Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT
and Annual Operational Review

State of Nevada Public Employee's Benefits Plans

Administered by HealthSCOPE Benefits

Audit Period: April 1, 2022 – June 30, 2022
Audit Number 1.FY22.Q4

Presented to

State of Nevada Public Employee's Benefits

October 28, 2022

CLAIM TECHNOLOGIES
INCORPORATED

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EXECUTIVE SUMMARY

This ***Quarterly Findings Report*** is a compilation of the detailed information, findings, and conclusions drawn from Claim Technologies Incorporated's (CTI's) audit of HealthSCOPE Benefits' (HealthSCOPE's) administration of the State of Nevada Public Employee's Benefits (PEBP) medical, dental, and health reimbursement arrangement (HRA) plan. This is the final audit report for HealthSCOPE as PEBP's administrator, future audit reports will be for the successor administrator, UMR.

Scope

CTI performed an audit for the period of April 1, 2022 through June 30, 2022 (quarter 4 (Q4) for Fiscal Year (FY) 2022). The population of claims and amount paid during the audit period reported by HealthSCOPE Benefits:

Medical and Dental	
Total Paid Amount	$52,980,341
Total Number of Claims Paid/Denied/Adjusted	189,022
Health Reimbursement Arrangement (HRA)	
Total Paid Amount	$835,298
Total Number of Claims Paid/Denied/Adjusted	8,492

The audit included the following components which are described in more detail in the following pages.

- Operational Review and Performance Guarantees Validation
- 100% Electronic Screening with Targeted Samples
- Random Sample Audit
- Data Analytics

Auditor's Opinion

Based on these findings, and in our opinion:

1. HealthSCOPE's Financial Accuracy and Payment Accuracy decreased in Q4 FY2022 and a penalty of 2.5% of administrative fees is owed.
2. HealthSCOPE should:
    - Review the financial errors identified in our random sample audit and determine if system changes or claim processor training could help reduce or eliminate errors of a similar nature in the future.
    - Review the 100% Electronic Screening with Targeted Sample results and focus on the most material findings.
    - Where appropriate, verify claim processor coaching, feedback, and retraining has occurred because most errors were manually processed.

Summary of HealthSCOPE's Guarantee Measurements

Based on CTI's Random Sample Audit results, HealthSCOPE did not meet one of the claims processing measurements for PEBP in Q4 FY2022 and a penalty is owed.

Quarterly Metric	Guarantee	Met/Not Met	Penalty
Financial Accuracy (p.13)	99%	Not Met – 98.92%	$28,267.93

AUDIT OBJECTIVES

This report contains CTI's findings from our audit of HealthSCOPE Benefits' (HealthSCOPE) administration of the State of Nevada Public Employee's Benefits (PEBP) plans. We provide this report to PEBP, the plan sponsor, and HealthSCOPE, the claim administrator. A copy of HealthSCOPE's response to these findings can be found in the Appendix of this report.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and information provided by PEBP and HealthSCOPE. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to obtain reasonable assurance claims were adjudicated according to the terms of the contract between HealthSCOPE and PEBP.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of policies, procedures, and systems HealthSCOPE used to pay PEBP's claims during the audit period. While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

The objectives of CTI's audit of HealthSCOPE's claim administration were to determine whether:

- HealthSCOPE followed the terms of its contract with PEBP;
- HealthSCOPE paid claims according to the provisions of the plan documents and if those provisions were clear and consistent; and
- members were eligible and covered by PEBP's plans at the time a service paid by HealthSCOPE was incurred.

ANNUAL OPERATIONAL REVIEW

Objective

CTI's Operational Review evaluates HealthSCOPE's claim administration systems, staffing, and procedures to identify any deficiencies that materially affect its ability to control risk and pay claims accurately on behalf of the plans.

Scope

The scope of the Operational Review included:

- Claim administrator information
  - Insurance and bonding
  - Conflicts of interest
  - Financial reporting
  - Business continuity planning
  - Claim payment system and coding protocols
  - Data and system security
- Claim funding:
  - Claim funding mechanism
  - Check processing and security
  - Large claim payment process
- Claim adjudication, customer service, and eligibility maintenance procedures:
  - Exception claim processing
  - Eligibility maintenance and investigation
  - Other insurance coverage and adjudication
  - Overpayment recovery
  - Network utilization
  - Utilization review, case management, and disease management
  - Subrogation and other third-party liability
  - Appeals processing
- HIPAA compliance

Methodology

CTI used an Operational Review Questionnaire to gather information from HealthSCOPE. We modeled our questionnaire after the audit tool used by certified public accounting firms when conducting an SSAE 18 audit of a service administrator. We modified that tool to elicit information specific to the administration of your plans.

We reviewed HealthSCOPE's responses and any supporting documentation supplied to gain an understanding of the procedures, staffing, and systems used to administer PEBP's plans. This allowed us to conduct the audit more effectively.

Findings

We observed the following:

- HealthSCOPE provided the following insurance coverage information:

Coverage	Amount
Errors and Omissions	$10,000,000
Crime	$5,000,000
Cyber Liability	$10,000,000

- HealthSCOPE indicated it had been audited by BDO USA, L.L.P (BDO), for compliance with the standards of the American Institute of Certified Public Accountants through the issuance of a Service Organization Controls (SOC) 1 Report. Under the SOC 1, the administrator is required to provide a description of its system, and controls, which the service auditor validates. CTI received a copy of the report for the period of November 1, 2020, to October 31, 2021. A bridge letter dated August 25, 2022 was also provided noting the transition of network architecture and associated computing environment to systems supported by UnitedHealth Group (UHG); which they anticipate will have an improved positive impact. PEBP should request a copy of the SOC 1 report from HealthSCOPE benefits.
- HealthSCOPE reports it honors assignment of benefits for non-network providers which allows non-network providers to receive payment directly from HealthSCOPE versus having to pay the member who would then have to pay the non-network provider. This is a best practice.
- HealthSCOPE had adequately documented training, workflow, procedures, and systems.
- Verification of initial or continued COB was not required by HealthSCOPE.
- HealthSCOPE reported 80% of claims were received electronically during the audit period and 64% of claims received were auto adjudicated.
- HealthSCOPE reported it did not have a minimum dollar threshold to recoup an overpayment and can automatically recoup a refund from the next payment made to the same provider. An overpayment recovery report was not provided for FY2022.
- HealthSCOPE outsourced subrogation recovery to Luper Neidenthal & Logan. The vendor has worked directly with PEBP on authority limits to reduce or waive a lien. Its fee was 18% of recovery amounts. HealthSCOPE provided subrogation detail reports for FY2022. The reports provided showed 2,671 cases were opened and 282 cases were closed, the remainder were open and pending. HealthSCOPE reported total recoveries over the fiscal year of $2,467,745 of $24,290,839 cases opened for a 10% recovery rate.
- The minimum threshold to prompt a subrogation investigation was $1,000 in aggregate claim payments. HealthSCOPE stated recoveries did not result in claim adjustments.
- HealthSCOPE provided a member appeal report for FY2022. This report showed a total of 291 member appeals. Of those appeals, 225 were processed timely while 66 took greater than 20 days to close. According to HealthSCOPE all member appeals should have a decision within 20 days of receipt to correspond to Nevada's Administrative Code 287.670.

- HealthSCOPE reported it used software specifically designed to identify potential provider fraud but did not use external resources to identify providers who have been sanctioned for having committed fraud. It also reported it worked with its PPO networks to identify provider fraud.
- 100% of rebates received for processing specialty drugs are shared with PEBP.
- HealthSCOPE indicated the plan never allows more than billed charges. However, in Q2 and Q4 there were sampled claims which HealthSCOPE paid more than billed charge. In Q4 the cases identified were paid in accordance with the Aetna contract.
- HealthSCOPE indicated HIPAA training is provided by the compliance department and training is provided annually to its employees. HealthSCOPE reported no breeches during the audit period.

QUARTERLY PERFORMANCE GUARANTEE VALIDATION

As part of CTI's quarterly audit of PEBP, we reviewed the Performance Guarantees included in its contract with HealthSCOPE. The results for Q4 FY2022 follow.

Metric	Guarantee Measurement	Actual	Met/ Not Met
Financial Accuracy	99% or greater of the dollars paid for the audited medical/dental claims to be paid accurately	98.92%	Not Met
Claims Payment Accuracy	98% or greater of medical/dental claims audited are paid accurately	98.50%	Met
Claim Processing Turnaround	99% of all medical/dental claims are to be processed within 30 days	99.92%	Met
Customer Service	• Telephone Response Time less than 30 seconds for inbound calls • Telephone Abandonment Rate less than 3% • First call Resolution greater or equal to 95%	3.3 Seconds 0.06% 97.97%	Met Met Met
Data Reporting	• 100% of standard reports within 10 business days of completion	Delivered 8/11/22	Met
Disclosure of Subcontractors	• Report access of PEBP data within 30 calendar days • Removal of PEBP member PHI within 3 business days after knowledge	No exceptions noted No exceptions noted	Met Met

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

CTI's Electronic Screening and Analysis System (ESAS®) software identified and quantified potential claim administration payment errors. PEBP and HealthSCOPE should discuss any verified under- or overpayments to determine the appropriate actions to correct the errors.

Scope

CTI electronically screened 100% of the service lines processed by HealthSCOPE during the audit period for both medical and dental claims. The accuracy and completeness of HealthSCOPE's data directly impacted the screening categories we completed and the integrity of our findings. We screened the following high-level ESAS categories to identify potential amounts at risk:

- Duplicate payments to providers and/or employees
- Plan exclusions and limitations
- Patient cost share
- Fraud, waste, and abuse
- Timely filing
- Subrogation/right of recovery from third party
- Workers' Compensation
- Coordination of benefits
- Large claim review
- Case and disease management
- Specific reinsurance reimbursement

Methodology

We used ESAS to analyze claim payment and eligibility maintenance accuracy as well as any opportunities for system and process improvement. Using the data file provided by HealthSCOPE, we readjudicated each line on every claim the plan paid or denied during the audit period against the plan's benefits. Our Technical Lead Auditor tested a targeted sample of claims to provide insight into HealthSCOPE's claim administration as well as operational policies and procedures. We followed these procedures to complete our ESAS process:

- ***Electronic Screening Parameters Set*** – We used your plan document provisions to set the parameters in ESAS.
- ***Data Conversion*** – We converted and validated your claim data, reconciled it against control totals, and checked it for reasonableness.
- ***Electronic Screening*** – We systematically screened 100% of the service lines processed and flagged claims not administered according to plan parameters.
- ***Auditor Analysis*** – If claims within an ESAS screening category represented a material amount, our auditors analyzed the findings to confirm results were valid. Note using ESAS could lead to false positives if there was incomplete claim data. CTI auditors made every effort to identify and remove false positives.
- ***Targeted Sample Analysis*** – From the categories identified with material amounts at risk, we selected the best examples of potential under- or overpayments to test. As cases were not

randomly selected, we cannot extrapolate results. We selected 50 cases and sent your administrator a questionnaire for each. Targeted samples verified if the claim data supported our finding and if our understanding of plan provisions matched HealthSCOPE's administration.

- ***Audit of Administrator Response and Documentation*** – We reviewed the responses and redacted the responses to eliminate personal health information. Based on the responses and further analysis of the findings, we removed false positives identified from the potential amounts at risk.
- ***Eligibility Verification of Every Claim by Date of Service*** – We used ESAS to compare service dates against the eligibility periods provided to us to look for claims paid for ineligible members.

Findings

We are confident in the accuracy of our ESAS results. It should be noted that dollar amounts associated with the results represent potential payment errors and process improvement opportunities. To substantiate the findings, CTI would have to perform additional testing to provide the basis for remedial action planning or reimbursement.

Categories for Process Improvement

The following detail report shows, by category, the number of line items or claimants with process improvement opportunities remaining after our analysis and removal of verified false positives. A CTI auditor reviewed HealthSCOPE's responses and supporting documentation. The administrator responses are copied directly from HealthSCOPE's reply to audit findings. **It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so you can discuss how to reduce errors and re-work in the future with your administrator.**

Categories for Potential Amount at Risk				
Client: PEBP **Screening Period:** Q4 FY2022				
Category	**Number of Line Items**	**Number of Claimants**	**Billed Charge**	**Allowed Amount***
Duplicate Payments				
Providers and/or Employees	190	42	$78,603	$12,767
Exclusions				
Experimental/Investigational	19	15	$55,281	$12,872
Fraud, Waste, and Abuse				
Spinal Region Upcoding – Number of spinal regions treated does not match number of spinal regions billed and allowed.	1,042	374	$73,539	$35,690
Preventive Services				
Deductible Applied	341	243	$50,419	$16,094
Coinsurance Applied	323	197	$59,049	$23,056

**Allowed amount equals total paid by plan and member combined.*

Electronic screening of all service lines processed revealed the potential for incorrectly paid claims. Analysis confirmed the opportunity for process improvement and further testing is recommended. For each potential error, we sent an ESAS Questionnaire (QID) to HealthSCOPE for written response. After review of the response and any additional information provided, CTI confirmed the potential for process improvement.

Manually adjudicated claims were processed by an individual claim processor. Auto-adjudicated claims were paid by the system with no manual intervention.

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
Duplicate Payments				
30	$228.00	Agree. The refund has not been received.	Procedural deficiency and overpayment remain. HealthSCOPE paid duplicate charges.	☒ M ☐ S
Plan Exclusions				
Experimental/Investigational				
49	$840.00	Agree. Analyst should have requested medical records.	Procedural deficiency and overpayment remain. Per page 94 of the SPD experimental treatment is excluded.	☒ M ☐ S
Potential Fraud, Waste, and Abuse				
Spinal Region Upcoding				
39	$83.99	Disagree. Services paid per plan guidelines.	Procedural deficiency and overpayments remain. The description for CPT codes for chiropractic care includes the number of regions of the spine or extraspinal regions treated and should be supported by the diagnosis. The provider billed three or four spinal regions treated; however, the diagnosis billed supported treatment of only one spinal region. These procedures are spinal region driven and should be billed with appropriate diagnosis codes to support billing.	☒ M ☐ S
40	$56.64			☒ M ☐ S
41	$67.19			☒ M ☐ S
Preventive Services				
Deductible Applied				
8	($1,737.57)	Agree. Claim should have paid at the routine benefit.	Procedural deficiency and underpayment remain. Deductible should have been waived.	☒ M ☐ S
9	($68.01)			☒ M ☐ S
With Coinsurance Applied				
12	($70.00)	Agree. Claim should have paid at the routine benefit.	Procedural deficiency and underpayment remain. Coinsurance should have been waived.	☒ M ☐ S

Through the targeted screening process, CTI observed instances where an error was not cited on the sampled case; however, an issue existed that PEBP should be aware of.

Observation	QID
NCCI Medically Unlikely Edits were not applied as the claims were paid according to the Aetna contract in place.	1, 2, 3
NCCI Procedure to Procedure Edits were not applied as the claims were paid according to the Aetna contract in place.	4, 5
CTI noted these claims paid greater than billed charges because the Aetna network contract does not include “lessor of” language.	21, 22

Annual Eligibility Verification

CTI electronically compared dates of service for FY2022 Q1 through Q4 and PEBP’s electronic eligibility file revealed that some services were paid during the audit period for potentially ineligible claimants. At this time, potentially overpaid amounts have been flagged into one of the following categories:

Employee Eligibility Screening Subcategory	Amount Paid
No Identification Match to Any Eligible Employee	$2,212,097
Payments Prior to Effective Date	$1,052,300
Payments During Gaps in Coverage	$835
After Termination Date of Employee's Coverage	$56,748
Subtotal	$3,321,980
Dependent Eligibility Screening Subcategory	**Amount Paid**
No Identification Match to Any Eligible Employee	$780,842
Payments Prior to Effective Date	$560,857
Payments During Gaps in Coverage	$3,892
After Termination Date of Employee's Coverage	$32,036
Subtotal	$1,377,626
COMBINED TOTAL*	**$4,699,606**

**CTI notes that 3.6% of the PEBP's total medical expense processed by HealthSCOPE was identified as paid for members who may not have been eligible for coverage. These results are high compared to the less than 1% CTI generally reports.*

Due to the brief change in eligibility vendors to BenefitFocus in January of 2022, PEBP eligibility data was not available for January 2022 through April 2022. Claims processed and incurred during that period were removed from CTI's eligibility analysis. With those claims removed, the total paid claims during the 8-month period were $130,088,521.

RANDOM SAMPLE AUDIT

Objectives

The objectives of our Random Sample Audit were to determine if medical and dental claims were paid according to plan specifications and the administrative agreement, to measure and benchmark process quality, and to prioritize areas of administrative deficiency for further review and remediation.

Scope

CTI's statistically valid Random Sample Audit included a stratified random sample of 200 paid or denied claims. HealthSCOPE's performance was measured using the following key performance indicators:

- Financial Accuracy
- Claims Payment Accuracy
- Claims Processing Accuracy

We also measured claim turnaround time, a commonly relied upon performance measure.

In addition, CTI sampled 50 health reimbursement arrangement (HRA) claims to ensure payment and processing accuracy.

Methodology

Our Random Sample Audit ensures a high degree of consistency in methodology and is based upon the principles of statistical process control with a management philosophy of continuous quality improvement. Our auditors reviewed each sample claim selected to ensure it conformed to plan specifications, agreements, and negotiated discounts. We recorded our findings in our proprietary audit system.

When applicable, we cited claim payment and processing errors identified by comparing the way a selected claim was paid and the information HealthSCOPE had available at the time the transaction was processed**. It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so you can discuss how to reduce errors and re-work in the future with your administrator.**

CTI communicated with HealthSCOPE in writing about any errors or observations using system-generated response forms. We sent HealthSCOPE a preliminary report for its review and written response. We considered HealthSCOPE's written response, as found in the Appendix, when producing our final reports. Note that the administrator responses have been copied directly from HealthSCOPE's reply.

Financial Accuracy

CTI defines Financial Accuracy as the total correct claim payments made compared to the total dollars of correct claim payments that should have been made for the audit sample.

The total paid in the 200-claim audit sample was $273,631.44. The claims sampled and reviewed revealed $413.15 in underpayments and $7,160.00 in overpayments, for an absolute value variance of $7,573.15. This reflects a weighted Financial Accuracy rate of 98.92% over the stratified sample. Detail provided in the table below, Random Sample Findings Detail Report.

HealthSCOPE did not meet the Performance Guarantee for PEBP in Q4 FY2022 of 99% for this measure. The penalty owed is 2.5% of the administrative fees of $1,130,717.25 or $28,267.93.

Claims Payment Accuracy

CTI defines Claims Payment Accuracy as the number of claims paid correctly compared to the total number of claims paid for the audit sample.

The audit sample revealed 3 incorrectly paid claims and 197 correctly paid claims. Detail provided in the table below, Random Sample Findings Detail Report.

Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid Claims	Overpaid Claims	
200	2	1	98.50%

Claims Processing Frequency

CTI defines Claims Processing Accuracy as the number of claims processed without errors compared to the total number of claims processed in the audit sample. Detail provided in the table below, Random Sample Findings Detail Report.

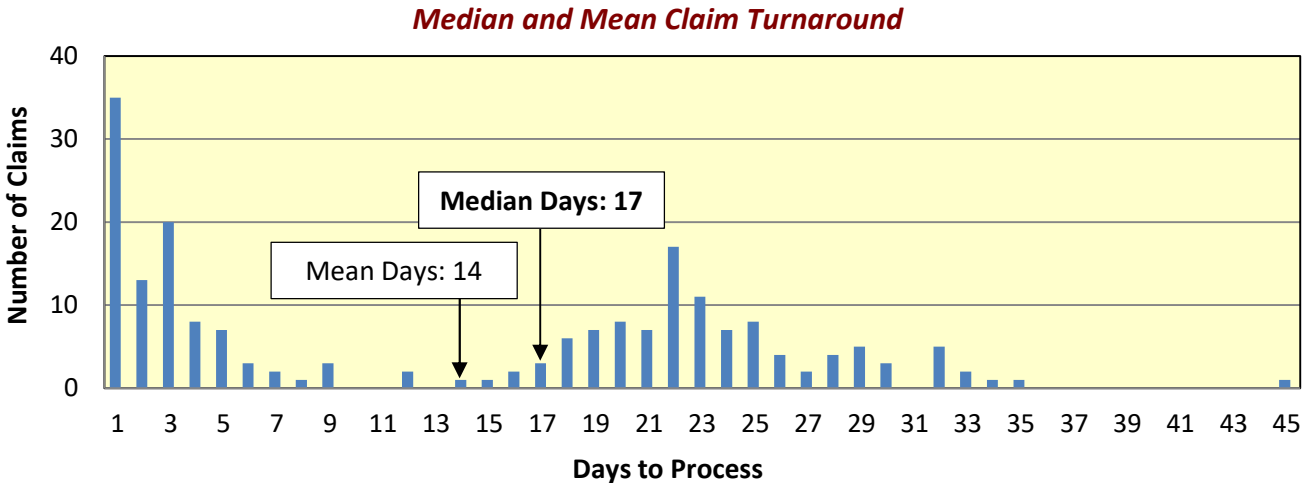
Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
197	0	3	98.50%

Random Sample Findings Detail Report				
Audit No.	Under/ Over Paid	HealthSCOPE Response	CTI Conclusion	Manual or System
Copay Calculation				
1026	($400.00)	Agree. PY2022 Premier page 37 outpatient surgery copay is $350	Procedural error and underpayment remain. The copay should have been $350.00 for outpatient surgery, and it was $750.00.	☒ M ☐ S
Denied Eligible Expense				
1113	($13.15)	Agree. Per the 2022 MPD routine hearing exam is covered under the plan.	Procedural error and underpayment remain. A hearing test is a component of a hearing exam. Per page 70 of the plan booklet, it is a covered expense.	☒ M ☐ S
PPO Discount				
1037	$7,160.00	Agree. Original claim xxxxx349 received and denied for accident details. HSB reconsidered on claim xxxxx115 and analyst did not transfer original Aetna pricing on reconsideration in error.	Procedural error and overpayment remain. No discount was applied on this free-standing surgical facility claim from a participating provider.	☒ M ☐ S

Claim Turnaround

CTI defines Claim Turnaround as the number of calendar days required to process a claim – from the date the claim was received by the administrator to the date a payment, denial, or additional information request was processed – expressed as both the Median and Mean for the audit sample.

Claim administrators commonly measure claim turnaround time in mean days. Median days, however, is a more meaningful measure for administrators to focus on when analyzing claim turnaround because it prevents just a few claims with extended turnaround time from distorting the true performance picture.



Additional Observations

During the Random Sample Audit, our auditor observed the following procedures or situations that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

Observation	Audit Number
CTI notes it took 68 days to process this claim through the high dollar claim process.	1073
Since this newborn was not added as a covered dependent and only covered for the first 31 days, only the individual deductible and out of pocket were required to be satisfied. The plan document language should be updated to reflect this administrative policy.	1096
PEBP should be aware of the HealthSCOPE processing protocol in which two routine ultrasounds per pregnancy are covered with no patient cost share. CTI notes HealthSCOPE paid six ultrasound services (sample 1137 – member history) with no patient cost-share. HealthSCOPE should review claims xxxxx707, xxxxx405, xxxxx406 and xxxxx973 and explain why these ultrasounds were paid with no patient cost-share.	1128, 1137
PEBP should be aware that HealthSCOPE does not apply a frequency limit on composite restorations performed on the same tooth and surface. In this case a one surface composite restoration was performed six months previous on the tooth in question.	2013
Per page 37 of the dental plan, facings on crowns or pontics posterior to the second bicuspid are considered cosmetic and not covered. Typically, the claim administrator will benefit a less expensive service. For a crown this would be the plan benefit for a metal crown. The plan document should be updated to be align with administration and plan intent.	2042, 2049

Health Reimbursement Arrangement (HRA) Findings

CTI also reviewed 50 HRA claims as part of our random sample. We communicated with HealthSCOPE in writing about any errors or observations found using response forms. In addition, we sent HealthSCOPE a preliminary report for its review and written response. We considered HealthSCOPE's written response, as found in the Appendix, when producing our final reports.

Our audit revealed no procedures or situations that may have caused an error on the sampled HRA claims.

DATA ANALYTICS

Medical Findings

This component of our audit used your electronic claim data to identify improvement opportunities and potential recoveries. The informational categories we analyzed include:

- Network Provider Utilization and Discount Savings;
- Sanctioned Provider Identification;
- Patient Protection and Affordable Care Act (PPACA) Preventive Services Payment Compliance;
- National Correct Coding Initiative (NCCI) Editing Compliance; and
- Global Surgery Prohibited Fee Period Analysis.

The following pages provide the scope and report for each data analytic to enable more-informed decisions about ways PEBP can maximize benefit plan administration and performance.

Network Provider Utilization and Discount Savings

The Network Provider Utilization and Discount Savings report provides an evaluation of provider network discounts obtained during the audit period. Since discounts can be calculated differently by administrators, carriers, and benefit consultants, we believe calculating discounts in the same manner for all our clients will allow for more meaningful comparisons to be made.

Scope

CTI compared submitted charges to allowable charges for all claims paid during the audit period. The review was divided into three subsets:

- In-network
- Out-of-network
- Secondary networks

Each of these subsets was further delineated into four subgroups:

- Ancillary services – such as durable medical equipment
- Non-facility services – such as an office visit
- Facility inpatient – such as services received at a hospital
- Facility outpatient – such as services received at a surgical center

Report

The following report relied on the data and data fields provided by your administrator. We made no assumptions when requested data fields were not provided.

Provider Discount Review PEBP - HealthSCOPE Paid Dates 4/1/2022 through 6/30/2022				
Proprietary and Confidential Information. Do not reproduce without express permission of Claim Technologies Inc.				
Total of All Claims				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$2,846,208	$5,543,503	66.1%	$2,483,935
Non-Facility	$25,704,109	$29,568,170	53.5%	$18,510,205
Facility Inpatient	$14,794,708	$29,222,437	66.4%	$13,695,244
Facility Outpatient	$17,020,694	$35,620,692	67.7%	$14,080,499
Total	**$60,365,719**	**$99,954,801**	**62.3%**	**$48,769,883**
In-Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$2,731,088	$5,543,503	67.0%	$2,410,930
Non-Facility	$24,629,301	$29,568,170	54.6%	$18,118,108
Facility Inpatient	$13,957,772	$28,215,883	66.9%	$13,091,230
Facility Outpatient	$16,711,412	$35,009,047	67.7%	$13,862,097
Total In-Network	**$58,029,573**	**$98,336,603**	**62.9%**	**$47,482,365**
% of Eligible Charge -	96.1%	% Claim Frequency -	97.0%	
Out of Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$115,120	$0	0.0%	$73,004
Non-Facility	$1,074,807	$0	0.0%	$392,098
Facility Inpatient	$836,936	$1,006,554	54.6%	$604,014
Facility Outpatient	$309,282	$611,644	66.4%	$218,402
Total Out of Network	**$2,336,146**	**$1,618,198**	**40.9%**	**$1,287,519**
% of Eligible Charge -	3.9%	% Claim Frequency -	3.0%	
Secondary				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$0	$0	0.0%	$0
Non-Facility	$0	$0	0.0%	$0
Facility Inpatient	$0	$0	0.0%	$0
Facility Outpatient	$0	$0	0.0%	$0
Total Secondary	**$0**	**$0**	**0.0%**	**$0**
% of Eligible Charge -	0.0%	% Claim Frequency -	0.0%	

Note: Paid claim totals exclude claims from Medicare eligible members aged 65 and older that may skew discount data.

PEBP's members had utilization of network or secondary network medical providers at 96.1% of all allowed charges and 97.0% of all claims.

Sanctioned Provider Identification

The Sanctioned Provider Identification report identifies services rendered by providers on the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE). OIG's LEIE provides information to the healthcare industry, patients, and the public about individuals and entities currently excluded from participation in Medicare, Medicaid, and all other federal health care programs.

Scope

We received and converted an electronic data file of all claims processed during the audit period. The claims screened included all medical (not including prescription drug) and dental claims paid or denied during the audit period. Through electronic screening, we identified all claims in the audit universe that were non-facility claims, i.e., claims submitted by providers of service other than hospitals, nursing, or skilled care facilities, or durable medical equipment suppliers. These claims predominantly include physician and other medical professional claims.

Report

We screened 100% of non-facility claims against OIG's LEIE and identified the following providers as sanctioned. Our screening indicated the following providers received payment from the administrator during the audit period.

NPI	Exclusion Date	Reinstatement Date	Exclusion Type	Provider Name	Claim Count	Total Charged	Total Allowed	Total Paid
1104912278	20191219	N/A	1128a4	JAMES SHELBY	4	$2,973	$2,935	$746
1548342025	20130820	N/A	1128b14	SIXTH DENTAL PARTNER	1	$1,560	$1,523	$761
				Totals	**5**	**$4,533**	**$4,458**	**$1,508**

According to the OIG, James Shelby was excluded on December 19, 2019 with for a felony-controlled substance conviction; Sixth Dental Partner was excluded on August 20, 2013 for default on health education loan.

PPACA Preventive Services Coverage Compliance

The Preventive Services Coverage Compliance report confirms that the administrator processed preventive services as required by PPACA and as regulated by the Department of Health and Human Services (HHS). The federal PPACA mandate for all health plans (unless grandfathered) requires that certain preventive services, if performed by a network provider, must be covered at 100% without copayment, coinsurance, or deductible. Our review analyzed in-network preventive care services to determine if your administrator paid services in compliance with PPACA guidelines.

Scope

Our review included all in-network services we believe should be categorized as preventive and paid at 100%. The guidance provided by HHS for the definition of preventive services is somewhat vague, leaving it up to individual health plans to define their own system edits. In addition to the U.S. Preventive Services Task Force recommendations, CTI researched best practices of major health plan administrators to develop a compliance review we believe reflects the industry's most comprehensive overview of procedures to be paid at 100%. Our review did not include services:

- performed by an out-of-network provider;
- adjusted or paid more than once (duplicate payments) during the audit period; or
- for which PPACA requirements suggest a frequency limitation such as one per year.

Our data analytics parameters relied upon the published recommendations from the sources HHS used to create the list of preventive services for which it has mandated coverage.

Reports

We analyzed the payments to determine if they were compliant. Types of services for which we identified non-compliance (if any) are listed first and the percentage of allowed charge paid is in the last column. To demonstrate full compliance with PPACA's requirements, the last column of this report should show 100% of services performed by network providers were paid and that no deductible, coinsurance, or copayment was applied.

Because services may be denied for reasons other than exclusion or limitation of non-covered services (e.g., a service could be denied because the patient was ineligible at the time it was performed), less than 100% of the preventive services may be paid.

The preventive services compliance review shows the frequency of claims paid at less than required benefit levels (i.e., claims reduced payment due to the application of deductibles, coinsurance, and/or copayments). We electronically screened 78 categories of preventive services that match the preventive care services specified by HHS including immunizations, women's health, tobacco use counseling, cholesterol and cancer screenings, and wellness examinations. This review either confirms compliance with PPACA or highlights areas for improvement.

CTI's analysis also found that 96.41% of the procedure codes identified as preventive services were paid by HealthSCOPE at 100% when provided in-network. A detailed list of the other 3.59% is available upon request.

The following reports provide an outline for discussion between PEBP and HealthSCOPE.

Preventive Care Services Compliance Review								
PEBP - HealthSCOPE								
Audit Period 4/1/2022 - 6/30/2022								
Filters: Exclude - out of network, adjustments, edits with frequency limits, claimants 65 or older								
Edit Guideline	Preventive Service Benefit	Number of Claim Lines	Number Denied	Number Applied	Number Applied	Number Applied	Paid @100%	
							Number	Percent
USPSTF-B	Breast cancer chemoprevention counseling- >17	11	0	5	1	4	0	.00%
USPSTF-A	Ambulatory blood pressure screening - adult	2	0	0	0	2	0	.00%
HHS	Breastfeeding support and counseling - women	38	5	3	14	7	9	27.27%
USPSTF-B	BRCA screening counseling - women	24	3	3	7	3	8	38.10%
USPSTF-A,B	Rh incompatibility screening - pregnant women	80	27	9	6	13	25	47.17%
USPSTF-A	Urinary tract infection screening - pregnant women	118	12	22	2	22	60	56.60%
USPSTF-A	Hepatitis B screening - women	33	1	6	1	6	19	59.38%
USPSTF-B	Healthy diet counseling	225	2	19	11	58	135	60.54%
USPSTF-A	Phenylketonuria (PKU) screening 0-90 days	12	0	1	0	3	8	66.67%
USPSTF-B	Depression screening - >18	74	3	10	6	6	49	69.01%
USPSTF-B	Tobacco use counseling - >18	25	2	3	0	4	16	69.57%
HHS	Gestational Diabetes Mellitus screening - women	104	0	9	0	20	75	72.12%
USPSTF-B	Depression screening - 12-18	33	0	2	5	2	24	72.73%
USPSTF-A	HIV screening - pregnant women	9	1	0	0	2	6	75.00%
USPSTF-B	Hepatitis C Virus (HCV) Screening	184	0	28	0	16	140	76.09%
USPSTF-A	HIV screening - >14	194	5	28	0	17	144	76.19%
USPSTF-A	Syphillis screening	48	0	4	0	6	38	79.17%
USPSTF-A	Syphilis screening - pregnant women	146	1	13	0	14	118	81.38%
ACIP	Immunizations - Influenza Age >18	42	0	4	0	2	36	85.71%
USPSTF-A,B	Chlamydia infection screening - women	293	1	22	0	16	254	86.99%
USPSTF-B	Gonorrhea screening - female	286	1	20	0	17	248	87.02%
Bright Futures	Dyslipidemia screening - 2-20	37	1	2	0	2	32	88.89%
USPSTF-A,B	Cholesterol abnormalities screening - women >19	725	0	42	0	22	661	91.17%
USPSTF-A	Cholesterol abnormalities screening - men 35-75	531	2	30	0	12	487	92.06%
Bright Futures	Iron Supplement - <21	99	1	4	0	2	92	93.88%
ACIP	Immunizations - Hepatitis A >18	19	0	0	0	1	18	94.74%
USPSTF-B	Alcohol misuse - screening and counseling	25	1	0	0	1	23	95.83%
USPSTF-A	Colorectal cancer screening - 45-75	695	2	13	3	8	668	96.39%
ACIP	Immunizations - Herpes Zoster >59	172	1	0	1	5	165	96.49%
Bright Futures	Hearing Screening 0-21 yrs	166	10	2	0	3	151	96.79%
ACIP	Immunizations - Pneumococcal >18	34	1	0	0	1	32	96.97%
HHS	Contraceptive methods - women	442	1	2	0	4	435	98.64%
HHS	Wellness Examinations - >18	736	0	6	0	2	728	98.91%
ACIP	Immunization Administration - >18	777	24	5	0	3	745	98.94%
USPSTF-B	Breast cancer mammography screening - >39	3,227	2	12	0	8	3,205	99.38%
USPSTF-A	Cervical Cancer Screening (Pap) - women	1,312	0	5	0	3	1,304	99.39%
Bright Futures	Developmental Autism screening - <3	190	1	1	0	0	188	99.47%
ACIP	Immunizations - Human papillomavirus	198	0	0	0	0	197	99.49%
HHS	Wellness Examinations - women	2,280	11	5	0	2	2,262	99.69%
HRSA/HHS	Wellness Examinations - <19	1,943	5	1	2	2	1,933	99.74%
ACIP	Immunizations - DTP <19	486	1	0	0	1	484	99.79%

NCCI Editing Compliance

While there are no universally accepted correct coding guidelines among private insurers and administrators, the Centers for Medicare & Medicaid Services (CMS), the nation's largest payer for health care, took the initiative to provide valuable guidance for medical benefit plans. Implementation of NCCI mandated several initiatives to prevent improperly billed claims from being paid under Medicare and Medicaid.

Scope

The two NCCI initiatives that can offer the greatest return benefit to self-funded employee benefit plans are the Procedure-to-Procedure (PTP) Edits and Medically Unlikely Edits (MUEs).

Our claim system code editing analysis identified services submitted to the plan and paid by HealthSCOPE that Medicare and Medicaid would have denied. **Since HealthSCOPE paid the billed charges, the payments represent a potential savings opportunity to PEBP.**

It is difficult to establish the extent to which administrators and carriers use NCCI edits; however, CTI recommends these reports be discussed with your administrator to determine the extent to which they incorporate CMS edits. Using these edits typically reduces claim expense and furthers efforts toward achieving standardized code-editing systems for all payers.

PTP Edits Reports

PTP Edits compare procedure codes from multiple claim lines on the same day to identify when procedures submitted on the same claim cannot be billed together. Our reports are grouped by outpatient hospital services and non-facility claims using CMS' quarterly updated data. If your administrator is not currently using these CMS edits, CTI's reports will help you evaluate the savings you would have realized had the PTP Edits been in place.

Procedure to Procedure Edits								
PEBP - HealthSCOPE								
Based on Paid Dates 4/1/2022 through 6/30/2022								
Outpatient Hospital Services (facility claims with codes not designated inpatient)								
Primary		Secondary		Mod Use	Primary Description	Secondary Description	Line Count	Amount CMS Would Deny
Code	Mod	Code	Mod					
63081		22551		YES	Remove vert body dcmprn crvl	NECK SPINE FUSE&REMOV BEL C2	2	$10,246
					More extensive procedure			
74177	TC	96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	10	$7,805
					Standards of medical / surgical practice			
86825		88185		YES	HLA X-MATH NON-CYTOTOXIC	FLOWCYTOMETRY/TC ADD-ON	1	$5,200
					CPT Manual or CMS manual coding instructions			
92526	GN	97110	GP	YES	ORAL FUNCTION THERAPY	THERAPEUTIC EXERCISES	14	$3,748
					Misuse of column two code with column one code			
71275	TC	96374		YES	CT ANGIOGRAPHY CHEST	THER/PROPH/DIAG INJ IV PUSH	4	$3,496
					Standards of medical / surgical practice			
74177	TC	96365		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG IV INF INIT	3	$2,787
					Standards of medical / surgical practice			
96374		96372		YES	THER/PROPH/DIAG INJ IV PUSH	THER/PROPH/DIAG INJ SC/IM	10	$2,441
					CPT Manual or CMS manual coding instructions			
74177		96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	12	$2,194
					Standards of medical / surgical practice			
94640		99285	CS,CR	YES	AIRWAY INHALATION TREATMENT	EMERGENCY DEPT VISIT	1	$2,159
					CPT Manual or CMS manual coding instructions			
94660		99285		YES	POS AIRWAY PRESSURE CPAP	EMERGENCY DEPT VISIT	1	$2,092
					CPT Manual or CMS manual coding instructions			
						Top 10 TOTAL	**58**	**$42,169**
						GRAND TOTAL	**413**	**$88,613**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)								
Primary		Secondary		Mod Use	Primary Description	Secondary Description	Line Count	Amount CMS Would Deny
Code	Mod	Code	Mod					
29881	RT	29877	RT	NO	KNEE ARTHROSCOPY/SURGERY	KNEE ARTHROSCOPY/SURGERY	1	$804
					Misuse of column two code with column one code			
90471		99396		YES	IMMUNIZATION ADMIN	PREV VISIT EST AGE 40-64	5	$506
					CPT Manual or CMS manual coding instructions			
32551		99292		YES	INSERTION OF CHEST TUBE	CRITICAL CARE ADDL 30 MIN	1	$439
					CPT Manual or CMS manual coding instructions			
44340		49000		NO	REVISION OF COLOSTOMY	EXPLORATION OF ABDOMEN	1	$411
					CPT "separate procedure" definition			
90471		99386		YES	IMMUNIZATION ADMIN	PREV VISIT NEW AGE 40-64	1	$310
					CPT Manual or CMS manual coding instructions			
99219		99218		NO	INITIAL OBSERVATION CARE	INITIAL OBSERVATION CARE	1	$276
					HCPCS/CPT procedure code definition			
90471		99385		YES	IMMUNIZATION ADMIN	PREV VISIT NEW AGE 18-39	1	$275
					CPT Manual or CMS manual coding instructions			
99218		99282		NO	INITIAL OBSERVATION CARE	EMERGENCY DEPT VISIT	1	$219
					CPT Manual or CMS manual coding instructions			
96372		99214		YES	THER/PROPH/DIAG INJ SC/IM	Office/outpatient visit for E&M of estab pat	2	$214
					Standards of medical / surgical practice			
29880	59	29874	59	NO	KNEE ARTHROSCOPY/SURGERY	KNEE ARTHROSCOPY/SURGERY	1	$191
					Misuse of column two code with column one code			
						Top 10 TOTAL	**15**	**$3,645**
						GRAND TOTAL	**103**	**$6,985**

MUE Reports

An MUE is an edit that tests claim lines for the same beneficiary, procedure code, date of service, and billing provider against a maximum allowable number of service units. The MUE rule for a given code is the maximum number of service units a provider should report for a single day of service. MUE errors could be caused by incorrect coding, inappropriate services performed, or fraud. MUEs do not require Medicare contractors to perform a manual review or suspend claims; rather, claim lines are denied and must be correctly resubmitted by providers, typically with a lesser payment amount.

CTI's MUE analyses are grouped into three separate reports, outpatient hospital, non-facility, and ancillary.

NCCI MUE Edits				
PEBP - HealthSCOPE				
Based on Paid Dates 4/1/2022 through 6/30/2022				
Outpatient Hospital Services (facility claims with codes not designated inpatient)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line Count Exceeding Limit**	**Amount CMS Would Deny**
75705	20	ARTERY X-RAYS SPINE	1	$68,248
		Rationale: Clinical: Data		
57425	1	LAPAROSCOPY SURG COLPOPEXY	1	$19,048
		Rationale: Anatomic Consideration		
58571	1	TLH W/T/O 250 G OR LESS	1	$19,048
		Rationale: Anatomic Consideration		
A9588	10	FLUCICLOVINE F-18	1	$11,688
		Rationale: Prescribing Information		
36215	2	PLACE CATHETER IN ARTERY	1	$11,219
		Rationale: Clinical: Data		
C1732	3	CATH, EP, DIAG/ABL, 3D/VECT	1	$8,937
		Rationale: Clinical: Data		
36245	3	INS CATH ABD/L-EXT ART 1ST	1	$7,337
		Rationale: Clinical: Data		
74177	2	CT ABD & PELV W/CONTRAST	1	$6,428
		Rationale: Clinical: Data		
36226	1	Place cath vertebral art	1	$6,204
		Rationale: CMS Policy		
88185	35	FLOWCYTOMETRY/TC ADD-ON	2	$5,366
		Rationale: Clinical: Data		
		Top 10 TOTAL	**11**	**$163,524**
		GRAND TOTAL	**84**	**$206,103**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line Count Exceeding Limit**	**Amount CMS Would Deny**
97799	1	PHYSICAL MEDICINE PROCEDURE	35	$21,170
		Rationale: Clinical: Data		
31298	1	Nasal/sinus endoscopy, w dilation (balloon dilation) frontal & sphenoid sinus ostia, transnasal	1	$4,404
		Rationale: CMS Policy		
88374	5	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-ass	10	$4,396
		Rationale: Clinical: Data		
90868	1	TCRANIAL MAGN STIM TX DELI	1	$1,935
		Rationale: Nature of Service/Procedure		
88342	4	IMMUNOHISTOCHEMISTRY	1	$1,840
		Rationale: Clinical: Data		
67028	1	INJECTION EYE DRUG	4	$1,271
		Rationale: CMS Policy		
J3480	40	INJ POTASSIUM CHLORIDE	8	$1,200
		Rationale: Clinical: Data		
97155	24	ADAPT BHV TX PRTCL MODIFICAJ PHYS/QHP EA 15 MIN	2	$1,193
		Rationale: Clinical: Society Comment		
88341	13	Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain pro	2	$959
		Rationale: Clinical: Data		
87502	1	INFLUENZA DNA AMP PROBE	6	$885
		Rationale: Code Descriptor / CPT Instruction		
		Top 10 TOTAL	**70**	**$39,253**
		GRAND TOTAL	**159**	**$52,076**

Ancillary (All other claims not flagged Inpatient, Outpatient Hospital, or non-facility)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line count Exceeding Limit**	**Amount CMS Would Deny**
E0465	2	Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)	14	$12,429
		Rationale: Nature of Equipment		
E2402	1	NEG PRESS WOUND THERAPY PUMP	1	$4,657
		Rationale: Nature of Equipment		
E0443	1	PORTABLE 02 CONTENTS, GAS	16	$1,140
		Rationale: Code Descriptor / CPT Instruction		
E0277	1	POWERED PRES-REDU AIR MATTRS	1	$950
		Rationale: Nature of Equipment		
E0260	1	HOSP BED SEMI-ELECTR W/ MATT	2	$478
		Rationale: Nature of Equipment		
K0001	1	STANDARD WHEELCHAIR	4	$448
		Rationale: Nature of Equipment		
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	8	$444
		Rationale: Nature of Equipment		
V2521	2	CNTCT LENS HYDROPHILIC TORIC	5	$440
		Rationale: Anatomic Consideration		
E0630	1	PATIENT LIFT HYDRAULIC	2	$342
		Rationale: Nature of Equipment		
A7520	1	TRACH/LARYN TUBE NON-CUFFED	4	$309
		Rationale: Published Contractor Policy		
		Top 10 TOTAL	**57**	**$21,638**
		GRAND TOTAL	**84**	**$22,888**

Global Surgery Prohibited Fee Period Analysis

CMS created the definition of global surgical package to make payments for services provided by a surgeon before, during, and after procedures. The objective of CTI's Global Surgery Prohibited Fee Period Analysis is to compare paid surgical claims to Medicare's payment guidelines and identify instances of unbundling and improper use of evaluation and management (E/M) coding.

Scope

The scope of the Global Surgery Prohibited Fee Period Analysis is surgery charges provided in any setting, including inpatient hospital, outpatient hospital, ambulatory surgical center (ASC), and physician's office. Claims for surgeon visits in intensive care or critical care units are also included in the global surgical package. Our analysis encompasses the three types of procedures with global surgical packages: simple, minor, and major. Each type has specific global periods including simple – one day, minor – ten days, and major – ninety days.

CMS allows providers to bill for an E/M service after surgery if the patient's condition required a significant, separately identifiable E/M service beyond the usual pre-operative and post-operative care. When this occurs, the provider can add a modifier 24, 25, or 57 to the E/M service procedure code but must submit supporting documentation with the claim.

Report

The following report provides a summary of:

- top 10 providers with and without E/M charges during prohibited periods and associated charges;
- analysis of same providers' surgeries with modifier 24, 25, or 57 when Medicare would have required supporting documentation before payment; and
- analysis of the same providers' surgeries without modifier 24, 25, or 57 when Medicare would have denied payment.

Payment of unbundled, post-surgical E/M services during the global fee period increases the cost of a claim. While there are no universally accepted guidelines for global surgery fee periods with 24, 25, or 57 modifiers, some states and groups mandate providers accept assignment of benefits on those claims. This mitigates the financial impact of unbundling and improper coding. When we discuss our findings, we will help you identify strategies to monitor and eliminate unbundling within your plan.

PEBP - HealthSCOPE									
Audit Period 4/1/2022 - 6/30/2022									
	Surgeries with 'CMS Defined' Prohibited Global Fee Periods					Evaluation and Management Services using Same ID as Surgeon and Within Prohibited Global Fee Period			
	Surgeries without E/M Procedures during Prohibited Global Fee		Surgery with E/M Charge during Prohibited Global Fee Periods			E/M Procedure Codes with Modifier 24, 25, or 57		E/M Procedure Codes without Modifier 24, 25, or 57	
Provider Id	Count	Allowed Charge	Count	% Surgeries with E/M Charges during Prohibited Global Fee Periods	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge
860800150	18	$13,009	4	18.2%	$9,517	2	$747	2	$540
910858192	106	$36,324	30	22.1%	$2,851	27	$2,535	2	$233
880218251	2	$119	1	33.3%	$645	0	$0	1	$131
813419791	48	$14,068	4	7.7%	$867	3	$465	1	$123
825259010	2	$100	1	33.3%	$114	1	$106	1	$106
860881749	10	$1,602	3	23.1%	$249	2	$230	1	$98
202523414	18	$1,464	2	10.0%	$1,442	1	$152	1	$95
880104714	38	$12,398	2	5.0%	$974	1	$80	1	$80
300047065	18	$2,563	1	5.3%	$1,191	0	$0	2	$77
942854057	16	$1,918	1	5.9%	$631	0	$0	1	$72
Top 10	**276**	**$83,564**	**49**	**15.1%**	**$18,479**	**37**	**$4,313**	**13**	**$1,555**
Overall Total	**4,877**	**$1,360,932**	**442**	**8.3%**	**$95,682**	**413**	**$47,277**	**14**	**$1,622**

FY2022 RECOMMENDATIONS

CTI has the following recommendations that represent recurring issues identified in the FY 2022 quarterly audits:

1. HealthSCOPE should review each of the financial errors identified in our FY2022 random sample audits and determine if system changes or claim processor training could help reduce or eliminate errors of a similar nature in the future. It should focus specifically on steps necessary to improve Financial Accuracy.
2. HealthSCOPE should conduct a focused analysis of the errors identified through ESAS to determine if overpayment recovery and/or system improvements are possible and to reduce or eliminate similar errors going forward. For the issues identified by ESAS, CTI can prepare claim detail for HealthSCOPE to use in its analysis.
3. HealthSCOPE should adjust claims when subrogation recoveries are received. This is not currently taking place and it is impacting member total out-of-pocket limits.
4. PEBP should discuss the subrogation recovery rate with HealthSCOPE. The recovery rate was lower in this period, with only a 10% recovery rate.
5. PEBP should review the results of the eligibility screening and perform causal analysis to identify workflow and/or system improvements to reduce or eliminate paying claims on ineligible claimants.
6. In CTI's experience PEBP's dental plan document is vague and/or silent on a number of dental services. We recommend that the language be updated to indicate specifically which services are covered and which are excluded.
7. PEBP should request regular member appeal reports that include the reason for appeal, as well as received and closed dates.
8. PEBP should request regular overpayment reports including overpayment reasons. Tracking the reason for overpayments will allow both PEBP to understand why overpayments occur.
9. HealthSCOPE should exclude from claim payment providers on the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE).

CONCLUSION

We consider it a privilege to have worked for, and with, your staff and administrator. Thank you again for choosing CTI.

APPENDIX – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Your administrator's response to the draft report follows.

Additional information submitted to CTI from the administrator in response to the draft report is reviewed and observations may be removed prior to the final report being published. While a removed observation will not be included in the final report, it may be referenced in the administrator's response to the draft report.

27 Corporate Hill Drive
Little Rock, AR 72205

October 14, 2022

Claim Technologies Incorporated
100 Court Avenue Suite 306
Des Moines, IA 50309

Dear Ms. Suckow,

Thank you for the opportunity to work with CTI on our mutual client State of Nevada Public Employees' Benefit Program.

Appendix – Administrator's Response to Draft Report for State of Nevada Public Employees' Benefit Program.

Summary of HealthSCOPE's Guarantee Measurements:
Quarterly Guarantee:
HealthSCOPE Benefits would like to request CTI to review the Random Sample Audit results for the financial accuracy and payment accuracy.

- Financial Accuracy Q4– 87.74% - **HSB Response**: Disagree with CTI conclusion regarding the financial accuracy detail information. There are errors that are calculated in the detail that should be re-evaluated based on the documentation and information provided to CTI.

- Payment Accuracy Q4– 95% - **HSB Response**: Disagree with CTI conclusion regarding the payment accuracy detail information. There are errors that are calculated in the detail that should be re-evaluated based on the documentation and information provided to CTI.

HealthSCOPE Benefits has reviewed Audit Number 1.FY22.Q4 draft report and would like to add the response to the conclusions within the audit report.

TARGETED SAMPLE ANALYSIS

ESAS Findings Detail Report:

Duplicate Payments:

QID 30 – HSB does agree with CTI conclusion. The duplicate edit was overridden by the analyst in error. Claim 11999741 was adjusted to deny as a duplicate claim and request a refund.

Plan Exclusions:

QID 49- HSB does agree with CTI conclusion. Analyst should have requested medical records.

Potential Fraud, Waste, and Abuse:

QID 39 – HSB does not agree with CTI conclusion. The claim was paid according to the plan guidelines under the Chiropractic benefit.

QID 40 – HSB does not agree with CTI conclusion. The claim was paid according to the plan guidelines under the Chiropractic benefit.

QID 41 – HSB does not agree with CTI conclusion. The claim was paid according to the plan guidelines under the Chiropractic benefit.

Preventive Services:

QID 8 – HSB does agree with CTI conclusion. The claim should have paid at the routine benefit.

QID 9 – HSB does agree with CTI conclusion. The claim should have paid at the routine benefit.

QID 12 – HSB does agree with CTI conclusion. The claim should have paid at the routine benefit.

Procedure to Procedure:

QID 4 – HSB does not agree with CTI conclusion. The claim was paid correctly and priced with the Aetna contract agreement.

QID 5 – HSB does not agree with CTI conclusion. A corrected claim was received from the facility and corrected pricing received from HTH. There is no outstanding overpayment on the account for these services. The claim was paid correctly.

Medically Unlikely Edits:

QID 1 – HSB does not agree with CTI conclusion. Authorization number 6158080 on file for services rendered. Claim was priced with the Aetna contract agreement.

QID 2 – HSB does not agree with CTI conclusion. Authorization number 6264924 on file for services rendered. Copy of the claim was provided to CTI to identify the date span listed on the service line. The claim was priced with the Aetna contract agreement.

QID 3 – HSB does not agree with CTI conclusion. The claim was priced with the Aetna contract agreement in place with this facility. The claim was paid correctly.
HealthSCOPE Benefits would like to ask CTI to update the HSB response outlined on QID 3 of the Draft report as it was entered with the incorrect response. The authorization number identified in QID 3 should be identified in QID 2 as outlined on the HSB response.

OBSERVATION:

QID 21 – QID 21 was processed with the Aetna contract agreement.

QID 22 – QID 22 was processed with the Aetna contract agreement.

RANDOM SAMPLE AUDIT:

Accurate Processing Detail Report:

Audit No. 1032 – HSB does not agree with CTI conclusion. On page 9 of the MPD it explains the Out-of-Pocket maximum. The Out-of-Pocket Maximum is the costs you pay toward your deductible and coinsurance. The member had an Individual Deductible amount of $1,782.01 and an Individual Coinsurance amount of $5067.99 that equals the total of $6,850.

Audit No. 1065 – HSB does not agree with CTI conclusion. The lab claim was received on 06/13/2022 and processed on 06/15/2022 as billed by the provider. The physician claim was received on 07/14/2022 and processed on 07/18/2022. The lab bill was processed correctly based on the claim received and on file at the time of adjudication. Received email directive from the client regarding routine lab.

Audit No. 1096 – HSB does not agree with CTI conclusion. The claim was considered under the newborn for services rendered. The Enrollment Eligibility MPD does define the Newborn eligibility. The newborn will be covered for the first 31 days under the plan. The newborn was not added to the policy and the benefit calculations were for individual coverage only. The newborn service applied coinsurance to satisfy the individual Out-of-Pocket maximum.

Audit No. 1012 – HSB does not agree with CTI conclusion. Per the 2022 MPD it states that this service is a $25 copay. See information below outlined from the 2022 MPD.

Page 42
Alcohol and Substance-Abuse Treatment
Intensive Outpatient Treatment Program: Copay was reduced to $25 Copay per Visit.
Outpatient Treatment: Copay was reduced to $25 Copay per Visit.

Audit No. 1026 – HSB does agree with CTI conclusion. The outpatient surgery copay is $350.

Audit No. 1041 – HSB does not agree with CTI conclusion. The member did meet the individual In-network deductible of $1,750 on this claim. The member has *employee only coverage* effective 07/01/2017.

Audit No. 1113 – HSB does agree with CTI conclusion. Per the 2022 MPD routine hearing exam is covered under the plan.

Audit No. 1121 – HSB does not agree with CTI conclusion. Eligibility file feed issue from Benefit Focus that terminated the coverage for this member retroactively to 01/01/2022. The claim was adjudicated and denied for no coverage based on the eligibility provided at that time. Claim was reconsidered after resolution of the issue. There is no outstanding underpayment on this account.

Audit No. 1037 – HSB does agree with CTI conclusion. Original claim was received and denied for accident details. The claim was reconsidered, and the analyst did not transfer the original Aetna pricing on reconsideration in error.

Audit No. 1141 – HSB does not agree with CTI conclusion. The patient went to the emergency room on 03/21/2022. The patient was transferred by Intermountain Life Flight to another facility for emergency surgery and was admitted as inpatient. The Low Deductible 2022 MPD does specify the following language as outlined below.

> Precertification is not required for medically necessary emergency services when a medical condition that manifests itself by symptoms of such sufficient severity that a prudent person would believe that the absence of immediate medical attention could result in:
> • Serious jeopardy to the health of the participant.
> • Serious jeopardy to the health of an unborn child.
> • Serious impairment of a bodily function; or
> • Serious dysfunction of any bodily organ or part.

The Plan further distinguishes the difference between Air/Flight Schedule Inter-Facility Transfer and Emergency Air Ambulance on page 41. Emergency air ambulance does not require prior authorization.

Audit No. 2042 – HSB does not agree with CTI conclusion. Services were rendered for tooth number 18. Tooth number 18 is the lower left mandibular and a second molar. The services billed were D2950 Core Build Up and D2740 Crown – Porcelain/Ceramic Substrate. HSB does not apply the dental alternate benefit provision per PEBP's directive.

Observation:

Audit Number 1073 – The claim was received and submitted for Aetna pricing. Once the pricing was received the claim was then submitted for Bill Review audit to verify services were billed appropriately. Once the claim did go through the workflow then the claim was processed and sent to management for review and to release the claim for payment.

Audit Number 1128 – Routine Ultrasounds, two routine per pregnancy are allowed and two routine ultrasounds were paid on this account. This is a different member from Audit Number 1137.

Audit Number 1137 – Routine Ultrasounds, two routine per pregnancy are allowed and two routine ultrasounds were paid on this account (11613707 and 11852973). Claim 11734406 did take coinsurance. This is a different member from Audit Number 1128.

Audit Number 2013 – Dental procedure D2391 is paid as a Basic Service as outlined in the Dental MPD.

RECOMMENDATIONS:

1. HealthSCOPE Benefits does review the valid financial errors from each quarterly audit. The errors are reviewed with the claims management team in order to identify if there are system programming updates necessary or additional examiner training for claims processing.
2. HealthSCOPE Benefits does review the focused audit error from each quarterly audit. The errors are reviewed with the claims management team in order to identify if there are system programming updates necessary or additional examiner training for claims processing.
3. The administrator is taking a pro-active approach to adjust claims if necessary due to plan changes, benefit calculations or other types of claim adjustments.
4. Client directive was for the member to retain the credit for any cost share assessed on a medical claim in the event of a third-party settlement.
5. The subrogation vendor does provide the client with quarterly reports. HSB would like to ask CTI for additional detail regarding the recovery analysis and how the 10% was calculated.

Thank you,

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