.47	($0.83)	Y	N	Lab charge paid at 90% instead of 100%	Agree
26	$0.00	$0.00	$0.00	N	Y	Charge for same rendering twice	Disagree
28	$148.20	$155.44	($7.24)	Y	N	Paid service with out of network provider suffix in error/Par Provider	Agree
38	$111.08	$93.58	$17.50	Y	N	Claim should pay at default rate of 50%	Agree
39	$27.00	$26.00	$1.00	Y	N	Incorrect fee schedule or old fee schedule	Agree
98	$1,387.54	$1,080.50	$306.99	Y	N	Multiple Surgery cutback not taken	Agree
120	$1,212.00	$1,101.00	($111.00)	Y	N	Claim should have with ER co-pay and 90% co-insurance	Agree
121	$4,307.83	$4,327.83	($20.00)	Y	N	Claim should pay at default rate of 30%	Agree

Ref #	Payment	Correct Payment	Payment Error	Financial Error (Y/N)	Procedural Error (Y/N)	Error Description	Status
137	$1,159.61	$1,169.61	$0.00	N	Y	Provider name on claim did not match remit to provider	Agree
142	$1,815.70	$1,785.70	$30.00	Y	N	Claim did not take Office Visit Co-pay	Agree
153	$3,816.00	$947.24	$2,868.76	Y	N	Claim did not take cutback for Assistant Surgeon charge	Agree

CIGNA RESPONSE

Denison Service Center

Denison, TX.

Claims Audit Report of CIGNA Corporation

Medical Claim Processing
Pharmacy Claim Processing

Electric Reliability Council of Texas

October 2008

Executive Summary:

Sagebrush Solutions Audit Objectives
To determine the degree of accuracy with which ERCOT medical and pharmacy claims are processed and provide an overview of CIGNA claims operations.

CIGNA Claim Accuracy Commitment to Electric Reliability Council of Texas

Medical Stratified Random Sample

CIGNA appreciates the feedback received from Sagebrush Solutions during this audit. The results of this review will be an integral part of our continuous Quality Improvement on behalf of Electric Reliability Council of Texas (ERCOT). We are very pleased with Sagebrush Solutions' findings for the Medical claim sample.

Medical	Industry Standard	Sagebrush Results Calculations
Financial Accuracy	99%	99.4%
Payment Accuracy	95% - 97%	95%
Processing Accuracy	95%	99%

The Client Service Partner has worked directly with the Claim Service Manager to provide appropriate feedback and training to the processing staff as a result of the errors identified during this audit.

In the medical claim sample of 200 claims, CIGNA agrees with most of the observations in the stratified random claim selection with the exception of:

Claim Sample #26 – Charge Previously Considered

For this sample both claims were billed with different tax identification numbers, group names, addresses and different total charges. A call to the provider was made on the sample claim, to validate the charges. Although the same rendering provider was noted on both bills, the provider we consulted did indicate the second billed service was not performed by their group. Based on our standard operating procedures and system edits for determine potential duplicate charges, along with the differences in the providers' billings, CIGNA believes these claims do not represent duplicate charges. Often with radiology procedures, CIGNA will receive separate billings for the professional and technical components of the procedure.

CIGNA's claim systems contain an effective process for duplicate identification that could fall into seven different categories. The most frequently identified are "Exact" duplicates or "Possible" duplicates. The system will compare the provider name, date of service, type of service and charges to flag for duplicate services.

Pharmacy Stratified Random Sample

We are extremely pleased with the Pharmacy audit findings reported by Sagebrush Solutions as they noted a result of 100% in each quality category listed below.

Pharmacy	Industry Standard	Sagebrush Results Calculations
Financial Accuracy	99%	100%
Payment Accuracy	95% - 97%	100%
Processing Accuracy	95%	100%

Time to Process
Sagebrush Solutions notes that CIGNA does not meet industry standards or CIGNA's internal goals for claim processing timeliness, specifically in the "percent processed within 30 calendar days" category. CIGNA disagrees with this statement. Time to process is systemically calculated on all claims, taking into consideration unclean claims where CIGNA was required to obtain information from the provider or member in order to finalize the claim. The data file used by Sagebrush Solutions does not contain all of the information required for this calculation.

ERCOT and Sagebrush Solutions are valued business partners and we look forward to reviewing the details of this audit with ERCOT and Sagebrush Solutions. CIGNA thanks Sagebrush Solutions for their work and the opportunity to respond to this draft report.

Recommendations & Responses

The following responses are related to the random sample review performed by Sagebrush.

Finding 1	In review of the claims Turnaround Time (TAT), Sagebrush tested the length of time CIGNA took to process claims and determined that 94.5% of claims were processed within 30 days. This fell short of the industry standard of 99% processed within 30 days
Recommendation	CIGNA should take necessary measures to ensure timely processing of claims that do not auto adjudicate. The monthly claim volume for ERCOT members is not prohibitively high.
CIGNA's Response	Sagebrush Solutions notes that CIGNA does not meet industry standards or CIGNA's internal goals for claim processing timeliness, specifically in the "percent processed within 30 calendar days" category. CIGNA disagrees with this statement. Time to process is systemically calculated on all claims, taking into consideration unclean claims where CIGNA was required to obtain information from the provider or member in order to finalize the claim. The data file used by Sagebrush Solutions does not contain all of the information required for this calculation. The Denison Service Center's Year-to-Date Turnaround Time results through August 31st are as follows: ▪ 96.0% of claims processed within 14 calendar days, and

	▪ 98.7% of claims processed within 30 calendar days.

Finding 2	Sagebrush identified instances in the random sample review and the focused review where multiple surgery cutbacks were not appropriately applied. Errors attributed to clinical editing software issues can be costly in the long run if they go un-checked.
Recommendation	CIGNA should periodically test the clinical editing software to ensure it is accurately applying the appropriate cutbacks for secondary procedures. Overpayments recovered by CIGNA overpayment vendor could be used to train individuals or as a tool to assist with system configuration going forward.
CIGNA's Response	CIGNA's Policy and Procedures team continuously monitors the success of the claim system and clinical editing software, along with changing industry coding standards to consider potential system updates. The majority of the errors within the multiple surgery reduction category were the result of processor error rather than system edits, and as a result, each error was shared with the individual processors' managers for individual coaching and feedback. Additional refresher training is being provided to entire processing team regarding correct application of Multiple Surgery Reduction provisions. For overpayments received by CIGNA, reports are regularly produced outlining overpayment data by reason code, provider, market, claim office, etc. and provided to an internal CIGNA team dedicated to analyzing trends and implementing error resolution. In addition, the claim offices are provided with error trend reports for their office on a monthly basis. These reports include summary level information, as well as detailed overpayment data at the individual claim processor level. These reports are also used for global claim office training and for individual processor re-training. Additionally, CIGNA monitors claim adjustment data for service improvement opportunities. Claim adjustments, while not always a result of an error, represent rework in the process. CIGNA strives to reduce rework by embracing Six Sigma concepts and methodologies to aid in identifying service improvement opportunities. Claim adjustment data, along with claim audit findings and customer feedback, are incorporated into our Six Sigma Quality improvement projects and work teams.

Finding	Sagebrush identified net overpayments amounting to $10,704.00 during the random sample review and focused tests.

Recommendation	CIGNA should take steps to recover on the identified overpaid claims on behalf of ERCOT.
CIGNA's Response	CIGNA has begun the steps in recovering all overpaid claims that were identified during the audit process. All overpayments were sent to CIGNA's overpayment recovery vendor, Accent, on August 27, 2008 to begin the recovery process. Also, any underpayments that were identified were reprocessed with additional payment on August 30, 2008.

The following responses are related to the focused review performed by Sagebrush. While some minor incidences were identified, because it is a focused review, it would not be considered statistically valid and does not represent the results of overall claim processing.

Finding	In the 40 sets Sagebrush identified nine (9) duplicate payments, totaling $2,318.43. CIGNA agreed to seven (7) of the overpayments for $918.11.
CIGNA's Response	All overpayments identified during the focused review were referred to Accent Recovery Services on October 14, 2008. CIGNA claim systems contain an effective process for duplicate identification that could fall into seven different categories. The most frequently identified are “Exact” duplicates or “Possible” duplicates. The system will compare the provider name, date of service, type of service and charges to flag for duplicate services.

Finding	▪ Sagebrush reviewed eighty (80) claims with potential mutually exclusive services. Five (5) claims were submitted to CIGNA with overpayments for $302.37. CIGNA agreed with four (4) for $281.07. ▪ Sagebrush identified twenty-five (25) potential multiple surgery episodes to determine whether the proper multiple procedure cutback was applied. Fifteen (15) claims were identified not taking the multiple surgery reduction for $6,305.18. CIGNA agreed with ten (10) errors for $4,892.71 ▪ Sagebrush reviewed fifty-seven (57) claims with procedures that may be incidental to another billed procedure on the same date of service. Seventeen (17) claims were submitted to CIGNA to review for $4,801.14. CIGNA agreed with one (1) overpayment for $681.67.
CIGNA's Response	All overpayments identified during the focused review were referred to Accent Recovery Services on October 14, 2008. Each error was shared with the individual processors’ managers for individual coaching and feedback.

Finding	Sagebrush identified eleven (11) members, based on the eligibility file provided by ERCOT, that had claims paid after the policy termination

	date. Eligibility information later verified on the CIGNA claims system revealed that ten (10) members had COBRA that extended coverage beyond the date noted in the ERCOT eligibility file. One (1) member had matching termination dates between ERCOT and CIGNA with overpayments totaling $190.26.
CIGNA's Response	The one member that was identified as terminated and having claims with overpayments totaling $190.26, has been sent to CIGNA's overpayment recovery vendor, Accent, for recovery on October 14, 2008.

Finding	Sagebrush conducted a review of claims funding transfers made by ERCOT against the claims data to ensure the funding reports matched the value of claims paid by CIGNA. ERCOT provided Electronic Funds Transfer data and claims data for review and CIGNA presented check log documents. Our analysis determined that the ERCOT funding matched the claim expenditures within 2.7 percent. ERCOT wired $4.6 million to CIGNA for claims paid during the audit period and CIGNA paid $4.7 million in claims. The difference is attributable to claim adjustments and to some extent the timing.
CIGNA's Response	The data file provided to Sagebrush Solutions for data analysis and audit sample selections contained finalized claim transactions during the audit scope period. Claims on the data file represented fee for service claims that were either paid, adjusted, or denied along with the date the claim was finalized by the claim processor. The data file does not include the date the check was cut or cleared, nor the date funding was requested from ERCOT. Additionally, the claim data file does not include any claim administration fees that may have been charged to ERCOT. As noted by Sagebrush, differences between the funding file and the claims paid file can be a result of the timing difference between claim finalization and claim funding. For example, if a claim was finalized by a processor during the last few days of the scope period, based on the funding cycle for the provider in question the actual payment (funding) may not occur for a few days (outside of the scope period). In this case the issuance of the funds by ERCOT would not be an exact match to the claims data file. CIGNA provided check log documents to Sagebrush to support the funding requests made from ERCOT. Due to the differences in the data sources, a 2.7% variance appears reasonable.
Finding	Operational Review: Based on the responses provided in the questionnaire, our understanding of CIGNA operations, and our testing of claims in the statistical claim audit, we conclude that CIGNA has appropriate and adequate guidelines and processes for each of the areas discussed above.
CIGNA's Response	CIGNA is pleased with Sagebrush Solutions findings that our operational procedures and controls appear appropriate and adequate.