NORTH CAROLINA STATE HEALTH PLAN
FOR TEACHERS AND STATE EMPLOYEES

Raleigh, North Carolina

PPO Medical Claims

Financial Statement, Supplemental Information and Compliance Section

Year Ended June 30, 2014

NC STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES
PPO Medical Claims
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INDEPENDENT AUDITORS' REPORT

Executive Administrator and Board of Trustees
North Carolina State Health Plan
for Teachers and State Employees
Raleigh, North Carolina

Report on Financial Statement

We have audited the accompanying statement of PPO medical claims paid of the North Carolina State Health Plan for Teachers and State Employees (the "Plan") for PPO medical claims processed by the Plan's Third Party Administrator ("TPA") as of and for the year ended June 30, 2014.

Management's Responsibility for the Financial Statement

Management is responsible for the preparation and fair presentation of the statement of PPO medical claims paid in accordance with the cash basis of accounting as described in Note 2; this includes determining that the cash basis of accounting is an acceptable basis for the preparation of the statement of PPO medical claims paid in the circumstances. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of the statement of PPO medical claims paid that are fee from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on the statement of PPO medical claims paid based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and *Government Auditing Standards,* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the statement of medical claims paid is free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the statement of PPO medical claims paid. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the statement of PPO medical claims paid, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statement in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the statement of PPO medical claims paid referred to above presents fairly, in all material respects, the PPO medical claims arising from cash transactions of the North Carolina State Health Plan for Teachers and State Employees for the year ended June 30, 2014.

Basis of Accounting

We draw attention to Note 2 of the statement of PPO medical claims paid, which describes the basis of accounting. The statement of PPO medical claims paid was prepared on the basis of cash disbursements, which is a comprehensive basis of accounting other than accounting principles generally accepted in the United States of America. Our opinion is not modified with respect to this matter.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards,* we have also issued our report dated September 8, 2014 on our consideration of the Plan's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Plan's internal control over financial reporting and compliance.

Thomas & Gibbs CPAs, PLLC

Durham, North Carolina
September 8, 2014

NC STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES

STATEMENT OF PPO MEDICAL CLAIMS PAID

Year Ended June 30, 2014

PPO medical claims paid during the year ended June 30, 2014, were as follows:

	Total Paid Value
Total PPO medical claims	$1,965,720,211

The accompanying notes are an integral part of the financial statement.

NC STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES
PPO MEDICAL CLAIMS
NOTES TO THE FINANCIAL STATEMENT
Year Ended June 30, 2014

Note 1 - Organization

In accordance with Article 3B of Chapter 135 of the General Statutes, the State of North Carolina established the North Carolina State Health Plan for Teachers and State Employees, referred to as the State Health Plan (the "Plan"). The Plan provides comprehensive healthcare benefits for employees and retirees of the State and their qualified dependents.

The Plan is administered by the State Treasurer, the Board of Trustees, and an Executive Administrator who is appointed by the State Treasurer. Health benefits and contribution rates are determined by the State Treasurer upon approval of the Board of Trustees.

The Plan currently offers a self-funded Preferred Provider Option ("PPO"). Contributions for employee and retiree coverage are made by the State through employing units. Employees and retirees also contribute to the cost of coverage for the 80/20 Standard PPO plan option. Contributions for dependent coverage are made by employees and retirees.

Medical claims processing and other administrative services are provided by Blue Cross and Blue Shield of North Carolina as the Third Party Administrator (the "TPA"). The TPA bills and collects premiums, processes claims and appeals, provides customer service, and administers cost containment programs such as pre-admission certification and mental health case management.

Note 2 - Basis of accounting

The statement of PPO medical claims paid is a summary of the cash activity of the Plan and does not present transactions that would be included in the financial statements of the Plan presented on the accrual basis of accounting, as contemplated by accounting principles generally accepted in the United States of America. In this regard, expenses are recognized when paid.

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INDEPENDENT ACCOUNTANTS' REPORT ON APPLYING AGREED-UPON PROCEDURES

Executive Administrator and Board of Trustees
North Carolina State Health Plan
for Teachers and State Employees
Raleigh, North Carolina

We have performed the procedures enumerated in Exhibit IV, which were agreed to by the North Carolina State Health Plan for Teachers and State Employees (the "Plan"), solely to assist you in evaluating the accompanying Summarization of Errors (prepared in accordance with the criteria specified therein) for the year ended June 30, 2014, as presented in Exhibit I. This agreed-upon procedures engagement was performed in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the specified users of the report. Consequently, we make no representation regarding the sufficiency of the procedures described in the attached report either for the purpose for which this report has been requested or for any other purpose.

We contracted with the Plan to perform certain agreed-upon procedures with respect to Preferred Provider Organization ("PPO") medical claims processed by Blue Cross and Blue Shield of North Carolina (the "Third Party Administrator") on behalf of the Plan during the twelve-month period of July 1, 2013 through June 30, 2014 (the "2014 contract period"). Our procedures were performed solely to assist the Executive Administrator of the Plan in evaluating the accuracy of the claims processed by the Third Party Administrator ("TPA"), and our report is not intended to be used for any other purposes.

The specific procedures performed are described in Exhibit IV. Our objective was to determine if claims were processed and paid by the TPA in accordance with the contract between the TPA and the Plan (the "Contract") for PPO medical claims effective July 1, 2013. Under the Contract, the TPA is required to meet the following performance guarantees:

- Processing accuracy rate: 97%
- Payment accuracy rate: 99%
- Financial accuracy rate: 99%

Financial accuracy rate, payment accuracy rate and processing accuracy rate are defined in the Contract, as follows:

"Processing accuracy" is defined as is the number of claims processed with no procedural errors divided by the total number of claims processed.

"Payment accuracy" is defined as the number of claims with the correct benefit dollars paid divided by the total amount of claims paid in the audit sample.

"Financial accuracy" is defined as the total dollar amount processed accurately divided by the total dollar amount processed in the audit sample. The total dollar amount processed accurately is calculated by subtracting the absolute value of the dollars processed in error from the total dollars processed. Underpayments and overpayments are not offset by one another.

Exhibit I, Summarization of Errors, presents the processing, payment, and financial accuracy rates and projected underpayment error noted for PPO medical claims for the year ended June 30, 2014. The following is a summary of the accuracy rates and projected underpayment error for PPO medical claims for the year ended June 30, 2014:

Reporting Period	Number of Errors	Processing Accuracy Rate	Payment Accuracy Rate	Financial Accuracy Rate	Projected Underpayment Error
YE June 30, 2014	8	98.67%	99.33%	99.89%	($996,659)
Performance guarantees	-	97%	99%	99%	-

For the year ended June 30, 2014, the processing accuracy rate of 98.67% exceeded the 97% rate required by the Plan; the payment accuracy rate of 99.33% exceeded the 99% rate required by the Plan; and the financial accuracy rate of 99.89% exceeded the 99% rate required by the Plan. The errors noted during the year ended June 30, 2014 are summarized as follows:

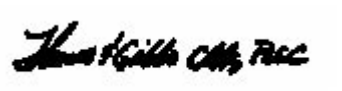
Description	2014 Contract Period
Keying errors	4
Pricing errors	3
Duplicate payment	1
Total	8

This is our final report for the year ended June 30, 2014. As reported above, eight (8) errors were noted during the year ended June 30, 2014.

Exhibit III presents our observations and recommendations regarding the TPA's claims processing procedures for the year ended June 30, 2014. The TPA's responses to our observations and recommendations are also provided.

Our procedures related only to claims processed by the TPA during the year ended June 30, 2014 and do not extend to any financial statements or systems of internal accounting control of the Plan or the TPA. These procedures are not intended to and do not constitute an audit made in accordance with auditing standards generally accepted in the United States of America because they are limited to the "agreed-upon procedures." Accordingly, we do not express an opinion on any accounts, records, or reports of the Plan or the TPA. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the use of the Plan's management, the Office of State Auditor and the TPA and is not intended to be and should not be used by anyone other than those specified parties.



Durham, North Carolina
September 8, 2014

EXHIBIT I

NC STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES
SUMMARIZATION OF ERRORS - PPO MEDICAL CLAIMS
Year Ended June 30, 2014

A. Claim accuracy rates

Description of Errors	**Processing** Accuracy Rate	**Payment** Accuracy Rate	**Financial** Accuracy Rate
Keying errors	4	-	$ -
Pricing errors	3	3	6,195
Coding errors	1	1	765
Number and amount of errors noted	8	4	6,960
Remainder in sample	592	596	6,375,432
Number and amount of claims in the sample	600	600	$ 6,382,392
Accuracy rates	98.67%	99.33%	99.89%

Processing accuracy rate: 98.67%

Processing accuracy rate is defined by the Contract as the number of claims processed with no procedural errors divided by the total number of claims processed. For the year ended June 30, 2014, the processing accuracy rate of 98.67% is computed as 592 claims divided by 600, the number of claims in the sample.

Payment accuracy rate: 99.33%

Payment accuracy rate is defined by the Contract as the number of claims with the correct benefit dollars paid divided by the total number of claims paid in the audit sample. For the year ended June 30, 2014, the payment accuracy rate of 99.33% is computed as 596 claims divided by 600, the number of claims in the sample.

Financial accuracy rate: 99.89%

Financial accuracy is defined by the Contract as the total dollar amount processed accurately divided by the total dollar amount processed in the audit sample. The total dollar amount processed accurately is calculated by subtracting the absolute value of dollars in error from the total dollars processed. Underpayments and overpayments are not offset by one another. For the year ended June 30, 2014, financial accuracy of 99.89% is computed as $6,375,432, the dollar amount of claims in the sample processed correctly, divided by $6,382,392, the total dollar amount of claims in the sample.

EXHIBIT I

NC STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES
SUMMARIZATION OF ERRORS - PPO MEDICAL CLAIMS
Year Ended June 30, 2014

B. Claims sample characteristics

	Number	%
Institutional (Hospital) claims	335	56%
Professional claims	265	44%
Total claims sampled	600	100%
System claims	338	56%
Manual claims	262	44%
Total claims sampled	600	100%
CDHP Claims	-	-
Non-CDHP Claims	600	100%
Total claims sampled	600	100%

C. Claims error characteristics

	Number	%
Institutional (Hospital) claims	7	87%
Professional claims	1	13%
Total claims sampled	8	100%
System claims	7	87%
Manual claims	1	13%
Total claims sampled	8	100%

D. Projected population payment error:

Net underpayment error	$ (3,236)	Net dollar amount of payment errors in the sample
Divided by the total sample	6,382,392	Dollar amount of the total sample
=	(0.000507)	Total
x Total paid claims	$ 1,965,720,211	Paid claims for the year
= Projected error	$ (996,659)	Projected population underpayment error

EXHIBIT II

NC STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES
EXPLANATION OF ERRORS - PPO MEDICAL CLAIMS
Year Ended June 30, 2014

	Net Overpayment (Underpayment)	**Absolute** Error Amount	Number of Errors
Keying errors:			
1. Service dates were entered incorrectly impacting the system's ability to process the claim correctly.	$ -0-	$ -0-	4
Pricing errors:			
2. Claim was manually priced incorrectly resulting in an overpayment.	93	93	1
3. Claims were incorrectly priced resulting in an underpayment.	(2,564)	6,102	2
Coding error:			
4. Service code on the claim was incorrectly denied resulting in an underpayment.	(765)	765	1
	$ (3,236)	$ 6,960	8

EXHIBIT III

NC STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES
PPO MEDICAL CLAIMS
OBSERVATIONS AND RECOMMENDATIONS
Year Ended June 30, 2014

OBSERVATIONS

Verification of Participant Data

During our review for the year ended June 30, 2014, we noted instances where the patient's membership information per the claim did not agree with the member's claim history, such as:

- 71 claims where the patient's address did not agree with the member's claims history.
- 4 claims where the patient's name did not agree with the member's claims history.
- 1 claim where the patient's gender did not agree with the member's claims history.
- 1 claim where the patient's date of birth did not agree with the member's claims history.

	Total
Address	71
Name	4
Gender	1
Date of birth	1
Total	77

Inaccurate participant information could result in incorrect claim payments for various procedures. We understand that annual participant data verifications are performed by having the Health Benefit Representative (HBRs) update a variety of participant information. However, we understand that not all HBRs complete the verification of this information.

RECOMMENDATIONS

We recommend that the Third Party Administrator continue to convey the importance of accurate membership information to the HBRs, and require that they attempt to verify all information. In addition, we recommend that the Third Party Administrator supplement the annual participant data verifications performed by the Health Benefit Representatives. Such a supplementary procedure could include mailing verification requests to participants who file a claim with contradictory information.

THIRD PARTY ADMINISTRATOR'S RESPONSE

State membership continues to stress the importance of annual member verifications to HBRs via HBR newsletters and cover letters sent with the verifications. As mentioned in previous year's responses, for some agencies the task is so monumental that some cannot perform the task on a timely basis or are unable to complete the task. We advise the HBRs that member verification is a State Health Plan requirement and not an optional task and for them to make every effort possible to distribute the verifications to their members.

Blue card Claims

During our claims review for the year ended June 30, 2014, we noted twenty-four (24) instances where the original claim image was not available to verify claims information submitted by the provider to the host plan.

Electronic data maintained in Third Party Administrator systems was utilized to satisfy claims testing attributes.

RECOMMENDATIONS

We recommend that the Third Party Administrator maintain claim images for each claim paid.

EXHIBIT IV

NC STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES
PPO MEDICAL CLAIMS
AGREED-UPON PROCEDURES
Year Ended June 30, 2014

I. SAMPLING METHODOLOGY

We will employ statistical sampling techniques to select a sample size of 600 PPO medical claims for the twelve-month period of July 1, 2013 through June 30, 2014 (the "2014 contract period"). Audit Command Language ("ACL") statistical sampling software will be used throughout the process to randomly select the sample.

We will use stratified random sampling and a related error estimation technique as described below:

A. Sample Size Determination - The sample will be selected from PPO claims payment files for the period July 1, 2013 through June 30, 2014, that will be reconciled to cash disbursement reports submitted to the North Carolina State Health Plan for Teachers and State Employees. The population will include all original claims or adjustments paid during the period.

1. Confidence Level - 98%
2. Estimated Error Rate - 0.25
3. Desired Precision - +/-2%
4. Claims Strata
   - less than $(5,350) (denials and adjustments)
   - $(5,349.99) - $(370) (denials and adjustments)
   - $(369.99) - $(.55) (denials and adjustments)
   - $(.54) - $14.99 (includes denials and adjustments)
   - $15 - $47.99
   - $48 - $98.99
   - $99 - $207.99
   - $208 - $486.99
   - $487 - $1,100.99
   - $1,101 - $2,430.99
   - $2,431 - $6,150.99
   - $6,151 - $17,000.99
   - $17,001 - $38,000.99
   - $38,001 - $999,999,999

B. Sample Selection - The sample will be randomly selected on an item selection basis where each item within any given claims strata has an equal probability of being chosen.

C. Definition of Claim Payment Error - A claim payment error is defined as the overpayment or underpayment of a claim transaction, which includes payment to an incorrect payee or to a payee's incorrect address that occurs through the fault of the Third Party Administrator. Also, claims showing a monetary adjustment after our sample has been selected will be counted as errors.

D. Analysis of Sample Results - The error rate based on the number of claims paid in error will be calculated by adding the number of claims containing overpayment errors to those containing underpayment errors and dividing by the total number of claims in the sample. The error rate based on the dollar value of claim payments will be calculated by adding the dollar amount of overpayment errors to the absolute dollar amount of underpayment errors and dividing by the total dollar value of claims in the sample.

E. Projection of Sample Results - We will extrapolate the dollar value of the claim payment error to the entire population to determine the projected monetary error.

F. Additional Testing - At the request of the State Health Plan's representatives, we will test additional claims within specified populations of claims as defined by the State Health Plan (Diagnosis Related Group claims, etc.) The Third Party Administrator will pull this additional sample, with any reprogramming also done by the Third Party Administrator. The results of the additional testing will not be combined with the statistical sample but will be for informational purposes only.

II. SUBSTANTIVE REVIEW APPROACH AND REVIEW OF INTERNAL CONTROLS

Our review approach will be totally substantive. Because of the nature of the engagement we must determine, for each selected sample claim, whether the benefits have paid properly. Although we will review internal controls over claims processing as a part of our engagement, we will not rely on such review to reduce the extent of our substantive testing.

III. SCOPE LIMITATIONS

Limitations on our ability to verify the propriety of claim payments are as follows:

A. Medical determinations - Decisions as to medical necessity of procedures and similar questions requiring medical expertise are beyond the scope of our engagement. In those situations, where medical determinations were required to administer a benefit we will determine that the Third Party Administrator adhered to medical policies.

B. Claim documents - Generally our audit procedures are designed to utilize the information available for on-line review at BCBS or contained on the following documents:

1. Claim copy
2. Claim history (claim details screen print from Power-MHS)
3. Explanation of Benefits
4. Various reference listings available from the Third Party Administrator

Situations requiring the review of the claim copies other than for the claims included in our sample are beyond the scope of our audit procedures. However, we may refer to such claims if provided by the Third Party Administrator to help resolve potential errors in processing claims.

IV. REVIEW PROCEDURES

A. General Procedures

The following general procedures will be applied to all claims selected.

1. Agree the details relating to the sample claim on the claim details to the copy of the claim provided by the Third Party Administrator.

2. Scan the member's claims payment history per the Power MHS Claim Inquiry Screen (CL1081) for duplicate payment by reference to dollar amounts, dates of service, and other details. Ascertain whether the sample claim is a duplicate payment, so the CL1081 should be reviewed for claims paid prior to the date that our sample claim was paid.

B. Eligibility

Requirements for eligibility for Plan membership are outlined under North Carolina General Statute 135-45.2. Our approach toward verifying eligibility will be to agree subscribers' names and subscriber's numbers to the subscriber/member coverage portion of the Power MHS Enrollment Entry Screen (ME1014).

1. To determine subscriber eligibility, we will ascertain whether:

    i. The subscriber is covered by comparing the effective dates on the subscriber/member coverage on the ME1014 in relation to the date(s) of service.
    ii. The patient is covered based upon the contract types (for example, if the claim is for a dependent, review that the contract type covers dependents). The dependents covered will be listed and reviewed on the subscriber/member coverage of the ME1014.

2. To determine dependent eligibility we will:

    a. Review the date of birth, as noted on the claim form, to ascertain the age of the dependent at time of service.
    b. Ascertain whether the date of birth on the ME1014 agrees to that on the claim.
    c. Where dependents are over the eligible age of 19, ascertain by a review of the subscriber/member coverage, that the dependent is a full-time student under age 26 or is deemed physically incapacitated, mentally incapacitated, and/or handicapped.

3. Additional eligibility criteria will be considered.

C. Covered Services

1. Ascertain that Charges are Covered – Applicable provisions of North Carolina General Statutes Chapter 135 outline services that are covered and will be used as a reference to determine whether specific charges are covered. We will refer to the statute as necessary to ascertain whether charges are covered.

2. Test for Pre-existing Conditions - For members of the Plan who do not enroll within 30 days after their date of eligibility, services rendered within 12 months after enrollment in connection with pre-existing conditions will not be covered by the Plan. Employees and their eligible dependents not enrolled at termination of employment, and later rehired within 12 months and enrolled by the same or another state agency, will be subject to the waiting period for pre-existing conditions. By reviewing Power MHS Authorization Entry Screen (CL1011), we will determine whether the patient was subject to the pre-existing condition limitation.

3. Institutional Claims - The following considerations will be reviewed regarding covered charges:

   a. Diagnostic Admissions

      Room and board related to diagnostic testing, which could be performed on an outpatient basis, is not covered. We will examine the claim for testing procedures performed in an inpatient setting and a clear indication that the claim is for a diagnostic admission. We will ascertain whether the room and board portion of a claim for diagnostic testing should have been denied.

   b. Skilled Nursing Facility

      Covered services are for skilled level of care only, required on a continuing basis for conditions for which the patient received inpatient services prior to their transfer to the SNF. Skilled Nursing Facilities require prior approval from the second day of coverage. Coverage is for not more than 100 days per fiscal year for the same reason.

      We will verify by a review of the claims history that the patient was hospitalized for at least 3 days within 2 weeks prior to nursing home admission for the same diagnosis. This will be done using dates of service and diagnosis codes.

   c. Mental Illness

      We will verify that inpatient mental health treatment is subject to case management. We also verify that:

      i. Benefits are available for inpatient psychiatric care, intensive outpatient crisis management, partial hospitalization treatment, and residential care and treatment only when authorized by the Mental Health Case Manager.

      ii. Case management is required for outpatient mental health services in excess of 26 visits per fiscal year.

   d. Chemical Dependency

      We will verify that claims for chemical dependency are subject to case management consisting of pre- certification for all treatment except for the first 26 combined mental health and chemical dependency outpatient visits each plan year.

   e. Ancillary Services

      Ancillary charges for personal items such as rental of televisions are not covered. We will review ancillary services on the "other" line of the claim and determine whether properly covered.

   f. Chiropractic Services

      We will verify by review of the CL1011 that the benefit period maximum for each covered individual has not been exceeded.

D. Ascertain that Benefits Were Properly Priced

The billed charges will be compared to the Usual, Customary and Reasonable ("UCR") charge and the lower of the Usual, Customary or charge amount should be allowed. The specific methodology used to compare prices to the UCR limits will vary based upon the type of services rendered.

When discrepancies are noted on UCR changes with retroactive effective dates, the following will be considered:

a. If it is a provider paid claim it is not an error, or
b. If it is a subscriber paid claim it is an error.

1. Physician's Fees

a. Using the on-line Usual and Customary Inquiry Data, we will determine the usual and customary charges for the procedure for the date on which the claim was paid, and compare to the actual charge. The lesser of the three will be deemed allowable.
b. In some cases, a reasonable charge may be allowed based on a review of the specific circumstances of the claim, to allow for unique circumstances. We will review CL1011 if there is evidence that the reasonable charge has been selected as the allowable.
c. Multiple Procedures – We will examine the claim form for multiple procedures and if multiple procedures are present:

i. Ascertain that no more than the greater UCR allowance plus 50% of the lesser UCR allowance was paid for the same procedure through separate incisions or approaches.

ii. Ascertain that the highest UCR allowance was paid for multiple procedures through the same incision or the same body system.

d. Multi-Stage procedures - The Plan provides that surgical procedures performed in two or more stages should be paid as if the entire procedure was in one stage. We will investigate situations that may indicate staged procedures.

i. If the claim provides evidence of staged procedures billed on a single claim, we will obtain a UCR price for the procedure and ascertain that the amount allowed was limited to the UCR amount.
ii. If the claim indicates that it is for the latter stage of a staged procedure, we will review the claim data per Power MHS to identify the second stage by reference to previous dates of service, like procedure codes and like provider numbers. We will ascertain that the total amount allowed for the combined procedures does not exceed the UCR price for the single procedure.

e. Assignment of Medicare benefits - The pricing methodology to be used on professional claims already processed by Medicare may vary from that used on other professional claims depending upon whether the patient has assigned his benefits under Medicare to the physician. If the physician has agreed to accept assignment of the patient's Medicare benefits as indicated by Medicare EOB (or electronic data sheet), he has agreed to accept the Medicare settlement for the claim

as his full charge for the services rendered. In this case the provider is precluded from charging the Medicare patient more than their deductible and coinsurance as determined by Medicare.

The effect on pricing the physicians' services is as follows:

If the physician has agreed to accept assignment of Medicare benefits, the allowed amount of the charge is equal to the amount allowed by the Medicare intermediary, subject to the maximum plan allowable. Benefits payable by the Plan are equal to the patient's Medicare deductibles and coinsurance along with the UCR charge for any services not covered by Medicare but covered by the Plan, subject to the Plan deductibles and coinsurance provisions.

If the physician has not accepted assignment of Medicare benefits, the allowed charges under the Plan are determined using the pricing methodology for professional claims. The amount payable by the Plan is the lower of the billed amount or the UCR charge less the amount paid by Medicare subject to deductibles and coinsurance under the Plan.

2. Anesthesia

Anesthesia prices are determined based upon the number of time units used during a given surgical procedure. We will:

a. Ascertain the propriety of the surgical procedure code.
b. Using the Power MHS Service Maintenance Screen (RF1031), determine the appropriate number of base units for the procedure.
c. Develop the preliminary allowed amount as number of time units from claim plus base units times RVS conversion factor from Power MHS RVS Conversion Amounts Screen (PR1022).
d. Multiply the preliminary allowable amount by the percentage shown in the “Percent” field of Power MHS Procedure Modifier Pricing Screen (PR1025) to obtain the final allowed amount.
e. Compare the final allowed amount to billed amount and ascertain that the lesser amount was allowed.

3. Supplies

Certain supplies are not covered by the Plan. Personal items (such as special brassieres, stockings, and diapers), disposable items (such as alcohol sponges and wipes, Betadine products, and cotton balls) are not covered. Surgical support hose, adaptive and protective supplies are also exclusions of the Plan. Most other supplies are allowed as billed. We will ascertain that for covered supplies claims, the amount allowed and amount billed are the same.

4. Institutional Claims

Institutional claims are paid based on contracted amounts with the various institutions. Inpatient claims are paid based on the All Patient Diagnosis Related Groups (AP-DRG), except for mental health and rehabilitation claims. These claims and outpatient claims are paid based on a contracted discount with the institution. Benefits are not available for more than one doctor providing medical services for treatment of the same condition on an inpatient basis.

a. Length-of-Stay Certification

Emergency and unscheduled hospital admissions will require a length-of-stay certification which should be obtained within 48 hours of admission or the next business day.

b. Pre-Admission Certification Program (PAC)

Pre-Admission Certification is required for all elective admissions. The penalty for not obtaining PAC approval before hospitalization may result in a 25% reduction in benefits or a full denial of benefits. See "Prior Authorization Or Certification" for more detailed information on certifications from Summary of Benefits. We will ascertain by a review of the CL1011 that the PAC was obtained, or that the penalty was properly applied, if applicable.

c. Room Rates (Outpatient, Mental Health, & Rehabilitation claims only)

Semi-private room rate charges will be allowed as billed. In cases involving a private room charge, the Plan provides for charges up to the most prevalent semi-private room charge. In instances where the institution only has private rooms then the private rate will be allowed as billed.

d. Emergency Room

The Plan will not cover the second deductible for allowable emergency room charges when admission to a hospital does not immediately follow. This provision applies only when less costly alternative means of emergency care are reasonably available.

e. Preferred Hospitals

Plan members must use a preferred (contracting) hospital when reasonably available or pay out-of-network co-payment and deductible in accordance with the members' respective Plan Summary of Benefits (See Exhibit VI).

6. Organ Transplants

Members are allowed to use the provider of their choice, however, the full Plan allowance will only be guaranteed if services are received from preferred providers. Heart-Lung, Lung and Pancreas transplants will be a covered benefit. Other covered organ transplants include, cornea, liver, bone marrow, heart, and kidney.

7. Services Requiring Prior Approval *(CL1011)*

We will consider services that require prior approval from the Third Party Administrator before claims can be paid. The list of services requiring prior approval in advance may change from time to time and is updated and distributed at www.shpnc.org. Appropriate documentation from the attending doctor attesting to the medical necessity of the proposed care must be submitted to the Medical Review Department for approval.

E. Coordination of Benefits

1. We will review the Power MHS Member Insurances Screen (ME1013) to evaluate evidence of other insurance.

2. Check for Medicare eligibility -

   a. By reference to the date of birth and Group ID on the claim, we will ascertain whether the patient was at least 65 years old and thus eligible. Active employees and spouses age 65 and over who elect the Plan will have the Plan as the primary coverage.
   b. In addition to attainment of age 65, other circumstances exist in which patients may be eligible for Medicare benefits. We will ascertain disabled workers under age 65 are eligible. We will rely on the Third Party Administrator for indications of eligibility for other than attainment of age 65, and we will verify that claims were processed in a manner consistent with the information contained on the member's coverage on the data sheet. We will review the member's status effective during the date of service.

3. In addition to Medicare, the Plan coordinates benefits with other group plans as, described under North Carolina General Statute section 135-40.13. Our procedures are limited to verification of the consistency of the indication of other insurance on the claim, and other insurance information on the computer files, and the manner of payment of the sample claim.

F. Applicability of Deductible and Co-Insurance

1. We will verify the application of deductibles.

   If a discrepancy on the sample item goes against the deductible and the individual's deductible exceeds the maximum per individual or per family deductible limit during the claim year under review, then this type of deductible discrepancy is considered an error.

   A co-payment is required in addition to the regular deductible and coinsurance for each hospital admission. If the patient is readmitted within 60 days for the same condition, the patient is not required to satisfy an additional co-payment. A co-payment applies to hospital outpatient and ambulatory surgical facility services over allowable limit per episode of care. Readmission within 30 days after discharge for the same reason is considered the same episode of care. Certain procedures are not subject to the co-payment. The Plan will not cover the second of allowable charges for each home, office, or skilled nursing facility for certain procedures.

   a. We will verify by reference to the Power MHS Error Processing Entry Screen (CL1034) screen that deductible limits were properly applied. This procedure will incorporate dates of service and paid dates including and prior to the sample claim. For cumulative deductible amounts we will refer to the Power MHS Membership Utilization Inquiry Screen (ME1088).

      Verify for family plans selected above that the deductible limit had been properly applied through the date of the claim.

b. Pre-admission testing – testing performed on an outpatient basis prior to a planned hospital admission is not subject to deductibles or coinsurance.

i. We will ascertain for claims for pre-admission testing that no deductible was applied. The claim should indicate the pre-admission testing procedures.

ii. We will review the claims history for subsequent admission of the same patient to a hospital within 14 days of the testing.

2. Verify application of coinsurance.

Members of the Plan must pay a percentage of the allowable charge after application of other insurance and deductibles. The maximum out-of-pocket expenditure per person per fiscal year for coinsurance is subject to individual Plan benefit offerings. See Exhibit VI. A number of situations require variations from the above rule as discussed below.

a. For all the above situations, we will re-compute the coinsurance amount.
b. In order to verify the correct accumulation of the coinsurance fiscal year maximum, we will re-compute coinsurance taken up to date of the sample claim.
c. The co-payment for professional services, which includes doctor services, physical therapy, inhalation therapy, speech therapy, occupational therapy, and chiropractic services varies by Plan. The co-payment applies only once per person per provider per day and does not apply to laboratory, pathology and radiology services. These co-payments do not apply to the annual deductible or co-insurance maximum out of pocket amounts. We will cross-reference the applicable co-payment to plan documents to verify appropriateness of amounts.

G. Payment to Proper Person or Provider

We will verify that payment was properly made either to the provider or to the subscriber as appropriate based upon the information on the claim form. The person to whom payment was made is indicated in the Payment code as “Py” in the field of the Power MHS Claim Processing Entry Screen (CL1032 for professional claims or CL1033 for institutional claims). The codes appearing in that field are as follows:

P = Pay Provider
S = Pay Subscriber

H. Special Situations

We will consider special situations other than those described above if those situations impact the payment of claims.

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REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF A FINANCIAL STATEMENT PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

Executive Administrator and Board of Trustees
North Carolina State Health Plan
for Teachers and State Employees
Raleigh, North Carolina – PPO Medical Claims

We have audited, in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, the statement of PPO medical claims paid (financial statement) of the North Carolina State Health Plan for Teachers and State Employees (the "Plan") for PPO medical claims processed by the Plan's Third Party Administrator ("TPA") as of and for the year ended June 30, 2014, and have issued our report thereon dated September 8, 2014.

Internal control over financial reporting

In planning and performing our audit of the financial statement, we considered the Plan's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statement, but not for the purpose of expressing an opinion on the effectiveness of the Plan's internal control. Accordingly, we do not express an opinion on the effectiveness of the Plan's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A material weakness is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the Plan's financial statement will not be prevented, or detected and corrected on a timely basis. A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and other matters

As part of obtaining reasonable assurance about whether the Plan's financial statement is free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards.*

Purpose of this report

This purpose of this report is solely to describe scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Plan's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Plan's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Thomas & Gibbs CPAs, PLLC

Durham, North Carolina
September 8, 2014