Draft as of June 14, 2022

Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employee Benefit Program Plans

Administered by HealthScope Benefits

Audit Period: January 1, 2022 through March 31, 2022
Audit Number 1.FY22.Q3

Presented to

State of Nevada Public Employee Benefit Program

June 14, 2022

CLAIM TECHNOLOGIES INCORPORATED

TABLE OF CONTENTS

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) administration of the State of Nevada Public Employee Benefit Program's (PEBP) medical, dental, and health reimbursement arrangement (HRA) plan.

Scope

CTI performed an audit of HealthScope's administration of the PEBP's medical, dental and HRA for the period of January 1, 2022 through March 31, 2022 (quarter 3 (Q3) 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	$53,704,711
Total Number of Claims Paid/Denied/Adjusted	188,118
Health Reimbursement Arrangement (HRA)	
Total Paid Amount	$880,745
Total Number of Claims Paid/Denied/Adjusted	9,828

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

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

Auditor's Opinion

Based on these findings, and in our opinion:

1. HealthSCOPE met its Financial Accuracy measurement in Q3 FY2022 and no penalty is owed.
2. HealthSCOPE should:
    - Review the 100% Electronic Screening with Targeted Sample results and focus on the most material findings in Duplicate Payments, Spinal Region Upcoding, and Timely Filing Payments.
    - Review the Random Sample Audit results and review the system error and how to prevent similar system errors going forward.

Summary of HealthSCOPE's Guarantee Measurements

Based on CTI's Random Sample Audit results, HealthSCOPE met both claims processing measurements for the PEBP in Q3 FY2022.

Quarterly Guarantee	Measure	Met/Not Met	Penalty
Financial Accuracy	99%	Met – 99.89%	None.
Payment Accuracy	98%	Met – 99.50%	None.

AUDIT OBJECTIVES

This report contains CTI's findings from our audit of HealthScope Benefits' (HealthScope) administration of the State of Nevada Public Employee Benefit Program (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.

OPERATIONAL REVIEW PERFORMANCE GUARANTEES

Performance Guarantees

As part of CTI's quarterly audit of PEBP, we reviewed the Performance Guarantees included in its contract with HealthSCOPE. The results for Q3 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.	99.89%	Met
Payment Accuracy	98% or greater of medical/dental claims audited are paid accurately.	99.50%	Met
Claim Processing Turnaround	99% of all medical/dental claims are to be processed within 30 days	99.94%	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%	6 Seconds Less than .01% 97.97%	Met Met Met
Data Reporting	• 100% of standard reports within 10 business days • Annual/Regulatory Documents within 10 business days of the Plan Year	No exceptions noted NA – Annual Report	Met NA
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
- Multiple surgical procedures

Methodology

We used ESAS to analyze claim payment 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 than 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.

Findings

We are confident in the accuracy of our ESAS results. It should be noted that the dollar amounts associated with the results represent potential payment errors and process improvement opportunities. We would have to perform additional testing to substantiate the findings that could then 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 the responses and supporting documentation. The administrator responses are copied directly from HealthScope's reply to audit findings.

Process Improvement Summary Report				
Client: PEBP **Screening Period:** Q3 FY2022				
Category	**Number of Service Codes**	**Number of Members**	**Billed Charge**	**Allowed***
Fraud, Waste and Abuse				
Spinal Region Upcoding – Number of spinal regions treated does not match number of spinal regions billed and allowed.	977	361	$66,983	$35,663

**Allowed 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 additional information provided, CTI confirmed the potential for process improvement. Note that all recommendations for HealthSCOPE process improvements will also be included in the Q4 FY2021 report.

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

Fraud, Waste, and Abuse Detail Report					
QID	**Category**	**Over Paid**	**HealthScope Response**	**CTI Conclusion**	**Manual or System**
35	Spinal Region Upcoding	$83.99	Disagree.	Procedural deficiency and overpayment remain. The description for CPT codes for chiropractic care includes the number of regions of spine or extraspinal regions treated and should be supported by the diagnosis. The provider billed five or more spinal regions treated; however, the diagnosis billed supported treatment of only two spinal regions. These procedures are spinal region driven and should be billed with appropriate diagnosis codes to support billing.	☒ M ☐ S
36		$56.76			☒ M ☐ S

Categories for Potential Amount at Risk

The following report shows, by category, the number of line items or claims and the total potential amount at risk remaining at the conclusion of our analysis, targeted samples, and removal of verified false positives. Following the report is a detailed explanation of our results with findings for all screening categories where, in our opinion, process improvement, recovery or savings opportunities exist. The administrator responses are copied directly from HealthScope's reply to audit findings.

Categories for Potential Amount at Risk				
Client: PEBP **Screening Period:** Q3 FY2022				
Category	**Number of Service Codes**	**Number of Members**	**Billed Charge**	**Allowed***
Duplicate Payments				
Providers and/or Employees	168	41	$102,937	$41,082
Timely Filing				
Paid after timely filing limit	803	231	$2,054,152	$736,947

**Allowed 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.

Duplicate Payments Detail Report				
QID	**Over Paid**	**HealthScope Response**	**CTI Conclusion**	**Manual or System**
30	$1,197.68	Agree. NEV.XXXX4785 is a duplicate claim. The edit was overridden by analyst in error.	Procedural deficiency and overpayment remain.	☒ M ☐ S
Timely Filing Detail Report				
QID	**Over Paid**	**HealthScope Response**	**CTI Conclusion**	**Manual or System**
12	$1,197.68	Disagree. Original claim NEV.XXXX6319 was received within the timely filing limit. The original claim was denied for Medicare EOB and itemized bill. The claim was split and NEV.XXXX8031 was reconsidered and paid according to the plan benefits.	Procedural deficiency and overpayment remain. Claim was processed 21 months after the date of service.	☒ M ☐ S
13	$21,157.31	Disagree. Original claim NEV.XXXX1429 was received within the timely filing limit. The provider submitted a correct claim that was received on 10/23/2021 and denied for itemization. The provider submitted the requested information within the timeframe and paid under NEV.XXX6334.	Procedural deficiency and overpayment remain. Claim was processed 16 months after the date of service.	☒ M ☐ S

There were also errors found under the dental benefit plan for services paid. CTI's review indicated three Dental Surgical Procedures paid for a total of $2,168.50 including:

- one Repair of maxillofacial and/or soft hard tissue defect;
- one Graft, bone; nasal, maxillary, or malar areas and
- one Sinus augmentation with Bone or Bone substitutes via a lateral open approach.

Additionally, there were Invalid Procedure Codes paid for a total of $1,463.68 including one each of Bone graft in conjunction with Periradicular surgery; Biologic material to aid in soft and osseous tissue; Surgical repair on root resorption; Intraorifice barrier; Splint-intra-coronal; Buccal/Labial Frenectomy and Lingual frenectomy.

In CTI's experience the 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. This will eliminate the option for medical necessity which means any claim currently submitted is being paid.

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
- Accurate Payment
- Accurate Processing

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 claims sampled and reviewed revealed $123.72 in underpayments and no overpayments, for an absolute value variance of $123.72.

The weighted Financial Accuracy rate was 99.89%.

Financial Accuracy Detail Report						
Error Description	**Audit No.**	**Under Paid**	**HealthScope Response**	**CTI Conclusion**	**Manual or System**	
Coinsurance Error	1127	$123.72	Agree. Claim should not have assessed a $123.72 coinsurance. There would be a $123.72 underpayment on this claim.	Procedural error and underpayment remain. Coinsurance amount should have not been assessed.	☐ M ☒ S	
Subtotal	**1**					
TOTALS	**1**	**VARIANCE $123.72**			**M: 0**	**S: 1**

Accurate Payment

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

The audit sample revealed 1 incorrectly paid claims and 199 correctly paid claims. Note CTI only uses adequately documented claims for this calculation.

Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid Claims	Overpaid Claims	
200	1	0	99.50%

Accurate Processing

CTI defines Accurate Processing as the number of claims processed without errors compared to the total number of claims processed in the audit sample.

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
199	1	0	99.50%

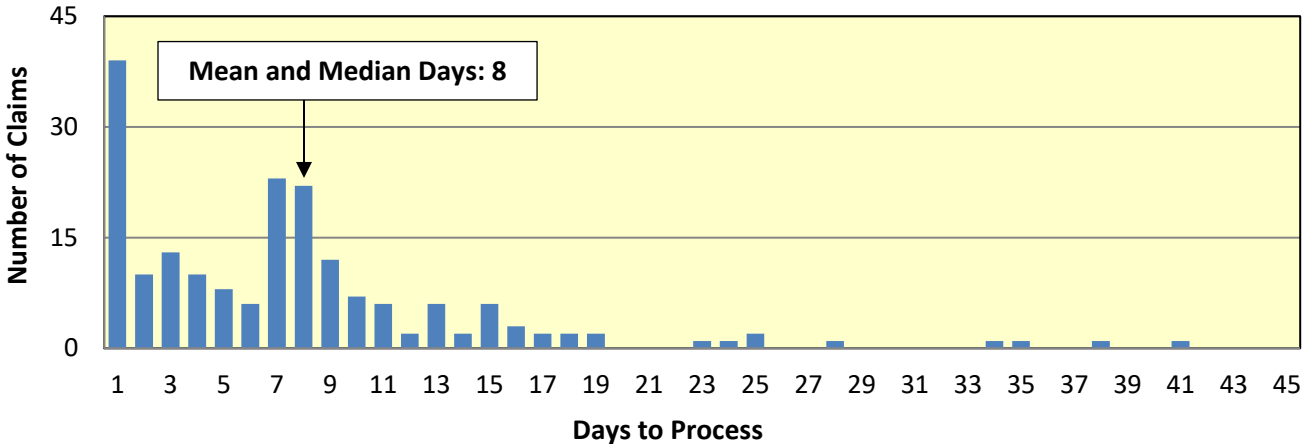
Accurate Processing Detail Report				
Error Description	**Audit No.**	**HealthScope Response**	**CTI Conclusion**	**Manual or System**
Managed Care				
Coinsurance Error	1127	Agree. Claim should not have assessed a coinsurance. There would be an underpayment on this claim.	Procedural error remains. Coinsurance should have not been assessed.	☐ 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 one or just a few claims with extended turnaround time from distorting the true performance picture.

Median and Mean Claim Turnaround



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
HealthSCOPE is denying any claim with a diagnosis code of T86.19 (Sepsis) pending completion of an accident report. This is delaying payment of members claims.	1055

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 claim.

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.

Paid Dates 1/1/2022 through 3/31/2022				
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	$2,689,116	$4,635,036	63.3%	$2,365,069
Non-Facility	$24,558,190	$27,363,997	52.7%	$17,184,442
Facility Inpatient	$16,456,761	$30,380,988	64.9%	$15,756,474
Facility Outpatient	$15,263,591	$33,833,190	68.9%	$12,293,734
Total	**$58,967,657**	**$96,213,211**	**62.0%**	**$47,599,719**
In-Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$2,574,564	$4,635,036	64.3%	$2,301,741
Non-Facility	$23,621,021	$27,355,839	53.7%	$16,862,951
Facility Inpatient	$16,261,466	$30,109,697	64.9%	$15,627,014
Facility Outpatient	$14,960,964	$33,312,429	69.0%	$12,072,300
Total In-Network	**$57,418,014**	**$95,413,001**	**62.4%**	**$46,864,006**
% of Eligible Charge -	97.4%	% Claim Frequency -	84.7%	
Out of Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$114,552	$0	0.0%	$63,328
Non-Facility	$937,169	$8,158	0.9%	$321,490
Facility Inpatient	$195,295	$271,291	58.1%	$129,460
Facility Outpatient	$302,627	$520,761	63.2%	$221,434
Total Out of Network	**$1,549,643**	**$800,210**	**34.1%**	**$735,713**
% of Eligible Charge -	2.6%	% Claim Frequency -	15.3%	

**Paid claim totals exclude claims from members aged 65 and older.*

PEBP's members had utilization of network or secondary network medical providers at 97.40% of all allowed charges and 84.70% 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	2	$332	$332	$197
1548342025	20130820	N/A	1128b14	7 DAY DENTAL	2	$924	$898	$453
				Totals	**4**	**$1,256**	**$1,230**	**$649**

According to the OIG, James Shelby was excluded on December 19, 2019 with for a felony-controlled substance conviction. 7 Day Dental has been excluded for default on a health education loan or scholarship.

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 94.73% of the procedure codes identified as preventive services were paid by HealthScope at 100% when provided in-network. A detailed list of the other 5.27% is available upon request.

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

Preventive Care Services Compliance Review Paid at Less than 100%

PEBP - HealthSCOPE

Audit Period 1/1/2022 - 3/31/2022

Plans: All

Filters: Exclude - out of network, adjustments, edits with frequency limits, claimants 65 or older

		Claim Lines Submitted	Denied	Applied Deductible		Applied Copay		Applied Coinsurance		Paid @100%		
Edit Guideline	Preventive Service Benefit	#	#	#	Amount	#	Amount	#	Amount	#	Amount	%
USPSTF-A	Hemoglobinopathies or sickle cell screening 0-90 days	1	0	1	$11	0	$0	0	$0	0	$0	.00%
USPSTF-B	Pre-Diabetes/Type 2 Diabetes	1	0	1	$184	0	$0	0	$0	0	$0	.00%
USPSTF-B	Breast cancer chemoprevention counseling- >17	12	0	5	$394	2	$100	4	$83	1	$251	8.33%
HHS	Breastfeeding support and counseling - women	28	0	10	$3,049	7	$340	6	$238	5	$358	17.86%
USPSTF-A,B	Rh incompatibility screening - pregnant women	85	22	15	$655	8	$467	25	$270	14	$337	22.22%
USPSTF-A	HIV screening - pregnant women	12	0	7	$409	0	$0	2	$10	3	$104	25.00%
USPSTF-B	BRCA screening counseling - women	28	3	5	$1,054	8	$340	2	$300	10	$8,767	40.00%
HHS	Gestational Diabetes Mellitus screening - women	128	0	27	$241	0	$0	32	$49	69	$801	53.91%
USPSTF-A	Hepatitis B screening - women	24	0	6	$63	0	$0	4	$7	14	$138	58.33%
USPSTF-B	Depression screening - >18	87	1	23	$392	3	$40	8	$25	52	$858	60.47%
USPSTF-A	HIV screening - >14	146	1	44	$1,014	0	$0	12	$99	89	$2,171	61.38%
USPSTF-B	Hepatitis C Virus (HCV) Screening	173	4	45	$772	0	$0	18	$96	106	$1,625	62.72%
USPSTF-A	Urinary tract infection screening - pregnant women	109	3	23	$710	5	$135	11	$93	67	$1,818	63.21%
USPSTF-B	Healthy diet counseling	237	0	27	$2,572	7	$242	50	$1,593	153	$24,133	64.56%
USPSTF-A	Syphillis screening	55	1	13	$47	0	$0	5	$4	36	$132	66.67%
USPSTF-B	Depression screening - 12-18	27	0	5	$30	0	$0	4	$6	18	$130	66.67%
USPSTF-A	Syphilis screening - pregnant women	131	0	27	$140	0	$0	14	$10	90	$460	68.70%
USPSTF-A,B	Chlamydia infection screening - women	259	1	54	$3,018	1	$82	24	$247	179	$7,880	69.38%
USPSTF-B	Gonorrhea screening - female	248	1	47	$2,589	1	$82	22	$193	177	$7,852	71.66%
USPSTF-B	Tobacco use counseling - >18	22	2	1	$9	0	$0	4	$20	15	$278	75.00%
USPSTF-A	Phenylketonuria (PKU) screening 0-90 days	8	0	2	$8	0	$0	0	$0	6	$159	75.00%
USPSTF-A,B	Cholesterol abnormalities screening - women >19	672	1	99	$1,252	0	$0	31	$94	541	$6,521	80.63%
USPSTF-B	Alcohol misuse - screening and counseling	26	0	4	$74	0	$0	1	$4	21	$388	80.77%
USPSTF-A	Cholesterol abnormalities screening - men 35-75	517	1	76	$941	0	$0	20	$90	420	$4,663	81.40%
Bright Futures	Lead screening - <21	14	0	2	$21	0	$0	0	$0	12	$146	85.71%
ACIP	Immunizations - Hepatitis A >18	15	0	1	$127	0	$0	1	$24	13	$1,305	86.67%
Bright Futures	Dyslipidemia screening - 2-20	32	0	3	$28	0	$0	0	$0	29	$356	90.63%
Bright Futures	Hearing Screening 0-21 yrs	149	11	4	$120	0	$0	8	$45	126	$2,713	91.30%
Bright Futures	Tuberculin testing - <21	12	0	1	$6	0	$0	0	$0	11	$128	91.67%
ACIP	Immunizations - Influenza Age >18	373	6	8	$245	0	$0	16	$122	343	$11,344	93.46%
ACIP	Immunizations - Pneumococcal >18	32	0	1	$110	0	$0	1	$25	30	$4,940	93.75%
Bright Futures	Iron Supplement - <21	84	0	3	$7	0	$0	0	$0	81	$221	96.43%
USPSTF-A	Colorectal cancer screening - 45-75	611	2	12	$1,252	5	$435	3	$36	589	$262,157	96.72%
ACIP	Immunizations - Herpes Zoster >59	177	1	2	$171	0	$0	3	$170	171	$62,599	97.16%
HHS	Contraceptive methods - women	375	0	4	$216	0	$0	2	$31	368	$134,749	98.13%
ACIP	Immunization Administration - >18	1,179	41	8	$586	0	$0	13	$250	1,117	$41,569	98.15%
USPSTF-A	Cervical Cancer Screening (Pap) - women	1,095	2	13	$464	1	$71	6	$81	1,073	$35,258	98.17%
USPSTF-B	Breast cancer mammography screening - >39	3,492	3	25	$1,863	3	$120	16	$344	3,445	$332,572	98.74%
HHS	Cervical Cancer Screening (HPV DNA) - women >29	669	1	6	$464	0	$0	2	$12	660	$26,122	98.80%
HHS	Wellness Examinations - >18	700	2	3	$103	1	$30	3	$27	691	$109,026	99.00%
Bright Futures	Developmental Autism screening - <3	189	0	1	$11	0	$0	0	$0	188	$2,906	99.47%
HHS	Wellness Examinations - women	2,262	8	5	$339	2	$55	3	$445	2,244	$373,760	99.56%
HRSA/HHS	Wellness Examinations - <19	1,847	3	2	$83	2	$55	0	$0	1,840	$237,749	99.78%
ACIP	Immunizations - DTP <19	486	2	1	$36	0	$0	0	$0	483	$51,637	99.79%

PPACA Preventive Services Coverage Compliance Detail Report

QID	Error Description	Under Paid	HealthScope Response	CTI Conclusion	Manual or System
7	Coinsurance Applied	$2,911.33	Agree. Claim should have been paid as preventive.	Procedural deficiency and underpayment remain. HealthSCOPE applied a deductible/ coinsurance to a preventive service.	☒ M ☐ S
8	Deductible Applied				

Preventive Care Services Compliance Review Paid at 100%												
PEBP - HealthSCOPE												
Audit Period 1/1/2022 - 3/31/2022												
Plans: All												
Filters: Exclude - out of network, adjustments, edits with frequency limits, claimants 65 or older												
		Claim Lines Submitted	Denied	Applied Deductible		Applied Copay		Applied Coinsurance		Paid @100%		
Edit Guideline	Preventive Service Benefit	#	#	#	Amount	#	Amount	#	Amount	#	Amount	%
ACIP	Immunization Administration - <19	2,174	19	0	$0	0	$0	0	$0	2,155	$82,096	100.00%
ACIP	Immunizations - Influenza <19	459	0	0	$0	0	$0	0	$0	459	$13,168	100.00%
FDA/CDC	Immunizations - Covid19	397	0	0	$0	0	$0	0	$0	397	$17,524	100.00%
ACIP	Immunizations - Rotavirus <19	205	0	0	$0	0	$0	0	$0	205	$31,834	100.00%
ACIP	Immunizations - Human papillomavirus	198	0	0	$0	0	$0	0	$0	198	$75,763	100.00%
ACIP	Immunizations - Hepatitis A <19	193	0	0	$0	0	$0	0	$0	193	$10,730	100.00%
ACIP	Immunizations - Meningococcal <19	147	0	0	$0	0	$0	0	$0	147	$31,732	100.00%
ACIP	Immunizations - Meningococcal >18	117	1	0	$0	0	$0	0	$0	116	$30,384	100.00%
USPSTF-B	Vision screening - 3- 5	110	3	0	$0	0	$0	0	$0	107	$996	100.00%
ACIP	Immunizations - Measles, Mumps, Rubella <19	93	0	0	$0	0	$0	0	$0	93	$39,442	100.00%
ACIP	Immunizations - Hepatitis B <19	91	0	0	$0	0	$0	0	$0	91	$5,119	100.00%
ACIP	Immunizations - Varicella <19	69	0	0	$0	0	$0	0	$0	69	$12,752	100.00%
ACIP	Immunizations - Inactivated Poliovirus <19	34	0	0	$0	0	$0	0	$0	34	$1,896	100.00%
ACIP	Immunizations - Hepatitis B >18	26	2	0	$0	0	$0	0	$0	24	$1,834	100.00%
ACIP	Immunizations - Varicella >18	10	0	0	$0	0	$0	0	$0	10	$1,501	100.00%

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 1/1/2022 through 3/31/2022								
Outpatient Hospital Services (facility claims with codes not designated inpatient)								
Primary		**Secondary**			**Primary Description**	**Secondary Description**	**Line**	**Amount CMS**
Code	**Mod**	**Code**	**Mod**	**Mod Use**			**Count**	**Would Deny**
74177	TC	96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	7	$4,662
					Standards of medical / surgical practice			
63081		22551		YES	Remove vert body dcmprn crvl	NECK SPINE FUSE&REMOV BEL C2	1	$3,855
					More extensive procedure			
51702		96361		YES	INSERT TEMP BLADDER CATH	HYDRATE IV INFUSION ADD-ON	1	$3,045
					Misuse of column two code with column one code			
70496	TC	70450	TC	YES	CT ANGIOGRAPHY HEAD	CT HEAD/BRAIN W/O DYE	5	$2,352
					Misuse of column two code with column one code			
51702		96366		YES	INSERT TEMP BLADDER CATH	THER/PROPH/DIAG IV INF ADDON	1	$2,290
					Misuse of column two code with column one code			
96372		99218		YES	THER/PROPH/DIAG INJ SC/IM	INITIAL OBSERVATION CARE	2	$2,257
					Standards of medical / surgical practice			
96374		96372		YES	THER/PROPH/DIAG INJ IV PUSH	THER/PROPH/DIAG INJ SC/IM	7	$1,943
					CPT Manual or CMS manual coding instructions			
81450		88374		YES	Targeted genomic sequence analysis panel, hema	Morphometric analysis, in situ hybridizatic	1	$1,828
					Misuse of column two code with column one code			
93653		99157		YES	Ep & ablate supravent arrhyt	MOD SED OTHER PHYS/QHP EACH ADDL 15 M	1	$1,757
					HCPCS/CPT procedure code definition			
92526	GN	97110	GP	YES	ORAL FUNCTION THERAPY	THERAPEUTIC EXERCISES	7	$1,756
					Misuse of column two code with column one code			
						Top 10 TOTAL	**33**	**$25,743**
						GRAND TOTAL	**347**	**$63,951**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)								
Primary		**Secondary**			**Primary Description**	**Secondary Description**	**Line**	**Amount CMS**
Code	**Mod**	**Code**	**Mod**	**Mod Use**			**Count**	**Would Deny**
63052		61783		YES		SCAN PROC SPINAL	1	$495
					Misuse of column two code with column one code			
90471		99204		YES	IMMUNIZATION ADMIN	Office/outpatient visit for E&M of new patie	1	$351
					CPT Manual or CMS manual coding instructions			
63047		69990		NO	Remove spine lamina 1 lmbr	MICROSURGERY ADD-ON	1	$342
					Misuse of column two code with column one code			
29824		29822		YES	SHOULDER ARTHROSCOPY/SURGERY	debridement, limited, 1 or 2 discrete structu	1	$281
					More extensive procedure			
90471		99396		YES	IMMUNIZATION ADMIN	PREV VISIT EST AGE 40-64	2	$270
					CPT Manual or CMS manual coding instructions			
00752	AA	95955	59,26	NO	ANESTH REPAIR OF HERNIA	EEG DURING SURGERY	1	$215
					Standard preparation / monitoring services for anesthesia			
00790	AA,P3	95955	59,26	NO	ANESTH SURG UPPER ABDOMEN	EEG DURING SURGERY	1	$215
					Standard preparation / monitoring services for anesthesia			
90471		99384		YES	IMMUNIZATION ADMIN	PREV VISIT NEW AGE 12-17	2	$211
					CPT Manual or CMS manual coding instructions			
90460		99392		YES	IM ADMIN 1ST/ONLY COMPONENT	PREV VISIT EST AGE 1-4	2	$210
					CPT Manual or CMS manual coding instructions			
90471		99385		YES	IMMUNIZATION ADMIN	PREV VISIT NEW AGE 18-39	2	$204
					CPT Manual or CMS manual coding instructions			
						Top 10 TOTAL	**14**	**$2,795**
						GRAND TOTAL	**82**	**$5,787**

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
- Ancillary

NCCI MUE Edits				
PEBP - HealthSCOPE				
Based on Paid Dates 1/1/2022 through 3/31/2022				
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**
93580	1	TRANSCATH CLOSURE OF ASD	1	$21,063
		Rationale: Anatomic Consideration		
A9588	10	FLUCICLOVINE F-18	1	$11,922
		Rationale: Prescribing Information		
88342	4	IMMUNOHISTOCHEMISTRY	3	$8,385
		Rationale: Clinical: Data		
C1889	2	IMPLANT/INSERT DEVICE, NOC	1	$8,299
		Rationale: Clinical: CMS Workgroup		
36215	2	PLACE CATHETER IN ARTERY	1	$7,219
		Rationale: Clinical: Data		
75705	20	ARTERY X-RAYS SPINE	1	$5,950
		Rationale: Clinical: Data		
99218	1	INITIAL OBSERVATION CARE	11	$5,712
		Rationale: Code Descriptor / CPT Instruction		
36245	3	INS CATH ABD/L-EXT ART 1ST	1	$3,944
		Rationale: Clinical: Data		
36226	1	Place cath vertebral art	1	$2,872
		Rationale: CMS Policy		
97799	1	PHYSICAL MEDICINE PROCEDURE	4	$2,774
		Rationale: Clinical: CMS Workgroup		
		Top 10 TOTAL	**25**	**$78,141**
		GRAND TOTAL	**142**	**$118,293**

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**
15879	1	Suction lipectomy lwr extrem	2	$18,750
		Rationale: CMS Policy		
19350	1	BREAST RECONSTRUCTION	1	$16,980
		Rationale: CMS Policy		
J9355	105	INJ TRASTUZUMAB EXCL BIOSIMI	1	$14,096
		Rationale: CMS Policy		
19380	1	Revision of reconstructed breast(eg,significant removal o	1	$7,778
		Rationale: CMS Policy		
77295	1	SET RADIATION THERAPY FIELD	1	$7,572
		Rationale: Nature of Service/Procedure		
97155	24	ADAPT BHV TX PRTCL MODIFICAJ PHYS/QHP EA 15 MIN	7	$4,567
		Rationale: Clinical: Society Comment		
J0475	8	BACLOFEN 10 MG INJECTION	2	$2,467
		Rationale: Prescribing Information		
88307	8	TISSUE EXAM BY PATHOLOGIST	2	$2,449
		Rationale: Clinical: Data		
95165	30	ANTIGEN THERAPY SERVICES	2	$2,419
		Rationale: Clinical: Data		
88374	5	Morphometric analysis, in situ hybridization (quantitativ	4	$1,812
		Rationale: Clinical: Data		
		Top 10 TOTAL	**23**	**$78,890**
		GRAND TOTAL	**127**	**$97,992**

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	1	$3,600
		Rationale: Nature of Equipment		
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	11	$875
		Rationale: Nature of Equipment		
V2520	2	CONTACT LENS HYDROPHILIC	8	$865
		Rationale: Anatomic Consideration		
E0630	1	PATIENT LIFT HYDRAULIC	4	$684
		Rationale: Nature of Equipment		
K0001	1	STANDARD WHEELCHAIR	6	$672
		Rationale: Nature of Equipment		
A7520	1	TRACH/LARYN TUBE NON-CUFFED	4	$475
		Rationale: Published Contractor Policy		
V2521	2	CNTCT LENS HYDROPHILIC TORIC	4	$440
		Rationale: Anatomic Consideration		
E0651	1	PNEUM COMPRESSOR SEGMENTAL	3	$411
		Rationale: Nature of Equipment		
E0443	1	PORTABLE 02 CONTENTS, GAS	8	$255
		Rationale: Code Descriptor / CPT Instruction		
E0260	1	HOSP BED SEMI-ELECTR W/ MATT	1	$239
		Rationale: Nature of Equipment		
		Top 10 TOTAL	**50**	**$8,516**
		GRAND TOTAL	**73**	**$9,809**

Medically Unlikely Edit Detail Report					
QID	**Error Description**	**Over Paid**	**HealthScope Response**	**CTI Conclusion**	**Manual or System**
1	Ancillary	$3,600.00	Agree. The edit was overridden by an analyst in error.	Procedural deficiency and underpayment remain as agreed.	☒ M ☐ S

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:

- Simple – One day
- Minor – Ten days
- 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 1/1/2022 - 3/31/2022									
	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
742851819	0	$0	1	100.0%	$26	0	$0	1	$196
680405220	64	$23,477	1	1.5%	$429	0	$0	1	$155
273905550	0	$0	2	100.0%	$3,414	0	$0	1	$151
263632448	34	$12,239	8	19.0%	$3,176	7	$1,334	1	$148
364105559	8	$1,662	2	20.0%	$719	1	$69	2	$138
880103557	336	$223,742	58	14.7%	$11,193	55	$6,534	1	$127
270028866	200	$86,259	25	11.1%	$2,994	24	$2,064	1	$106
880115812	4	$5,990	10	71.4%	$4,179	8	$767	1	$103
880133501	308	$123,207	21	6.4%	$4,202	21	$2,734	1	$102
853177121	0	$0	1	100.0%	$1,775	0	$0	1	$95
Top 10	**954**	**$476,577**	**129**	**11.9%**	**$32,107**	**116**	**$13,503**	**11**	**$1,320**
Overall Total	**4,650**	**$1,463,711**	**409**	**8.1%**	**$83,403**	**382**	**$43,872**	**12**	**$1,362**

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.

27 Corporate Hill Drive
Little Rock, AR 72205

June 13, 2022

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

Dear Ms. Nisius,

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.

HealthSCOPE Benefits has reviewed Audit Number 1.FY22.Q3 draft report and would like to add the response to the conclusions within the audit report.

PERFORMANCE GUARANTEES:

HealthSCOPE Benefits has provided the information to CTI regarding the FY.22.Q3 reporting requirements.

TARGETED SAMPLE ANALYSIS:

Fraud, Waste, and Abuse Detail Report:

QID 35 – HSB does not agree with CTI conclusion. The claim was considered according to the plan benefits.

QID 36 - HSB does not agree with CTI conclusion. The claim was considered according to the plan benefits.

Duplicate Payment Detail Report:

QID 30- HSB does agree with CTI conclusion. The duplicate edit was overridden by the analyst in error.

Timely Filing Detail Report:

QID 12 – HSB does not agree with CTI conclusion. The original claim was received within the timely filing limits and denied for Medicare EOB and itemized bill. Once the additional information was received the claim was reconsidered. No overpayment on file.

QID 13 – HSB does not agree with CTI conclusion. The original claim was received within the timely filing limits and considered under the plan. The provider submitted a corrected claim on 10/23/21 and denied for itemized bill due to the additional charges received. Once the requested information was received the claim was reconsidered with the corrected charges. No overpayment on file.

Durable Medical Precertification Detail Report:

QID 38 – HSB does not agree with CTI conclusion regarding the precertification on file. Authorization on file # 6127890 for services rendered.

RANDOM SAMPLE AUDIT:

Financial Accuracy Detail Report:

Audit No. 1127 – HSB does agree with CTI conclusion. The claim should not have assessed a $123.72 coinsurance. There would be a $123.72 underpayment.

Accurate Processing Detail Report:

Audit No. 1127 – HSB does agree with CTI conclusion. The claim should not have assessed a $123.72 coinsurance. There would be a $123.72 underpayment.

Observation:

Audit Number 1055 – The claim was investigated based on ICD 10 T86.19 as listed on the possible subrogation list in our policy and procedures.

PPACA Preventive Services Coverage Compliance Detail Report:

QID 7 – HSB does agree with CTI conclusion. The claim should have paid as preventive.

QID 8 – QID 8 is the same claim and same member as identified in QID 7 listed above.

Medically Unlikely Edit Detail Report:

QID 1 - HSB does agree with CTI Conclusion. The analyst overrode the edit for the units billed on this claim.

Thank you,

Jennifer Spencer, Associate Director of Quality Assurance
HealthSCOPE Benefits, Inc

CLAIM TECHNOLOGIES INCORPORATED

100 Court Avenue – Suite 306 • Des Moines, IA 50309

(515) 244-7322 • claimtechnologies.com