Wolcott & Associates, Inc.

October 28, 2022

City of San Luis
1090 E. Union Street
San Luis, AZ 85349

Dear Ladies and Gentlemen:

We have completed our review and test procedures related to the claim processing of 90 Degree Benefits using the Siarmed network as they relate to the City of San Luis (City) for the period September 1, 2021 through August 31, 2022.

The review and test procedures performed were as described in our proposal dated August 2, 2022 and as agreed to in our contract with the City, which became effective on September 22, 2022.

As requested by the City, the scope of our services was limited and does not constitute a financial statement audit made in accordance with generally accepted auditing standards. As a result, we do not express an opinion on any of the financial statement elements relating to the City or the health care benefits portion thereof. Projection of any evaluation of the system of internal controls to future periods may produce inaccurate results due to changes in conditions and/or the degree of compliance with procedures.

Other than those reported herein, no matters came to our attention that cause us to believe that claims filed under the self-insured, health care plan portion of the City are not processed and paid in accordance with the contractual agreements between City and 90 Degree Benefits using the Siarmed network.

We appreciate the opportunity to be of service to the City.

Yours truly,

Wolcott & Associates, Inc.

City of San Luis Healthcare System Audit of the Healthcare Plan's Administrator By 90 Degree Benefits Using the Siarmed Network

For the Period September 1, 2021 to August 31, 2022

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Exhibits

I - INTRODUCTION

The City of San Luis (City) sponsors a self-funded health care plan which is administered by 90 Degree Benefits using the Siarmed network. The plan provides medical, dental and prescription drug benefits for City employees and their eligible dependents electing coverage under the plan. For purposes of this audit, only medical and dental claims were considered in the testing.

SCOPE OF SERVICE

Wolcott & Associates, Inc. was engaged to conduct an audit of the plan's administration at 90 Degree Benefits using the Siarmed network.

The scope of our services included:

- Conduct a statistically valid claim audit to measure the claim payment accuracy for medical claims processed under the plan.

AUDIT TIMING AND STAFF

We began preparation for the field work on September 25, 2022. The initial test work began on October 6, 2022 and the audit was completed on October 28, 2022.

The following describes the individuals involved in the audit and the location of testing:

Name	Title	Location of Testing
Marie Pollock	Project Director	Remote
David Simmons	Audit Manager/CPA	Remote
Richard Reese	Actuary/Statistician	Remote
Brian Wyman	Senior Auditor/VP	Remote

II - CLAIM PROCESSING ACCURACY – MEDICAL/DENTAL

Our test work to determine payment accuracy of health claims processed during the period September 1, 2021 through August 31, 2022 was performed on 300 previously processed claims (225 medical claims and 75 dental claims). Information regarding the sample selection, tests performed, and results is presented below.

SAMPLE SELECTION

We were provided claim data by 90 Degree Benefits. The data was stratified, and the 300 claims were randomly selected.

Each selected claim was the original submission. We did not treat any correcting entries as the selected claim.

INDIVIDUAL TESTS

The following tests were performed on sample claims selected:

- Review of previously processed claims to determine if a selected claim is a duplicate of a previously processed claim.
- Re-computation of each claim selected for testing to determine its accuracy including analysis of any refunds due and/or payable.
- Review of the nature of the claim to ascertain the allowability of costs as defined in the contract (e.g., processed within the proper allowance and medical necessity guidelines, pre-existing conditions limitation, pre-certification requirements and other benefit limitation guidelines).
- Comparison of each claim to supporting documentation submitted by the member or the provider of services to ensure that the claim reflects the documentation and that it is properly authorized for payment.
- Comparison of each claim to other claims for that individual with the same date of service to ensure congruency of payment with all claims for that date of service.
- Review of the scanned copies and source documents, when appropriate, to determine if there are any indications of fraud.
- Abusive Treatment Patterns - Each selected claim was evaluated to determine that all prolonged treatment is appropriate for the diagnosis and has been prescribed by a physician.
- Fraudulent Claims - Each selected claim document, electronic submission, processor overrides and administrator's controls was reviewed for irregularities or indications of fraud.

ADJUDICATION ACCURACY

For audit purposes, a claim included all charges pertaining to the claim number. In most situations, this included the total charges submitted. However, the system can only process a limited number of line items. In a few situations, our definition of a claim resulted in test work being performed on more than one claim in order to review all charges submitted on the claim.

Information presented below describes the payment errors identified during our test work performed on the 300 sample claims.

The average dollar amount for each claim in the total population (total dollar paid divided by number of paid claims) was $82.00. The average dollar amount for all of Wolcott & Associates, Inc. claim audits for the year was approximately $340.00.

PAYMENT ERROR DEFINITION

A claim was determined to have a payment error if:

- the payment amount was incorrect,
- an incorrect amount was applied to the deductible,
- the payment was made to the wrong payee or on behalf of an incorrect family member,
- payment of a covered expense was denied in part or in total or,
- the check and/or EOB was mailed even if the transaction was subsequently corrected.

Determination of correct payment amounts, and deductible applications were based on the written plan document provided to us, plus any amendments or administrative changes agreed upon by the City in writing.

PAYMENT ERRORS

We identified fifteen (15) payment errors in our sample of 300 claims. This represents a frequency of payment error of 5.00% or 95.00% payment accuracy rate. This rate is less favorable than the range of the 2.0% to 4.0% error rate normally observed by Wolcott & Associates, Inc. during the conduct of similar audits. The error rate does not meet 90 Degree Benefits' internal standard of 97% accuracy.

Each identified error is listed in **Exhibit A**.

Based on the results, and the size and method of selecting the sample and the method of extending the sample results to the population, we are 95% confident that the true frequency of payment error in the population ranges from 6.00% to 4.00% (5.00% plus and minus a precision level of 1.0%). Conversely, we are 95 percent confident that the true frequency of payment accuracy in the population ranges from 96.00% to 94.00% (95.00% plus and minus a precision level of 1.0%.

MAGNITUDE OF DOLLAR ERROR

The magnitude of the errors in our sample of 300 claims, was 0.55% ($577.90 absolute value of over and underpayments divided $104,590.75 of sample dollars).

This error rate is more favorable than the .5% to 1.0% error rate normally observed by Wolcott & Associates, Inc. during the conduct of similar audits. In addition, this error rate meets 90 Degree Benefits' internal standard of 99% accuracy (1% error rate).

The error magnitude, extended to the population, produces a projected net overpayment of $10,233.00 (1.62% of $ 632,040.60).

As a result, we are 95% confident that the true value of medical paid claims during the period ranges from $628,128.01 (the $632,040.60 recorded claims, minus the $10,233.00 projected net error, plus the $6,320.41 value of the 1.0 percent precision) and $615,487.19 (the $632,040.60 recorded claims, minus the $10,233.00 projected net error, minus the $6,320.41 value of the 1.0 percent precision).

90 Degree Benefits insured us that claims will be adjusted to correct any errors.

ANALYSIS OF ERRORS BY TYPE

Each of the identified errors was analyzed to determine the reason for the error. The results of this analysis are presented in the following table.

Description of Error	Number of Errors	Error Amount
Incorrect copayment applied	2	($10.00)
No ER copayment taken.	7	473.90
Data entry error	3	(29.00) net
Covid claims should have been paid at 100%.	2	(25.00)
Incorrect charge on fee schedule taken.	1	8.00
Total	**15**	**$417.90 net**

RECOMMENDATIONS

We identified issues that we believe warrant further discussion.

- We identified several claims that had an incorrect copayment or no copayment (ER service) when there should have been a copayment.
- We recommend 90 Degree Benefits and Siarmed discuss procedures to correctly take the benefit copayment. We also recommend the claim system edits be reviewed to process claims within the plan parameters.
- We identified one claim charge for services that did not agree with Siarmed fee schedule amount.
- We recommend Siarmed process benefit claims using the agreed upon amount on their fee schedule.
- We identified two claims that were for Covid benefits that should have been paid at 100%, with no copayment taken.
- We recommend increasing training and update system edits for Covid claims to process correctly.
- We identified three claims with data entry errors which caused payment error on the claims.
- We recommend increasing training for data entry employees to eliminate these type of errors.

III - CLAIM PROCESSING TIME

The administrative agreement defined the claim processing measurement period to be from (1) the date received to (2) the date determination is made to pay, deny or request additional information.

PROCEDURE

The claim history in the system contains the dates the claim was:

1. received
2. processed and
3. check and/or EOB was issued.

RESULTS – PROCESSING

We measured the elapsed time between the date of receipt and the processed date for each of 300 claims in our sample.

Of the 300 claims in our sample, 145 or 48% were processed within 7 calendar days, 143 or 47 were processed between 8 to 14 calendar days, and 12 or 5% were processed after 14 calendar days.

CONCLUSION

These results are more favorable as compared to the standard of 80% to 85% of claims processing within 14 calendar days per our familiarity with other claim processors' adjudication standards.