

Healthcare Data Audit

November 2010



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Audit objectives

The objectives of this audit were to:

- Examine whether the work performed by Healthcare Data Management met its intended purpose
- Evaluate the Risk Management Division's progress of correcting issues and implementing the recommendations

Background

The Risk Management Division works to protect the City government against the financial consequences of loss and to minimize the total long term costs of all activities related to the identification, prevention, and control of losses and their consequences to the City government. The Risk Management Division administers the City's self-insured worker's compensation program, administers some employee benefit plans, manages the City's IWP (injury with pay) program by validating and approving claims, selects and manages various property and casualty insurance policies for the City, and administers the City's Employee Health Clinic. The various plans the Risk Management Division handles include medical, life, disability, and flexible spending accounts (FSA).

The Association of Certified Fraud Examiners along with industry experts agree that up to 14% of all healthcare expenses are lost to fraud, abuse, and overpayments. The City's 2007 healthcare claims totaled about \$73 million. Since the City is self-insured, research suggests that more than \$9 million could fall into the above mentioned areas annually. Prior to this, the Risk Management Division had not completed a review of healthcare claims with the health care provider in over a decade, compounding the risk that taxpayer dollars are being wasted.

On December 14, 2007 the Risk Management Division signed an agreement with Healthcare Data Management (HDM) for a review of the City's healthcare expenditures. The scope of HDM's audit was to review, assess, and analyze the work product and data of the healthcare plan administrator (Anthem) to measure performance, evaluate contract compliance, evaluate discounts, review claims, and evaluate and recommend means and procedures to identify and/or recover overpayments. The review covered active employees' claims, retired employees' claims, and prescription claims for 2006 and 2007. The total cost for the review was \$101,250 plus travel expenses up to \$10,000. The Risk Management Division was to pay about 42% and the Cincinnati Retirement System (CRS) agreed to pay about 58%.

Findings

Minimal action taken on the HDM findings and recommendations

HDM completed their review and submitted their final report to the Risk Management Division in November 2008. HDM found \$342,000 in erroneous medical payments with active employees (exhibit 1), \$809,000 with retirees (exhibit 2), and \$270,000 in prescription payments (exhibit 3) for a total of over \$1.42 million paid or denied in error by the third party administrator, Anthem, in the years audited. In 2009 IAD learned of the existence of this report and met with the Risk Manager to follow up on the report since no apparent resolution could be readily identified. The Risk Manager acknowledged that he was the primary contact during the audit and was responsible for following up with HDM once they completed their review and ultimately responsible for its implementation and to make any changes. A final meeting was never held between HDM and the Risk Management Division. IAD has been a part of two conference calls with HDM in an attempt to ascertain what went wrong in the audit process and how this healthcare audit could be completed. HDM officials have indicated that they would return to Cincinnati at their expense to conclude this audit and act as the City's agent in negotiating financial resolution.

It is equally important to note that the HDM report covered years 2006 and 2007. It is conceivable that the same issues identified in the reports continue to exist throughout 2008, 2009 and 2010.

Recommendations

Recommendation 1: IAD recommends that the Risk Management Division facilitate a final meeting with HDM and finalize this report.

Recommendation 2: IAD recommends that the CRS and the Risk Management Division work together to ensure that HDM's recommendations are implemented and any monies due to the City are collected from Anthem.

Recommendation 3: IAD recommends that the Risk Management Division administer an RFP to enter into an agreement for conducting a similar review of all medical payments made by the City in 2008 and 2009 and the extent of claims paid this year.

Finance Department Reply

The Finance Director agreed to facilitate a meeting with HDM to finalize this healthcare audit report.

Exhibit 1



**REVIEW OF
ANTHEM BLUE CROSS
BLUE SHIELD'S
HEALTH PLAN
ADMINISTRATION**

For

City of Cincinnati Active Employees

November 20, 2008

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Confidentiality

This report may contain medical and personal information concerning employees that may be subject to state, federal or other regulatory authority privacy and confidentiality laws and regulations. Information provided by the claims administrator was released with similar confidentiality restrictions. All claims and medical situations discussed in this report are identified by a number rather than by actual employee and/or dependent names. Use or distribution of any confidential information contained in this report should be limited to authorized individuals.

Section I - Executive Summary

Engagement Overview

The City of Cincinnati (Cincinnati) engaged the services of Healthcare Data Management, Inc. (HDM) to conduct a health plan review to assess Anthem Blue Cross Blue Shield's (Anthem's) administration of Cincinnati's self-funded health plan for its active employees and determine if Anthem is in compliance with the terms of the Administrative Services Agreement. This engagement examined Anthem's claims adjudication accuracy relative to all claims incurred by Cincinnati's plan members. In addition, HDM was engaged to perform an operational review and a financial review to assess the policies, procedures, and controls that support the administration of Cincinnati's active employee health plan and confirm whether Anthem is accurately invoicing Cincinnati for paid claims and crediting back recoveries.

Claim Review Scope

A sample of 118 claims incurred by Cincinnati's plan participants from January 1, 2006 to December 31, 2007 and paid through January 31, 2008 was selected for onsite testing and review. The sample was selected based on various exception areas identified in the entire population of claims processed during the review period. These exception areas were based on standard claim processing scenarios (e.g. duplicate claims), specific plan benefits described in the Summary Plan Document (SPD) and industry standards.

Review Conclusions

Of the 118 claims tested, 25 exceptions were validated as errors with a dollar impact of \$7,030. Based on the specifics of the sample findings, HDM performed additional analyses on the entire claims population and identified additional exceptions totaling \$334,971. The following chart compares the total dollar amount of all exceptions identified by this review against the total dollar amount of Cincinnati's entire claims population.

Overall Claim Review Results	Amount
Total dollar amount of all Cincinnati active employee healthcare claims for the review period	\$51,476,626
Total dollar amount of claims sample	\$387,015
Total dollar amount of errors/exceptions identified in claims sample	\$7,030
Total dollar amount of all potential exceptions identified from HDM's analysis of Cincinnati's entire claims population based on the attributes of HDM's claim sample findings	\$342,001

The results include claims that were both overpaid and underpaid by Anthem from Cincinnati's perspective. The dollar figures shown reflect the absolute dollar amount of the exceptions regardless of whether the claims was overpaid or underpaid.

Based on the results of the review, there were several areas identified that should be addressed in order to improve the contractual relationship between Cincinnati and Anthem and the accuracy of claims processing. HDM has several recommendations that, if implemented, would improve claims processing and result in savings to Cincinnati. These recommendations and the additional findings are detailed below and in Appendix A of this report.

The results of the operational review indicated that Anthem has the proper organizational structure, workflows and policies and procedures in place to support the Cincinnati account.

The results of the financial review determined that Anthem is properly invoicing Cincinnati for paid claims and giving credits for recoveries.

Summary of Key Findings & Recommendations

Based on the results of the engagement, the following issues represent the greatest opportunity for both Cincinnati and Anthem regarding the administration of the active employee health plans. HDM will provide Anthem with reports detailing the additional claims identified as potential exceptions. In addition, it should be noted that there are other findings detailed in Appendix A of this report that require Anthem's attention.

Claim Unbundling

Anthem uses the ClaimCheck software program to identify situations where a claim should be "bundled" in order to avoid payment for procedures which are clinically included in the primary procedure performed. Anthem's application of claims edits does not preclude bundling logic and therefore does not agree to the correct coding initiatives (CCI) established by the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA). The Plan is paying monies in excess of federal guidelines. Attempts by providers to submit unbundled claims represent abusive or fraudulent billing practices.

HDM identified over 6,000 claims involving incidental procedures, laboratory charges and procedures that are components of other services therefore resulting in overpayments of approximately \$178,000. This represents an opportunity for claims expense reduction and should lead to discussions between Cincinnati and Anthem regarding establishing ClaimCheck edits that meet Cincinnati's expectations, and ensure providers are paid properly and reduce claims expense.

Coinsurance Application

HDM identified claims in the sample where Anthem was not applying the correct coinsurance percentage based on the benefit information received from the City of Cincinnati. It should be noted that Anthem has agreed to some of the findings. Exceptions resulting from Anthem's position that the services rendered were preventive could not be resolved. The SPD clearly defines the preventive services that should be covered.

HDM identified in excess of 2,700 claims where the incorrect coinsurance was applied resulting in \$51,000 in over payments.

HDM recommends that Cincinnati and Anthem review how benefits are being administered to ensure that Cincinnati's requirements are being followed.

Duplicate Claims

HDM identified claims that were paid as duplicates. In the entire claims population, HDM identified 260 potential duplicate claims totaling approximately \$40,000 in overpayments.

HDM recommends that Anthem review its claims adjudication logic to identify potential duplicate claims as well as its procedures for over-riding duplicate claim logic to ensure that the possibility of a duplicate claim being paid is minimized.

Surgery Payments

HDM identified claims where Anthem was not reducing services for assistant surgeons, bilateral procedures, multiple surgeries and certified registered nurse anesthetists (CRNA) in agreement with industry standards. Over 300 claims were identified in the population totaling approximately \$41,000 in overpayments. Anthem asserts these claims were paid according to contractual agreements.

This situation presents another opportunity for Cincinnati to discuss with Anthem claims variations to ensure that Cincinnati is receiving the maximum financial benefit from Anthem's administration. HDM recommends that Cincinnati discuss with Anthem the possibility of modifying the payments for the claims noted above and that Anthem modify its processing logic to closely align with industry standards.

BenefitsWatch

HDM has taken the liberty to analyze your historical data utilizing HDM's proprietary software, BenefitsWatch. The analysis will be provided under separate cover.

BenefitsWatch is a monitoring/compliance service provided by HDM that gives employers control over health benefits administration and holds carriers and pharmacy benefits managers accountable for claims errors and recovery of overpayments. HDM developed this proprietary solution to ensure prompt delivery of a return on investment and realization of lasting results for the long term. BenefitsWatch is an effective tool in any continuous improvement process.

On a concurrent basis, BenefitsWatch monitoring solution will provide Cincinnati with:

- The identification and recovery of overpaid or erroneous medical and prescription drug claims
- The detection and correction of inappropriate billing practices

- The benchmarking of data to monitor the effectiveness and accuracy of Anthem's contract administration and pricing compliance with your signed contracts and SPDs
- Negotiation and implementation of corrective actions, and
- The correction of past erroneous practices.

Section II – Engagement Approach

The following is a description of HDM’s objectives and methodology with regard to this engagement.

Claims Review Objectives

HDM performed a retrospective review of Anthem’s adjudication of Cincinnati’s employee health plan claims during the review period to assess Anthem’s claim processing accuracy and overall effectiveness as Cincinnati’s health plan administrator. This included a comprehensive evaluation of Anthem’s:

- Adherence to Cincinnati’s benefit plan requirements and benefit specifications
- Application of copayments and coinsurance
- Efforts to ensure claim payments are for eligible claimants and for eligible health care services
- Controls to identify aberrant billing practices and improper provider billing/coding
- System edits to detect and prevent duplicate claim payments
- Provider discount applications, fee schedules, and usual and customary allowances
- Handling of claim payment appeals, adjustments and refunds
- Identification and recovery of overpayments
- Ongoing quality assurance
- Coordination of benefits with other group plans, payors and Medicare
- Enforcement of claim documentation requirements and medical necessity reviews

Claims Review Methodology

HDM’s review approach and methodology included the following:

- Review of health plan documentation including Summary Plan Description and Administrative Services Agreement
- Analysis of 100% of Cincinnati’s claims processed and paid during the review period
- Data analysis and claims sampling selection
- Onsite claims review to assess claims adjudication accuracy and to identify any systemic problems, financial issues, contract compliance issues
- Root cause analysis of errors and quantification of the financial impact of errors across the entire claims population, if applicable
- Preparation of report and solicitation of Anthem’s action plans to address key findings and overpayment concerns

Claim Sampling

HDM obtained the SPD from Cincinnati and a claims data file from Anthem containing detailed records of 100% of Cincinnati's claims and corresponding benefit reimbursements processed during the review period. Additionally, an eligibility file was obtained containing the covered employees and their dependents. Using this data, a customized data warehouse was created and HDM's reviewers and data analysts performed a series of analyses of 100% of Cincinnati's claims processed based on various business rules. These business rules were generated from the SPD, various industry guidelines and proprietary HDM data. Based on HDM's claims analyses, a claims sample consisting of 118 medical claim payments totaling \$387,015 was selected for testing. The sample identified claims that may have been paid in error or did not comply with standard industry guidelines for claims administration.

The following chart summarizes the claim counts and payments by plan for the entire claim population and claim sample.

Plan Type	Claim Population		Claim Sample	
	Count	Paid	Count	Paid
Blue Access/PPO 80/20	244,760	\$51,476,626	118	\$387,015
Total	244,760	\$51,476,626	118	\$387,015

The next chart displays the distribution associated with the Cincinnati claim sample by place of service and claim type.

Place Of Service	Sample Claim Count	Facility Claims		Professional Claims	
		Count	Paid	Count	Paid
Blue Access/PPO 80/20					
Ambulatory Surgical Center	2	-	-	2	\$859
Ambulance	4	-	-	4	\$1,389
Emergency Room	8	6	\$7,623	2	\$123
Home	7	1	\$361	6	\$10,780
Independent Lab	4	-	-	4	\$5,329
Inpatient Hospital	15	10	\$328,676	5	\$139
Office	52	-	-	52	\$12,161
Outpatient Hospital	24	18	\$14,941	6	\$4,397
Urgent Care Facility	2	-	-	2	\$237
Total	118	35	\$351,601	83	\$35,414

Claims Data Analysis

As referenced previously, HDM created a data warehouse and completed a series of analyses on Cincinnati's claims data. This analysis was instrumental in the structure and selection of Cincinnati's claims sample. In addition, analysis was completed on 100% of Cincinnati's entire claim population for the review period in order to calculate Cincinnati's average provider discount that was achieved as a result of Cincinnati's plan members utilizing Anthem's participating provider network, as well as Anthem's average claim processing turnaround time for all claims incurred during the review period.

Onsite Claim Review

HDM conducted an onsite review of Cincinnati's claim sample at Anthem's office located in Springfield, MO during the week of July 7, 2008. HDM was granted access and were given hard-copy claims and contractual discount documentation for all sample claims, which enabled HDM to conduct an effective review of Cincinnati's health claim payments for error detection and root-cause validation.

For any claim payment discrepancies encountered, HDM presented documented questions to a designated Anthem representative for response, confirmation and assessment of the origin of the exception. This approach provided Anthem with an opportunity to clarify benefit determinations and provide any additional information or documentation to support claim payment decisions.

Examples of the types of questions and issues addressed throughout HDM's review of Cincinnati's claims sample are provided in the following chart. This is intended to provide a sense of the questions that were raised, but this list is not all-inclusive.

<i>Focus Areas</i>	<i>What We Looked For</i>
Claimant Eligibility	Were all employee/dependent eligibility fields within Anthem's system reflecting correct information in accordance with claim documents?
Coordination of Benefits/ Other Party Liability	Were primary benefit plans and other party liabilities identified and properly flagged in the system? Were benefits coordinated correctly?
System Edits and Alerts	Were system flags and edits effective for alerting claim processors to potential duplicate claims, aberrant billing practices, overcharging by medical providers, etc?
Provider Discounts	Were appropriate discounts applied on claim payments?
Data Integrity	Were all critical data fields entered correctly from paper and electronically submitted claim documents?
Benefit Guidelines and Provisions	Were Cincinnati's specific plan requirements, benefit exclusions, service limitations, and maximums correctly applied?
Administrative Procedures	Were all claims processed in accordance with Anthem's normal administrative procedures and industry standard practices?
Managed Care	Were the appropriate cost-containment and managed care guidelines reviewed, documented, and adhered to?

Supporting Documentation	Were necessary claims and medical documentation for each sample claim payment requested, obtained, and on file?
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Global Analysis of Exceptions

Based on the attributes of all confirmed payment exceptions, HDM reviewers and data analysts performed additional analyses on Cincinnati’s claims population. As a result, HDM identified additional claim payment exceptions similar to those confirmed during the onsite review. These claim payment exceptions are detailed in Section III “Detailed Findings and Observations” as well as Appendix A of the report. HDM will provide Anthem with detailed claim exception reports for review and, if necessary, adjustment of the claims.

The results of the additional findings in this report are not based on an extrapolation of this review’s exception ratios or performance measurements. Instead, these results reflect actual claim payments during the review period which are similar to the sample findings confirmed onsite. All exceptions will require Anthem’s review, confirmation and discussion with Cincinnati as to how overpayments should be handled.

Operational Review

During the onsite review at Anthem, HDM completed an operational review of Anthem’s operations and procedures that have an impact on the administration of Cincinnati’s health claims. The review was based on information and documentation Anthem provided through completion of a comprehensive procedural questionnaire and onsite interviews with key management personnel. The information and documentation provided helpful insight regarding Anthem’s operations and was an integral part of the overall process for identifying administrative issues that may affect the claim payment exceptions confirmed during the onsite review.

Financial Review

HDM also performed a financial review that consisted of a reconciliation of Cincinnati’s paid claims against Anthem’s corresponding billings and banking records for several months of the review period. The purpose of this review was to confirm whether Cincinnati was accurately invoiced by Anthem and if Cincinnati was receiving appropriate credits for recoveries from claim overpayments.

Section III – Detailed Findings and Observations

Claims Sample Results

The chart that follows provides a summary of the claim counts and related payments that were included in the medical claims sample, as well the corresponding counts and financial impact of the claim payment exceptions that were identified.

<i>Exception Area</i>	<i>Claim Sample</i>		<i>Sample Findings</i>	
	<i>Count</i>	<i>Paid</i>	<i>Count</i>	<i>Financial Impact</i>
Blue Access/PPO 80/20				
Administrative Services Agreement				
Case Management	6	\$13,507	-	-
Contract Review	7	\$275,710	-	-
Other Party Liability	3	\$267	-	-
Plan Provisions				
Coinsurance Application	60	\$31,113	13	\$530
Ineligible Services	9	\$31,998	1	\$1,355
Maximum Exceeded	5	\$464	4	\$172
System Controls				
Correct Coding Initiative	3	\$1,750	-	-
Deductible	2	\$13,359	-	-
Duplicate Claim Payment	12	\$11,674	3	\$2,038
Eligibility	5	\$3,013	3	\$2,915
Standard Operating Procedures	1	\$2,495	-	-
Surgery Payments	5	\$1,665	1	\$20
Total	118	\$387,015	25	\$7,030

HDM performed additional analysis of the entire claims population for the review period using the attributes of the claim payment exceptions identified. This analysis identifies and quantifies additional findings with similar characteristics and adjudication outcomes. The results of this analysis are provided in the following chart.

<i>Exception Area</i>	<i>Sample Findings</i>		<i>Additional Findings</i>	
	<i>Count</i>	<i>Paid</i>	<i>Count</i>	<i>Financial Impact</i>
Blue Access/PPO 80/20				
Plan Provisions				
Coinsurance Application	13	\$530	2,732	\$50,785

Ineligible Services	1	\$1,355	13	\$2,122
Maximum Exceeded	4	\$172	155	\$6,282
System Controls				
Correct Coding Initiative	-	-	6,076	\$178,458
Duplicate Claim Payment	3	\$2,038	263	\$40,057
Eligibility	3	\$2,915	82	\$15,732
Surgery Payments	1	\$20	331	\$41,534
Total	25	\$7,030	9,652	\$334,971

All findings, recommendations, and conclusions relative to HDM's specific claims sample findings and global analysis of Cincinnati's entire claims population, are further detailed in Appendix A.

Section IV - Operational Review

As part of the engagement, HDM conducted an operational review to assess the capabilities of Anthem in support of the Cincinnati account. The review consisted of a combination of onsite interviews of management and staff to discuss departmental staffing, workflows, procedures and controls; review of selected departmental documentation; review of policies and procedures; review of questionnaires completed by Anthem prior to the engagement and an onsite walk-through. The operational review covered the following areas:

- Mail Room Operations
- Claims
- Customer Service
- Membership/Enrollment
- Other Party Liability
- Disaster Recovery Planning
- Business Continuity Planning
- Special Investigations
- HIPAA Privacy

Based on the work performed, it appears that Anthem has the proper organizational structure, workflows and policies and procedures in place to support the Cincinnati account.

The following is a summary of the key aspects of each department/function reviewed.

Mail Room Operations

Since July 2006, Anthem has outsourced its mail room services to an outside vendor. The vendor is also responsible for imaging and data entry of claims. The mail is picked up from the Post Office in Louisville, KY at 4:00 AM, 6:00 AM and 8:00 AM, Monday through Saturday. At the vendor's facility it is opened and sorted between claims and correspondence. The claims are further sorted and batched by type (facility, professional, dental, member). The mail is opened and date stamped. Once the sorting process is completed, the claims are ready for scanning.

Kodak scanning equipment is utilized. Each document scanned is assigned a document control number (DCN) for tracking purposes. The receipt date assigned is imbedded in the DCN. Claims are then data entered by the vendor and the images and data files are sent to Anthem's Reconciliation and Balancing Database for receipt acknowledgement.

Following the claims being scanned, the vendor will key all of the fields on the claim into the FACETS system. The claims data is then transferred to the FACETS system for processing based on a Blue Cross Blue Shield plan code for BlueCard claims and through a business distribution system for all other claims. Quality checks are performed on the keying process.

The paper claims and related documents are kept on site for 14 days and are then shredded by an outside company. Anthem maintains two years of claim history online and historical claims are archived for seven years.

Anthem has a service level agreement with the vendor to ensure that a certain performance level is met for the mail processing, imaging and keying process. In general the expected turnaround time for the entire process – from initial receipt to keying – is 48 to 72 hours. The vendor also has a quality assurance team that performs six sigma audits on the mail room operations on a monthly basis. Anthem management receives a copy of the report. Anthem's internal audit department also audits the mail room annually.

Claims

Anthem uses the FACETS system to process claims on behalf of Cincinnati. The system has been in place since 1998 and has been updated on an ongoing basis to ensure the latest state of the art processing technology. Claims involving another Blue Cross Blue Shield Plan are processed through the Inter-Plan Teleprocessing System (ITS) as part of the BlueCard Program.

The claims for Cincinnati follow the regular claims flow through FACETS and there are no dedicated claims processors for Cincinnati. There are over 600 employees in Central Claims Operations where Cincinnati's claims are processed. The examiners process all claim types.

Approximately 90% of claims received by Anthem for all of its lines of business are received electronically. Of all claims received, approximately 70% are auto-adjudicated by the FACETS system. Claims are routed electronically using a system router based on member eligibility and the unique member identification number. All pended claims are stored in FACETS Work Manager by queues to determine the level of expertise required and the processor skill set. Pended claims are divided between beginner, intermediate and advanced. The level of pends that a processor can work depends on their level of experience, their quality scores and the availability of positions. There are numerous edits set up in the system to ensure the validity and accuracy of the claims data and to identify claims which require manual intervention and/or review. Anthem also utilizes a software package to ensure providers are billing appropriately. This software checks for proper billings over a number of categories, including, but not limited to, edits for unbundling of services, mutually exclusive procedures and incidental services. Reference materials for claim processing procedures are available on-line and in the form of hard copy manuals.

Anthem has also instituted various dollar thresholds for claims to be reviewed prior to payment. The review level is on a progressive scale based on the type of claim and dollar amount; meaning that the higher the payment the higher the level of personnel required to review and approve the claim. Professional claims over \$15,000 and inpatient and outpatient claims over \$30,000 are reviewed.

Claims are processed on a first-in, first-out basis. Inventory levels are checked on a regular basis by Claims Department management. The IT Department balances the claims inventory on a daily basis. Out-of-balance situations are brought to the attention of Claims Department management.

Experienced Claims Department employees have certain levels of production and claim processing accuracy that they are expected to achieve. These are monitored through the quality assurance process. The production standard for a fully trained claims examiner is 15 claims per hour. The accuracy level for experienced processors is 97%. Through the quality program, examiners have between five and thirty four claims reviewed on a monthly basis. The number of claims to be audited is reviewed on a quarterly basis depending on the processor's level of performance.

Employees in the Claims Department are subject to a training program that lasts approximately ten weeks. The training takes place in a classroom setting. There is standard testing throughout and examples of production claims are used. Following the training program, 100% of a new employee's claims are reviewed on a pre-payment basis. Once they reach a 95% accuracy level, the examiners are subject to the regular quality assurance program.

Customer Service

The Cincinnati account is supported by Anthem's Customer Service Department in Mason, OH. The department is primarily responsible for responding to telephone and written inquiries. The department also processes some claims adjustments resulting from member inquiries. There are approximately thirty Customer Care Representatives (CCRs) in the unit that handles Cincinnati's telephone inquiries. The CCRs' average experience level is approximately five years. Anthem also has "hot line" CCRs who Cincinnati's Human Resources Department has access to. The unit has a dedicated phone number.

Telephones are staffed from 8:00 AM to 6:00 PM, Monday through Friday. In total, each CCR takes approximately 65 calls per day. If a member calls after regular business hours they are given the option to call back during regular hours or have their call answered through Interactive Voice Response (IVR). They are also referred to Anthem's web site and can send an e-mail. A workforce management system is utilized to monitor and analyze call volumes and make schedule determinations.

The CCRs have immediate access to online claims information for responses to member inquiries. Examples of common inquiries include claim status, benefit information, claim payment dates and provider information. Aging reports are available and monitored by management for those inquiries not resolved on initial contact.

All calls are recorded for potential subsequent review through the Verint system. For approximately 30% of the calls, Anthem records each system screen accessed by the CCR during the call. This information is used for the quality assurance process and for training purposes.

As noted, CCRs have the ability to process claim adjustments. Only adjustments that pay an additional amount on the claim can be processed and there are restrictions placed on the dollar amount and type of adjustment that can be made.

CCRs are subject to quality assurance reviews conducted by call coaches from an outside department. At a minimum, three calls are monitored per CCR per month. CCRs are expected to perform, based on the scoring system in place, at or above 96.68%. The call coaches meet with each CCR monthly to review their performance and discuss opportunities to improve member satisfaction and service skills. If an employee is not performing at an acceptable level, an operations expert or manager will monitor one or two calls per week. If necessary, a performance improvement plan will be put in place. In those situations, weekly meetings with the CCR are held. In addition, management can monitor telephone calls for quality or in situations where a CCR may need assistance (e.g. long call).

CCRs complete a training program that lasts approximately nine weeks. This program covers system navigation and all programs/applications the CCR may have to access. During the training, the new CCR will shadow an experienced CCR. After approximately seven weeks, the new CCR will take some live calls which are monitored. CCRs must pass various quizzes throughout the training program and must achieve a final score of 95 on the final test given at the end of the training.

Membership/Enrollment

Anthem has assigned a dedicated enrollment and billing specialist to process membership transactions for Cincinnati. There is a back-up in place.

All enrollment/membership transactions are handled via paper. Transactions (additions, terminations, changes) for active employees are received two times per month and transactions for retirees are received once a month. The volume varies, however the average batch received has approximately fifty transactions. The turnaround time for processing membership transactions is three to five business days.

The membership transactions processed are subject to quality review. On a monthly basis a random sample of transactions are audited by the Internal Audit Department.

All membership changes including effective and termination dates are provided by Cincinnati. Cincinnati is also responsible for informing Anthem of members who are eligible for Medicare. For dependent eligibility, Anthem also relies on Cincinnati to notify them of dependents over 19 who are full-time students. The membership system is automatically updated each year until Anthem is notified of the termination. Members are reminded through Explanation of Benefit (EOB) statements to notify Cincinnati if the dependent is no longer a full time student.

Other Party Liability (OPL)

OPL includes situations covering subrogation and workers compensation where another entity may be responsible for claim payments resulting from an automobile accident or on-the-job injury. Anthem primarily manages subrogation and workers compensation in-house and has identified a number of procedure codes with a diagnosis that could be related to trauma or an accident. These codes are generally updated in conjunction with revisions to the ICD-9 manual, which lists diagnosis codes for medical conditions. When a claim containing an accident-related

or trauma-related diagnosis is processed, Anthem will flag the claim. A \$200 threshold is used for OPL cases and if the claims processed are below \$200, Anthem's software program has logic to accumulate the claims to the threshold. Once the \$200 threshold is met, Anthem sends a letter and questionnaire to the member that requests certain information be provided to establish if an accident of work-related injury has occurred and also seeks information regarding liability. If no response is received after 30 days, a second letter is sent and the member has fifteen days to respond. Following three attempts without a response, the case is handed over to outside counsel to pursue. Members can respond by replying to the questionnaire, calling a toll free number or accessing a web site.

Once an OPL case is established, Anthem follows a pay and pursue approach. Anthem retains 25% of the recoveries from its subrogation activities to cover its costs. If a third party is involved in the recovery process, 15% of the recoveries are retained. Claims previously paid by Anthem in a subrogation or workers compensation case are adjusted on a dollar for dollar basis up to the net recovery amount. There is no fee charged for cases that do not result in a recovery.

Disaster Recovery Planning

Anthem's disaster recovery plan is designed to protect against data loss and provide recovery from major unplanned interruptions to computing services. Anthem has a disaster recovery plan in place for the FACETS system. The IBM data center located in Sterling Forest, NY serves as the hot site for FACETS. Other systems and applications are protected by a hot site agreement with SunGard. Applications and data would be recovered from backup tapes stored at offsite locations. Recovery times would range from three days to two weeks or more, depending on system criticality.

The Disaster Recovery Team includes six full time employees and a manager. The disaster recovery plans are updated annually or more frequently if necessary depending on system changes. In 2007, steps were taken to have all disaster recovery plans follow a standard format.

A comprehensive disaster recovery testing program is in place for Anthem's systems. Up to 112 testing hours are provided annually under the hot site contracts. The recovery exercises include personnel from IT and Operations. The last recovery exercise for FACETS took place in November 2007 and involved over fifty employees. All critical systems and applications are tested annually.

Results of recovery exercises are documented in a report which is distributed to IT management, the applicable hot site vendor and Internal Audit. An internal software tool is used to track issues and the Disaster Recovery Team monitors them to closure. Post-recovery exercise meetings are also held.

Business Continuity Planning

Business continuity plans provide for recovery of critical business functions. Anthem has a comprehensive state-of-the art business continuity planning program in place covering all aspects of its operations across the country.

The Business Continuation Department for Anthem reports to the Chief Financial Officer. Its purpose is to coordinate and manage the business continuity program and ensure consistency across the Anthem organization.

Process experts within each department, using a standardized approach and methodology, build business continuity plans. Plans are documented using both Microsoft Word and Microsoft Excel and are maintained in a document management system that was developed by Anthem. The focus of the business continuity plans is process-oriented, with less reliance on the availability of the actual personnel. The approach relies on the skill sets of management to execute the business continuity plans in place. Plans are updated at least annually.

Anthem regularly tests its business continuity plans and strategies. Exercises are usually pre-planned but unannounced (e.g. building evacuation). Each critical process is tested at least once per year.

The business continuity plans are primarily developed based on the availability of resources, not on an event. They are developed to handle varying time frames that the business may be down – hours, days or weeks. A different strategy/plan would be used based on these time frames. The strategy deployed would also be based on different situations (e.g. facilities not available, personnel not available, systems not available, etc.).

In the event of a situation that would require the business continuity plans to be put into action, shared resources would be deployed to the affected area to support the efforts. A mobile van is available with full technology capacity. Many of Anthem's facilities are equipped to link with the technology in the van. Additionally, Anthem's Executive Leadership Team has determined which functions/processes will be resumed first in the event of a major business interruption. The priority is based on the criticality of the functions'/processes' customer interface.

Business continuity plans are kept in a central location and key managers are required to maintain a copy offsite.

Each Anthem location has an Emergency Procedures Manual that is given to each employee. The manual covers various emergency events including site evacuation. The manual also describes the emergency management program which includes a hot line, location of virtual command centers and listings of corporate resources, local resources and emergency response leaders. The corporate resources include a Corporate Incident Response Team that includes senior management from various disciplines.

Special Investigations

The Special Investigations Unit (SIU) for Anthem is comprised of three regional Investigative Units (East, Central, and West), a Central Intake Unit, a Clinical Investigations Unit and a Reporting and Data Analysis Unit. The Central Region is primarily responsible for the Cincinnati account, but the other units are all part of Anthem's enterprise-wide approach to fraud and abuse identification and prevention.

The Investigative Units primarily handle cases in their regions, but can also be involved in investigations that are enterprise wide. These units include investigators with clinical backgrounds as well as law enforcement backgrounds. Their credentials include Certified Fraud Examiner (CFE), Accredited Healthcare Fraud Investigator (AHFI) and certified coder.

The Central Intake Unit allows one point for intake/referral and reporting. The Clinical Investigations Unit utilizes nurses, physicians and chiropractors dedicated to investigation efforts and proactive data analysis of medical billing practices. The Data Analysis Unit utilizes actuarial and investigative experience and has data analysts dedicated to enterprise wide investigations. The Data Analysis Unit uses various analytical tools including specialized software that focuses on the identification of abusive or fraudulent claims. The management teams of the Clinical Investigations and Data Analysis units have extensive backgrounds in healthcare and investigations.

Anthem offers a computer based fraud and abuse training course that all of its employees are required to complete. Separate courses are offered to claims and customer service personnel and the general employee population. Throughout the courses there are various quizzes based on the material and employees must achieve a score of 80% or higher in order to complete the training. There are tracking mechanisms in place to ensure employees complete the training. Outreach activities involve SIU employees participating in marketing presentations, multi-disciplinary committees, local task forces and anti-fraud associations such as the National Health Care Anti-Fraud Association (NHCAA), Association of Certified Fraud Examiners, National Association of Drug Diversion Investigators, the Blue Cross Blue Shield Association (BCBSA) and the National Society of Professional Insurance Investigators.

Referrals and proactive identification of cases come from internal leads, law enforcement, hotline calls, anti-fraud associations and data mining. The SIU often works with the FBI, US Attorney, State Agencies and local law enforcement in their investigations. The hotline is promoted to members through mailings, Explanation of Benefit statements (EOBs) and on Anthem's web site. Data mining involves the use of Business Objects, which builds models and patterns of providers, and SIRIS, which is a software tool developed through a joint venture between Anthem and NCR. Business Objects is used as a reactive tool and SIRIS is used as a proactive tool. The central region SIU also implemented the VIPS Stars software in 2007, which is also used by other Anthem plans.

As part of the fraud and abuse process, Anthem takes various actions that include provider education, provider investigation, root cause analysis and corrective action. Anthem's SIUs will follow up on issues they investigate or identify.

There are various remedies used by Anthem for an investigation including mutual agreement/settlement with the provider, civil litigation, referral to law enforcement, network termination, claim processing changes and Medical Policy revisions. When warranted, Anthem frequently uses network termination when a provider is found to have been involved in fraudulent or abusive practices. If a Cincinnati employee was found to have been involved in a fraudulent situation, Anthem would notify Cincinnati through the account representative.

HIPAA Privacy

Anthem uses several methods to ensure HIPAA compliance. There are various policies and procedures available to employees on the company's intranet for reference and review regarding HIPAA Privacy and Security. A comprehensive privacy policy provides employees with guidance on how to protect confidential information. All employees are required to complete annual security and privacy training, which is provided through on-line modules. Reminders on Privacy and Security policies and procedures are also sent to employees, especially customer service representatives, during the year. The reminders are sent via newsletters and on-line notices.

Anthem has a designated Privacy and Security Officer pursuant to the HIPAA regulations and individual managers are responsible for ensuring HIPAA compliance within their departments. The Privacy Department handles the training and awareness programs and investigates potential violations of the release of protected health information (PHI). They will also perform spot checks in departments where previous privacy issues have been identified.

Anthem's Notice of Privacy Practices describes the circumstances under which Anthem may access or disclose PHI. Members have the ability to restrict the release of PHI and this is noted in the system. Anthem will not disclose PHI to Cincinnati without a HIPAA compliant authorization from the individual member. Anthem will, however, be willing to disclose PHI to Cincinnati if the representative can demonstrate that he or she has been granted authority from the individual to do so in a way that is HIPAA compliant.

Anthem maintains and stores PHI in secure locations and only allows access by authorized employees. The authorized employees only have access to the minimum necessary information to fulfill their job functions and responsibilities.

Section V - Financial Review

Objectives / Methodology

The objective of the financial review is to verify the accuracy and correctness of claim funding amounts, assure that adequate documentation is available to substantiate funding transactions and reconcile all supporting documentation to determine if any exceptions exist for the period reviewed. This review also assures that recoveries from claim overpayments are offset against the invoicing for claim funding requests.

The reports and documents utilized by HDM to perform the Financial Review consist of the following:

- Invoices from Anthem to Cincinnati for the months of April 2006, August 2006, February 2007 and November 2007
- Detail claim information from Anthem for specific billing periods in the months of April 2006, August 2006, February 2007 and November 2007

HDM utilized the claim file provided by Anthem to compare the amounts from these documents to the claims on the file. The resulting comparison did not indicate any significant differences between the amounts invoiced and the detail claim information provided by Cincinnati and Anthem.

Based on the results of the analyses performed, Anthem is properly invoicing Cincinnati for paid claims and adjustments.

Section VI – Value-Added Information

Average Discount Savings

The following chart provides a breakdown of Cincinnati's average provider discount savings by plan and by claim/service types for all claims processed during the review period.

<i>Place of Service</i>	<i>Claim Count</i>	<i>Charge</i>	<i>Allowed</i>	<i>Paid</i>	<i>Discount %</i>
Blue Access/PPO 80/20					
Facility					
Ambulatory Surgical Center	1,263	\$2,966,880	\$1,093,586	\$894,624	63%
Ambulance-Ground	18	\$34,501	\$21,270	\$17,364	38%
Comprehensive Inpatient Rehab Center	11	\$349,432	\$116,510	\$115,827	67%
Emergency Room	5,201	\$7,300,431	\$4,083,527	\$3,165,562	44%
Home	410	\$185,517	\$167,213	\$163,077	10%
Hospice	55	\$87,138	\$79,502	\$79,502	9%
Inpatient Hospital	1,638	\$30,136,124	\$14,301,010	\$13,419,580	53%
Outpatient Hospital	15,355	\$26,582,015	\$14,077,247	\$11,909,879	47%
Other	74	\$171,343	\$100,482	\$91,295	41%
Skilled Nursing Center	40	\$224,891	\$161,370	\$161,105	28%
Subtotal	24,056	\$68,038,273	\$34,201,717	\$30,017,814	50%
Professional					
Ambulatory Surgical Center	1,595	\$2,137,788	\$881,875	\$733,249	59%
Ambulance - Air	2	\$23,333	\$23,333	\$23,333	0%
Ambulance	561	\$314,177	\$185,269	\$156,822	41%
Community Mental Health Center	4	\$1,056	\$698	\$558	34%
Comprehensive Inpatient Rehab Center	143	\$19,030	\$12,566	\$12,264	34%
Comprehensive Outpatient Rehab Center	13	\$986	\$438	\$374	56%
Custodial Care Facility	1	\$74	\$43	\$34	42%
Emergency Room	5,422	\$911,435	\$561,889	\$441,905	38%
End Stage Renal Treatment Facility	67	\$28,541	\$23,605	\$17,690	17%
Fed Quality Health Center	21	\$2,542	\$1,324	\$1,304	48%
Home	4,125	\$2,344,170	\$1,670,699	\$1,491,631	29%
Independent Lab	21,245	\$3,928,348	\$679,327	\$586,271	83%
Intermediate Care Facility	1	\$45	\$10	\$10	77%
Inpatient Hospital	9,390	\$5,972,046	\$3,393,135	\$3,037,824	43%
Inpatient Psych Facility	6	\$1,405	\$963	\$944	31%
Nursing Facility	67	\$4,411	\$2,422	\$2,327	45%
Office	118,926	\$25,053,113	\$14,631,432	\$12,161,602	42%
Outpatient Hospital	13,932	\$6,675,430	\$3,039,693	\$2,622,927	54%

Other	706	\$201,399	\$134,691	\$119,410	33%
Psychiatric Facility	10	\$3,754	\$3,543	\$2,932	6%
Skilled Nursing Center	70	\$7,972	\$5,127	\$4,922	36%
State/Local Public Health Clinic	11	\$935	\$719	\$719	23%
Urgent Care Facility	567	\$86,998	\$52,816	\$39,622	39%
Subtotal	176,796	\$47,718,988	\$25,305,617	\$21,458,675	47%
Total	200,852	\$115,757,261	\$59,507,334	\$51,476,490	49%

Claim Turnaround Time

Anthem processed approximately 88% of all Cincinnati's claims received during the review period within 14 days or less. The industry standard is to process 90% of all claims within this timeframe. Please note this analysis gives equal weight to all claims received and processed regardless of whether they were received electronically and auto-adjudicated, or submitted on paper and manually processed. The following chart shows the turnaround time of all claims received by Anthem.

<i>Tiers</i>	<i>Claim Count</i>	<i>Percentage</i>
Blue Access/PPO 80/20		
01/01/2006		
0-14 Elapsed Days	114,448	91.52%
15-30 Elapsed Days	4,934	3.95%
30+ Elapsed Days	5,675	4.54%
01/01/2007		
0-14 Elapsed Days	110,682	92.48%
15-30 Elapsed Days	4,768	3.98%
30+ Elapsed Days	4,233	3.54%

APPENDIX A

The following charts provide additional details relative to the claim payment exceptions identified as a result of HDM’s onsite claims review and claims analysis. The charts also include Anthem’s response and HDM’s recommendation and conclusion regarding the specific issue. Cincinnati and Anthem should review these findings and determine the appropriate course of action, i.e. claim recovery, reimbursement to Cincinnati, etc.

Plan Provisions

Coinsurance Application			
<i>Sample Findings</i>		<i>Additional Findings</i>	
<i>Claim Count</i>	<i>Financial Impact</i>	<i>Claim Count</i>	<i>Financial Impact</i>
13	\$530	2,732	\$50,785
Facility, Emergency Room			
HDM Assessment	Sample #13: Per SPD, medical services performed in an emergency room setting are covered at 80%. The sample claim was paid at 100% of the allowable charge. This resulted in an overpayment of \$50.40.		
TPA Response	<p>Anthem agrees #13 is an exception. The claim has been sent for review and adjustment.</p> <p>November 3rd updated response from Anthem: Anthem originally agreed to this exception; however, upon further research, the claim processed correctly. The member was already responsible for the billed charge amount of \$177 – which was applied to the deductible. Our allowed amount is higher than the billed charges – so the member responsibility is limited to billed amount. As we are contracted to allow \$429, we were obligated to make a payment of \$252, which was the balance of the contracted amount – minus member responsibility.</p>		
Conclusion	Both HDM and Anthem agree that emergency room services are covered at 80% and that sample claim was overpaid. Anthem has referred claim for adjustment. HDM has identified an additional 92 claims in this category resulting in potential overpayments in the amount of \$3,141. HDM will provide Anthem with the detailed claims information for the additional claims. All exceptions require review by Anthem.		
Facility, Out-Patient Hosp			
HDM Assessment	Sample #58: Per SPD, outpatient surgery is covered at 80%. The sample claim was paid at 100% of the allowable charge. This resulted in an overpayment of \$260.22.		
TPA Response	Anthem agrees #58 is an exception. An adjustment request has been sent.		
Conclusion	Both HDM and Anthem agree that outpatient surgeries are covered at 80% and that sample claim was overpaid. Anthem has referred claim for adjustment. HDM has identified 1 additional claim in this category resulting in potential overpayment in the amount of \$54. HDM will provide Anthem with the detailed claim information for the additional claim. Anthem is		

	required to review the additional exception.
Professional, Independent Lab	
HDM Assessment	<p>Sample #47: Per SPD, outpatient diagnostic services are covered at 80% if the service is not preventive care. The diagnosis presented on the sample claim V25.09 (other services, contraceptive management,) is not considered preventive care under the plan. This resulted in an overpayment of \$1.80.</p> <p>Sample #72: Per SPD, Preventive Care includes pap testing which is covered and reimbursed at 100%. The sample claim was for a pap smear (lab test - 88142), which was related to a routine OB/GYN visit performed on the same day. HDM concludes that procedure code 88142 billed in conjunction with a routine OB/GYN visit should be paid at the routine benefit, and reimbursed at 100%. The sample claim was reimbursed at 80%. This resulted in an underpayment of \$4.00.</p>
TPA Response	<p>Anthem agrees #47 is an exception. The overpaid amount, \$1.80, is under the \$25.00 threshold amount; therefore, no adjustment will be processed.</p> <p>Anthem does not agree #72 is an exception. The claim was not submitted as a preventive visit; therefore, preventive benefits do not apply.</p>
Conclusion	<p>Both HDM and Anthem agree that contraceptive management is not a preventive care service and that sample claim #47 was overpaid. HDM has identified an additional 801 claims in this category resulting in potential overpayments in the amount of \$10,984.</p> <p>The SPD states that "Routine cytologic screening for the presence of cervical cancer and chlamydia screening (including pap test) is a preventive care service, payable at 100%. The pap smear was related to a routine OB/GYN visit; therefore, the finding remains. HDM has identified 1 additional claim in this category resulting in potential underpayment in the amount of \$4. HDM will provide Anthem with the detailed claim information for the additional claim. Anthem is required to review the additional exception.</p>
Professional, Office	
HDM Assessment	<p>Per SPD, outpatient services for non-network providers are reimbursed at 50%. The member's liability is 50% coinsurance.</p> <p>Sample #18: Anthem reimbursed OON physical therapy services at 80%. This resulted in an overpayment of \$3.40.</p> <p>Per SPD, durable medical equipment is reimbursed at 80%. The member's liability is 20% coinsurance.</p> <p>Sample #23: Anthem reimbursed durable medical equipment at 100% of the allowable charge. This resulted in an overpayment of \$15.95.</p> <p>Per SPD, office visits with a medical diagnosis are reimbursed at 80%. The member's liability is 20% coinsurance.</p> <p>Samples #35, #46: Services billed were for an evaluation and management office visit along with a laboratory test. The diagnosis presented on the</p>

	<p>sample claim V25.09 (other services, contraceptive management) is not considered part of the routine benefit under the plan. Anthem reimbursed this claim under the routine benefit at 100%. This resulted in an overpayment of \$12.70.</p> <p>Per SPD, outpatient mental nervous services are reimbursed at 50% for non-network providers. The member's liability is 50% coinsurance.</p> <p>Sample #50: Sample claim was for non-network outpatient mental nervous services that were paid at the in-network level at the request of Cincinnati. Anthem reprocessed the claim but applied a co-payment of \$24.55 and then 80% coinsurance. This resulted in an underpayment of \$19.64.</p> <p>Per SPD, Preventive Care which includes immunizations is covered at 100%.</p> <p>Sample #53: Services were for a routine child health exam with corresponding immunizations. Anthem reimbursed the claim at 80%, based on a non-routine diagnosis submitted with the bill. HDM concludes that based on the procedure codes 99395 (preventive physical exam 18-34 years old), 90734 and 90471 (both immunizations), the service is for a preventive and routine exam, and not a non-routine visit. This resulted in an underpayment of \$40.02.</p> <p>Sample #74: Services were for a routine child health exam with corresponding immunizations. Anthem paid all the procedures and immunizations at 100% except the tetanus shot. Anthem reimbursed the tetanus shot at 80%, based on a non-routine diagnosis submitted with the claim. Anthem believes that a tetanus shot is not necessarily routine and can be medical in nature. HDM concludes that the main diagnosis submitted with the claim V20.2 (routine child exam) along with the preventive medical visit code 99393 (preventive physical exam 5-11 years old) supports that the tetanus shot was part of the routine visit, and therefore should have been paid under the routine benefit. This resulted in an underpayment of \$10.00.</p>
TPA Response	<p>Anthem does agree to exceptions on #18, #23, and #50. #s 18 and 23 are under the \$25.00 threshold amount; therefore, no adjustments will be processed. #50 was adjusted to pay an additional \$19.64 on 7/9/08. Anthem does not agree #35 and #46 are exceptions. The claims were processed under the member's preventive benefits based on the diagnosis code submitted on the claims. Anthem does not agree to exceptions on #53 or #74. The claims were processed correctly as the services were not submitted as preventive care by the provider.</p>
Conclusion	<p>Per SPD, the member's responsibility is 20% for in-network providers and 50% for non-network providers with the exception of preventive care (which is covered at 100%) until the out-of-pocket (OOP) limit is satisfied. Preventive care services are listed in the SPD and include routine or periodic screening examinations and immunizations.</p> <p>HDM has identified an additional 1,014 claims in this category resulting in potential overpayments in the amount of \$13,558. HDM will provide Anthem with the detailed claims information for the additional claims. All exceptions require review by Anthem.</p>

Professional, Outpatient Hospital	
HDM Assessment	Sample #105: Per SPD, outpatient surgery is covered at 80%. Anthem incorrectly reimbursed surgery procedure 25620 at 100%. This resulted in an overpayment of \$109.
TPA Response	<p>Anthem agrees #105 is an exception. The claim has been sent for review. Once the review is finalized, an adjustment will be requested.</p> <p>November 3rd updated response from Anthem: Coinsurance was to apply to this claim; however, this claim is past the recovery time frame. Therefore, an adjustment will not be processed.</p>
Conclusion	Both HDM and Anthem agree that outpatient hospital services are covered at 80% and that sample claim was overpaid. Anthem has referred claim for adjustment. HDM has identified an additional 41 claims in this category resulting in potential overpayments in the amount of \$924. HDM will provide Anthem with the detailed claims information for the additional claims. All exceptions require review by Anthem.

Professional, Urgent Care Facility	
HDM Assessment	Sample #68: Per SPD, services performed in an Urgent Care Facility are covered at 80%. Anthem reimbursed procedure code 90718 (tetanus shot – diagnosis: cellulites) at 100%. This resulted in an overpayment of \$3.20.
TPA Response	Anthem agrees #68 is an exception. The overpaid amount, \$3.18, is under the \$25.00 threshold amount; therefore, an adjustment will not be processed.
Conclusion	<p>Both HDM and Anthem agree that urgent care services are covered at 80% and that sample claim was overpaid. HDM has identified an additional 24 claims in this category resulting in potential overpayments in the amount of \$201.</p> <p>In addition to the above findings, HDM has identified an additional 758 coinsurance claim issues resulting in potential under/overpayments in the amount of \$21,919. HDM will provide Anthem with the detailed claims information for the additional claims. All exceptions require review by Anthem.</p>

Ineligible Services			
<i>Sample Findings</i>		<i>Additional Findings</i>	
<i>Claim Count</i>	<i>Financial Impact</i>	<i>Claim Count</i>	<i>Financial Impact</i>
1	\$1,355	13	\$2,122

Facility, Outpatient Hosp	
HDM Assessment	Sample #84: Per SPD, services necessary to adjust or fit a hearing aid prescribed and dispensed by an audiologist is covered; however, hearing aids are not a covered item. Anthem incorrectly paid for a hearing aid. This resulted in an overpayment of \$1,355.31.
TPA Response	Anthem does not agree #84 is an exception. Per the benefit booklet, dispensing fee and related services, such as medical supplies, are eligible for benefits.

Conclusion	<p>Anthem incorrectly paid for a specific Plan exclusion on sample #84. Hearing aids or examinations for prescribing or fitting them are excluded under the Plan. HDM has identified an additional 2 claims in this category resulting in potential overpayments in the amount of \$90.</p> <p>In addition to the above findings, HDM has identified an additional 11 ineligible claims (claims for hearing aid exams; hearing aid DME; vision frame and lenses; activity of daily living and administrative purposes) resulting in potential overpayments in the amount of \$2,032. HDM will provide Anthem with the detailed claims information for the additional claims. All exceptions require review by Anthem.</p>		
Maximum Exceeded			
<i>Sample Findings</i>		<i>Additional Findings</i>	
<i>Claim Count</i>	<i>Financial Impact</i>	<i>Claim Count</i>	<i>Financial Impact</i>
4	\$172	155	\$6,283
Professional Office			
HDM Assessment	<p>Per SPD, outpatient mental nervous visits are limited to 50 visits annually. The non-network benefit specifically states "Limited to 50 visits annually combined with network."</p> <p>Samples #86, #87: The annual maximum of 50 outpatient visits for mental nervous was exceeded on the sample claims. Anthem applies 50 visits per calendar year for network providers and 50 visits for non-network providers. HDM concludes that the visit maximum should be 50 visits for combined network and non-network providers. This resulted in overpayments totaling \$140.69 (\$75.16 for sample #86 and \$65.53 for sample #87).</p> <p>Per SPD, there is a 12 visit maximum for Spinal Manipulations. This maximum is combined between network and non-network. The SPD further defines "Spinal manipulation as services to correct by manual or mechanical means structural imbalance or subluxation to remove nerve interference from or related to distortion, misalignment or subluxation of or in the vertebral column. Manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for spinal manipulation services as specified in the Schedule of Benefits".</p> <p>HDM has identified two interrelated administrative issues which need to be addressed. Plan maximums are being exceeded and Anthem is reimbursing for procedure code 98943 which literally translates to chiropractic manipulative treatment (CMT); extraspinal, one or more regions. The five extraspinal regions referred to are: head (including temporomandibular joint, excluding atlanto-occipital) region; lower extremities; upper extremities; rib cage (excluding costotransverse and costovertebral joints) and abdomen. The SPD specifies coverage for manual or mechanical manipulation of the spine only (CPT codes 98940 through 98942) and then extraspinal or 98943 would not be covered at all.</p> <p>Samples #89, #90: The 12 visit maximum was exceeded on the sample claims. This resulted in overpayments totaling \$31.78 (\$15.40 for sample #89 and \$16.38 for sample #90).</p>		
TPA Response	Anthem does not agree #86 and #87 are exceptions. The outpatient mental health visit maximum is 50 visits network and 50 visits non-network. These		

	<p>visit maximums are separate and not combined per instruction from the group. #86 had 40 network visits and 2 non-network visits for 2006. #87 had 36 non-network visits for 2006. According to our records, neither member had exceeded the visit maximums. This is an example where the benefit summary HDM used during the audit did not match the benefit summary for the product on the sampled claims. Anthem does not agree #89 and #90 are exceptions. CPT code 98943 does not apply toward the visit maximum for this product. According to claims history, the visit maximum was not exceeded.</p>
Conclusion	<p>The Comparison Chart indicates there is a 50 visit maximum for outpatient mental health services combined between in-network and non-network; however, the SPD provided by Anthem indicates there is a 50 visit separate maximum for in-network and non-network, thereby increasing the visit maximum to 100. HDM suggests that Cincinnati and Anthem discuss this issue as it has financial implications for Cincinnati. HDM has identified an additional 17 claims in this category resulting in potential overpayments in the amount of \$4,262.</p> <p>Per SPD, there is a 12 visit maximum for spinal manipulations. This maximum is combined between in-network and non-network. Anthem does not count CPT code 98943 or chiropractic manipulative treatment (CMT); extraspinal, one or more regions towards the visit maximum. HDM suggests that Cincinnati and Anthem discuss this issue as it has financial implications for Cincinnati. HDM has identified an additional 138 claims in this category resulting in potential overpayments in the amount of \$2,021. HDM will provide Anthem with the detailed claims information for the additional claims. All exceptions require review by Anthem.</p>

System Controls

Correct Coding Initiative			
<i>Sample Findings</i>		<i>Additional Findings</i>	
<i>Claim Count</i>	<i>Financial Impact</i>	<i>Claim Count</i>	<i>Financial Impact</i>
0	\$0	6,076	\$178,458
Unbundling			
HDM Assessment	Unbundling is a practice in which providers' bill for separate (procedure or revenue) codes which are typically included as one code. HDM has identified areas for which Anthem and its partners are allowing unbundled codes to be processed.		
TPA Response	Anthem does not agree #92, #93, nor #94 are exceptions. #92, CPT code 97010 is considered separately reimbursable from the other services billed. #93, lab charges submitted by an independent lab are considered separately reimbursable the inpatient hospital claim. #94, the chemotherapy services billed are considered separately reimbursable. Please note: At the end of the onsite audit, these sampled items were determined to be processed correctly by both the audit firm and Anthem.		
Conclusion	Applying CMS (Center for Medicare/Medicaid Services), industry standards, and AMA (American Medical Association) unbundling guidelines to Cincinnati's claims for the audit period, HDM has identified 6,076 claims in categories of incidental procedures, independent labs, and procedures that		

	are components of each other resulting in potential overpayments in the amount of \$178,458. HDM will provide Anthem with the detailed claims information for the additional claims. All exceptions require review by Anthem.
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Duplicate Claim Payment			
<i>Sample Findings</i>		<i>Additional Findings</i>	
<i>Claim Count</i>	<i>Financial Impact</i>	<i>Claim Count</i>	<i>Financial Impact</i>
3	\$2,038	263	\$40,057

Hard Duplicate

HDM Assessment	<p>HDM identified that duplicate (identical) charges were reimbursed.</p> <p>Sample #95: REV codes 250 and 258 are duplicate payment of claim number 070661D6A. This resulted in an overpayment of \$15.62.</p> <p>Sample #97: Sample claim is a duplicate of claim number 0711500093. Services provided were paid twice. This resulted in an overpayment of \$2,005.42.</p> <p>Sample #102: Procedure code 97110 is a duplicate payment of claim number 060883E705. This resulted in an overpayment of \$17.29.</p>
TPA Response	<p>Anthem does agree #95, #97, and #102 are exceptions. The overpaid amounts on #95 and #102 are under the \$25.00 threshold amount; therefore, no adjustments will be processed. An adjustment request has been sent for #97 to recover the overpaid amount, \$2005.42.</p>
Conclusion	<p>For sample #97, after the claim has been adjusted, Anthem needs to report the recovery status directly to Cincinnati.</p> <p>HDM has identified an additional 263 duplicate claims resulting in potential overpayments in the amount of \$40,057. HDM will provide Anthem with the detailed claims information for the additional claims. All exceptions require review by Anthem.</p> <p>HDM recommends that Anthem expand their current duplicate system logic and procedures in place to reduce this type of financial error in the future.</p>

Eligibility			
<i>Sample Findings</i>		<i>Additional Findings</i>	
<i>Claim Count</i>	<i>Financial Impact</i>	<i>Claim Count</i>	<i>Financial Impact</i>
3	\$2,915	82	\$15,732

DOS Outside TPA Eligibility

HDM Assessment	<p>Per SPD, the plan does not provide benefits for service or supplies incurred after the termination date of a member's coverage.</p> <p>Sample #107: Sample claim was reimbursed for charges after a cancellation of coverage/termination date of 1/31/06. The termination date was received after the claim was processed. This resulted in an overpayment of \$2,854.99.</p>
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	<p>Sample #108: Sample claim was reimbursed for charges after a cancellation of coverage/termination date of 6/30/06. The termination date was received after the claim was processed. This resulted in an overpayment of \$57.98.</p> <p>Sample #109: Sample claim was reimbursed for charges after a cancellation of coverage/termination date. The termination date was received after the claim was processed. This resulted in an overpayment of \$1.60.</p> <p>Anthem has submitted an "Adjustment Request" for review of possible overpayments.</p>
TPA Response	Anthem does not agree #107, #108, and 109 are exceptions as the claims processed correctly per the eligibility information on file. The updated information was not received until after the claims were finalized.
Conclusion	Benefits were released which the dates of service were outside the eligibility period. HDM has identified an additional 82 claims in this category resulting in potential overpayments in the amount of \$15,732. HDM will provide Anthem with the detailed claims information for the additional claims. All exceptions require review by Anthem.

Surgery Payments			
<i>Sample Findings</i>		<i>Additional Findings</i>	
<i>Claim Count</i>	<i>Financial Impact</i>	<i>Claim Count</i>	<i>Financial Impact</i>
1	\$20	331	\$41,534

Assistant Surgeon Reduction

HDM Assessment	Sample #115: The American Medical Association (AMA) standard is that assistant surgeons are reimbursed at 20% of the primary surgeon's allowable rate. Anthem processed assistant surgeons based on the provider contracted rate. This resulted in an overpayment of \$19.79.
TPA Response	Anthem does not agree #115 is an exception. The claim priced correctly per the contractual agreement with the provider. The services are allowed at 16% per the negotiated rate.
Conclusion	<p>Anthem contractual agreement is to reimburse assistant surgical fee at 16%. Industry standard is to reimburse assistant surgeon's 20% of the primary surgeon's allowable rate. The error remains. HDM has identified an additional 10 claims in this category resulting in potential overpayments in the amount of \$559. HDM will provide Anthem with the detailed claims information for the additional claims. All exceptions require review by Anthem.</p> <p>In addition to the above findings, HDM has identified an additional 321 surgical claims for bilateral procedures, CRNA, multiple surgical claims, etc. resulting in potential overpayments in the amount of \$40,975. HDM will provide Anthem with the detailed claims information for the additional claims. All exceptions require review by Anthem.</p>

Exhibit 2



**REVIEW OF
ANTHEM BLUE CROSS
BLUE SHIELD'S
HEALTH PLAN
ADMINISTRATION**

For

City of Cincinnati Retirees

November 20, 2008

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Confidentiality

This report may contain medical and personal information concerning employees that may be subject to state, federal or other regulatory authority privacy and confidentiality laws and regulations. Information provided by the claims administrator was released with similar confidentiality restrictions. All claims and medical situations discussed in this report are identified by a number rather than by actual employee and/or dependent names. Use or distribution of any confidential information contained in this report should be limited to authorized individuals.

Section I - Executive Summary

Engagement Overview and Scope

The City of Cincinnati (Cincinnati) engaged the services of Healthcare Data Management, Inc. (HDM) to conduct a health plan review to assess Anthem Blue Cross Blue Shield's (Anthem's) administration of Cincinnati's self-funded retiree health plans and determine if Anthem is in compliance with the terms of the Administrative Services Agreement. This engagement examined Anthem's claims adjudication accuracy relative to claims incurred by Cincinnati's plan members. In addition, HDM was engaged to perform an operational review and a financial review to assess the policies, procedures, and controls that support the administration of Cincinnati's health plan and confirm whether Anthem is accurately invoicing Cincinnati for paid claims and crediting back recoveries.

Claim Review Scope

A sample of 109 claims incurred by Cincinnati's plan participants from January 1, 2006 to December 31, 2007 and paid through January 31, 2008 was selected for onsite testing and review. The sample was selected based on exception areas identified in the entire population of claims processed during the review period. These exception areas were based on standard claim processing scenarios (e.g. duplicate claims); specific plan benefits described in the Summary Plan Document (SPD) and industry standards.

Review Conclusions

Of the 109 claims tested, 36 exceptions were validated as errors with a dollar value of \$4,140. Based on the specifics of the sample findings, HDM performed additional analyses on the entire claims population and identified additional exceptions totaling \$804,565. The following chart compares the total dollar amount of all exceptions identified by this review against the total dollar amount of Cincinnati's entire claims population.

Overall Claim Review Results	Amount
Total dollar amount of all Cincinnati retiree healthcare claims for the review period	\$45,840,902
Total dollar amount of claims sample	\$332,758
Total dollar amount of errors/exceptions identified in claims sample	\$4,140
Total dollar amount of all potential exceptions identified from HDM's analysis of Cincinnati's entire claims population based on the attributes of HDM's claim sample findings	\$808,705

The results include claims that were both overpaid and underpaid by Anthem from Cincinnati's perspective. The dollar figures shown reflect the absolute dollar amount of the exceptions regardless of whether the claims was overpaid or underpaid.

Based on the results of the review, there were several areas identified that should be addressed in order to improve the contractual relationship between Cincinnati and Anthem and the accuracy of claims processing. HDM has several recommendations that if implemented, would improve claims processing and result in savings to Cincinnati. These recommendations and the additional findings are detailed below and in Appendix A of this report.

The results of the operational review indicated that Anthem has the proper organizational structure, workflows and policies and procedures in place to support the Cincinnati account.

The results of the financial review determined that Anthem is properly invoicing Cincinnati for claims incurred and recoveries received.

Summary of Key Findings & Recommendations

Based on the results of the engagement, the following issues represent the greatest opportunity for both Cincinnati and Anthem regarding the administration of the retiree health plans. HDM will provide Anthem with reports detailing the additional claims identified as potential exceptions. In addition, it should be noted that there are other findings detailed in Appendix A of this report that require Anthem's attention.

Plan Benefit Conflicts

HDM noted Anthem is not consistently administering benefits according to the benefit information provided by Cincinnati. Specifically, the application of coinsurance and copayments are not being applied properly. Anthem stated the benefits were being administered according to specific products. While these issues did not have a significant financial impact on Cincinnati for the review period, all benefits should be reviewed and Anthem should administer the benefits according to Cincinnati's intentions.

Specific examples of benefit discrepancies include:

- Surgery performed in a physician's office
- Allergy treatment and services
- Outpatient psychiatric services

In addition, it does not appear that deductibles are being applied consistently for the Blue Access plan and the Blue Traditional plan. Anthem appears to be cross-accumulating the deductible and out-of-pocket expenses for the Blue Access plan and not applying a deductible for the Blue Traditional plan.

Coordination of Benefits

HDM identified claims in the sample where Anthem processed as the primary payor when Medicare should have been the primary payor. Based on the sample findings, we identified approximately 6,500 claims where Medicare should have been the primary payor on the claim.

These claims totaled over \$500,000 in payments, but because Anthem would have some responsibility as the secondary payor, not all of the \$500,000 can be considered a recoverable amount.

HDM recommends that, in addition to reviewing the claims in question, Anthem review with Cincinnati the procedures for determining the primary payor for Medicare-eligible members and ensure that the membership records are properly updated. If not being performed, periodic surveys should be conducted of the Medicare-eligible members.

Claim Unbundling

Anthem uses the ClaimCheck software program to identify situations where a claim should be “bundled” in order to avoid payment for procedures which are typically included in the primary procedure performed. In some cases this bundling logic does not agree to the correct coding initiative (CCI) guidelines established by the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA). In addition, attempts by providers to submit unbundled claims represent abusive or fraudulent billing practices.

HDM identified over 3,000 claims involving incidental procedures, laboratory charges and procedures that are components of each other resulting in potential overpayments of approximately \$108,000. This represents an opportunity for discussion between Cincinnati and Anthem regarding customizing ClaimCheck to meet Cincinnati’s expectations, ensure provider’s are paid properly and reduce claims expense.

Duplicate Claims

HDM identified claims in our sample that were paid as duplicates. Two of the sample claims were paid as a result of a manual processing error. For the entire claims population, we identified approximately 1,100 potential duplicate claims totaling approximately \$67,000 in overpayments.

HDM recommends that Anthem review its system logic for identifying potential duplicate claims and its procedures for over-riding a potential duplicate claim to ensure that the possibility of a duplicate claim being paid is minimized.

Benefits Paid After Termination

HDM identified approximately 70 claims totaling approximately \$31,000 that were paid after the member’s termination date.

Coinsurance and Copayments

HDM noted claims in the sample where Anthem did not apply the proper coinsurance or copayment. As noted above, some of these findings resulted from discrepancies between the benefit documentation from Cincinnati and the products being used by Anthem. In all, over 2,600 claims were identified across the entire population resulting in findings totaling approximately \$50,000 in payment exceptions.

BenefitsWatch

HDM has taken the liberty to analyze your historical data utilizing HDM's proprietary software, BenefitsWatch. The analysis will be provided under separate cover.

BenefitsWatch is a monitoring/compliance service provided by HDM that gives employers control over health benefits administration and holds carriers and pharmacy benefits managers accountable for claims errors and recovery of overpayments. HDM developed this proprietary solution to ensure prompt delivery of a return on investment and realization of lasting results for the long term. BenefitsWatch is an effective tool in any continuous improvement process.

On a concurrent basis, BenefitsWatch monitoring solution will provide Cincinnati with:

- The identification and recovery of overpaid or erroneous medical and prescription drug claims
- The detection and correction of inappropriate billing practices
- The benchmarking of data to monitor the effectiveness and accuracy of Anthem's contract administration and pricing compliance with your signed contracts and SPDs
- Negotiation and implementation of corrective actions, and
- The correction of past erroneous practices.

Section II – Engagement Approach

The following is a description of HDM’s objectives and methodology with regard to this engagement.

Claims Review Objectives

HDM performed a retrospective review of Anthem’s adjudication of Cincinnati’s retiree health plan claims incurred during the review period to assess Anthem’s claim processing accuracy and overall effectiveness as Cincinnati’s health plan administrator. This included a comprehensive evaluation of Anthem’s:

- Adherence to Cincinnati’s benefit plan requirements and benefit specifications
- Application of copayments and coinsurance
- Efforts to ensure claim payments are for eligible claimants and for eligible health care services
- Controls to identify aberrant billing practices and improper provider billing/coding
- System edits to detect and prevent duplicate claim payments
- Provider discount applications, fee schedules, and usual and customary allowances
- Handling of claim payment appeals, adjustments and refunds
- Identification and recovery of overpayments
- Ongoing quality assurance
- Coordination of benefits with other group plans, payors and Medicare
- Enforcement of claim documentation requirements and medical necessity reviews

Claims Review Methodology

HDM’s review approach and methodology included the following:

- Review of health plan documentation including Summary Plan Description and Administrative Services Agreement
- Analysis of 100% of Cincinnati’s claims processed and paid during the review period
- Data analysis and claims sampling selection
- Onsite claims review to assess claims adjudication accuracy and to identify any systemic problems, financial issues, contract compliance issues
- Root cause analysis of errors and quantification of the financial impact of errors across the entire claims population, if applicable
- Preparation of report and solicitation of Anthem’s action plans to address key findings and overpayment concerns

Claim Sampling

HDM obtained the SPD from Cincinnati and a claims data file from Anthem containing detailed records of 100% of Cincinnati's claims and corresponding benefit reimbursements processed during the review period. Additionally, an eligibility file was obtained containing the covered employees and their dependents. Using this data, a customized data warehouse was created and HDM's reviewers and data analysts performed a series of analyses of 100% of Cincinnati's claims processed based on various business rules. These business rules were generated from the SPD, various industry guidelines and proprietary HDM data. Based on HDM's claims analyses, a claims sample consisting of 109 medical claim payments totaling \$332,758 was selected for testing. The sample identified claims that may have been paid in error or did not comply with standard industry guidelines for claims administration.

The following chart summarizes the claim counts and payments by plan for the entire claim population and claim sample.

<i>Plan Type</i>	<i>Claim Population</i>		<i>Claim Sample</i>	
	<i>Count</i>	<i>Paid</i>	<i>Count</i>	<i>Paid</i>
Blue Priority/HMO-100% Retirees/COBRA	57,083	\$10,778,155	23	\$95,556
Blue Access/PPO-\$10 Copay Retirees/COBRA	48,645	\$11,148,765	42	\$160,038
Blue Traditional/Indemnity-80/20 Retirees/COBRA	180,054	\$23,913,982	44	\$77,164
Total	285,782	\$45,840,902	109	\$332,758

The next chart displays the distribution associated with the Cincinnati claim sample by place of service and claim type.

<i>Place Of Service</i>	<i>Sample Claim Count</i>	<i>Facility Claims</i>		<i>Professional Claims</i>	
		<i>Count</i>	<i>Paid</i>	<i>Count</i>	<i>Paid</i>
Blue Priority/HMO-100% Retirees/COBRA					
Ambulatory Surgery Center	2	1	\$485	1	\$82
Emergency Room	1	1	\$293	-	-
Home	6	-	-	6	\$8,318
Independent Lab	1	-	-	1	\$59
Inpatient Hospital	3	2	\$84,122	1	\$260
Office	8	-	-	8	\$1,456
Outpatient Hospital	2	1	\$336	1	\$146
Total	23	5	\$85,236	18	\$10,321

	<i>Sample Claim</i>	<i>Facility Claims</i>		<i>Professional Claims</i>	
Blue Access/PPO-\$10 Copay Retirees/COBRA					
Ambulatory Surgery Center	2	1	\$450	1	\$333
Emergency Room	1	1	\$48	-	-
Home	4	-	-	4	\$983
Independent Lab	1	-	-	1	\$43
Inpatient Hospital	4	3	\$148,836	1	\$258
Skilled Nursing Facility	1	-	-	1	\$155
Office	22	-	-	22	\$3,116
Outpatient Hospital	7	5	\$5,503	2	\$314
Total	42	10	\$154,837	32	\$5,202
Blue Traditional/Indemnity-80/20 Retirees/COBRA					
Ambulance	2	1	\$78	1	\$54
Emergency Room	1	1	\$206	-	-
Home	7	-	-	7	\$2,174
Independent Lab	1	-	-	1	\$2
Inpatient Hospital	5	4	\$69,620	1	\$38
Office	21	-	-	21	\$3,543
Outpatient Hospital	6	3	\$1,042	3	\$358
Urgent Care Facility	1	-	-	1	\$50
Total	44	9	\$70,946	35	\$6,219
Grand Total	109	24	\$311,019	85	\$21,742

Claims Data Analysis

As referenced previously, HDM created a data warehouse and completed a series of analyses on Cincinnati's claims data. This analysis was instrumental in the structure and selection of Cincinnati's claims sample. In addition, analysis was completed on 100% of Cincinnati's entire claim population for the review period in order to calculate Cincinnati's average provider discount that was achieved as a result of Cincinnati's plan members utilizing Anthem's participating provider network, as well as Anthem's average claim processing turnaround time for all claims incurred during the review period.

Onsite Claim Review

HDM conducted an onsite review of Cincinnati's claim sample at Anthem's office located in Springfield, MO during the week of July 7, 2008. HDM was granted access and were given hard-copy claims and contractual discount documentation for all sample claims, which enabled

HDM to conduct an effective review of Cincinnati’s health claim payments for error detection and root-cause validation.

For any claim payment discrepancies encountered, HDM presented documented questions to a designated Anthem representative for response, confirmation and assessment of the origin of the exception. This approach provided Anthem with an opportunity to clarify benefit determinations and provide any additional information or documentation to support claim payment decisions.

Examples of the types of questions and issues addressed throughout HDM’s review of Cincinnati’s claims sample are provided in the following chart. This is intended to provide a sense of the questions that were raised, but this list is not all-inclusive.

<i>Focus Areas</i>	<i>What We Looked For</i>
Claimant Eligibility	Were all employee/dependent eligibility fields within Anthem’s system reflecting correct information in accordance with claim documents?
Coordination of Benefits/ Other Party Liability	Were primary benefit plans and other party liabilities identified and properly flagged in the system? Were benefits coordinated correctly?
System Edits and Alerts	Were system flags and edits effective for alerting claim processors to potential duplicate claims, aberrant billing practices, overcharging by medical providers, etc?
Provider Discounts	Were appropriate discounts applied on claim payments?
Data Integrity	Were all critical data fields entered correctly from paper and electronically submitted claim documents?
Benefit Guidelines and Provisions	Were Cincinnati’s specific plan requirements, benefit exclusions, service limitations, and maximums correctly applied?
Administrative Procedures	Were all claims processed in accordance with Anthem’s normal administrative procedures and industry standard practices?
Managed Care	Were the appropriate cost-containment and managed care guidelines reviewed, documented, and adhered to?
Supporting Documentation	Were necessary claims and medical documentation for each sample claim payment requested, obtained, and on file with claims file?

Global Analysis of Exceptions

Based on the attributes of all confirmed payment exceptions, HDM reviewers and data analysts performed additional analyses on Cincinnati’s claims population. As a result, HDM identified additional claim payment exceptions similar to those confirmed during the onsite review. These claim payment exceptions are detailed in Section III “Detailed Findings and Observations” as well as Appendix A of the report. HDM has provided Anthem with detailed claim exception reports for review and, if necessary, adjustment of the claims.

The results of the additional findings in this report are not based on an extrapolation of this review's exception ratios or performance measurements. Instead, these results reflect actual claim payments during the review period which are similar to the sample findings confirmed onsite. All exceptions will require Anthem's review, confirmation and discussion with Cincinnati as to how overpayments should be handled.

Operational Review

During the onsite review at Anthem, HDM completed an operational review of Anthem's operations and procedures that have an impact on the administration of Cincinnati's health claims. The review was based on information and documentation Anthem provided through completion of a comprehensive procedural questionnaire and onsite interviews with key management personnel. The information and documentation provided helpful insight regarding Anthem's operations and was an integral part of the overall process for identifying administrative issues that may affect the claim payment exceptions confirmed during the onsite review.

Financial Review

HDM also performed a financial review during the onsite review at Anthem that consisted of a reconciliation of Cincinnati's paid claims against Anthem's corresponding billing records for several months of the review period. The purpose of this review was to confirm whether Cincinnati was accurately invoiced by Anthem and if Cincinnati was receiving appropriate credits for recoveries from claim overpayments.

Section III – Detailed Findings and Observations

Claims Sample Results

The chart that follows provides a summary of the claim counts and related payments that were included in the medical claims sample, as well as the corresponding counts and financial impact of the claim payment exceptions that were identified.

Exception Area	Claim Sample		Sample Findings	
	Count	Paid	Count	Financial Impact
Blue Priority/HMO-100% Retirees/COBRA				
Administrative Services Agreement				
Case Management	2	\$544	-	-
Contract Review	1	\$61,577	-	-
Plan Provisions				
Coinsurance Application	4	\$7,265	1	\$51
Copayment Application	4	\$533	-	-
Ineligible Services	1	\$1,020	2	\$51
Maximum Exceeded	2	\$153	1	\$152
System Controls				
Duplicate Claim Payment	4	\$518	-	-
Eligibility	2	\$741	1	\$115
Standard Operating Procedures	1	\$22,545	-	-
Surgery Payments	2	\$659	1	\$114
Subtotal	23	\$95,556	6	\$483
Blue Access/PPO-\$10 Copay Retirees/COBRA				
Administrative Services Agreement				
Case Management	1	\$55	-	-
Contract Review	5	\$127,590	-	-
Other Party Liability	2	\$502	3	\$565
Plan Provisions				
Coinsurance Application	8	\$1,683	2	\$51
Copayment Application	18	\$29,291	3	\$70
Maximum Exceeded	1	\$15	1	\$15
System Controls				
Correct Coding Initiative	2	\$82	-	-
Deductible	1	\$213	-	-
Duplicate Claim Payment	3	\$522	2	\$648
Surgery Payments	1	\$85	1	\$85

Subtotal	42	\$160,038	12	\$1,434
Blue Traditional/Indemnity-80/20 Retirees/COBRA				
Administrative Services Agreement				
Case Management	2	\$231	-	-
Contract Review	1	\$59,589	-	-
Other Party Liability	2	\$284	1	\$142
Plan Provisions				
Coinsurance Application	22	\$4,980	10	\$298
Copayment Application	4	\$1,503	-	-
Ineligible Services	-	-	3	\$103
Maximum Exceeded	2	\$368	1	\$96
System Controls				
Correct Coding Initiative	1	\$2	1	\$2
Duplicate Claim Payment	7	\$9,966	2	\$1,582
Eligibility	1	\$13	-	-
Surgery Payments	2	\$227	-	-
Subtotal	44	\$77,164	18	\$2,223
Total	109	\$332,758	36	\$4,140

HDM performed additional analysis of the entire claims population for the review period using the attributes of the claim payment exceptions identified. This analysis identifies and quantifies additional findings with similar characteristics and adjudication outcomes. The results of this analysis are provided in the following chart.

<i>Exception Area</i>	<i>Sample Findings</i>		<i>Additional Findings</i>	
	<i>Count</i>	<i>Paid</i>	<i>Count</i>	<i>Financial Impact</i>
Blue Priority/HMO-100% Retirees/COBRA				
Administrative Services Agreement				
Other Party Liability	-	-	838	\$80,962
Plan Provisions				
Coinsurance Application	1	\$51	5	\$30
Copayment Application	2	\$51	17	\$258
Ineligible Services	-	-	7	\$553
Maximum Exceeded	1	\$152	1	\$15
System Controls				
Correct Coding Initiative	-	-	597	\$25,386
Duplicate Claim Payment	-	-	303	\$16,280
Eligibility	1	\$115	10	\$571
Surgery Payments	1	\$114	81	\$3,037
Subtotal	6	\$483	1,859	\$127,092

Blue Access/PPO-\$10 Copay Retirees/COBRA				
Administrative Services Agreement				
Other Party Liability	3	\$565	531	\$57,146
Plan Provisions				
Coinsurance Application	2	\$51	11	\$174
Copayment Application	3	\$70	166	\$5,936
Ineligible Services	-	-	7	\$310
Maximum Exceeded	1	\$15	118	\$2,816
System Controls				
Correct Coding Initiative	-	-	1,370	\$54,057
Duplicate Claim Payment	2	\$648	73	\$5,340
Eligibility	-	-	2	\$368
Surgery Payments	1	\$85	111	\$10,908
Subtotal	12	\$1,434	2,389	\$137,055
Blue Traditional/Indemnity-80/20 Retirees/COBRA				
Administrative Services Agreement				
Other Party Liability	1	\$142	5,113	\$379,035
Plan Provisions				
Coinsurance Application	10	\$298	2,444	\$42,760
Copayment Application	-	-	10	\$450
Ineligible Services	1	\$96	20	\$1,605
Maximum Exceeded	3	\$103	12	\$2,134
System Controls				
Correct Coding Initiative	1	\$2	1,149	\$28,328
Duplicate Claim Payment	2	\$1,582	748	\$45,873
Eligibility	-	-	61	\$29,732
Surgery Payments	-	-	140	\$10,501
Subtotal	18	\$2,223	9,697	\$540,418
Total	36	\$4,140	13,945	\$804,565

All findings, recommendations, and conclusions relative to HDM's specific claims sample findings and global analysis of Cincinnati's entire claims population, are further detailed in Appendix A.

Section IV - Operational Review

As part of the engagement, HDM conducted an operational review to assess the capabilities of Anthem in support of the Cincinnati account. The review consisted of a combination of onsite interviews of management and staff to discuss departmental staffing, workflows, procedures and controls; review of selected departmental documentation; review of policies and procedures; review of questionnaires completed by Anthem prior to the engagement and onsite walk-through. The operational review covered the following areas:

- Mail Room Operations
- Claims
- Customer Service
- Membership/Enrollment
- Other Party Liability
- Disaster Recovery Planning
- Business Continuity Planning
- Special Investigations
- HIPAA Privacy

Based on the work performed, it appears that Anthem has the proper organizational structure, workflows and policies and procedures in place to support the Cincinnati account.

The following is a summary of the key aspects of each department/function reviewed.

Mail Room Operations

Since July 2006, Anthem has outsourced its mail room services to an outside vendor. The vendor is also responsible for imaging and data entry of claims. The mail is picked up from the Post Office in Louisville, KY at 4:00 AM, 6:00 AM and 8:00 AM, Monday through Saturday. At the vendor's facility it is opened and sorted between claims and correspondence. The claims are further sorted and batched by type (facility, professional, dental, member). The mail is opened and date stamped. Once the sorting process is completed, the claims are ready for scanning.

Kodak scanning equipment is utilized. Each document scanned is assigned a document control number (DCN) for tracking purposes. The receipt date assigned is imbedded in the DCN. Claims are then data entered by the vendor and the images and data files are sent to Anthem's Reconciliation and Balancing Database for receipt acknowledgement.

Following the claims being scanned, the vendor will key all of the fields on the claim into the FACETS system. The claims data is then transferred to the FACETS system for processing based on a Blue Cross Blue Shield plan code for BlueCard claims and through a business distribution system for all other claims. Quality checks are performed on the keying process.

The paper claims and related documents are kept on site for 14 days and are then shredded by an outside company. Anthem maintains two years of claim history online and historical claims are archived for seven years.

Anthem has a service level agreement with the vendor to ensure that a certain performance level is met for the mail processing, imaging and keying process. In general the expected turnaround time for the entire process – from initial receipt to keying – is 48 to 72 hours. The vendor also has a quality assurance team that performs six sigma audits on the mail room operations on a monthly basis. Anthem management receives a copy of the report. Anthem's internal audit department also audits the mail room annually.

Claims

Anthem uses the FACETS system to process claims on behalf of Cincinnati. The system has been in place since 1998 and has been updated on an ongoing basis to ensure the latest state of the art processing technology. Claims involving another BlueCross BlueShield Plan are processed through the Inter-Plan Teleprocessing System (ITS) as part of the BlueCard Program.

The claims for Cincinnati follow the regular claims flow through FACETS and there are no dedicated claims processors for Cincinnati. There are over 600 employees in Central Claims Operations where Cincinnati's claims are processed. The examiners process all claim types.

Approximately 90% of claims received by Anthem for all of its lines of business are received electronically. Of all claims received, approximately 70% are auto-adjudicated by the FACETS system. Claims are routed electronically using a system router based on member eligibility and the unique member identification number. All pending claims are stored in FACETS Work Manager by queues to determine the level of expertise required and the processor skill set. Pending claims are divided between beginner, intermediate and advanced. The level of pends that a processor can work depends on their level of experience, their quality scores and the availability of positions. There are numerous edits set up in the system to ensure the validity and accuracy of the claims data and to identify claims which require manual intervention and/or review. Anthem also utilizes a software package to ensure providers are billing appropriately. This software checks for proper billings over a number of categories, including, but not limited to, edits for unbundling of services, mutually exclusive procedures and incidental services. Reference materials for claim processing procedures are available on-line and in the form of hard copy manuals.

Anthem has also instituted various dollar thresholds for claims to be reviewed prior to payment. The review level is on a progressive scale based on the type of claim and dollar amount; meaning that the higher the payment the higher the level of personnel required to review and approve the claim. Professional claims over \$15,000 and inpatient and outpatient claims over \$30,000 are reviewed.

Claims are processed on a first-in, first-out basis. Inventory levels are checked on a regular basis by Claims Department management. The IT Department balances the claims inventory on a daily basis. Out-of-balance situations are brought to the attention of Claims Department management.

Experienced Claims Department employees have certain levels of production and claim processing accuracy that they are expected to achieve. These are monitored through the quality assurance process. The production standard for a fully trained claims examiner is 15 claims per hour. The accuracy level for experienced processors is 97%. Through the quality program, examiners have between five and thirty four claims reviewed on a monthly basis. The number of claims to be audited is reviewed on a quarterly basis depending on the processor's level of performance.

Employees in the Claims Department are subject to a training program that lasts approximately ten weeks. The training takes place in a classroom setting. There is standard testing throughout and examples of production claims are used. Following the training program, 100% of a new employee's claims are reviewed on a pre-payment basis. Once they reach a 95% accuracy level, the examiners are subject to the regular quality assurance program.

Customer Service

The Cincinnati account is supported by Anthem's Customer Service Department in Mason, OH. The department is primarily responsible for responding to telephone and written inquiries. The department also processes some claims adjustments resulting from member inquiries. There are approximately thirty Customer Care Representatives (CCRs) in the unit that handles Cincinnati's telephone inquiries. The CCRs' average experience level is approximately five years. Anthem also has "hot line" CCRs who Cincinnati's Human Resources Department has access to. The unit has a dedicated phone number.

Telephones are staffed from 8:00 AM to 6:00 PM, Monday through Friday. In total, each CCR takes approximately 65 calls per day. If a member calls after regular business hours they are given the option to call back during regular hours or have their call answered through Interactive Voice Response (IVR). They are also referred to Anthem's web site and can send an e-mail. A workforce management system is utilized to monitor and analyze call volumes and make schedule determinations.

The CCRs have immediate access to online claims information for responses to member inquiries. Examples of common inquiries include claim status, benefit information, claim payment dates and provider information. Aging reports are available and monitored by management for those inquiries not resolved on initial contact.

All calls are recorded for potential subsequent review through the Verint system. For approximately 30% of the calls, Anthem records each system screen accessed by the CCR during the call. This information is used for the quality assurance process and for training purposes.

As noted, CCRs have the ability to process claim adjustments. Only adjustments that pay an additional amount on the claim can be processed and there are restrictions placed on the dollar amount and type of adjustment that can be made.

CCRs are subject to quality assurance reviews conducted by call coaches from an outside department. At a minimum, three calls are monitored per CCR per month. CCRs are expected to perform, based on the scoring system in place, at or above 96.68%. The call coaches meet with each CCR monthly to review their performance and discuss opportunities to improve member satisfaction and service skills. If an employee is not performing at an acceptable level, an operations expert or manager will monitor one or two calls per week. If necessary, a performance improvement plan will be put in place. In those situations, weekly meetings with the CCR are held. In addition, management can monitor telephone calls for quality or in situations where a CCR may need assistance (e.g. long call).

CCRs complete a training program that lasts approximately nine weeks. This program covers system navigation and all programs/applications the CCR may have to access. During the training, the new CCR will shadow an experienced CCR. After approximately seven weeks, the new CCR will take some live calls which are monitored. CCRs must pass various quizzes throughout the training program and must achieve a final score of 95 on the final test given at the end of the training.

Membership/Enrollment

Anthem has assigned a dedicated enrollment and billing specialist to process membership transactions for Cincinnati. There is a back-up in place.

All enrollment/membership transactions are handled via paper. Transactions (additions, terminations, changes) for active employees are received two times per month and transactions for retirees are received once a month. The volume varies, however the average batch received has approximately fifty transactions. The turnaround time for processing membership transactions is three to five business days.

The membership transactions processed are subject to quality review. On a monthly basis a random sample of transactions are audited by the Internal Audit Department.

All membership changes including effective and termination dates are provided by Cincinnati. Cincinnati is also responsible for informing Anthem of members who are eligible for Medicare. For dependent eligibility, Anthem also relies on Cincinnati to notify them of dependents over 19 who are full-time students. The membership system is automatically updated each year until Anthem is notified of the termination. Members are reminded through Explanation of Benefit (EOB) statements to notify Cincinnati if the dependent is no longer a full time student.

Other Party Liability (OPL)

OPL includes situations covering subrogation and workers compensation where another entity may be responsible for claim payments resulting from an automobile accident or on-the-job injury. Anthem primarily manages subrogation and workers compensation in-house and has identified a number of procedure codes with a diagnosis that could be related to trauma or an accident. These codes are generally updated in conjunction with revisions to the ICD-9 manual, which lists diagnosis codes for medical conditions. When a claim containing an accident-related

or trauma-related diagnosis is processed, Anthem will flag the claim. A \$200 threshold is used for OPL cases and if the claims processed are below \$200, Anthem's software program has logic to accumulate the claims to the threshold. Once the \$200 threshold is met, Anthem sends a letter and questionnaire to the member that requests certain information be provided to establish if an accident of work-related injury has occurred and also seeks information regarding liability. If no response is received after 30 days, a second letter is sent and the member has fifteen days to respond. Following three attempts without a response, the case is handed over to outside counsel to pursue. Members can respond by replying to the questionnaire, calling a toll free number or accessing a web site.

Once an OPL case is established, Anthem follows a pay and pursue approach. Anthem retains 25% of the recoveries from its subrogation activities to cover its costs. If a third party is involved in the recovery process, 15% of the recoveries are retained. Claims previously paid by Anthem in a subrogation or workers compensation case are adjusted on a dollar for dollar basis up to the net recovery amount. There is no fee charged for cases that do not result in a recovery.

Disaster Recovery Planning

Anthem's disaster recovery plan is designed to protect against data loss and provide recovery from major unplanned interruptions to computing services. Anthem has a disaster recovery plan in place for the FACETS system. The IBM data center located in Sterling Forest, NY serves as the hot site for FACETS. Other systems and applications are protected by a hot site agreement with SunGard. Applications and data would be recovered from backup tapes stored at offsite locations. Recovery times would range from three days to two weeks or more, depending on system criticality.

The Disaster Recovery Team includes six full time employees and a manager. The disaster recovery plans are updated annually or more frequently if necessary depending on system changes. In 2007, steps were taken to have all disaster recovery plans follow a standard format.

A comprehensive disaster recovery testing program is in place for Anthem's systems. Up to 112 testing hours are provided annually under the hot site contracts. The recovery exercises include personnel from IT and Operations. The last recovery exercise for FACETS took place in November 2007 and involved over fifty employees. All critical systems and applications are tested annually.

Results of recovery exercises are documented in a report which is distributed to IT management, the applicable hot site vendor and Internal Audit. An internal software tool is used to track issues and the Disaster Recovery Team monitors them to closure. Post-recovery exercise meetings are also held.

Business Continuity Planning

Business continuity plans provide for recovery of critical business functions. Anthem has a comprehensive state-of-the art business continuity planning program in place covering all aspects of its operations across the country.

The Business Continuation Department for Anthem reports to the Chief Financial Officer. Its purpose is to coordinate and manage the business continuity program and ensure consistency across the Anthem organization.

Process experts within each department, using a standardized approach and methodology, build business continuity plans. Plans are documented using both Microsoft Word and Microsoft Excel and are maintained in a document management system that was developed by Anthem. The focus of the business continuity plans is process-oriented, with less reliance on the availability of the actual personnel. The approach relies on the skill sets of management to execute the business continuity plans in place. Plans are updated at least annually.

Anthem regularly tests its business continuity plans and strategies. Exercises are usually pre-planned but unannounced (e.g. building evacuation). Each critical process is tested at least once per year.

The business continuity plans are primarily developed based on the availability of resources, not on an event. They are developed to handle varying time frames that the business may be down – hours, days or weeks. A different strategy/plan would be used based on these time frames. The strategy deployed would also be based on different situations (e.g. facilities not available, personnel not available, systems not available, etc.).

In the event of a situation that would require the business continuity plans to be put into action, shared resources would be deployed to the affected area to support the efforts. A mobile van is available with full technology capacity. Many of Anthem's facilities are equipped to link with the technology in the van. Additionally, Anthem's Executive Leadership Team has determined which functions/processes will be resumed first in the event of a major business interruption. The priority is based on the criticality of the functions'/processes' customer interface.

Business continuity plans are kept in a central location and key managers are required to maintain a copy offsite.

Each Anthem location has an Emergency Procedures Manual that is given to each employee. The manual covers various emergency events including site evacuation. The manual also describes the emergency management program which includes a hot line, location of virtual command centers and listings of corporate resources, local resources and emergency response leaders. The corporate resources include a Corporate Incident Response Team that includes senior management from various disciplines.

Special Investigations

The Special Investigations Unit (SIU) for Anthem is comprised of three regional Investigative Units (East, Central, and West), a Central Intake Unit, a Clinical Investigations Unit and a Reporting and Data Analysis Unit. The Central Region is primarily responsible for the Cincinnati account, but the other units are all part of Anthem's enterprise-wide approach to fraud and abuse identification and prevention.

The Investigative Units primarily handle cases in their regions, but can also be involved in investigations that are enterprise wide. These units include investigators with clinical backgrounds as well as law enforcement backgrounds. Their credentials include Certified Fraud Examiner (CFE), Accredited Healthcare Fraud Investigator (AHFI) and certified coder.

The Central Intake Unit allows one point for intake/referral and reporting. The Clinical Investigations Unit utilizes nurses, physicians and chiropractors dedicated to investigation efforts and proactive data analysis of medical billing practices. The Data Analysis Unit utilizes actuarial and investigative experience and has data analysts dedicated to enterprise wide investigations. The Data Analysis Unit uses various analytical tools including specialized software that focuses on the identification of abusive or fraudulent claims. The management teams of the Clinical Investigations and Data Analysis units have extensive backgrounds in healthcare and investigations.

Anthem offers a computer based fraud and abuse training course that all of its employees are required to complete. Separate courses are offered to claims and customer service personnel and the general employee population. Throughout the courses there are various quizzes based on the material and employees must achieve a score of 80% or higher in order to complete the training. There are tracking mechanisms in place to ensure employees complete the training. Outreach activities involve SIU employees participating in marketing presentations, multi-disciplinary committees, local task forces and anti-fraud associations such as the National Health Care Anti-Fraud Association (NHCAA), Association of Certified Fraud Examiners, National Association of Drug Diversion Investigators, the Blue Cross Blue Shield Association (BCBSA) and the National Society of Professional Insurance Investigators.

Referrals and proactive identification of cases come from internal leads, law enforcement, hotline calls, anti-fraud associations and data mining. The SIU often works with the FBI, US Attorney, State Agencies and local law enforcement in their investigations. The hotline is promoted to members through mailings, Explanation of Benefit statements (EOBs) and on Anthem's web site. Data mining involves the use of Business Objects, which builds models and patterns of providers, and SIRIS, which is a software tool developed through a joint venture between Anthem and NCR. Business Objects is used as a reactive tool and SIRIS is used as a proactive tool. The central region SIU also implemented the VIPS Stars software in 2007, which is also used by other Anthem plans.

As part of the fraud and abuse process, Anthem takes various actions that include provider education, provider investigation, root cause analysis and corrective action. Anthem's SIUs will follow up on issues they investigate or identify.

There are various remedies used by Anthem for an investigation including mutual agreement/settlement with the provider, civil litigation, referral to law enforcement, network termination, claim processing changes and Medical Policy revisions. When warranted, Anthem frequently uses network termination when a provider is found to have been involved in fraudulent or abusive practices. If a Cincinnati employee was found to have been involved in a fraudulent situation, Anthem would notify Cincinnati through the account representative.

HIPAA Privacy

Anthem uses several methods to ensure HIPAA compliance. There are various policies and procedures available to employees on the company's intranet for reference and review regarding HIPAA Privacy and Security. A comprehensive privacy policy provides employees with guidance on how to protect confidential information. All employees are required to complete annual security and privacy training, which is provided through on-line modules. Reminders on Privacy and Security policies and procedures are also sent to employees, especially customer service representatives, during the year. The reminders are sent via newsletters and on-line notices.

Anthem has a designated Privacy and Security Officer pursuant to the HIPAA regulations and individual managers are responsible for ensuring HIPAA compliance within their departments. The Privacy Department handles the training and awareness programs and investigates potential violations of the release of protected health information (PHI). They will also perform spot checks in departments where previous privacy issues have been identified.

Anthem's Notice of Privacy Practices describes the circumstances under which Anthem may access or disclose PHI. Members have the ability to restrict the release of PHI and this is noted in the system. Anthem will not disclose PHI to Cincinnati without a HIPAA compliant authorization from the individual member. Anthem will, however, be willing to disclose PHI to Cincinnati if the representative can demonstrate that he or she has been granted authority from the individual to do so in a way that is HIPAA compliant.

Anthem maintains and stores PHI in secure locations and only allows access by authorized employees. The authorized employees only have access to the minimum necessary information to fulfill their job functions and responsibilities.

Section V - Financial Review

Objectives / Methodology

The objective of the Financial Review is to verify the accuracy and correctness of claim funding amounts, assure that adequate documentation is available to substantiate funding transactions and reconcile all supporting documentation to determine if any exceptions exist for the period reviewed. This review also assures that recoveries from claim overpayments are offset against the invoicing for claim funding requests.

The reports and documents utilized by HDM to perform the Financial Review consist of the following:

- Invoices from Anthem to Cincinnati for the months of April 2006, August 2006, February 2007 and November 2007
- Detail claim information from Anthem for specific billing periods in the months of April 2006, August 2006, February 2007 and November 2007

HDM utilized the claim file provided by Anthem to compare the amounts from these documents to the claims on the file. The resulting comparison did not indicate any significant differences between the amounts invoiced and the detail claim information provided by Cincinnati and Anthem.

Based on the results of the analyses performed, Anthem is properly invoicing Cincinnati for paid claims and adjustments.

Section VI – Value-Added Information

Average Discount Savings

The following chart provides a breakdown of Cincinnati's average provider discount savings by plan and by claim/service types for all claims processed during the review period. The discount percentage is the difference between the charge amount and allowed amount divided by the charge amount.

<i>Place of Service</i>	<i>Claim Count</i>	<i>Charge</i>	<i>Allowed</i>	<i>Paid</i>	<i>Discount %</i>
Blue Priority/HMO-100% Retirees/COBRA					
Facility					
Ambulatory Surgery Center	180	\$410,382	\$117,340	\$86,786	71%
Ambulance	10	\$12,805	\$9,229	\$3,916	28%
Comprehensive Inpatient Rehabilitation Center	4	\$134,989	\$19,053	\$19,053	86%
Emergency Room	773	\$1,523,288	\$646,352	\$404,211	58%
Home	96	\$40,753	\$39,501	\$39,501	3%
Hospice	13	\$41,233	\$36,535	\$36,535	11%
Inpatient Hospital	518	\$14,699,098	\$5,752,433	\$2,752,808	61%
Outpatient Hospital	3,377	\$11,440,907	\$5,389,385	\$2,934,141	53%
Other	21	\$61,594	\$32,535	\$15,114	47%
Skilled Nursing Center	109	\$803,190	\$601,853	\$241,597	25%
Subtotal	5,097	\$29,168,240	\$12,644,216	\$6,533,662	57%
Professional					
Ambulatory Surgery Center	491	\$562,908	\$247,867	\$108,167	56%
Ambulance-air	1	\$11,788	\$11,788	\$11,788	0%
Ambulance	477	\$281,582	\$167,839	\$88,728	40%
Comprehensive Inpatient Rehabilitation Center	425	\$40,974	\$35,386	\$12,240	14%
Custodial Care Facility	57	\$4,231	\$2,783	\$722	34%
Emergency Room	1,493	\$209,939	\$143,387	\$81,372	32%
End Stage Renal Treatment Facility	152	\$66,236	\$62,718	\$34,329	5%
Home	1,857	\$939,928	\$581,740	\$361,514	38%
Independent Lab	3,732	\$551,086	\$92,632	\$80,223	83%
Inpatient Hospital	7,197	\$2,288,551	\$1,204,256	\$571,893	47%
Inpatient Psychiatric Facility	1	\$77	\$72	\$11	7%
Mobile Unit	23	\$7,610	\$2,764	\$2,072	64%
Skilled Nursing Facility	199	\$16,813	\$10,080	\$3,114	40%
Office	30,027	\$7,670,147	\$4,180,500	\$2,393,337	45%
Outpatient Hospital	3,435	\$1,898,211	\$731,425	\$444,180	61%
Other	527	\$95,895	\$75,991	\$38,536	21%

Skilled Nursing Center	337	\$33,476	\$22,213	\$8,294	34%
Urgent Care Facility	16	\$1,870	\$1,146	\$1,072	39%
Subtotal	50,419	\$14,681,322	\$7,574,586	\$4,241,592	48%
Plan Total	55,516	\$43,849,562	\$20,218,802	\$10,775,254	54%

**Blue Access/PPO-\$10 Copay
Retirees/COBRA**

Facility

Ambulatory Surgery Center	381	\$824,888	\$305,523	\$268,587	63%
Ambulance	6	\$5,256	\$2,379	\$2,179	55%
Comprehensive Inpatient Rehabilitation Center	3	\$80,561	\$38,185	\$37,885	53%
Emergency Room	560	\$908,128	\$439,795	\$329,326	52%
Home	202	\$50,937	\$45,650	\$45,506	10%
Hospice	23	\$69,894	\$62,846	\$62,846	10%
Inpatient Hospital	283	\$8,378,306	\$3,464,732	\$2,585,404	59%
Outpatient Hospital	3,879	\$8,586,741	\$4,309,219	\$2,738,011	50%
Other	9	\$18,970	\$8,194	\$6,611	57%
Skilled Nursing Center	31	\$215,015	\$162,909	\$120,259	24%
Subtotal	5,377	\$19,138,696	\$8,839,432	\$6,196,613	54%

Professional

Ambulatory Surgery Center	569	\$711,429	\$293,890	\$224,548	59%
Ambulance	193	\$119,830	\$81,843	\$66,638	32%
Community Mental Health Center	18	\$2,710	\$1,310	\$890	52%
Comprehensive Inpatient Rehabilitation Center	50	\$10,590	\$5,792	\$4,716	45%
Custodial Care Facility	2	\$277	\$217	\$131	22%
Emergency Room	894	\$151,599	\$96,754	\$76,116	36%
End Stage Renal Treatment Facility	80	\$35,042	\$28,248	\$13,397	19%
Home	1,508	\$628,355	\$417,032	\$355,423	34%
Independent Lab	4,805	\$898,416	\$140,298	\$130,205	84%
Independent Clinic	2	\$3,730	\$731	\$138	80%
Inpatient Hospital	3,011	\$1,521,332	\$786,104	\$649,731	48%
Inpatient Psychiatric Facility	2	\$197	\$131	\$131	34%
Mass Immunization Center	1	\$26	\$26	\$26	0%
Mobile Unit	1	\$195	\$61	\$61	69%
Nursing Facility	113	\$7,654	\$5,269	\$4,446	31%
Office	27,276	\$6,870,655	\$3,622,888	\$2,812,556	47%
Outpatient Hospital	3,814	\$1,620,077	\$675,835	\$574,745	58%
Other	182	\$47,522	\$34,144	\$25,105	28%
Skilled Nursing Center	121	\$11,636	\$7,675	\$6,722	34%
Urgent Care Facility	63	\$10,040	\$6,202	\$4,041	38%
Subtotal	42,654	\$12,651,312	\$6,204,451	\$4,949,766	51%
Plan Total	48,031	\$31,790,009	\$15,043,883	\$11,146,379	53%

Blue Traditional/Indemnity-80/20 Retirees/COBRA					
Facility					
Ambulatory Surgery Center	467	\$959,500	\$643,201	\$373,128	33%
Ambulance	67	\$67,033	\$60,132	\$25,493	10%
Comprehensive Inpatient Rehabilitation Center	9	\$301,046	\$142,830	\$65,300	53%
Emergency Room	2,255	\$3,810,990	\$3,050,175	\$763,385	20%
Home	155	\$64,970	\$56,735	\$56,735	13%
Hospice	45	\$81,001	\$76,646	\$71,048	5%
Inpatient Hospital	1,791	\$43,169,208	\$27,500,621	\$6,773,703	36%
Skilled Nursing Facility	1	\$410	\$410	\$410	0%
Outpatient Hospital	15,151	\$32,454,769	\$25,657,154	\$6,677,677	21%
Other	92	\$205,826	\$172,002	\$55,156	16%
Skilled Nursing Center	534	\$4,373,474	\$3,217,129	\$1,172,715	26%
Subtotal	20,561	\$85,488,226	\$60,577,036	\$16,034,751	29%
Professional					
Ambulatory Surgery Center	2,432	\$3,044,112	\$1,271,347	\$331,958	58%
Ambulance-air	1	\$12,257	\$3,168	\$767	74%
Ambulance	2,939	\$1,396,037	\$696,354	\$245,801	50%
Community Mental Health Center	38	\$8,677	\$2,300	\$1,920	73%
Comprehensive Inpatient Rehab Center	248	\$40,556	\$25,148	\$7,203	38%
Comprehensive Outpatient Rehabilitation Center	1	\$131	\$83	\$66	37%
Custodial Care Facility	355	\$31,418	\$21,326	\$6,273	32%
Emergency Room	4,283	\$770,061	\$458,423	\$140,415	40%
End Stage Renal Treatment Facility	417	\$210,100	\$115,449	\$45,004	45%
Fed Qual Health Center	4	\$413	\$170	\$73	59%
Home	9,515	\$3,322,688	\$1,695,026	\$673,520	49%
Hospice	5	\$306	\$184	\$59	40%
Independent Lab	5,370	\$1,084,789	\$272,630	\$169,945	75%
Independent Clinic	3	\$7,281	\$1,334	\$400	82%
Intermediate Care Facility	18	\$786	\$385	\$262	51%
Inpatient Hospital	23,324	\$7,998,433	\$3,918,801	\$1,222,293	51%
Inpatient Psychiatric Facility	5	\$1,344	\$911	\$420	32%
Mass Immunization Center	3	\$92	\$57	\$45	38%
Military Treatment Center	2	\$1,441	\$699	\$140	51%
Mobile Unit	8	\$1,465	\$794	\$309	46%
Skilled Nursing Facility	2,239	\$199,260	\$111,722	\$39,393	44%
Office	83,123	\$21,175,873	\$11,177,646	\$4,021,229	47%
Outpatient Hospital	14,928	\$5,214,723	\$2,147,208	\$796,313	59%
Other	1,864	\$456,100	\$289,700	\$82,082	36%
Rural Health Clinic	4	\$612	\$251	\$143	59%

Skilled Nursing Center	2,759	\$266,762	\$175,021	\$53,538	34%
State/Local Public Health Clinic	4	\$530	\$422	\$244	20%
Urgent Care Facility	119	\$17,655	\$10,785	\$5,380	39%
Subtotal	153,836	\$45,263,902	\$22,397,343	\$7,845,196	51%
Plan Total	174,397	\$130,752,129	\$82,974,379	\$23,879,947	37%

Claim Turnaround Time

Anthem processed approximately 88% of all Cincinnati's claims received during the review period within 14 days or less. The industry standard is to process 90% of all claims within this timeframe. Please note this analysis gives equal weight to all claims received and processed regardless of whether they were received electronically and auto-adjudicated, or submitted on paper and manually processed. The following chart shows the turnaround time of all claims received by Anthem.

<i>Tiers</i>	<i>Claim Count</i>	<i>Percentage</i>
Blue Priority/HMO-100% Retirees/COBRA		
01/01/2006 – 12/31/2006		
0-14 Elapsed Days	25,569	83.46%
15-30 Elapsed Days	1,563	5.10%
30+ Elapsed Days	3,506	11.44%
01/01/2007 – 12/31/2007		
0-14 Elapsed Days	23,650	89.44%
15-30 Elapsed Days	1,454	5.50%
30+ Elapsed Days	1,339	5.06%
Blue Access/PPO-\$10 Copay Retirees/COBRA		
01/01/2006 – 12/31/2006		
0-14 Elapsed Days	20,592	87.56%
15-30 Elapsed Days	1,197	5.09%
30+ Elapsed Days	1,728	7.35%
01/01/2007 – 12/31/2007		
0-14 Elapsed Days	22,782	90.67%
15-30 Elapsed Days	1,308	5.21%
30+ Elapsed Days	1,037	4.13%
Blue Traditional/Indemnity-80/20 Retirees/COBRA		
01/01/2006 – 12/31/2006		
0-14 Elapsed Days	80,824	81.28%
15-30 Elapsed Days	6,841	6.88%
30+ Elapsed Days	11,779	11.84%

01/01/2007 – 12/31/2007		
0-14 Elapsed Days	70,638	87.65%
15-30 Elapsed Days	5,484	6.80%
30+ Elapsed Days	4,473	5.55%

APPENDIX A

The following charts provide additional details relative to the claim payment exceptions identified as a result of HDM's onsite claims review and claims analysis. The charts also include Anthem's response and HDM's recommendation and conclusion regarding the specific issue. Cincinnati and Anthem should review these findings and determine the appropriate course of action, i.e. claim recovery, reimbursement to Cincinnati, etc.

Administrative Services

Coordination of Benefits (COB)			
Sample Findings		Additional Findings	
Claim Count	Financial Impact	Claim Count	Financial Impact
4	\$707	6,482	\$517,143
No COB			
HDM Assessment	<p>Per the SPD for all three Plans, "The benefits under the Plans for Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part B."</p> <p>Sample #4: Member had Medicare Part A & B effective 1/1/2006. Sample claim was paid 1/26/2006. Anthem did not have knowledge of Medicare coverage at the time of claim processing.</p> <p>Neither sample claim nor claim history file has been reviewed or adjusted. HDM will consider the entire "paid amount" as overpaid until Anthem requests the Explanation of Medicare Benefits (EOMB) and adjusts the claim. Sample claim is overpaid \$84.35.</p> <p>Sample #5: Medicare Part B coverage was indicated on the actual sample claim. Anthem had knowledge of Medicare but did not request the corresponding EOMB. HDM will consider the entire "paid amount" as overpaid until Anthem requests the Explanation of Medicare Benefits (EOMB) and adjusts the claim. Sample claim is overpaid \$418.09.</p> <p>Sample #44: Medicare's effective date for member was 9/01/2001. This Medicare effective date was not added to Anthem's system until 2/7/2007. HDM will consider the entire "paid amount" as overpaid until Anthem requests the Explanation of Medicare Benefits (EOMB) and adjusts the claim. Sample claim is overpaid \$142.38.</p> <p>Anthem, as Claim Administrator, has a fiduciary responsibility/obligation to Cincinnati to request Medicare vouchers, adjust the claims impacted and seek recovery of overpayments if necessary.</p> <p>Per Anthem, they cannot calculate the overpayments for samples #4, #5 and #44 until EOMBs (Explanation of Medicare's Benefits) are received. Their position is that the onus is on the member or a provider to submit the EOMB.</p> <p>Per the SPD, "When this plan is secondary, its payments will be based on the balance left after the primary plan has paid. It will pay no more than that balance."</p>		

	<p>Sample #66: Anthem was the secondary carrier for this sample claim. Anthem's liability was only the copay plus the allowed amount for line 5 of \$13.93 (other insurance denied line 5). There is an overpayment of \$62.49 on this sample claim. Anthem agreed to this finding.</p>
TPA Response	<p>Anthem does not agree to #4, #5, and #44 as exceptions. The claims processed correctly based on the information Anthem had on file at the time the claims finalized. Additionally for items #4 and #5, updated Medicare information was received April 2006, after the claims processed. The member has Medicare Part A, but does not have Medicare Part B. As these claims are for Medicare Part B charges, the claims processed correctly.</p> <p>Anthem does agree #66 is an exception. An adjustment request was sent on 7/14/08 to recover the overpaid amount.</p>
Conclusion	<p>All benefits provided under Cincinnati health plans are subject to coordination of benefits except prescription drug benefits. Anthem, as Claim Administrator, has a fiduciary responsibility to determine which plan is primary and process the claims accordingly. Regardless of when Anthem receives information that another plan (Medicare or any other commercial carrier) is primary. Anthem is obligated to request the other insurance carriers' vouchers, adjust the claims impacted and seek recovery of overpayments if necessary.</p> <p>Samples #4 and #5 were for the same member. According to the information received, member had Medicare Part A & B effective 1/1/2006. Sample claim #5 actually indicted on the claim that Medicare Part B coverage was in effect. Anthem had knowledge of Medicare but did not request the corresponding EOMB. HDM requested documentary evidence that Part B was not in effect. To date HDM has not received this documentation. Findings will remain.</p> <p>For sample #44, member had Medicare Part A & B coverage in effect 9/1/2001. Finding will remain. HDM and Anthem agree to the \$62.49 overpayment. Anthem should report the status of their recovery attempt directly to Cincinnati.</p> <p>In addition to the above findings, HDM has identified an additional 6,482 claims where there is coordination of benefit findings resulting in potential overpayments in the amount of \$517,143. HDM will provide Anthem with the detailed claims information for the additional claims. All exceptions require review by Anthem.</p>

Plan Provisions

Coinsurance Application			
<i>Sample Findings</i>		<i>Additional Findings</i>	
<i>Claim Count</i>	<i>Financial Impact</i>	<i>Claim Count</i>	<i>Financial Impact</i>
13	\$400	2,460	\$42,964
Professional Home			
HDM Assessment	<p>Per the SPD for the Blue Priority Plan, "Prosthetic Devices and Durable Medical Equipment are covered at 80%". The member's liability is the 20% co-insurance. However, if the Prosthetic Device or DME is obtained in the PCP's office or another network provider's office, then these items would be</p>		

	<p>covered in full.”</p> <p>Sample #21: On this sample claim, a breast prosthesis and a mastectomy bra were obtained in a nursing home. The breast prosthesis was covered in full and the bra was reimbursed at 80%. This resulted in an overpayment of \$50.75.</p>
TPA Response	Anthem does not agree #21 is an exception. Prosthetics/Orthotics in a home or office setting is covered in full under product TGSO0015.
Conclusion	<p>The SPD is silent on obtaining prosthetic devices or DME in a nursing home setting.</p> <p>The current processing for prosthetic devices in a nursing home is not in adherence to plan language. It is also inconsistent with the reimbursement for DME items. HDM has identified an additional 5 claims in this category resulting in potential overpayments in the amount of \$30.</p>
Professional In-Patient Hospital	
HDM Assessment	<p>Per the SPD for the Blue Access Plan, inpatient professional services are covered in full.</p> <p>Sample #17: On this sample claim a co-pay was incorrectly applied to professional inpatient services. This was a claim processor error that resulted in an underpayment of \$20.00.</p>
TPA Response	Anthem agrees #17 is an exception. The claim was adjusted to pay an additional \$20 on 7/9/2008 per the benefits under product ANPO0786.
Conclusion	Both HDM and Anthem agree that inpatient professional services are covered in full and that sample claim was underpaid. Anthem has adjusted this claim and paid out an additional \$20.00. HDM has identified an additional 5 claims in this category resulting in potential underpayments in the amount of \$88.
Professional Nursing Facility	
HDM Assessment	<p>Per the SPD for the Blue Access Plan, “Orthotic Devices (A rigid or semi-rigid supportive device which limits or stops motion of a weak or diseased body part) are covered. The member’s liability is 20% co-insurance for both in-network and out-of-network providers.” If the Orthotic device is obtained in a network provider’s office, then the physician office service co-payment of \$10.00 applies.</p> <p>Sample #19: For this sample claim, an orthotic was dispensed in a nursing home (member’s residence). The member’s responsibility was 20%. However, Anthem assessed a co-pay and paid the balance at 100%. This resulted in an overpayment of \$30.98.</p>
TPA Response	Anthem does not agree #19 is an exception. Prosthetics/Orthotics in a home or office setting is covered in full under product ANPO0947.
Conclusion	<p>The SPD is silent on obtaining orthotic devices in a nursing home setting.</p> <p>The current processing for prosthetic devices in a nursing home is not in adherence to plan language.</p>

Professional Office	
HDM Assessment	<p>Per SPD/Comparison Charts (summary of benefits by Plan) for the Blue Traditional Plan, "Surgery" in a physician's office is reimbursed at 80% co-insurance. The member's liability is 20% co-insurance.</p> <p>Sample #14: Anthem reimbursed the surgical procedure code 11730 (Removal of nail plate) at 100% of the allowable amount. This resulted in an overpayment of \$12.99.</p> <p>Sample #41: Anthem reimbursed the surgical procedure code 11305 (Shave skin lesion) at 100% of the allowable amount. This resulted in an overpayment of \$11.23.</p> <p>Per SPD, "Allergy Treatment" Testing and Treatment 80% office co-insurance for the Blue Traditional Plan. The member's liability is 20% co-insurance.</p> <p>Sample #28: Anthem reimbursed procedure codes 95004 & 95024 (allergy tests) at 100% of allowable amount while the office visit code 99203 was reimbursed at 80%. This resulted in an overpayment of \$56.00.</p> <p>Per SPD, Under Allergy Treatment "Injections and serum are covered in full if no office visit charge is charged."</p> <p>Sample #29: Anthem reimbursed procedure 95165 or Antigen therapy services at 80%. This resulted in an underpayment of \$29.66.</p> <p>Per SPD, "Diagnostic Services are covered in full for the Blue Traditional Plan".</p> <p>Sample #39: Anthem reimbursed diagnostic procedures at 80% co-insurance. This resulted in an underpayment of \$105.41.</p> <p>Per SPD, Chemotherapy is reimbursed at the reasonable charge (covered in full).</p> <p>Sample #43: Anthem applied co-insurance (80%) to this benefit. This resulted in an underpayment of \$12.34.</p> <p>Per SPD the Blue Traditional Plan, "Surgery" in a physician's office is reimbursed at 80% co-insurance. The member's liability is 20% co-insurance. Per medical industry standards, endorsed by CMS and the AMA (American Medical Association), procedure codes 11719-11765 are considered to be Surgical procedures in the Integumentary System (Nails).</p> <p>Sample #45: Anthem incorrectly reimbursed office surgery procedure 11721 or debridement of nails at 100%. This resulted in an overpayment of \$15.95.</p> <p>Per SPD, Preventive Care services are not subject to co-insurance up to \$500.00 benefit for the Blue Traditional Plan.</p> <p>Sample #48: Anthem incorrectly reimbursed preventive care services at 80%. This resulted in an underpayment of \$20.72.</p>

<p>TPA Response</p>	<p>Anthem does not agree #14 and #41 are exceptions. Surgery in an office setting is covered in full under product CNAO0101.</p> <p>Anthem does not agree #28 is an exception. Allergy testing is covered in full under the diagnostic services benefit under product CNAO0154.</p> <p>Anthem does not agree #29 is an exception. These services are subject to the deductible and coinsurance under product CNAO0101.</p> <p>Anthem does not agree #39 is an exception. Claim processed correctly based on the CPT and diagnosis code submitted on line 1 of the sampled claim.</p> <p>Regarding sample #43, our records show this should be sample #42. Anthem does not agree #42 is an exception as the claim processed per Anthem's policies and procedures. When the provide accepts Medicare assignment, we are to allow network benefits.</p> <p>Anthem does not agree sample #45 is an exception. These services are not subject to deductible and coinsurance nor are they subject to the preventive care annual \$500 maximum.</p> <p>Anthem does agree #48 is an exception. The claim has been referred for adjustment to recoup the overpaid amount.</p>
<p>Conclusion</p>	<p>Findings for Samples #14, #41 and #45 will remain. HDM has identified an additional 847 claims in this category resulting in potential overpayments in the amount of \$19,010.</p> <p>Based on the Comparison Charts provided, Allergy Testing and Treatment is reimbursed at 80% co-insurance for the Blue Traditional Plan. Anthem agreed to this finding while on site. Anthem now states that allergy testing and treatment are considered as 'diagnostic' services and as such are reimbursed in full. Finding for sample #28 will remain. HDM has identified an additional 3 claims in this category resulting in potential overpayments in the amount of \$262.</p> <p>Based on the Comparison Charts provided Under Allergy Treatment "Injections and serum are covered in full if no office visit charge is charged", for the Blue Traditional Plan. Finding for sample #29 will remain. HDM has identified an additional 271 claims in this category resulting in potential overpayments in the amount of \$1,572.</p> <p>Per the SPD language, "Diagnostic Services are covered in full" for the Blue Traditional Plan. The service performed/billed on sample claim was CPT code 78465 or Myocardial perfusion imaging. The diagnosis was 428.0 or congestive heart failure. Anthem incorrectly reimbursed this diagnostic procedure at 80% co-insurance. HDM has identified an additional 7 claims in this category resulting in potential overpayments in the amount of \$42.</p> <p>Per the SPD, Chemotherapy is "covered in full" for the Blue Traditional Plan. Anthem incorrectly applied co-insurance (80%) to this benefit on sample #43. HDM has identified an additional 18 claims in this category resulting in potential overpayments in the amount of \$311.</p> <p>Per the SPD, Preventive Care services are not subject to co-insurance up</p>

	<p>to \$500.00 benefit for the Blue Traditional Plan. Anthem incorrectly reimbursed preventive care services at 80% on sample #48. Anthem and HDM agree on this finding. Anthem has referred claim for adjustment. HDM has identified an additional 3 claims in this category resulting in potential overpayments in the amount of \$52.</p>
<p>Professional, Out-Patient, Hospital</p>	
<p>HDM Assessment</p>	<p>Per the SPD for the Blue Traditional Plan, "Outpatient Medical Services are covered in full if that care is not related to surgery, maternity, mental illness or substance abuse."</p> <p>Sample #30: The place of service was outpatient hospital. Sample claim was billed on a HCFA bill type and represents a professional billing related to a surgery. The diagnosis presented was V7283 (Pre-operative exam). Co-insurance should have applied. Anthem incorrectly reimbursed charges at 100%. This resulted in an overpayment of \$13.06.</p> <p>There is conflicting information between the SPD material and comparison charts for the reimbursement of outpatient mental health services under the Blue Traditional Plan. The SPD states that "Outpatient Psychiatric Services are limited to a 10 maximum per calendar year - then services are eligible under Major Medical." The Comparison Chart clearly indicates that outpatient treatment of mental/nervous disorders is covered at 80%.</p> <p>Sample #37: Anthem reimbursed outpatient psychiatric services at 100% of allowable amount. This resulted in an overpayment of \$20.61.</p>
<p>TPA Response</p>	<p>Anthem does not agree sample #30 is an exception. The member's cost share is based on the place of service billed. Per the member's benefits, services are covered in full.</p> <p>Anthem does not agree #37 is an exception. The claim processed correctly per the member's benefits under product CNAO0101.</p>
<p>Conclusion</p>	<p>"Outpatient Medical Services are covered in full if that care is not related to surgery, maternity, mental illness or substance abuse." The diagnosis presented was V7283 (Pre-operative exam); clearly indicating that medical services rendered were related to a surgery. As such, charges should not have been paid in full. HDM has identified an additional 251 claims in this category resulting in potential overpayments in the amount of \$2,699.</p> <p>Outpatient Psychiatric Services are covered in full and limited to a 10 visit maximum per calendar year. The Comparison Chart clearly indicates that outpatient treatment of mental/nervous disorders is covered at 80%. Anthem reimbursed outpatient psychiatric services at 100% of allowable amount. HDM has identified an additional 49 claims in this category resulting in potential overpayments in the amount of \$874.</p> <p>In addition to the above findings, HDM has identified an additional 1,001 coinsurance claims issues resulting in potential under/overpayments in the amount of \$18,024. HDM will provide Anthem with the detailed claims information for the additional claims. All exceptions require review by Anthem.</p>

Co-payment Application			
<i>Sample Findings</i>		<i>Additional Findings</i>	
<i>Claim Count</i>	<i>Financial Impact</i>	<i>Claim Count</i>	<i>Financial Impact</i>
3	\$70	193	\$6,643
Facility, Ambulatory Surgical Center			
HDM Assessment	<p>Per the SPD for the Blue Access Plan, a \$50 co-pay applies to Out-Patient Surgery.</p> <p>Sample #62: Anthem failed to apply the \$50 co-pay to out-patient facility services on this sample claim. This resulted in an overpayment of \$50.</p>		
TPA Response	Anthem does not agree #62 is an exception. Preventive services are covered in full per the member's benefits.		
Conclusion	<p>While on site Anthem agreed to this finding. Anthem now states services and diagnoses were routine preventive care. HDM disagrees. The diagnoses presented on the bill were V76.51 or special screening for malignant neoplasms of colon and 211.4 or benign neoplasm of rectum and anal canal. The procedure on sample claim was diagnostic. As such, a co-pay should have applied. HDM has identified an additional 102 claims in this category resulting in potential overpayments in the amount of \$4,530.</p>		
Professional, Office			
HDM Assessment	<p>Per the SPD for the Blue Access Plan, surgical procedures performed in a physician's office are subject to a \$10 co-payment.</p> <p>Per medical industry practice, determined by the American Medical Association (AMA) in their Current Procedural Terminology book, procedure code 51784 (Electromyography studies (EMG) of anal or urethral sphincter, any technique) is classified as a surgical procedure.</p> <p>Sample #64: Anthem considers 51784 as a diagnostic procedure, and therefore did not apply the \$10 co-pay. This resulted in an overpayment of \$10.00.</p>		
TPA Response	Anthem does not agree #64 is an exception. Diagnostic services are covered in full per the member's benefits under product ANPO0786.		
Conclusion	<p>The SPD mandates \$10.00 co-pay for surgical procedures performed in a physician's office. Per the CPT Book, procedure code 51784 (Electromyography studies (EMG) of anal or urethral sphincter, any technique) is classified as a surgical procedure. Anthem's Medical Department does not consider this procedure as a surgery and therefore does not assess a co-pay. HDM has identified an additional 8 claims in this category resulting in potential overpayments in the amount of \$80.</p> <p>HDM suggests that Cincinnati and Anthem discuss this issue as there are financial implications for Cincinnati. Anthem should provide Cincinnati with a listing of all surgical codes (as endorsed in the CPT Book), that are not considered "surgical" but rather "diagnostic" by Anthem.</p>		

Professional, Out-Patient Hospital			
HDM Assessment	<p>Per the SPD for the Blue Access Plan, "Routine eye exams fall under Preventive Care services and are subject to a co-pay."</p> <p>Sample #52: Anthem did not apply a co-pay to a routine eye exam on the sample claim. This resulted in an overpayment of \$10.00.</p> <p>Anthem stated that "there was a case exception; vision covered at no cost share. Group is aware of this benefit."</p>		
TPA Response	<p>Anthem does not agree #52 is an exception. Per information from the group, routine eye exams are covered in full.</p>		
Conclusion	<p>The SPD mandates \$10.00 co-pay for routine eye exams (which fall under the Preventive Care services). Anthem states that "there is a case exception effective 7/1/2007 covering unlimited vision exams and unlimited routine physical exams at no cost share regardless if routine/preventive or diagnostic if provided by a network provider."</p> <p>The finding for sample #52 will remain. HDM identified only 1 additional claim in this category resulting in a potential overpayment in the amount of \$10.</p> <p>In addition to the above findings, HDM has identified an additional 82 co-payment claim issues resulting in potential under/overpayments in the amount of \$2,023. HDM will provide Anthem with the detailed claims information for the additional claims. All exceptions require review by Anthem.</p>		
Ineligible Services			
<i>Sample Findings</i>		<i>Additional Findings</i>	
<i>Claim Count</i>	<i>Financial Impact</i>	<i>Claim Count</i>	<i>Financial Impact</i>
5	\$154	34	\$2,468
Professional, Home			
HDM Assessment	<p>Per the SPD for all three Plans, "Any benefits covered under both the Plan and Medicare will be paid pursuant to Medicare Secondary Payor Legislation, regulations and Health Care Financing Administration guidelines, etc."</p> <p>Anthem has a fiduciary obligation to administer all Plan provisions, (including medical necessity requirement), exclusions, limitations, etc. as mandated in the Plans' SPDs whether Medicare or another commercial insurance carrier is involved or not.</p> <p>Benefits for eyeglasses or contact lenses are excluded from coverage (except for the initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition).</p> <p>Sample #74: Anthem incorrectly paid for replacement lens and frames on the sample claim. This resulted in an overpayment of \$33.47.</p> <p>Benefits for durable medical equipment (DME) are eligible for coverage if the item/equipment meets certain criteria. In particular, "This equipment</p>		

	<p>must serve only a medical purpose.” A physician’s prescription is also required.</p> <p>Sample #77: Anthem reimbursed charges for a water circulating heat pad with pump. This resulted in an overpayment of \$84.40.</p> <p>This item is routinely purchased at a retail pharmacy as an ‘over the counter’ item.</p>
TPA Response	<p>Anthem does not agree #74 and #77 are exceptions. Anthem is secondary to Medicare. Anthem coordinates benefits using Medicare’s allowed amount. Anthem’s payment and Medicare’s payment combined may not be more than the provider would have received under Medicare guidelines.</p>
Conclusion	<p>The SPD language states “Any benefits covered under both the Plan and Medicare will be paid pursuant to Medicare Secondary Payor Legislation, regulations and Health Care Financing Administration guidelines, etc.”</p> <p>Anthem incorrectly paid for a specific Plan exclusion on sample #74. Eyeglasses or contact lenses are exclusions under all Cincinnati Plans. HDM has identified an additional 12 claims in this category resulting in potential overpayments in the amount of \$912.</p> <p>Sample #77 Anthem incorrectly paid for a water circulating heat pad with pump, which does not meet the definition of a DME item (as noted in SPD) and can be purchased over the counter. This finding will remain. HDM identified 1 additional claim in this category resulting in a potential overpayment of \$1.</p> <p>It appears that Anthem reimburses any services/item after Medicare regardless if service/item is a covered benefit under Cincinnati Plans. HDM suggests that Cincinnati and Anthem discuss this issue as there are financial implications for Cincinnati.</p>
Professional Office	
HDM Assessment	<p>Cincinnati’s Plans exclude coverage for items/services: 1) “Which are Experimental/Investigative or related to such... and 2) For (services or supplies related to) alternative or complimentary medicine.”</p> <p>Sample #69: Anthem reimbursed procedure Code 90882 which literally translates to “Environmental intervention for medical management purposes on a psychiatric patient’s behalf with agencies, employers, or institutions.” Services are being provided on behalf of the member; treatment is not being rendered to the member. The service is not a covered expense. It has not been proven effective in treating mental health conditions and is considered experimental and investigational. This resulted in an overpayment of \$17.97.</p> <p>Sample #76: Anthem reimbursed acupuncture charges incorrectly. Acupuncture is one of the specific therapies excluded under Alternative or Complimentary medicine. This resulted in an overpayment of \$0.75.</p>

TPA Response	<p>Anthem does not agree #69 is an exception. The mental health claim submitted by the provider processed correctly under the member's individual therapy benefits.</p> <p>Anthem does not agree #76 is an exception. Anthem coordinates benefits using Medicare's allowed amount. Anthem's payment and Medicare's payment combined may not be more than the provider would have received under Medicare guidelines.</p>
Conclusion	<p>Findings for both samples #69 and #76 remain. Anthem incorrectly reimbursed for "Environmental intervention for medical management" on sample #69. This service does not directly treat the patient. HDM has identified an additional 7 claims in this category resulting in potential overpayments in the amount of \$553.</p> <p>On sample #76 Anthem incorrectly reimbursed 'acupuncture' services after Medicare. Acupuncture is a specific exclusion under the Plans.</p> <p>It appears that Anthem reimburses any services/item after Medicare regardless if service/item is a covered benefit under Cincinnati Plans. HDM suggests that Cincinnati and Anthem discuss this issue as there are financial implications for Cincinnati.</p>
Facility, Outpatient Hospital	
HDM Assessment	<p>Per the SPD, "Any benefits covered under both the Plan and Medicare will be paid pursuant to Medicare Secondary Payor Legislation, regulations and Health Care Financing Administration guidelines, etc."</p> <p>The Cincinnati Plans exclude coverage "For self-help training and other forms of non-medical self care."</p> <p>Sample #75: Anthem reimbursed procedure code 97537 which literally translates to "Community/work reintegration training (e.g., shopping, transportation, money management, vocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment)." Community/work reintegration training is not a covered expense under the Plans. This resulted in an overpayment of \$17.76.</p>
TPA Response	<p>Anthem does not agree #75 is an exception. Anthem coordinates benefits using Medicare's allowed amount. Anthem's payment and Medicare's payment combined may not be more than the provider would have received under Medicare guidelines.</p>
Conclusion	<p>Anthem incorrectly paid for a specific Plan exclusion on sample #75. Cincinnati Plans exclude coverage "For self-help training and other forms of non-medical self care." HDM has identified an additional 6 claims in this category resulting in potential overpayments in the amount of \$91.</p> <p>In addition to the above findings, HDM has identified an additional 8 claims that are ineligible under Cincinnati Plans' resulting in potential overpayments in the amount of \$911. HDM will provide Anthem with the detailed claims information for the additional claims. All exceptions require review by Anthem.</p>

Maximum Exceeded			
Sample Findings		Additional Findings	
Claim Count	Financial Impact	Claim Count	Financial Impact
3	\$263	131	\$4,966
Professional - Office			
HDM Assessment	<p>Per the SPD, for the Blue Access Plan, there is 12 visit maximum for Spinal Manipulations. This maximum is combined between Network and Non-Network. The SPD further defines "Spinal manipulation as services to correct by manual or mechanical means structural imbalance or subluxation to remove nerve interference from or related to distortion, misalignment or subluxation of or in the vertebral column. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for spinal manipulation services as specified in the Schedule of Benefits."</p> <p>HDM identified two interrelated administrative issues which need to be addressed. Plan maximums are being exceeded and Anthem is reimbursing for procedure code 98943 which literally translates to chiropractic manipulative treatment (CMT); extraspinal, one or more regions. The five extraspinal regions referred to are: head (including temporomandibular joint, excluding atlanto-occipital) region; lower extremities; upper extremities; rib cage (excluding costotransverse and costovertebral joints) and abdomen. The SPD specifies coverage for manual or mechanical manipulation of the spine only (CPT codes 98940 through 98942), and then extraspinal or 98943 would not be covered at all.</p> <p>Sample #79: The 12 visit maximum was exceeded on the sample claim. Nineteen chiropractic visits were reimbursed on the following dates for 2006: 6/21, 7/12, 7/25, 8/16, 8/30, 9/19, 9/26, 9/27, 10/18, 10/25, 10 /27, 11/1, 11/10, 11/15, 11/21, 11/22, 11/29, 12/11, 12/20. In addition, Anthem does not count CPT code 98943 or chiropractic manipulative treatment (CMT); extraspinal, one or more regions, towards Plan chiropractic maximum. This resulted in an overpayment of \$14.97.</p> <p>Per the SPD for the Blue Priority Plan, "One routine screening mammogram is covered per calendar year regardless of age."</p> <p>Sample #81: Anthem reimbursed a second routine Mammogram (Technical Component for 76092 performed on 12/15/06) on the sample claim. The first routine mammogram was performed on 2/20/06 (claims 06075F4EEB & 0605912040). The sample claim exceeded plan limitation. Sample claim is overpaid \$93.93 technical component (TC) and \$58.66 on 07016F5C9B for professional component. The total overpayment for this sample is \$152.59.</p>		
TPA Response	<p>Anthem does not agree #79 is an exception. CPT code 98943 does not apply toward the visit maximum for this product. According to claims history, the visit maximum was not exceeded.</p> <p>Anthem does not agree #81 is an exception. The service billed is for the technical component of a mammogram. These services are considered allowed as part of the member's mammogram benefits for product TGSO0015. The benefits do not stipulate a limitation for this service.</p>		

Conclusion	<p>Sample #80 - Anthem incorrectly reimbursed for 19 spinal manipulations. There is a 12 visit combined maximum for spinal manipulations between in-network and out-of-network providers. Anthem does not count CPT code 98943 or chiropractic manipulative treatment (CMT); extraspinal, one or more regions towards the visit maximum. HDM suggests that Cincinnati and Anthem discuss this issue as it has financial implications for Cincinnati. HDM has identified an additional 107 claims in this category resulting in potential overpayments in the amount of \$1,502.</p> <p>Anthem incorrectly paid for a second routine mammogram in a calendar year on sample #81. According to Anthem, there is no limitation for routine mammograms. Findings remain based on the documentation provided to HDM. HDM has identified 1 additional claim in this category resulting in a potential overpayment in the amount of \$15.</p>
Facility, Out-Patient, Hospital	
HDM Assessment	<p>Per the SPD/Comparison Chart that was provided to HDM for the Blue Traditional Plan, there is a 20 visit limit annually for speech therapy.</p> <p>Sample #80: Sample claim exceeded the annual maximum for speech therapy. This resulted in an overpayment of \$95.92.</p> <p>It should be noted that Anthem indicated that for 2006, the plan maximum for speech therapy is 40.</p>
TPA Response	<p>Anthem does not agree #80 is an exception. Anthem coordinates benefits using Medicare's allowed amount. Anthem's payment and Medicare's payment combined may not be more than the provider would have received under Medicare guidelines.</p>
Conclusion	<p>There is a 20 visit maximum limit annually for speech therapy, sample #80 exceeded this limit. Anthem states that the annual speech therapy limit is 40 for 2006. Findings remain based on the documentation provided to HDM.</p> <p>In addition to the above findings, HDM has identified an additional 23 claims that exceeded maximum limitations under Cincinnati Plans' resulting in potential overpayments in the amount of \$3,449. HDM will provide Anthem with the detailed claims information for the additional claims. All exceptions require review by Anthem.</p>

System Controls

Correct Coding Initiative			
<i>Sample Findings</i>		<i>Additional Findings</i>	
<i>Claim Count</i>	<i>Financial Impact</i>	<i>Claim Count</i>	<i>Financial Impact</i>
1	\$2	3,116	\$107,771
Unbundling			
HDM Assessment	<p>Unbundling is a practice in which providers' bill for separate (procedure or revenue) codes which are typically included as one code. HDM has identified areas for which Anthem and its partners are allowing unbundled</p>		

	<p>codes to be processed.</p> <p>Sample #85: This was a BlueCard claim. Member/patient was hospitalized (in-patient). Anthem reimbursed CPT code 85018 (Hemoglobin) billed by an independent lab. This charge should not have been paid. This resulted in an overpayment of \$2.35.</p>
TPA Response	Anthem does not agree #85 is an exception. As the Home Plan, Anthem must pay the claim according to the pricing rules established by the Host Plan based on their contractual arrangements with their providers.
Conclusion	<p>Regardless of whether the Home or Host Plan paid this claim, independent laboratory charges should not have been paid while the member was hospitalized. Laboratory, x-rays, tests, etc are all included in the inpatient facility fees. The exception would be if the admitting hospital was not capable of performing a specific laboratory test. On sample #85 a blood count; hemoglobin or CPT code 85018 was performed.</p> <p>This is one basic type of unbundling where the intent is to increase revenue and have additional and inappropriate fees paid by Cincinnati.</p> <p>Applying CMS (Center for Medicare and Medicaid Services), industry standards, and AMA (American Medical Association) unbundling guidelines to Cincinnati's claims for the audit period, HDM has identified an additional 3,116 claims in categories of incidental procedures, independent labs, and procedures that are components of each other resulting in potential overpayments in the amount of \$107,771. HDM will provide Anthem with the detailed claims information for the additional claims. All exceptions require review by Anthem.</p>

Duplicate Claim Payment			
<i>Sample Findings</i>		<i>Additional Findings</i>	
<i>Claim Count</i>	<i>Financial Impact</i>	<i>Claim Count</i>	<i>Financial Impact</i>
4	\$2,230	1,124	\$67,493

Hard Duplicate

HDM Assessment	<p>HDM identified that duplicate (identical) charges were reimbursed.</p> <p>Sample #87: Duplicate charges were considered under two policies (Retiree and Cobra). Member was covered under her spouse's policy until 1/31/2007. COBRA election form was received for an effective date of 2/1/2007. The date of service for the sample claim was 3/28/2007. The claim was processed on 8/3/2007 and paid on 8/7/2007. This resulted in an overpayment of \$435.10.</p> <p>Sample #89: Duplicate out-patient hospital charges were paid due to manual intervention. This resulted in an overpayment of \$590.00.</p> <p>Sample #91: Duplicate in-patient hospital charges were paid due to manual intervention. This resulted in an overpayment of \$992.00.</p> <p>Sample #104: Duplicate charges for an orthotic device were paid. It appears that one claim was paid as an in-network benefit and the other paid out-of-network. Provider of service is in-network. This resulted in an overpayment of \$213.23.</p>
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TPA Response	<p>Anthem does not agree #87 is an exception. The claim processed correctly based on the eligibility information received from the group. The chronological detail of events was supplied during the onsite audit showing when the updated eligibility information was received from the group.</p> <p>Anthem agrees #89 and #91 are exceptions. The overpayments were recovered on 3/14/2008 and 4/18/2008 respectively. The errors were discovered by Anthem and corrected prior to the audit and receipt of the sample list from HDM.</p> <p>Anthem agrees #104 is an exception. The claim has been referred for adjustment to recoup the overpaid amount.</p>
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Conclusion	<p>Samples #87, #89 and #91 were duplicate payments. Anthem has recovered the overpayments.</p> <p>For sample #104, after the claim has been adjusted, Anthem needs to report the recovery status directly to Cincinnati.</p> <p>HDM has identified an additional 1,124 duplicate claims resulting in potential overpayments in the amount of \$67,493. HDM will provide Anthem with the detailed claims information for the additional claims. All exceptions require review by Anthem.</p> <p>HDM recommends that Anthem expand their current duplicate system logic and procedures in place to reduce this type of financial error in the future.</p>
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Eligibility			
<i>Sample Findings</i>		<i>Additional Findings</i>	
<i>Claim Count</i>	<i>Financial Impact</i>	<i>Claim Count</i>	<i>Financial Impact</i>
1	\$115	73	\$30,671

DOS Outside TPA Eligibility

HDM Assessment	<p>Per the SPD for all three Plans, the Plan does not provide benefits for services or supplies incurred after the termination date of this coverage.</p> <p>Sample #101: Sample claim was reimbursed for charges after a cancellation of coverage/termination date of 5/31/2007. The termination date was received after the claim was processed. This resulted in an overpayment of \$114.79.</p> <p>Anthem has submitted an "Adjustment request for review of possible overpayments."</p>
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TPA Response	<p>Anthem does not agree #101 is an exception. The claim was processed based on the eligibility information received from the group. Updated information was not received until after the claim had finalized.</p>
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Conclusion	<p>Reimbursement was incorrectly issued after benefit eligibility termination date. HDM has identified an additional 73 claims in this category resulting in potential overpayments in the amount of \$30,671. HDM will provide Anthem with the detailed claims information for the additional claims. All exceptions require review by Anthem.</p>
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Surgery Payments			
<i>Sample Findings</i>		<i>Additional Findings</i>	
<i>Claim Count</i>	<i>Financial Impact</i>	<i>Claim Count</i>	<i>Financial Impact</i>
2	\$199	332	\$24,445
Bilateral			
HDM Assessment	<p>HDM uses CMS and AMA billing/coding edits and guidelines for multiple and bilateral procedure processing. Reimbursement methodology differs depending on type of service and modifiers billed.</p> <p>Bilateral procedures are identical procedures performed on both sides of the body during the same session or on the same day. The fee schedule for a single code 92136 already includes RVU value based on the procedure being performed as a bilateral one.</p> <p>Sample #107: The reimbursement should have been 100% of the fee schedule for a single code (92136) or \$113.68. Sample claim paid CPT code 92136 twice. This resulted in an overpayment of \$113.68.</p>		
TPA Response	Anthem does not agree #107 is an exception. The claim processed correctly as the provider submitted both –LT and –RT modifiers.		
Conclusion	The finding remains. The bilateral procedure on sample #107 was 92136. The fee schedule for a single code for 92136 includes payment for both left and right sides. HDM has identified an additional 42 claims in this category resulting in potential overpayments in the amount of \$3,548.		
Global Surgical Package			
HDM Assessment	<p>Per medical industry standards, most major surgeries have a one day pre-operative period and a ninety day post-operative period included in the fee schedule for the surgery.</p> <p>Sample #83: HDM is not disputing that pre/post operative care is covered, but that the consult visit on 2/20/2006 was already included in the major surgery allowance performed on 2/21/2006. The 2/20/2006 consultation should not have been reimbursed. This resulted in an overpayment of \$84.89.</p>		
TPA Response	Anthem does not agree #83 is an exception. The claim was billed as a second surgical opinion, which is separately reimbursed.		
Conclusion	<p>The surgical allowance for major surgery code 28890 performed on 2/21/06 includes 1 pre-operative visit. This pre-operative visit was on 2/20/06 and should not have been reimbursed. Pre/Post surgical or global surgery visits are standard and accepted industry medical practice. HDM has identified an additional 215 claims in this category resulting in potential overpayments in the amount of \$10,640.</p> <p>In addition to the above findings, HDM has identified an additional 75 claims in this category resulting in potential overpayments in the amount of \$10,257. HDM will provide Anthem with the detailed claims information for the additional claims. All exceptions require review by Anthem.</p>		

Exhibit 3



**REVIEW OF
ANTHEM BLUE CROSS BLUE
SHIELD OF OHIO RX'S
PHARMACY CLAIMS
ADMINISTRATION**

For

City of Cincinnati

November 2008

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Confidentiality

This report may contain medical and personal information concerning employees that may be subject to state, federal or other regulatory authority privacy and confidentiality laws and regulations. Information provided by the claims administrator was released with similar confidentiality restrictions. All claims and medical situations discussed in this report are identified by a number rather than by actual employee and/or dependent names. Use or distribution of any confidential information contained in this report should be limited to authorized individuals.

Section I - Executive Summary

Engagement Overview

City of Cincinnati (Cincinnati) engaged the services of Healthcare Data Management (HDM) to conduct a pharmacy claims review to assess Anthem BlueCross BlueShield of Ohio's RX (Anthem) administration of Cincinnati's self-funded pharmacy plan(s) and determine if Anthem is in compliance with the terms of the Administrative Agreement. This engagement encompassed an audit of Anthem to assess the accuracy and appropriateness of its fiduciary responsibility as the plan's administrative agent including the prescription adjudication process, compliance with pricing agreements, contract terms and review of quality control procedures. HDM performed an electronic audit of all the claims adjudicated by Anthem from January 1, 2006 to December 31, 2007.

Claim Review Scope

HDM selected a sample of claims incurred by Cincinnati's plan participants during the audit scope for testing and review. The sample was selected based on HDM exception analysis identified in the claims processed during the audit period. These exceptions were based on standard administrative rules such as quantity limits, ample day supply, copayments, and eligibility specific to the plan benefits described in the Summary Plan Document (SPD).

Audit Conclusions

The sample claims were reviewed and based on Anthem's responses, a total of 102 exceptions were identified. HDM evaluated all 809,948 claims adjudicated by Anthem from January 1, 2006 to December 31, 2007. Based on Anthem's responses HDM identified exceptions totaling \$270,365.27 in potential overpayments. The following chart compares the total cost of all exceptions identified by this audit against the total cost of Cincinnati's entire claims population. The AWP discount and gender inappropriate discrepancies seen in Section III, page 7-8 totaling \$88,880.10 is not reflected in the total cost of all exceptions since wording for these two categories was not found in the contract.

Overall Audit Results	Paid
Total cost of all Cincinnati employee healthcare claims	\$47,136,812
Total cost of claims sample	\$17,711.18
Total dollar errors/exceptions identified in claims sample	\$4,784.60
Total cost of all potential exceptions identified from HDM's analysis of Cincinnati's entire claims population (based on the attributes and root-causes of HDM's claim sample findings)	\$270,365.27

The financial impact of all exceptions identified through this review is \$270,365.27 in potential overpayments representing 0.57% of Cincinnati's total spend. Based on the results of the review,

HDM has several recommendations that, if implemented, would improve the overall claims processing accuracy rate and could result in savings to Cincinnati. In general Anthem has done an excellent job in following the contract terms.

Summary of Key Findings & Recommendations

The following summarizes HDM's key recommendations based on findings identified in Cincinnati's entire claims population:

Key Findings:

1. Early Refills-HDM identified a significant number of prescriptions filled at retail and mail within days of each other.
2. AWP Discounts- Discounts are below national averages & dispensing fees are higher than the national average.
3. Quantity Limitations – Medication was dispensed for quantities in excess of the maximum quantity allowed for a specific number of days as stated in the plan design.
4. Gender Inappropriate- Gender specific medications were dispensed to the wrong gender without intervention.
5. Discount Analysis- Using the national discount rates for mail and retail supplied by Anthem, HDM verified that Anthem did not meet their target discount. This caused an overpayment of \$161,731, primarily within mail order. Please refer to the charts on pages 8 and 9. Contractually there was no guaranteed discount or dispensing fee stated.
6. Mail Order Rates- Rates are below industry standards for generics currently at AWP-40%.

Recommendations:

1. Criteria for gender specific medications should be implemented to reduce errors in prescribing. A hard edit should be activated to prevent incorrect prescribing.
2. Mail order and retail claims processing systems should interface to prevent prescriptions from being refilled prior to 70% to 75% of the day's supply being exhausted.
3. Discount and dispensing rates should be negotiated to mirror the national averages. National averages observed by HDM are: Retail Discounts-AWP-16% for brand-name drugs, AWP-20% for generic drugs and AWP-67% for MAC drugs; Retail Dispensing Fees-\$ 1.75 for brands, \$2.00 for generic and \$2.00 for MAC list drugs; Mail Order Discounts-AWP-20% - 22% for brands and AWP-60% - 64% for generics. Mail Order Dispensing Fee-\$0.
4. The City of Cincinnati should negotiate a guaranteed discount rate for specialty drugs targeting a discount of AWP-18% for most oral and injectable products.
5. The City of Cincinnati should incorporate terms in their agreement to ensure appropriate allocation of rebates. HDM has observed rebate contract terms paid on a per claim basis in the range of \$3-\$4 per retail claim and \$12-\$14 per mail claim. Rebates are contingent on plan design, formulary and financial incentives to drive to the preferred products.
6. Anthem's current refill to soon logic at retail allows scripts to be filled at 0% if the day supply is 1-3 days, 50% if day supply is 4-10 days and 60% if day supply is 11-20 days.

Anthem's current refill to soon logic at mail allows scripts to fill at 5% if the day supply is 30 to 59 days and 68% if day supply is 61 to 999 days. Anthem should apply the following logic:

Retail: 85% refill logic to scripts with a day supply greater than 21 days.

Mail: 75% refill logic to scripts with a day supply greater than 30 days.

Details of these findings and conclusions are presented in Section III of this report under HDM's "Detailed Findings and Observations".

Section II – Engagement Approach

The following is a description of HDM's objectives and methodology with regard to this engagement.

Claims Review Objectives

HDM performed a retrospective review of Anthem's adjudication of Cincinnati's Managed Prescription Drug Program and plan design. This included a comprehensive evaluation of Anthem:

- Determine compliance with both administrative contract terms and plan documents
- Assess financial accuracy of paid claims and administrative processes, including error and fraud detection
- Evaluate accuracy of payments and identify overpayments, duplicates and other errors
- Identify control weaknesses, their causes and suggest process enhancement/cost savings prospects
- Review Cincinnati's role regarding administration and offer recommendations
- Identify, validate, and monitor the adjustment of claim errors and claim overpayment recoveries
- Evaluate current rebate structure and make recommendations

Claims Review Methodology

HDM's review approach and methodology included the following:

- Review of the contract terms between Cincinnati and Anthem to ensure proper accounting accumulation and reporting for all administrative expenses;
- Analysis of 100% of Cincinnati's claims processed and paid during the review period according to the Managed Prescription Drug Program Agreement, formulary and summary plan documents;
- Data analysis and claims sampling selection;

- An Rx sample was selected and provided to Anthem to review. Anthem was also asked to explain the administrative discrepancies uncovered in the review process.

Claim Sampling

HDM obtained the SPD from Cincinnati and a claims data file from Anthem containing detailed records of 100% of Cincinnati claims and corresponding benefit reimbursements processed during the review period. Additionally, an eligibility file was obtained containing the covered employees and their dependents. Using this data, a customized data warehouse was created and HDM’s auditors and data analysts performed a series of analyses of 100% of Cincinnati’s claims processed based on various business rules. These business rules were generated from the SPD and formulary and various industry guidelines as well as proprietary HDM rules. Based on HDM’s claims analyses, a claims sample totaling \$17,711 was selected for testing. The sample identified claims that may have been paid in error or did not comply with standard industry guidelines.

The following chart summarizes the claim counts and payments by plan for the entire claim population and claim sample.

<i>Plan Type</i>	<i>Claim Population</i>			<i>Prior Authorization</i>		
	<i>Claims</i>	<i>Member</i>	<i>Paid</i>	<i>Claims</i>	<i>Member</i>	<i>Paid</i>
City of Cincinnati	809,948	18,977	\$47,136,812	15,207	3,670	\$4,877,071

Section III – Detailed Findings and Observations

Claims Sample Results

The chart that follows provides a summary of the claim counts and related payments that were included in the pharmacy claims sample, as well the corresponding counts and financial impact of the claim payment exceptions that were identified after receiving responses from Anthem.

<i>Exception Area</i>	<i>Claim Sample</i>		<i>Sample Findings</i>	
	<i>Count</i>	<i>Paid</i>	<i>Count</i>	<i>Financial Impact</i>
City of Cincinnati				
Plan Provisions				
Copayment Application	23	9,245.91	2	149.60
Ineligible Services	5	320.11	2	41.70
Maximum Exceeded	7	1,864.28	7	1,864.28
AWP	21	1,983.73	6	1151.60
System Controls				
NDC No Match	10	727.99	0	0.00
Duplicate	10	325.04	7	205.53
Early Refill	26	3,244.12	4	1,371.89
Gender Inappropriate	0	0.00	0	0.00
Total	102	17,711.18	28	4,784.60

HDM performed additional analysis of the entire claims population for the review period using the attributes of the claim payment exceptions identified after receiving responses to the samples. This analysis identifies and quantifies additional findings with similar characteristics and adjudication outcomes. The results of this analysis are provided in the following chart.

<i>Exception Area</i>	<i>Sample Findings</i>		<i>100% Claims Analysis</i>	
	<i>Count</i>	<i>Financial Impact</i>	<i>Count</i>	<i>Financial Impact</i>
City of Cincinnati				
Plan Provisions				
Copayment Application	2	149.60	790	8,032.08
Ineligible Services	2	41.70	141	3,624.77
Maximum Exceeded	7	1,864.28	827	104,694.94
AWP	6	1151.60	2891	85,255.33
System Controls	6	1151.60		

NDC No Match	0	0.00	0	0.00
Duplicate	7	205.53	51	1,545.81
Early Refill	4	1,371.89	811	152,467.67
Gender Inappropriate	0	0.00	23	3,646.69
Total	28	4,784.60	5534	359,267.29

All findings, recommendations, and conclusions relative to HDM's specific claims sample findings and global analysis of Cincinnati's entire claims population are further detailed in Appendix A.

Discount and Dispensing Fee Analysis 2006

Drug Type	Clm Gnt	Ingr Cost	Dispense Fee	Actual Disc	Disc Terms	Financial Impact	Actual Disp Fee	Disp Terms	Financial Impact
2006									
Group 1 Mail DS 1-59									
Brand	219	\$64,094	\$841	17%	15%		\$3.84	\$2.00	-\$403
Generic	232	\$8,206	\$450	39%	40%	-\$176	\$1.94	\$2.00	
Group 1 Mail DS 60-99									
Brand	4,791	\$1,627,210	\$12,051	18%	18%		\$2.52	\$2.00	-\$2,469
Generic	3,443	\$314,262	\$6,553	38%	40%	-\$11,222	\$1.90	\$2.00	
Group 2 Mail DS 1-59									
Brand	747	\$212,223	\$3,742	17%	16%		\$5.01	\$3.50	-\$1,127
Generic	320	\$11,477	\$1,100	40%	40%	-\$87	\$3.44	\$3.50	
Group 2 Mail DS 60-99									
Brand	4,510	\$886,132	\$16,935	16%	16%		\$3.75	\$3.50	-\$1,150
Generic	3,661	\$201,884	\$12,299	38%	40%	-\$6,862	\$3.36	\$3.50	
Retail									
Brand	188,166	\$18,775,534	\$282,135	17%	16%		\$1.50	\$1.60	
Generic	191,794	\$3,125,602	\$447,812	62%	16%		\$2.33	\$2.35	
Subtotal						-\$18,347			-\$5,149

Group 1 00081115A838, 00109613B355
 Group 2 00081117A500, 00081117A839, 00081117A856, 00081116A945
 Group 3 00109613F065

The chart above uses Anthem's national discounts at retail and mail for 2006 claims. HDM verified the effective/blended discount rates for brand and generics by comparing the actual paid amounts to the Medispan AWP reference. The variance to the Anthem discounts and dispensing fee was an overpayment of \$23,496.

Discount and Dispensing Fee Analysis 2007

Drug Type	Clm Cnt	Ingr Cost	Dispense Fee	Actual Disc	Disc Terms	Financial Impact	Actual Disp Fee	Disp Terms	Financial Impact
2007									
Group 1 Mail DS 1-59									
Brand	123	\$47,362	\$471	17%	15%		\$3.83	\$2.00	-\$225
Generic	109	\$3,860	\$210	39%	40%	-\$90	\$1.93	\$2.00	
Group 1 Mail DS 60-99									
Brand	2,461	\$923,704	\$6,085	18%	18%		\$2.47	\$2.00	-\$1,163
Generic	1,964	\$201,577	\$3,696	37%	40%	-\$8,536	\$1.88	\$2.00	
Group 2 Mail DS 1-59									
Brand	970	\$312,859	\$4,513	17%	16%		\$4.65	\$3.50	-\$1,118
Generic	303	\$11,999	\$1,028	38%	40%	-\$474	\$3.39	\$3.50	
Group 2 Mail DS 60-99									
Brand	4,902	\$1,035,783	\$18,079	16%	16%	-\$124	\$3.69	\$3.50	-\$922
Generic	4,925	\$308,508	\$16,182	38%	40%	-\$9,088	\$3.29	\$3.50	
Group 3 Mail DS									
Brand	2,357	\$963,619	\$5,628	17%	22%	-\$52,566	\$2.39	\$0.00	-\$5,628
Generic	1,893	\$198,287	\$3,557	38%	55%	-\$54,745	\$1.88	\$0.00	-\$3,557
Retail									
Brand	179,026	\$19,415,663	\$268,318	16%	16%		\$1.50	\$1.60	
Generic	210,281	\$3,575,599	\$488,496	65%	16%		\$2.32	\$2.35	
Subtotal						\$125,623			-\$12,612

Group 1 00081115A838, 00109613B355
 Group 2 00081117A500, 00081117A839, 00081117A856, 00081116A945
 Group 3 00109613F065

The chart above uses Anthem's national discounts at retail and mail for 2007 claims to compare contracted discounts and dispensing fees to the actual discounts and dispensing fees. HDM verified the effective/blended discount rates for brand and generics by comparing the actual paid amounts to the Medispan AWP reference. The variance to the Anthem discounts and dispensing fee was an overpayment of \$138,235.

Section IV – Rebate Analysis

HDM reviewed spreadsheets of rebate credits received by the City Cincinnati to ensure that they met the contractual guarantees spelled out in the Administrative Services Agreement with Anthem. The review consisted of checking rebates received for the audit period from January 1, 2006 to December 31, 2007.

The rebate credit of \$5.56 per subscriber per month was effective from January 1, 2006 to December 31, 2006.

The rebate credit of \$6.03 per subscriber per month was effective from January 1, 2007 to June 3, 2007.

The rebate credit of \$12.97 per subscriber per month was effective from July 1, 2007 to December 31, 2007.

Anthem passes on 80% of the rebate as a credit to the ASO fee.

HDM has concluded that Anthem did comply with the terms agreed to in the Administrative Services Agreement and did receive all of the rebate credit the City of Cincinnati was entitled to.

APPENDIX A

The following charts provide additional details relative to the claim payment exceptions identified as a result of HDM's electronic claims review and claims analysis. The charts also include Anthem's response and HDM's recommendation and conclusion regarding the specific issue. Cincinnati and Anthem should review these findings and determine the appropriate course of action, i.e. claim recovery, reimbursement to Cincinnati, etc.

Administrative Services

Plan Provisions

Copayment Application				
HDM Assessment		Exceptions were noted for copay application. 26 claims were selected for the sample.		
ANTHEM Response		<ol style="list-style-type: none"> 1. Sample #55- submitted with DAW 5 (brand drug dispensed as generic). Generic copay is correct. 2. Sample #57 & 58- Day supply submitted 30 & 7. copay correct. 3. Sample #60- VA network where pharmacy is reimbursed \$51.00 and member copay is \$0. 4. Sample #62- WellPoint Nextrx agrees. 5. Sample #64, 65, 66, 68 & 69 – Day supply submitted 20 to 30. Copay correct. 6. Sample 71, 72, 73, 83, 84, 85, 86 & 87 – Day supply submitted 30, 30 & 28. Copay correct. 7. Sample 75, 79, 80, 81, 89, 90 & 91- Think generics-refer to program document. 		
Conclusion		<p>HDM re-evaluated copays based on Wellpoint Nextrx responses above.</p> <ol style="list-style-type: none"> 1. HDM agrees. 2. Mail order brand-formulary copay claims for prescriptions filled for less than a 34 day supply have been removed from the analysis. 3. List of VA pharmacies has been received and has been added to HDM's data base. 4. This will remain as an exception. 5. HDM did not count as errors. After further review HDM agrees that retail copay applies to 34 day supply or less at mail. 6. HDM agrees and template has been adjusted. 7. Think generic program set up to have copay waived on first generic fill. These claims were not counted as errors in HDM's assessment. 		
Copayment Application		Sample Findings		100% Claims Analysis
Exception		Count	\$\$ Impact	Count
BRAND COPAY A500 \$12.00		1	10	69
BRAND RETAIL FORMULARY COPAY F065/B355 \$20.00				9
				508
				120

COPAY DIABETIC SUPPLIES \$0.00	1	-30	3	-63
G/B MAIL COPAY A839 \$10.00			235	2,242
G/B MAIL COPAY A856 \$6.00			41	246
G/B RETAIL NON-FORM COPAY F065/B355 \$30.00			14	415
GENERIC COPAY A500 \$5.00			228	768
GENERIC MAIL COPAY FORMULARY F065/B355 \$20.00			189	3,509
GENERIC RETAIL COPAY FORMULARY F065/B355 \$10.00			33	70
Copayment Application TOTAL	2	-20	821	7,815

Ineligible Services

HDM Assessment

Exceptions were noted for copay application. 5 claims were selected for the sample

ANTHEM Response

1. Sample 173 – Paid using prior authorization. Screen print provided.
2. Sample 175 & 176 - The immunization claim (Vivotif Bern) is APM's standard set up to pay. Immunizations are normally covered under medical; however Vivotif Bern caps is not covered by medical. APM has it set up to pay under the drug benefit.
3. Sample 178 & 180 - Paid using prior authorization. Screen print provided.

Conclusion

HDM re-evaluated ineligible services based on the above responses.

1. HDM will adjust.
2. Anthem did supply a list of covered immunizations and changes were made before draft was issued.
3. HDM will make the adjustment.

<i>Ineligible Services</i>	<i>Sample Findings</i>		<i>100% Claims Analysis</i>	
	<i>Exception</i>	<i>Count</i>	<i>\$\$ Impact</i>	<i>Count</i>
BIOLOGICALS/BLOOD PRODUCTS/IMMUNIZATIONS/VACCINES NON-COVERED	2	42	126	2,739
COSMETICS NON-COVERED			11	836
QUALAQUIN PA REQUIRED NON-COVERED			2	25
QUINERVA PA REQUIRED NON-COVERED			2	25
Ineligible Services TOTAL	2	42	141	3,625

Maximum Exceeded

HDM Assessment

Exceptions were noted in the sample. 7 claims were selected

ANTHEM Response

Retail claim processed followed by mail.

Conclusion

The claims system should recognize both retail and mail claims when enforcing benefit limitations. HDM still considers these as errors.

<i>Maximum Exceeded</i>	<i>Sample Findings</i>		<i>100% Claims Analysis</i>	
	<i>Exception</i>	<i>Count</i>	<i>\$\$ Impact</i>	<i>Count</i>
ACTONEL 12 DISPENSED 84/DD			16	2,812
AMBIEN 90 DISPENSED 90/DD	1	231	7	1,756
AZMACORT 120 DISPENSED 90/DD			1	534

BONIVA 3 DISPENSED 84/DD			11	1,782
CELEBREX 180 DISPENSED 90/DD	1	456	10	4,802
CELEBREX 90 DISPENSED 90/DD			6	2,004
CELEXA 135 DISPENSED 90/DD			8	905
CELEXA 90 DISPENSED 90/DD			4	484
CYMBALTA 180 DISPENSED 90/DD			4	2,274
DURAGESIC 45 DISPENSED 90/DD			2	913
ED- ORAL PA 6 DISPENSED 30/DD	1	136	499	30,564
EFFEXOR XR 90 DISPENSED 90/DD			2	579
FLONASE 48 DISPENSED 90/DD	1	150	44	6,085
FOSAMAX 12 DISPENSED 84/DD			34	5,912
FOSAMAX PLUS D 12 DISPENSED 84/DD			16	2,816
LEXAPRO 135 DISPENSED 90/DD			10	1,778
LEXAPRO 90 DISPENSED 90/DD	1	178	18	3,243
MIGRAINE AGENTS 27 DISPENSED 90/DD	1	365	23	7,599
MOBIC 90 DISPENSED 90/DD			5	1,036
NASACORT AQ 51 DISPENSED 90/DD			11	1,709
NASONEX 51 DISPENSED 90/DD			19	3,026
PAXIL 135 DISPENSED 90/DD			3	370
PAXIL 180 DISPENSED 90/DD			1	303
PROZAC 360 DISPENSED 90/DD			3	1,102
PULMICORT 360 DISPENSED 90/DD			2	1,837
PULMICORT TURBUHALER 3 DISPENSED 75/DD			4	1,096
RHINOCORT AQUA 54 DISPENSED 90/DD			1	394
SARAFEM 90 DISPENSED 90/DD			1	344
SPIRIVA HANDIHALER 90 DISPENSED 90/DD			7	2,212
TEST STRIPS 612 DISPENSED 90/DD			12	5,124
ZOLOFT 135 DISPENSED 90/DD			18	2,419
ZOLOFT 180 DISPENSED 90/DD	1	347	9	2,963
Maximum Exceeded TOTAL	7	1,864	811	100,778

System Controls

Duplicate				
HDM Assessment	Exceptions were noted in the sample. 7 claims were selected			
ANTHEM Response	Referenced new refill to soon limit documentation			
Conclusion	Adjusted our refill logic based on new documentation and 160 claims processed incorrectly. HDM did not apply refill to soon logic to duplicates.			
	Sample Findings		100% Claims Analysis	
Duplicate Exception	Count	\$\$ Impact	Count	\$\$ Impact
MAIL DUPLICATE	4	169	3	310

RETAIL DUPLICATE	3	37	157	9,962
Duplicate TOTAL	7	206	160	10,272
Early Refill				
HDM Assessment	Exceptions were noted in the sample. 30 claims were selected			
ANTHEM Response	Referenced new refill to soon limit documentation UCF claim correctly submitted.			
Conclusion	Adjusted our refill logic based on new documentation and responses. 806 claims processed incorrectly. Prior authorizations were not found on these claims.			
<i>Early Refill Exception</i>	<i>Sample Findings</i>		<i>100% Claims Analysis</i>	
	<i>Count</i>	<i>\$\$ Impact</i>	<i>Count</i>	<i>\$\$ Impact</i>
MAIL 31-60D 50% .50			3	361
MAIL 61-999D 68% .68			3	494
RETAIL 11-20D 60% .60			22	5,753
RETAIL 21-60D 85% .85	1	25	768	143,139
RETAIL 4-10D 50% .50	3	1,347	6	952
RETAIL 61-100D 90% .90			4	721
Early Refill TOTAL	4	1,372	806	151,421
Gender Inappropriate				
HDM Assessment	Exceptions were noted for gender inappropriate claims.			
ANTHEM Response	No samples were sent therefore no response.			
Conclusion	HDM applied FDB and industry standards to assess gender inappropriate claims. As a result 23 claims remain in the 100% claim analysis. Minimal financial impact.			
<i>Gender Inappropriate Exception</i>	<i>Sample Findings</i>		<i>100% Claims Analysis</i>	
	<i>Count</i>	<i>\$\$ Impact</i>	<i>Count</i>	<i>\$\$ Impact</i>
GENDER INAPPROPRIATE GENDER INAPPROPRIATE			23	3,647
Gender Inappropriate TOTAL			23	3,647