Audit of Medical Claims Processed by United Healthcare, Inc.

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March 2014

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Office of the Comptroller

March 3, 2014

To the Mayor and
the Honorable Common Council
City of Milwaukee

Dear Mayor Barrett and Council Members:

As a component of Internal Audit's 2013 audit work plan, the Segal Company was engaged to provide audit services to the City of Milwaukee for its self-funded medical and pharmacy plans administered by United Healthcare (UHC) and Express Scripts, Inc. The purpose of the audits was to determine if claims are processed and paid in accordance with plan provisions and industry standards.

The Segal Company has completed the UHC group health plan medical bill claims audit which is included in the City's overall health insurance claims audit. Internal Audit has recently received the enclosed final audit report which contains findings and recommendations that highlight opportunities for UHC to provide improved services regarding specific City of Milwaukee contract stipulations.

As the City became self-insured as of January 1, 2012, the test period for the audit was calendar year 2012. The testing performed indicated that UHC is serving the City well. Of the 75 stratified claims audited, 74 were processed without error. This exceeds industry standards. A targeted sample of claims was also tested. From this sample, the Segal Company made the following recommendations to improve UHC's processes.

The following four recommendations will improve the medical bill adjudication process.

1. *UHC should generate a system analysis to identify and validate additional duplicate payments during the audit period. Results should be provided to the City to determine the financial impact to the Plan.*

2. *UHC should provide examiner retraining to stress the importance of accurate claim history investigation when the system attaches a potential duplicate edit to a claim.*

3. *The underpayment should be reopened and additional payments sent to the employee and/or provider with an explanation. Refund recovery for the identified duplicate overpayments should be issued based on the City's direction.*

4. *UHC should advise the City of Milwaukee of any modification to system programming or changes in adjudication procedures resulting from this audit.*

UHC's responses to the recommendations are provided in the following report.

Internal Audit would like to thank all parties involved in the assistance and completion of this audit.

Sincerely,

Aycha Sirvanci, CPA
Audit Manager

City of Milwaukee

UNITED HEALTHCARE

Analysis of Claims Processing and Payment Procedures

For the Period

January 1 through December 31, 2012

Final Report Released

September 16, 2013

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CONFIDENTIALITY STATEMENT

Release of electronic and hardcopy information for this analysis required execution of an agreement signed by the City of Milwaukee, The Segal Company, and United Healthcare on behalf of itself and its subsidiaries.

All audit information and findings prepared and presented in this report are considered confidential and proprietary. Sharing of contents with any other party or the copying of information herein is expressly prohibited without the written consent of the agreeing parties.

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City of Milwaukee
Final Report Released
September 16, 2013

Section I – Executive Summary

This report analyzes and evaluates the claims processing and payment procedures utilized by United Healthcare (UHC) in their administration of the City of Milwaukee's group health plan benefits. Lynda Sheldon conducted the onsite review at UHC's Oldsmar, Florida claims office during the week of July 8, 2013.

Scope of Services

A data file of all medical claims processed during the audit period January 1 through December 31, 2012, representing $90,988,987.02 in benefit payments on 239,086 claims, was provided by UHC for our sampling purposes. Our claims review included the following components:

- An Adjudication Review to assess claim control measures;
- A stratified sample of 75 claims totaling $1,135,230.55 in benefit payments to provide statistical validity with comparison to industry standards; and
- A targeted sample of claims to provide representation of selected benefit types and potential duplicate payments.

The auditor completed a form for each claim sample selected; this worksheet was the primary documentation on which our report is based. Due to the confidentiality of names, diagnosis, etc., claims addressed within this report are referred to as "Worksheets." The letter T preceding the Worksheet number indicates the sample is a target sample selection.

Statistical Achievement

Of the 75 stratified claims audited, 74 were processed without error. One procedural error was assessed. An Other Claim Matter is noted on an out-of-sample claim where the calendar year coinsurance was exceeded; this is noted for informational purposes and is not included in the calculation of statistical achievements.

Performance Measurement		
Category	**Statistical Achievement**	**Industry Standard**
Financial Accuracy (dollar value)	100.00%	99.00%
Claims Processing Accuracy (overall incidence)	99.86%	95.00%
Payment Accuracy (incidence)	100.00%	97.00%
Processing Timeliness (within 10 business days)*	98.72%	90.00%

*100% electronic calculation based on 14 calendar day measurement.

Based on the statistical findings, UHC's achievement exceeded industry standards in each category during the benefit year. Error details are included in Section II as Exhibit A. Turnaround time is presented in Exhibit B; the stratification table is Exhibit C.

A basic principle of the sampling technique is that the stratified audit findings are representative of all claims; therefore, the respective strata error rate is used to project the total errors for each stratum. The total projected errors are used to calculate the statistical accuracy levels for comparison to industry standards. With an observed error rate of 3% or less, the 75 claim sample produces a 90% confidence level with ±5% precision.

Industry standards are developed through ongoing review and comparison of measures utilized by major carriers and third party administrators nationwide. Standards include acceptable performance for administration of fully-insured and self-insured corporate, public, and multi-employer plan benefits.

Targeted Sample

Fifteen targeted claims were included as part of the review. The data file was queried to identify potential discrepancies based on calendar year benefit maximums or plan exclusions in the following areas:

- Physical Therapy services exceeding 50 visits
- Temporomandibular Joint treatment exceeding $1,250 in payments
- Hearing aids for ages 19 and older
- Acupunture, acupressure, massage therapy service payments
- Dental care other than those identified under Dental Services
- Routine foot care (cutting or removal of corns, nail trimming, debriding) not associated with a severe systemic disease or individuals with diabetes
- Biofeedback services

Our electronic analyses did not identify any potential errors; therefore, seven claims were selected from specific claim types not represented in the stratified selection (*i.e.*, ambulance services, diabetic management items, ostomy supplies); our review determined all claims were paid based on Plan benefits.

The remaining eight claims selected for review were identified as potential duplicates from our electronic analysis of 100% of claims. Four duplicates were confirmed totaling $6,159.63. Onsite review of claims documentation and UHC review revealed the remaining potential duplicates were explained (*i.e.*, different providers under one group name, modifiers, adjustments). Based on our findings, all errors resulted from human intervention and override of the system edit during processing.

Segal recommends UHC generate a system analysis to identify and validate additional duplicate payments during the audit period. Results should be provided to the City to determine the financial impact to the Plan. Segal also recommends UHC provide examiner retraining to stress

the importance of accurate claim history investigation when the system attaches a potential duplicate edit to a claim.

Recommendations

All questions and comments regarding the statistical and targeted claim samples were reviewed with UHC personnel. The following recommendations are offered for addressing concerns identified in this report. UHC was presented with a draft report for their review and comment; their August 13th responses have been paraphrased in italics. Their complete response is included as Section III.

- UHC should generate a system analysis to identify and validate additional duplicate payments during the audit period. Results should be provided to the City to determine the financial impact to the Plan. (TARGETED SAMPLE, PAGE 2 AND EXHIBIT A, ERROR LISTING, PAGE 6)

  UHC's standard process is to run impact reports on the errors that are identified as repeatable (e.g., system programming). Manual adjudication errors are handled as single events.

  Segal notes that all errors associated with duplicate payments were the result of manual adjudication.

- UHC should provide examiner retraining to stress the importance of accurate claim history investigation when the system attaches a potential duplicate edit to a claim. (TARGETED SAMPLE, PAGE 2 AND EXHIBIT A, ERROR LISTING, PAGE 6)

  Feedback and refresher training has been reviewed with the responsible processors.

- The underpayment should be reopened and additional payments sent to the employee and/or provider with an explanation. Refund recovery for the identified duplicate overpayments should be issued based on the City's direction. (EXHIBIT A, PAGE 6)

  Each sample error has been reviewed and the root cause along with remediation efforts to reduce similar occurrences has been discussed within UHC. The Account Management team will report back to the City of Milwaukee quarterly with the amounts recovered from the requested overpayments.

- UHC should advise the City of Milwaukee of any modification to system programming or changes in adjudication procedures resulting from this review.

  UHC will be happy to discuss modifications to system programming with the City of Milwaukee that are a direct result of this review.

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This report would be incomplete without recognition of the cooperation and professionalism extended by UHC staff during the preparation and onsite phase of this project.

Section II – Claims Audit Review

UHC provided a data file of all medical claims processed and paid from January 1 through December 31, 2012 to use in our electronic analyses and audit preparations. Relevant claims processing information was verified through UHC's responses to our adjudication questionnaire, onsite discussions, auditor observations, and the individual claims review.

Individual Claims Review

Prior history and benefit maximums were reviewed, as applicable, on each stratified claim. In addition to verifying the amount paid, audit samples were thoroughly reviewed to determine that:

- Claims were paid in strict accordance with Plan provisions.
- Documentation (provider bills, physician statements, surgical reports, etc.) was on file for claims paid and verified when necessary.
- Claims were paid only on behalf of eligible individuals, based on eligibility data contained in the claims system.
- Amounts paid were within the designated non-contracted allowances and/or discounted fees for the area where treatment was rendered, with due consideration given for the severity of the condition treated, based on schedules utilized. We did not determine medical necessity, but did ascertain that the claims personnel properly reviewed or referred claims as appropriate.
- Benefits were paid under the proper benefit classification, diagnostic, and procedure codes, as an incorrect entry may affect payment accuracy or future benefit determinations.
- Appropriate benefit limitations, deductibles, and coinsurance were applied.
- Coordination of benefits provisions were enforced, where applicable.
- Arithmetic calculations were correct.
- Duplicate claims were properly denied.

Premium Physicians

UHC's premium program is available to City members as a resource in selecting providers who provide quality care efficiently. Members are encouraged to utilize premium providers to help minimize their cost-share and the plans' responsibility.

The data was queried and categorized based on the Premium Provider Indicator assigned to the claim. We eliminated those claims where services were rendered in a market where UHC does not offer the premium provider program. Our analysis of the remaining program-eligible claims reflected approximately 48% of the plan payments (approximately 51% of claims) were

submitted for services provided by premium providers. Our analysis is based on claims incurred by all eligible members (*e.g.*, actives, early retirees, and Medicare eligible retirees).

Selection of Claims

The selection of claims was stratified by dollar amount to give large claims more valid representation in the sample. The methodology of our stratified selection process utilizes formulae designed to take full advantage of statistical sampling procedures that allow a quantifiable degree of confidence so the results obtained in the audit sample are a true reflection of the actual way all claims were processed during the audit period.

Turnaround Time Analysis

UHC bases timeliness on business days, which excludes holidays and weekends. Industry standards indicate 90% of all claims should be processed within 10 business days or 14 calendar days. Best practice, which follows Department of Labor regulations, requires 100% within 20 business or 30 calendar days.

Segal performed an electronic turnaround time analysis for 100% of all paid claims based on the received and processed dates provided on the claim data file. The results of our analysis revealed UHC exceeded industry standards with 98.72% of all claims processed in 14 calendar days; the results were 99.84% in 30 calendar days.

Our review identified 378 claims processed between 31 and 229 days; however, we were unable to determine any additional received or processed dates for claim intervals due to adjustments within or outside the audit period. This is typically evidenced in the number of claims exceeding 90 days. Three claims within the statistical sample fell within the 31 to 229 days; adjustments were due to providers submitting late charges or corrected bills.

Claim Control Measures

Our audit samples review and onsite discussions revealed UHC utilizes the following claim control measures in the processing and payment of claims:

- review of claims data for adequacy of information needed to process the claim
- claims received electronically (88.57%); auto-adjudication (85.36%)
- automated duplicate checking edits
- established procedures for the denial and appeal process
- automated calculation of fee allowance based on date of service
- established internal audit procedures for quality control

Worksheet	Over Payments	Explanation
STRATIFIED SAMPLE		
46F	Procedural	Request for a Medicare explanation of benefits was made in error during manual adjudication to an individual for a date of service prior to her 65th birthday; the original processing event resulted in a "no pay" claim.
64F	Other Claim Matter	**$68.40 file underpayment**. Calendar year coinsurance maximum was exceeded on a manually adjudicated claim.
TARGETED SAMPLE		
T1	$813.34	Duplicate payments made during manual adjudication.
T4	$836.73	
T5	$1,737.55	
T8	$2,772.01	
Total	$6,159.63	4 Overpayments 1 Procedural 1 Other Claim Matter ($68.40 underpayment)

Segal recommends the underpayment be reopened and additional payment sent to the employee and/or provider with an explanation. Refund recovery for the identified duplicate overpayments should be issued based on the City's direction.

Calendar Days	Number of Claims	Individual Percent	Cumulative Percent*
0	48,024	20.09%	20.09%
1	106,024	44.35%	64.43%
2	10,622	4.44%	68.87%
3	16,096	6.73%	75.61%
4	15,989	6.69%	82.29%
5	7,416	3.10%	85.40%
6	14,809	6.19%	91.59%
7	7,323	3.06%	94.65%
8	3,006	1.26%	95.91%
9	2,003	0.84%	96.75%
10	1,526	0.64%	97.39%
11	796	0.33%	97.72%
12	831	0.35%	98.07%
13	828	0.35%	98.41%
14	**723**	**0.30%**	**98.72%**
15	626	0.26%	98.98%
16	417	0.17%	99.15%
17	266	0.11%	99.26%
18	277	0.12%	99.38%
19	198	0.08%	99.46%
20	92	0.04%	99.50%
21	124	0.05%	99.55%
22	107	0.04%	99.60%
23	98	0.04%	99.64%
24	87	0.04%	99.67%
25	88	0.04%	99.71%
26	69	0.03%	99.74%
27	59	0.02%	99.76%
28	71	0.03%	99.79%
29	66	0.03%	99.82%
30	47	0.02%	99.84%
31-89	352	0.15%	99.99%
91-229	26	0.01%	100.00%
Total	239,086	100.00%	*may not add due to rounding

Strata	Dollar Range of Strata	Number in Audit Selection	Number of Claims in Range	Dollar Amount in Audit Selection	Total Dollar Amount in Strata
A	$0.01 - $69.99	13	99,239	$348.00	$2,915,311.11
B	$70.00 - $279.99	12	93,634	$1,874.02	$14,465,065.10
C	$280.00 - $949.99	10	31,188	$5,529.81	$14,784,279.68
D	$950.00 - $2,999.99	10	10,600	$16,178.09	$16,981,653.32
E	$3,000.00 - $9,499.99	10	3,422	$45,727.58	$17,286,156.16
F	$9,500.00 - $42,499.99	10	894	$155,140.85	$15,105,236.54
G	$42,500.00 - $241,078.41	10	109	$910,432.20	$9,451,285.11
Totals		75	239,086	$1,135,230.55	$90,988,987.02

- **Claim Definition**: The definition for audit purposes is the action taken by an administrator with respect to a submission (any form, bill, or other documentation submitted in one transmission), including all adjustments made after the initial transaction.

- **Stratification Process**: Our stratified sampling procedure provides a quantifiable degree of confidence (90% with ±5% precision) so the sample dollar value and incidence results are a true reflection of the way all claims were processed during the audit period.

- **Zero Payments**: The data file contained 74,301 zero payment claims for the audit period, representing 23.71% of all claims. This percentage is within reasonable limits for denials (*i.e.*, duplicates, insufficient information, exceeding benefit maximums, etc.).

Section III – UHC's Report Response

City of Milwaukee

Initial External Audit Response Report

Tuesday, August 13, 2013

UnitedHealthcare®

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Introduction

- City of Milwaukee engaged the services of The Segal Company (Segal) to perform both a random medical claim audit and a focused medical claim audit during the week of July 8, 2013. We have received a copy of the audit report, including any analysis of the findings and recommendations for improvement.

- Within the following pages you will find the UnitedHealthcare, Employer and Individual (UnitedHealthcare) initial response to the audit findings.

- Our response is intended to detail:
  - our initial findings to the recently received auditor's report
  - what action steps have already been taken
  - additional action steps that will be taken to complete our remediation process

- In addition, we would like to plan a meeting date to:
  - discuss our final audit response which will include updates to our current findings and final disposition of each issue identified in this audit
  - supply you with additional detail around our ongoing corporate quality improvement initiatives

Medical Claim Review – Executive Summary

Summary of Audit:

Population	Sample Size	Extract Period	Audit Location	Date Audit Performed
City of Milwaukee Medical Benefit Plan (Random Audit)	75 Claims	January 1, 2012 through December 31, 2012	Oldsmar Florida Transaction Center	Week of July 8, 2013
City of Milwaukee Medical Benefit Plan (Focused Audit)	15 Claims	January 1, 2012 through December 31, 2012	Oldsmar Florida Transaction Center	Week of July 8, 2013

- As with all audit data, UnitedHealthcare clearly recognizes that Segal's findings are meaningful and represent opportunity for continued improvement in our processing and administration of the City of Milwaukee benefit plan.
- A detailed listing of all sample items can be found in both Appendix A and B of this document.

Medical Claim Review – Executive Summary

- The preliminary results of the random medical claim audit are reflected in the table below.

Performance Category	Statistical Achievement	Industry Standard
Financial Accuracy (dollar value)	**100.00%	99.00%
Claims Processing Accuracy (overall incidence)	**99.86%	95.00%
Payment Accuracy (incidence)	**100.00%	97.00%
Processing Timeliness (within 10 business days)*	**98.72%	90.00%

*Based on 14 calendar day measurement **Met or exceeded industry standard

Medical Claim Review – Executive Summary

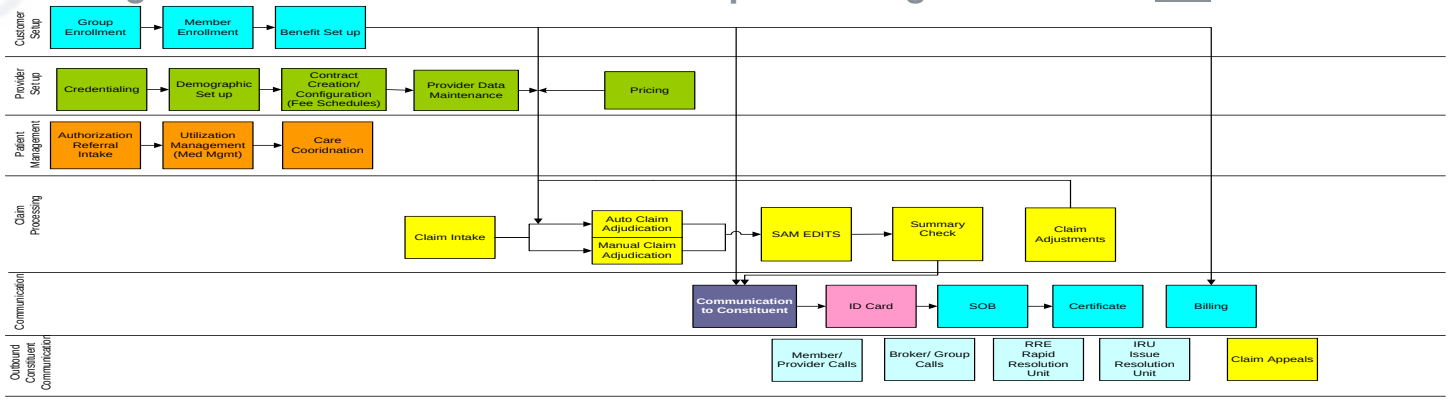
- UnitedHealthcare analyzes audit data on many levels to drive remediation not only at the specific customer level, but also for our global initiatives. Opportunities identified through our functional real time quality programs, focused claim audits, external audit findings, and our end to end process audits are combined and prioritized using a standard categorization.

- We have performed both a root cause and group impact analysis on the errors identified during this audit. We have found the following error categories are indicated:

Status	Source Detail	Random Audit In-Sample Volume	Random Audit Out-of-Sample Volume	Random Audit Sample Numbers		Focused Audit In-Sample Volume	Focused Audit Sample Numbers
Agreed to Error	Manual Adjudication	1	1	46, oos64		3	1, 4, 5
Agreed to Error	Systems	0	0	Not Applicable		1	8

Driving Process Improvement Organizationally

A High Level View of the Process….implementing solutions at the root cause!



- Organizational Department
- Employer and Broker Ops
- UnitedHealth Networks
- Transactions
- Care Coordination
- Medical Policy
- System
- Customer Care
- Optum Health
- Account Management Team

Remediation Plans 2013		
	Individual / Departmental Plans	**Corporate Initiatives**
Manual	Where applicable: • Feedback and refresher training provided to the responsible processor • Training materials updated and enhanced • Policies and Procedures updated to ensure quality • Business Process updated and enhanced • Quality Programs implemented or revised as needed • Implementation of Individual processor incentive compensation programs • Functional teams develop Individual Client Specific Remediation plans as necessary	• Pipeline report that reflects and prioritizes root cause impact across quality programs, which allows us to determine high priority projects
Benefit		• Enhanced formalized defect reduction plan to address trends. Include a cross-functional team to review benefit capture and benefit coding opportunities
Provider		• Improved accountability using real-time information and feedback • Evaluation and remediation to the rate correction process
System		• Reduce duplicate claim volume • Reduce co-pay adjustments

Our all-inclusive approach allows us to work together in order to improve processes and ultimately your outcomes.

Claim Review and Remediation Plan
Random Medical Claim Audit

Agreed to Findings

Agreed to Error Review

Sample 46	Error Source: Manual Adjudication		Type of Error: Procedural
	Impact to DAR: 0.00%	Impact to CPA: 0.00%	Segal Report Pages 1 & 6
Error Description	UnitedHealthcare agreed to a procedural (non-payment) error when the claim payment processor denied the claim and requested a copy of the Medicare Explanation of Benefits in error.		
Corrective Action	• Sample claim was corrected on 06.01.2012. • Feedback and refresher training were provided to the claim payment processor on 08.06.2013.		

Out-of-Sample 64	Error Source: Manual Adjudication		Type of Error: Financial
	Impact to DAR: Not Applicable	Impact to CPA: Not Applicable	Segal Report Pages 1 & 6
Error Description	UnitedHealthcare agreed to an underpayment of $68.40 when the claim payment processor applied the incorrect coinsurance (70% versus 100%) for professional services rendered during an inpatient confinement.		
Corrective Action	• Out-of-sample claim was corrected on 08.01.2013. • Feedback and refresher training were provided to the claim payment processor on 08.06.2013.		

Claim Review and Remediation Plan
Focused Medical Claim Audit

Agreed to Findings

Agreed to Error Review

Samples 1, 4 and 5	Error Source: Manual Adjudication	
	Sample Category: Duplicate Payments	Segal Report Pages 2 & 6
Error Description	UnitedHealthcare agreed to overpayments of $813.34, $836.73 and $1,737.55 respectively when the claim payment processors allowed duplicate charges to be paid in error.	
Corrective Action	• Sample 1 was corrected on 08.01.2013. Recovery efforts will not be initiated due to provider contract language. The check issue date for this claim is greater than 12 months for this in-network provider. • Sample 4 was corrected and the overpayment of $836.73 was recovered and credited back to the City of Milwaukee on 07.25.2013. • Sample 5 was corrected on 07.31.2013 with an overpayment request to the provider of service. Recovery efforts are underway. • Feedback and refresher training were provided to the claim payment processors on 08.06.2013.	

Sample 8	Error Source: Systems	
	Sample Category: Duplicate Payments	Segal Report Pages 2 & 6
Error Description	UnitedHealthcare agreed to an overpayment of $2,772.01 when the claim payment system allowed duplicate charges to be paid in error.	
Corrective Action	• Claim payment system correction is scheduled for 3rd Quarter 2014. • Smart Audit Master (SAM) Edit Rule 1765 was activated to capture and report this system limitation until the global system fix can be completed. • Sample claim was corrected on 08.01.2013 with an overpayment request to the provider of service. Recovery efforts are underway. • A meaningful systemic Impact report for this error is not obtainable.	

Medical Claim Findings And Recommendations

Segal Recommendation

Segal Recommendation	UnitedHealthcare Response
• UHC should generate system analysis to identify and validate additional duplicate payments during the audit period. Results should be provided to the City to determine the financial impact to the Plan. (Targeted Sample, Page 2 and Exhibit A, Error Listing, Page 6)	UnitedHealthcare's standard process is to run impact reports on the errors that would have a repeatable impact to the population to identify the exact dollars impacted from an audit. An example of 'Repeatable impact' would be benefit related errors where UnitedHealthcare set up the benefit incorrectly (i.e. have the wrong copay set up). Our process would be to have the system corrected, pull all the impacted claims from history, determine the mispayment amount and make the corrections to the customer's files. We provide updates to the customer as the remediation process continues and we determine these impacts and work to resolve these for the customer. Manual adjudication errors (i.e.: human error) are handled as single events as the error was due to an individual making an error on a single claim.
• UHC should provide examiner retraining to stress the importance of accurate claim history investigation when the system attaches a potential duplicate claim edit to a claim. (Targeted Sample, Page 2 and Exhibit A, Error Listing, Page 6)	Feedback and refresher training regarding the error conditions has been reviewed with the responsible processors as outlined in the preceding pages of this report.
• The underpayment should be reopened and additional payments sent to the employee and/or provider with an explanation. Refund recovery for the identified overpayments should be issued based on the City's direction. (Exhibit A, Page 6)	In the preceding pages of this report, each sample error cited by Segal has been thoroughly reviewed and the root cause along with remediation efforts to reduce similar occurrences has been discussed in detail. The UnitedHealthcare Account Management Team will report back to City of Milwaukee quarterly with the amounts recovered from the requested overpayments.
• UHC should advise the City of Milwaukee of any modification to system programming or changes in adjudication procedures resulting from this review.	The UnitedHealthcare Account Management Team will be happy to discuss modifications to system programming with City of Milwaukee that are a direct result of this review.

Conclusion

- UnitedHealthcare is committed to our partnership with the City of Milwaukee and appreciates the work performed by Segal on their behalf to identify areas of opportunity relative to the targeted sample categories.
- UnitedHealthcare will continue to work aggressively to ensure that all corrections are made and all remediation completed.
- The UnitedHealthcare team looks forward to a continued partnership as we strive to provide you with the best service in the industry.

Appendix A: Random Medical Claim Audit Table of Error Findings

Table of Error Findings and Decisions

Sample	Decision	Source Detail	Error Type	Sample Financial Impact	Sample Financial Status	Estimated Group Financial Impact	Group Financial Status
46	Agree	Manual Adjudication	Procedural	$0.00	Sample Corrected	Not Applicable	Not Applicable
oos64	Agree	Manual Adjudication	Financial	($68.40)	Sample Corrected	Not Applicable	Not Applicable

Appendix B: Focused Medical Claim Audit Table of Error Findings

Table of Error Findings and Decisions

Sample	Decision	Source Detail	Error Type	Sample Financial Impact	Sample Financial Status	Estimated Group Financial Impact	Group Financial Status
1	Agree	Manual Adjudication	Financial	$813.34	Sample Corrected No Recovery > 12 mos.	Not Applicable	Not Applicable
4	Agree	Manual Adjudication	Financial	$836.73	Sample Corrected Recovered and Credited	Not Applicable	Not Applicable
5	Agree	Manual Adjudication	Financial	$1,737.55	Sample Corrected Recovery Underway	Not Applicable	Not Applicable
8	Agree	Systems	Financial	$2,772.01	Sample Corrected Recovery Underway	Not Applicable	Not Applicable