Claims and System Audit Report

for

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

Audit Period: PEBP Plan Year 2020, Quarter One
July, August and September 2019

Audited Vendor:

HealthSCOPE BENEFITS

Healthy People
Healthy Business
Healthy Futures

Submitted By:
Health Claim Auditors, Inc.
October 2019

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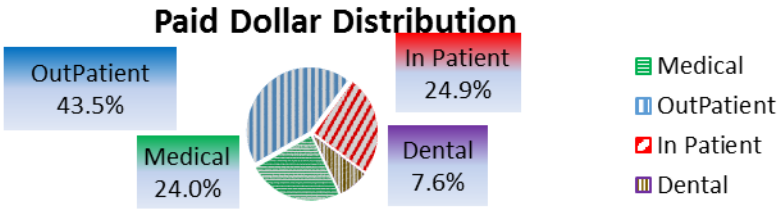
EXECUTIVE SUMMARY

Audited Random Selection Data

Total number of claims: 500
Total Charge Value of random selection: $1,033,860.82
Total Paid Value of random selection: $ 259,647.98



Performance Guaranteed Metric Results

Metric	Guarantee Measurement	Actual	Pass/Fail
Payment Accuracy	≥ 98% of claims audited are to be paid accurately	99.4%	Pass
Financial Accuracy	≥ 99% of the dollars paid for the audited claims is to be paid accurately	99.65%	Pass
Claim Processing Turnaround Time	- 99% of all claims are to be processed within 30 days.	99.59%	Pass
Customer Service	-Telephone Response Time: ≤ 30 seconds. -Telephone Abandonment Rate: ≤ 2%. -First Call Resolution: ≥ 95%	20 sec. 1.66% 95.03%	Pass Pass Pass
Data Reporting	-100% of standard reports w/in 10 bus. days -Annual/Regulatory Documents w/in 10 business days of Plan Year end	No Exceptions Noted	Pass
Disclosure of Subcontractors	-Report access of PEBP data within 30 c. days -Removal of PEBP member PHI within 3 business days after knowledge	No Exceptions Noted	Pass

The following notations within the Executive Summary section are reported as follow up to previous findings and/or issues considered as an "outlier" of findings typically detected within the PEBP quarterly audits which require attention and/or acknowledgement for possible action(s).

Previous Recommendation(s)

HCA is pleased to report that all previous recommendations accepted by the PEBP Board of Directors has been implemented and/or in the process of application.

Current/Updated Issue Findings

1) **Repricing by Hometown Health**

Previous audits have detected a trend in which the allowable rates repriced by Hometown Health and provided to HealthSCOPE for adjudication of Preferred Provider Organization (PPO) network claims are incorrect. Claims within this audit reflect as adjusted and/or audited as bias errors (not charged to HealthSCOPE performance statistics) due to incorrect repriced rate(s) provided during the original adjudication(s).

The audit for this period identified 2,868 claims incorrectly repriced as "NON PPO" for submissions by PPO providers due to a change HTH made to improve the system logic causing HSB to apply Usual & Customary (U&C) rates versus the network negotiated rates and the addition of incorrect member deductibles and copayment(s). The errors within this issue were identified in September 2019 and repriced by HTH in October 2019. HealthSCOPE has confirmed that all the claims affected by this issue were adjusted and repaid with a completion date of 04 November 2019.

2) An issue detected within this audit concerns a HealthSCOPE system issue regarding routine colonoscopies. PEBP changed the frequency to obtain these to reflect what ages and how often these can be done. The HSB system was changed to accommodate this but it has caused an issue where only one claim (facility or surgeon, whichever comes in first) to be paid as routine with the other paid as illness. HSB was made aware of this and has opened a ticket for plan building to correct as well as having a report run to identify all potential claims that this has affected.

Trends/Issues

The audit revealed the following issues or trends detected from the random selection and bias selected claims. Please note: the reference numbers in **bold type** are claims from the random selection and are included within the statistical calculations. Reference numbers in normal type were identified as issues in bias claims as defined earlier and are not included within the statistical calculations of this audit. Specific information regarding supporting reference numbers can be found in the Audit Results Section in numerical sequence, which begins on page 26.

Incorrect rate due to network re-pricing;
Supporting reference nos. 012, 091, 102, 163 and 458

Provider repriced as non-par by network in error;
Supporting reference nos. 001, 308, 479 and 480

Routine colonoscopy charge paid as medical;
Supporting reference nos. 248, 272, 364 and 448

Claim not reprocessed after requested information received;
Supporting reference nos. 237 and 246

Corrected claim denied as duplicate in error;
Supporting reference nos. 358 and 488

Claim denied in error; Supporting reference nos.417 and 492

Incorrect allowable used for assistant surgeon;
Supporting reference no. **014**

Add on CPT code bundled in error;
Supporting reference no. 091

Duplicate paid; Supporting reference no. 149

Preventive claim paid as medical; Supporting reference no. 340

Incorrect network used; Supporting reference no. **395**

Paid under incorrect patient; Supporting reference no. 431

Discount not applied; Supporting reference no. **480**

CLAIM PROCEDURES/SYSTEM CAPABILITIES/SUPPORT DATA

Introduction

In October 2019, Health Claim Auditors, Inc. (HCA) performed a Claims and System Audit of HealthSCOPE Benefits (HealthSCOPE) located in Little Rock, Arkansas on behalf of The State of Nevada Public Employees' Benefits Program (PEBP).

This audit was performed by collecting information to assure that HealthSCOPE is doing an effective job of controlling claim costs while paying claims accurately within a reasonable period of time. This report was presented to HealthSCOPE for any additional comments and responses on 24 October 2019.

Breakdown of Claims Audited

The individual claims audited were randomly selected from PEBP's claims listings as supplied by HealthSCOPE. These claims had dates of service ranging from March 2018 to September 2019 and were processed by HealthSCOPE from 01 July 2019 through 30 September 2019 (PEBP's First Quarter Plan Year 2020). These claims were stratified by dollar volume to assure that HCA audited all types of claims. The audit also includes large dollar paid amounts that are considered as bias* selected claims.

*Bias claims are not part of the random selection but were audited by HCA because of some "out of the ordinary" characteristic of the claim. There are multiple criteria to identify the "out of the ordinary" characteristics. Examples are duplicates, CPT up coding, exceeding benefit limits, etc.

The breakdown of the 500 random selected claims audited is as follows:

Type of Service	Charge Amount	Paid Amount	Paid Distribution	No. of Claims
Medical	$ 205,199.04	$ 62,168.49	24.0%	337
Outpt. Hospital	$ 490,153.20	$ 113,178.78	43.5%	55
Inpt. Hospital	$ 279,489.58	$ 64,598.16	24.9%	5
Dental	$ 59,019.00	$ 19,702.55	7.6%	103
TOTAL	**$1,033,860.82**	**$ 259,647.98**	**100%**	**500**

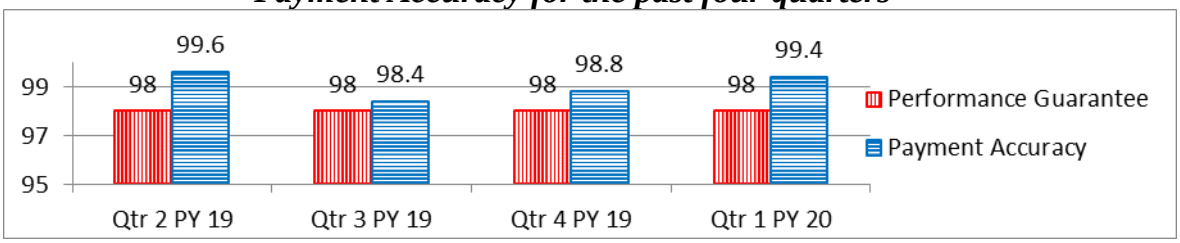
Payment Accuracy

Per PEBP, the Service Performance Standards and Financial Guarantees Agreement for the payment accuracy is to be 98% or above of claims adjudicated are to be paid correctly or a penalty of 2.5% of Quarterly Administration Fees for each percentage (%) point, or fraction thereof, below performance guarantee is to be applied. Payment Accuracy is calculated by dividing the total number of claims not containing payment errors in the audit period by the number of claims audited within the random selection.

The Payment Accuracy Percentage of the number of claims paid correctly from the HealthSCOPE random selection for this audited quarter is 99.4%.

Number of claims:	500
Number of claims paid incorrectly:	3
Percentage of claims paid incorrectly:	0.6%
Number of claims paid correctly:	497
Percentage of claims paid correctly:	99.4%

Payment Accuracy for the past four quarters



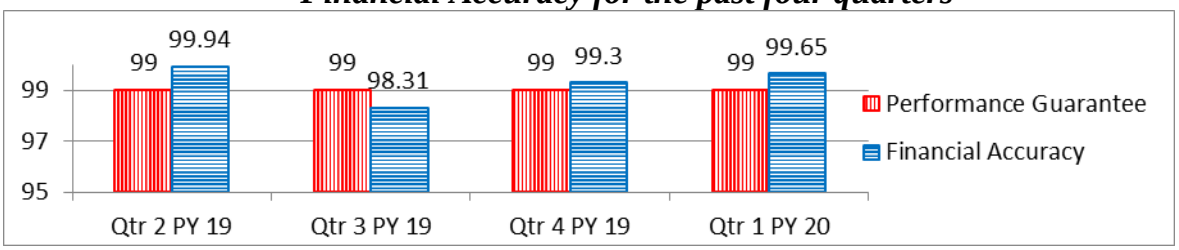
Financial Accuracy

Per PEBP, the Service Performance Standards and Financial Guarantees Agreement for the financial accuracy of the total dollars paid for claims adjudicated is to be paid correctly at 99% or above or a penalty of 2.5% of Quarterly Administration Fees for each percentage (%) point, or fraction thereof, below performance guarantee is to be applied. Financial Accuracy is calculated by dividing the total audited dollars paid correctly by the total audited dollars processed within the random selection.

The Financial Accuracy Percentage of paid dollars remitted correctly on the HealthSCOPE claims selected randomly for this audited quarter is 99.65%. This audit reflected eighty-six and seven tenths percent (86.7%) of the audited errors within the valid random selection were overpayments.

Paid dollars audited	$ 259,647.98
Amount of paid dollars remitted incorrectly	$ 921.38
Percentage of Dollars paid incorrectly	0.35%
Paid Dollars of claims paid correctly	$ 258,726.60
Percentage of Dollars Paid correctly	99.65%

Financial Accuracy for the past four quarters



Historical Statistical Data of Performance Guarantees

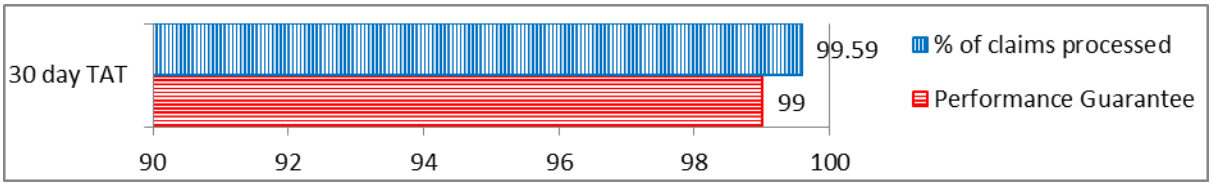
The following reflects the historical statistical data since the origin of PEBP medical claims administration by HealthSCOPE. The entries designated in **bold red type** are measurable categories with underperformance of the Service Performance Guarantees Agreement.

Period Audited	Payment Accuracy	Financial Accuracy	Turnaround Time	Telephone Response	Telephone Abandon Rate	First Call Resolution
1st Qtr PY 2012	95.7%	98.6%	7.6 days	:17	1.43%	N/A
2nd Qtr PY 2012	**93.3%**	**97.3%**	12.7 days	:12	1.16%	N/A
3rd Qtr PY 2012	**96.8%**	**98.6%**	3.7 days	:18	1.32%	N/A
4th Qtr PY 2012	**95.8%**	99.5%	11.4 days	:14	0.93%	N/A
1st Qtr PY 2013	97.2%	99.4%	10.4 days	:20	1.06%	N/A
2nd Qtr PY 2013	98.5%	99.3%	7.3 days	:11	0.87%	N/A
3rd Qtr PY 2013	98.0%	**95.7%**	6.4 days	:25	1.98%	N/A
4th Qtr PY 2013	98.4%	99.7%	6.2 days	:29	1.61%	N/A
1st Qtr PY 2014	98.8%	99.6%	5.4 days	:14	0.84%	N/A
2nd Qtr PY 2014	99.2%	99.2%	5.9 days	:29	1.96%	N/A
3rd Qtr PY 2014	98.0%	**98.5%**	5.2 days	**:30.5**	1.92%	N/A
4th Qtr PY 2014	99.0%	99.8%	4.4 days	:28	1.96%	N/A
1st Qtr PY 2015	98.8%	99.27%	4.9 days	:29.4	1.94%	N/A
2nd Qtr PY 2015	99.0%	99.35%	8.1 days	:22	1.18%	N/A
3rd Qtr PY 2015	98.6%	99.8%	5.9 days	:29.7	1.97%	N/A
4th Qtr PY 2015	99.6%	**95.6%**	4.9 days	:29.4	1.91%	N/A
1st Qtr PY 2016	99.0%	**98.9%**	4.8 days	:29.1	1.94%	N/A
2nd Qtr PY 2016	98.6%	99.7%	3.5 days	:24.0	1.14%	N/A
3rd Qtr PY 2016	98.8%	**98.53%**	5.3 days	:29.0	1.96%	N/A
4th Qtr PY 2016	99.0%	99.52%	6.3 days	:29.5	1.98%	N/A
1st Qtr PY 2017	99.0%	99.23%	6.6 days	:29.8	1.93%	N/A
2nd Qtr PY 2017	99.6%	99.78%	4.3 days	:29.3	1.96%	N/A
3rd Qtr PY 2017	98.2%	**93.83%**	3.7 days	:29.8	1.97%	N/A
4th Qtr PY 2017	99.0%	99.66%	4.6 days	:29.3	1.98%	N/A
1st Qtr PY 2018	99.2%	99.83%	4.4 days	:26.0	1.61%	98.79%
2nd Qtr PY 2018	99.6%	99.9%	4.3 days	:12.8	1.12%	98.28%
3rd Qtr PY 2018	98.6%	99.7%	3.5 days	:28.5	1.97%	98.65%
4th Qtr PY 2018	99.4%	99.5%	4.2 days	:21.0	1.50%	97.65%
1st Qtr PY 2019	98.8%	**98.2%**	5.4 days	:21.0	1.49%	97.85%
2nd Qtr PY 2019	99.6%	99.9%	5.6 days	:21.0	1.40%	97.18%
3rd Qtr PY 2019	98.4%	**98.31%**	5.8 days	:14.0	1.21%	95.89%
4th Qtr PY 2019	98.8%	99.30%	6.7 days	:14.0	1.09%	96.38%
1st Qtr PY 2020	**99.4%**	**99.65%**	**7.1 days**	**:20.0**	**1.66%**	**95.03%**

Turnaround Time

Per the Service Performance Standards and Financial Guarantees Agreement, the turnaround time for payments of claims is measured in calendar days from the date HealthSCOPE receives the claim until the date of process. Ninety nine percent (99%) of complete claims adjudicated are to be processed within thirty (30) calendar days, excluding federal holidays, or a penalty of two percent (2.0%) of Quarterly Administration fees for each two and a half percent (2.5%) of non-compliance complete claims is to be applied. HCA had requested the report that reflects the measurement of this issue. This report reflected that 99.59% of "complete" claims were processed within 30 calendar days, in compliance with the performance guarantee. This report also displayed the total turnaround process time for all claims at 7.1 days.

Turnaround Time Measurements



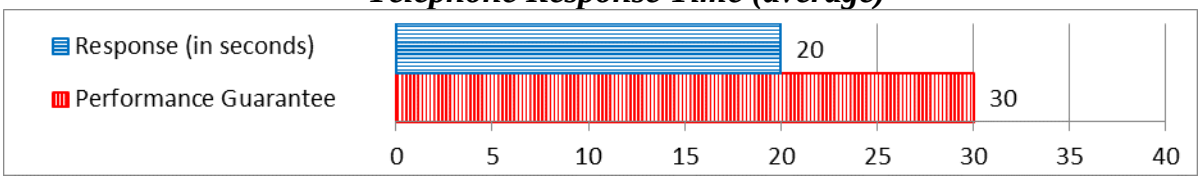
The turnaround time, measured only from the random selected claims, for Medical claims 16.7 calendar days, Out Patient Hospital claims was 19.9 calendar days, In Patient Hospital claims was 21.8 calendar days and Dental claims was 3.4 calendar days.

During the audit period of 01 July 2019 to 30 September 2019, HealthSCOPE had received 1,411 PEBP e-mail inquiries for information via the internet. The average turnaround time for these inquiries was calculated at approximately 7.0 hours.

Customer Service Satisfaction

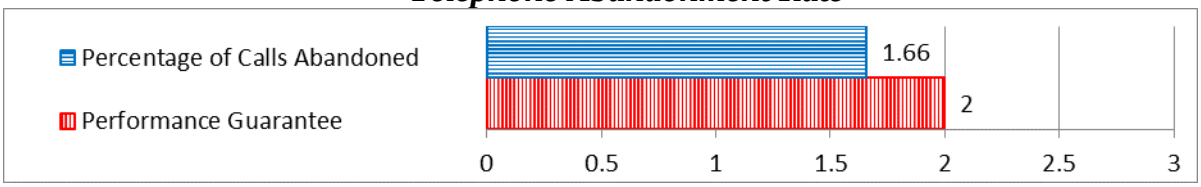
Per the Service Performance Standards and Financial Guarantees Agreement, the telephone response time reflects all calls must be answered within thirty (30) seconds or a penalty of one percent (1%) of Quarterly Administration fees for each second in non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP first fiscal quarter Plan Year 2020, which revealed the average incoming answer speed to be 20.0 seconds (0:20.0). The telephone response time was 19 seconds for July 2019, 20 seconds for August 2019 and 20 seconds for September 2019.

Telephone Response Time (average)



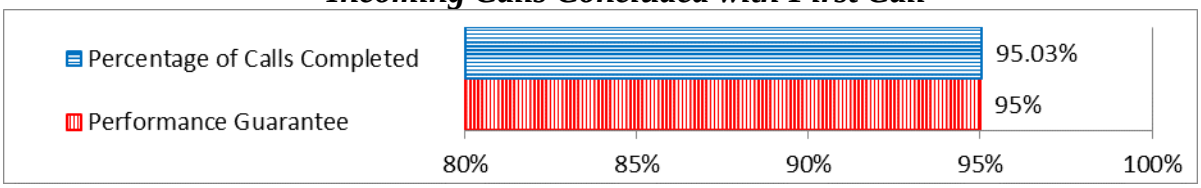
Per the Service Performance Standards and Financial Guarantees Agreement, the abandonment rate must be under two percent (2%) of total calls or a penalty of one percent (1%) of Quarterly Administration fees for each percentage point or fraction thereof in non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP first fiscal quarter Plan Year 2020, which revealed the abandoned calls ratio to be 1.66%. The telephone abandonment rate was 1.73% for July 2019, 1.49% for August 2019 and 1.75% for September 2019.

Telephone Abandonment Rate



Per the Service Performance Standards and Financial Guarantees Agreement, ninety five percent (95%) of incoming PEBP member problems must be resolved to conclusion on the first call or a penalty of one percent (1%) of Quarterly Administration fees for non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP fourth fiscal quarter Plan Year 2020, which revealed that HealthSCOPE documented 95.03% of incoming calls were brought to completion on the first call.

Incoming Calls Concluded with First Call



HealthSCOPE has eighty plus (80+) Customer Service Reps (CSRs), of which, the majority are in the Little Rock office with an average of eight (8) years experience.

Health SCOPE currently has eighteen (18) CSRs dedicated to the PEBP plan.

HealthSCOPE stated that customer service hours of operation will be applied to PEBP direction for proper service levels.

Benefit data is supplied by electronic documentation so that the analyst may explain benefit information to clients, members and providers by HealthSCOPE.

HealthSCOPE stated that the customer service representatives will not have the ability to make system changes.

HealthSCOPE's telephone conversations are documented for future reference.

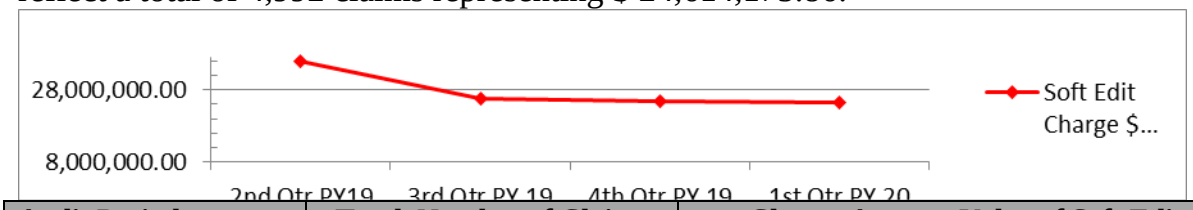
HealthSCOPE does have an audit process for Customer Service Representatives.

HealthSCOPE is able to monitor trends/errors found through Customer Service.

HealthSCOPE can conduct customer service satisfaction surveys to determine employee satisfaction of claims administration and service upon client request.

Soft Denied Claims

The audit identifies the volume of claims adjudicated and placed in a "soft denied" status. HCA recognizes and respects the need to place certain claims in a soft denied status such as claims that require additional information or special calculation of payment. It is important to include this data within this report to disclose the outstanding unpaid claims that could create an artificial debit/savings during the time that these claims were adjudicated. Note: The measurement of this data was provided as a "snapshot" report. The report reflected the "soft edit" amounts as they were reported on the specific day that the report was recorded. The report for the current claims placed in a "soft denied" status reflect a total of 4,992 claims representing $ 24,614,175.86.



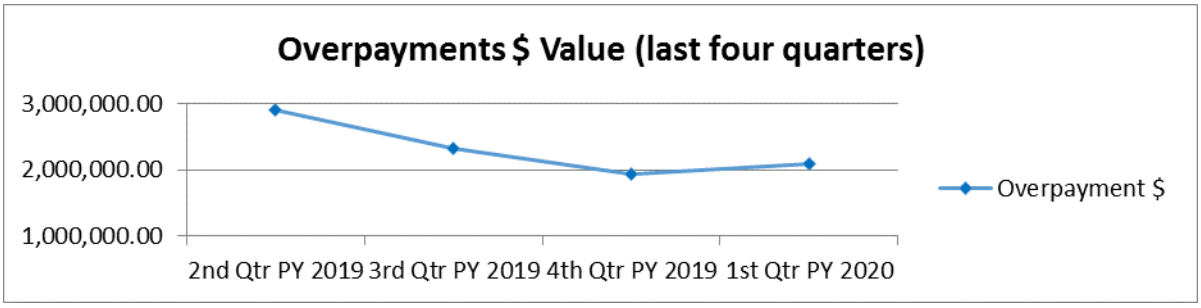
Audit Period	Total Number of Claims	Charge Amount Value of Soft Edits
1st Qtr PY 2012	2,607	$ 7,544,177.55
2nd Qtr PY 2012	4,068	$10,697,954.53
3rd Qtr PY 2012	1,536	$ 6,472,249.56
4th Qtr PY 2012	559	$ 2,205,318.16
1st Qtr PY 2013	1,053	$ 3,413,738.12
2nd Qtr PY 2013	1,107	$ 5,019,961.70
3rd Qtr PY 2013	1,023	$ 4,179,542.34
4th Qtr PY 2013	1,094	$ 3,049,481.74
1st Qtr PY 2014	1,389	$ 3,853,629.07
2nd Qtr PY 2014	1,157	$ 2,510,539.33
3rd Qtr PY 2014	1,621	$ 7,873,432.21
4th Qtr PY 2014	1.487	$ 4,665,197.77
1st Qtr PY 2015	1,404	$ 5,901,903.17
2nd Qtr PY 2015	1,668	$ 6,930,288.41
3rd Qtr PY 2015	2,897	$10,800,874.08
4th Qtr PY 2015	2,498	$10,685,255.24
1st Qtr PY 2016	3,071	$13,027,717.82
2nd Qtr PY 2016	2,543	$13,547,682.34
3rd Qtr PY 2016	2,871	$10,360,017.78
4th Qtr PY 2016	3,107	$15,262,995.27
1st Qtr PY 2017	2,580	$ 8,558,641.28
2nd Qtr PY 2017	3,876	$15,960,661.94
3rd Qtr PY 2017	3,696	$18,864,824.74
4th Qtr PY 2017	4,768	$20,217,736.28
1st Qtr PY 2018	3,926	$15,683,180.63
2nd Qtr PY 2018	4,073	$20,576,701.38
3rd Qtr PY 2018	4,144	$17,375,843.66
4th Qtr PY 2018	4,544	$21,591,987.11
1st Qtr PY 2019	4,624	$24,992,938.88
2nd Qtr PY 2019	5,558	$36,168,714.98
3rd Qtr PY 2019	5,476	$25,662,843.33
4th Qtr PY 2019	5,248	$24,848,496.79
1st Qtr PY 2020	**4,992**	**$24,614,175.86**

Overpayments

HCA requested an overpayment report that reflects the identified current outstanding overpayments incurred since the beginning of the contract period with HealthSCOPE. This report reflected a current total potential recovery value of $1,940,930.88 (an increase of $152,555.74). Detailed information regarding outstanding overpayments can be reviewed in a separate Supplemental Report, which for confidentiality purposes, is not included in this report but is made available to PEBP staff should they request it.

HSB's policy is to keep all identified overpayments active for potential recoupment(s The breakout of overpayments identified by the year paid are as follows:

Period	Due/Potential Recovery
- Fiscal Year 2012	$ 108,925.13
- Fiscal Year 2013	$ 147,942.33
- Fiscal Year 2014	$ 63,408.28
- Fiscal Year 2015	$ 171,529.51
- Fiscal Year 2016	$ 194,078.02
- Fiscal Year 2017	$ 119,586.14
- Fiscal Year 2018	$ 384,589.26
- Fiscal Year 2019	$ 298,158.36
- Fiscal Year 2020 (to date)	$ 605,269.59
TOTAL	$2,093,486.62



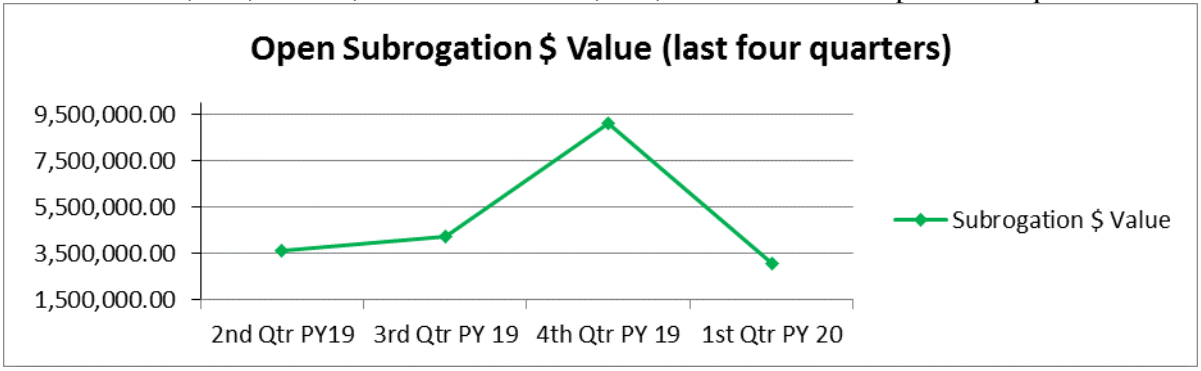
Of the 1,113 most current (4th Qtr Plan Year 2019 + 1st Qtr Plan Year 2020) identified outstanding overpayments (HSB only), 51% were found to be caused by external sources that are not a cause of the HealthSCOPE adjudication processes. Breakout of the HealthSCOPE's most current overpayments (by claim count) are listed by reason as follows:

20.27%	No COB on file
16.31%	Incorrect Benefit Applied
13.78%	Corrected HTH Network Pricing
10.27%	SHO Pricing Correction
10.00%	COB incorrectly calculated or not applied
9.28%	Provider caused, rebilled, charges billed in error, corrected EOB
6.31%	Retro termination
5.14%	Incorrect Rate Applied
1.98%	Duplicate
0.90%	Paid in excess of max limit
0.90%	Service not covered
0.63%	Previous Information Received
0.63%	Paid NON PPO as PPO
0.54%	Adjusted after medical review
0.54%	Processed under the incorrect provider
0.36%	Incorrect assignment applied
0.36%	Processed under incorrect patient
0.27%	Stop Payment
0.27%	Eligibility
0.18%	Category error
0.18%	Pre-Certification
0.18%	Benefit Clarification
0.18%	Denied in Error
0.09%	Asst Surgeon paid as Surgeon
0.09%	Subrogation error
0.09%	Entry Error
0.09%	Paid PPO provider as NON PPO
0.09%	Multiple Surgery Reduction not applied
0.09%	Stale Dated Check

Subrogation

HCA requested a subrogation report that can be reviewed in a separate Supplemental Report, which for confidentiality purposes is not included in this report. It is made available to PEBP staff should they request it.

This report reflects open subrogation claims representing a current potential recovery amount of $3,049,326.35; a decrease of $6,032,953.09 from the previous quarter.



Reports received from HealthSCOPE reflect that subrogation recoveries for the audited period was $216,634.45. After contingency fees were paid, PEBP received $162,475.85.

HealthSCOPE system will apply a pursue and pay subrogation policy as directed by PEBP. Per HealthSCOPE, subrogation is determined and pursued on all claims where the total amount paid equals to or exceeds $1000 (one thousand).

HealthSCOPE does identify possible subrogation cases internally. HealthSCOPE utilizes a third party vendor for recovery of monies. Vendors are paid a contingency of which the administrator receives a portion of and disclosed within RFP 1983 for Third Party Claims Administration.

HealthSCOPE does not conduct auditing of outstanding subrogation cases sent to their vendors, but sends any cases not picked up by the main vendor to another vendor for review.

HealthSCOPE depends on the external vendors to conduct the appropriate International Classification of Diseases (ICD) sweep checks for subrogation detections. HealthSCOPE is currently utilizing the new ICD-10 conversions and the coding has been completed within their system.

Per HealthSCOPE, claims related to Worker's Compensation are denied.

Recoupment and payments for subrogation claims are assigned as directed by PEBP.

High Dollar Claimants

Per the request of PEBP staff, HCA has requested a report to identify the number of active, retiree or COBRA elected participants or dependents who have obtained a plan paid level of $750,000.00 or greater.

This report reflected thirty-nine (39) active members and twenty-nine (29) dependents for a total of 68 active participants, who have obtained this level of plan payment participation representing an accrued dollar paid amount of $92,995,906.24.

Personnel

The audit included a review of the HealthSCOPE personnel dedicated or assigned to PEBP. The current Organization Chart for individuals assigned to the PEBP plan, is, with changes, as follows:

- State of Nevada Manager;
- Vice President – Quality Assurance;
- Sr. Vice President Operations Customer Care;
- Executive Account Manager;
- Client Relations Manager;
- Financial Operations Director;
- Provider Maintenance Specialist;
- Financial Analysts, 3 individuals;
- Funding Supervisor;
- Claims Administration Manager;
- Claims Administration Supervisor;
- Claims Analysts, 15 individuals;
- Eligibility Director;
- Eligibility Supervisor;
- Customer Service Vice President;
- Customer Service Director;
- Customer Service Representatives, **CHANGE**, 3 individuals added and 3 removed for a total of 18 individuals;
- Scanning Services Manager;
- Recoveries Manager;
- Recoveries Specialists, 2 individuals;
- Vice President Data Services;
- Senior Data Analyst;
- Chief Information Officer;
- Data Architect
- Computer Domain Hosting (CDH) Services Manager;
- Sr. Vice President-Legal and Compliance;
- COBRA Service Manager;
- Customer Care Supervisor;
- Customer Care Representatives, 3 individuals.

HealthSCOPE POLICY/PROCEDURES/SYSTEM CAPABILITIES

The following section displays HealthSCOPE policies, procedures and system capabilities as they pertain to adjudication of PEBP claims. Due that system edit and functions do not change frequently, the following section appears only in the first quarter audit each Plan Year.

Eligibility

The HealthSCOPE system systematically denies claims for services rendered prior to or after the effective date.

The HealthSCOPE system systematically adjudicates claims pertinent to the date of service for those claims received prior to or after any benefit changes.

The HealthSCOPE system has the capability to load by line of coverage tiers (i.e.: single medical/family dental, etc.).

HealthSCOPE can, if requested, request divorce decrees or court orders for those dependents of divorced or separated parents.

The HealthSCOPE system will enforce IRS regulations if the Plan Document does not require stricter requirements.

Disabled (handicapped) dependent status is determined by PEBP when a covered dependent child has reached the age of 26, which would terminate his/her status as a dependent. HealthSCOPE can determine disabled dependent status with internal medical personnel if required.

HealthSCOPE has stated that they would not ever add a member dependent without PEBP authorization.

HealthSCOPE stated that the turnaround time to add or delete a member's eligibility is within 24 hours of receipt.

If a member is terminated retroactively, HealthSCOPE will review that member's claim history to determine any overpayments for possible recoveries and proceed per PEBP instructions.

Deductibles, Out-of-Pocket and Benefit Maximums

The HealthSCOPE system is capable of separate PPO and Non PPO accumulators.

All deductibles, out-of-pocket expenses and most benefit maximums are tracked by the HealthSCOPE system.

The HealthSCOPE system contains automated carry over deductible features if necessary.

HealthSCOPE system contains integrated deductibles for dental and medical claims.

HealthSCOPE does have experience of applying the Prescription Drug and Medical claims deductibles as reflected within the PEBP SPD.

Unbundling/Rebundling

The HealthSCOPE system can systematically edit to identify laboratory, diagnostic and radiology charges that have been unbundled and billed separately.

The HealthSCOPE system has the electronic capacity to match multiple claims in history for application of the unbundling edit.

The HealthSCOPE system systematically soft edits for multiple surgical guidelines, for those situations where a surgeon is billing for more than one (1) surgical procedure during the same operative session. The HealthSCOPE system has the capacity to match claims in history for application of the multiple procedure reduction edit.

For Network providers and Non-PPO providers where multiple surgical procedures have been performed, the HealthSCOPE system will electronically adjudicate and apply 100% of the Reasonable and Customary (R&C) or the provider specific fee schedule amount for the major procedure, 50% of the R&C or network fee schedule amount for subsequent procedures or any deviation designed by the network contract. This application is conducted manually with HealthSCOPE. The system can calculate the claim by global or individual allowance accounting.

For Network providers and Non-PPO providers where bilateral surgical procedures have been performed, the HealthSCOPE system will not electronically adjudicate to allow 100% of the Reasonable and Customary (R&C) or the provider specific fee schedule amount for the major procedure and 50% of the R&C or network fee schedule amount for the secondary procedure. This application is manually applied.

HealthSCOPE manually breaks this issue into separate line services for adjudication.
The HealthSCOPE system is automated to identify pre/post operative care related to surgical procedures.

The HealthSCOPE system denies incidental procedures when in relation to primary procedures.

The HealthSCOPE system systematically identifies claims that contain a same day procedure (procedures that are not customarily billed on the same day as a surgical procedure) unless billed under the same provider.

HealthSCOPE will allow the doctor to bill the initial obstetrical diagnostic office visit. The subsequent visits are paid and then manually tracked and applied to the global obstetrical fee. Reasonable and Customary (R&C) allowance or network fee schedule amount is applied to the global obstetrical fee. Obstetrical lab and diagnostic procedures are allowed to be billed separately.

Concurrent Care

The HealthSCOPE system is not automated to identify situations where more than one (1) physician is billing for services during the same time period for the same diagnosis. The claims analysts rely on the system's possible duplicate edit to detect this situation.

Code Creeping

The HealthSCOPE system is automated to identify code creeping. An example of this occurs when a physician is consistently billing for an initial or new patient office/hospital visit when services performed are actually rendered for a subsequent or established patient visit.

Procedure, Diagnosis and Place of Service

The HealthSCOPE system is automated to determine the correct usage of the Current Procedural Terminology (CPT) code. The system is automated to edit if the patient's age or gender does not concur with the (CPT) code.

The HealthSCOPE system edits if multiple CPT codes that are billed on the same claim don't belong together.

The HealthSCOPE system is automated to identify if the place of service does not concur with the (CPT) code.

The HealthSCOPE system is also automated to edit if a diagnosis does not concur with the (CPT) code.

The HealthSCOPE system has the capability to edit for routine/medical diagnosis' to determine which benefits are allowable under routine versus medical.

Experimental and Cosmetic Procedures

The HealthSCOPE system is automated to assist processors in identifying those procedures that are or could be cosmetic. Analysts are also trained to identify these claims. These procedures can also be identified during the pre-certification process.

The HealthSCOPE system can be programmed to systematic hold or deny these types of claims, depending upon plan election.

Medical Necessity/Potential Abuse Guidelines and Procedures

The HealthSCOPE system is automated to determine the appropriateness of an assistant surgeon based on the surgery performed. These claims can be pended or denied, depending upon the plan election.

The HealthSCOPE system is automated to determine the appropriateness of an anesthesiologist based on the service performed. These claims can be held or denied, depending upon the plan election.

The HealthSCOPE system is not automated to determine if anesthesia is billed by both the hospital and anesthesiologist under both a revenue code and separate CPT service code.

HealthSCOPE determines medical necessity for the rental or purchase of durable medical equipment (DME) by prescription from a physician or internal Medical Reviewers.

Rental cost of DME is tracked up to the purchase price by HealthSCOPE to assure that PEBP will pay no more for rental than it would if this equipment had been purchased. HealthSCOPE tracks this issue on a manual basis within their system.

HealthSCOPE investigates to determine if a prescription is a federal legend drug. They utilize the Medi-Span database for this procedure.

Claims involving chiropractic care, physical therapy are determined for medical necessity by HealthSCOPE. Therapeutic treatment needs to be rendered by a licensed physical therapist. Treatment must be commonly and customarily recognized as appropriate within the doctor's profession.

Per HealthSCOPE, medical necessity for infusion services are usually determined by Utilization Review but can be determined internally if necessary.

The HealthSCOPE system can comply with authorization, repricing and all requirements as they pertain to adjudication of Mental Health claims.

HealthSCOPE does execute on a regular basis, daily exception reports, which are run for supervisors to review edits that are overridden.

The HealthSCOPE system has the capability to identify repeat tests being done by both primary physicians and specialists.

Patterns of Care and Treatment for Physicians

HealthSCOPE has the capability to conduct evaluations of patterns of care of physicians on patient outcome studies (success) for various procedures and communicate facts to physicians to eliminate unnecessary or ineffective care or disclose potential fraud or trends of fraud.

Mandatory Outpatient/Inpatient Procedures

The HealthSCOPE system is not automated to determine those procedures that do not require hospitalization. Pre-certification is required for an inpatient stay and many surgical procedures, of which, most procedures will be identified at that time.

Duplicate Claim Edits

The HealthSCOPE system is automated to identify duplicate claims. The HealthSCOPE system will "soft" edit a claim under partial match and a "hard" edit under exact match circumstances. The following criteria are matches: Date of Service, CPT including modifier and Provider tax identification number.

In the event of multiple provider submissions, the PEBP member will receive an Explanation of Benefits (EOB) for all claims paid.

Adjusted Claims

In the event that a claim was previously paid and an adjustment is made to the original adjudication, the HealthSCOPE system will assign a "claim identification number" to the adjustment that reflects the original paid claim. HealthSCOPE links the original with the adjusted claim(s) with a notation on subsequent claim screens.

Hospital and Other Discounts

HealthSCOPE can automate all PPO Provider discounts including per diem and Diagnosis Related Group (DRG) arrangements.

HealthSCOPE stated that PPO (Preferred Provider Organization) provider rates which can be obtained can be repriced in-house.

If a network has negotiated a prompt payment discount, the HealthSCOPE system is programmed to apply the discount.

Attempts to negotiate non-PPO provider discounts are conducted by HealthSCOPE's vendors, with contingencies as reported within the response to RFP 1893. PEBP can set this issue at as low as $0 for HealthSCOPE.

HealthSCOPE declared that they do not collect any year end settlements, rebates, etc. other than those declared within their response(s) to RFP 1893.

HealthSCOPE stated that they would review and disclose any provider discount contracts relative to PEBP claims for the absence of any "Hold Harmless" language as an aid in protecting PEBP members.

Hospital Bills (UB-92) and Audits

HealthSCOPE requires itemized hospital bills to determine non-covered items. Itemization for all hospital bills over $100,000.00 is required by HealthSCOPE to determine non-covered items.

The HealthSCOPE system utilizes revenue codes when processing hospital bills.

HealthSCOPE has an internal hospital audit program in place. All non-PPO claims over $50,000.00 are sent for audit. HealthSCOPE also stated that some claims are audited through their external audit process. HealthSCOPE is willing to accept any amount PEBP determines as a minimum for this issue. Contingency fees and administrator percentage shares are disclosed within their responses to RFP 1983.

Filing Limitations

The HealthSCOPE system can systematically apply the appropriate standard filing limitation for submitting all claims. The standard filing limitation for submitting claims for PEBP is twelve (12) months after date of service.

Unprocessed Claims Procedures

Unprocessed claims are logged on the HealthSCOPE system for verification of receipt. HealthSCOPE has paper claims scanned and entered into their adjudication system within twenty four (24) hours of receipt.

HealthSCOPE stated that this process and data entry will be conducted by individuals within the continental United States. HealthSCOPE stated that they do utilize a company that conducts this process outside the United Sates, however, has ensured that PEBP data stays on shore.

Reasonable/Customary and Maximum Allowances

HealthSCOPE is utilizing R&C allowances for non-network providers. HealthSCOPE is utilizing R&C data for medical claims at the seventieth (70^{th}) percentile. Out of Network dental providers are paid using the same allowables as in-network dental providers, subject to the appropriate geographic location rates.

R&C is applied utilizing the date of service and geographical location (zip code). R&C data is updated four times per year by HealthSCOPE, last updated in August 2019.

HealthSCOPE does not have separate R&C schedules for Facilities versus Professional services, however, HealthSCOPE uses a vendor that can apply reductions for Non PPO facilities.

HealthSCOPE will pay medical claims at the appropriate network negotiated rates. Non network providers and non- negotiated services will be paid at the lesser of the MDR rate at the percentile chosen by the PEBP plan or the billed amount. Dental claims will be paid at the lesser of the MDR rate at the percentile chosen by the PEBP plan or the billed amount.

The HealthSCOPE system will pay the lower of charges or scheduled amount when contracts allow.

The HealthSCOPE system utilizes modifiers to determine R&C for professional and technical components for diagnostic, laboratory and radiological procedures.

Assistant surgical charges, when performed by MDs will be systematically calculated at no more than 20% of the R&C amount (or the network fee schedule) allowable for the surgeon's procedure performed.

HealthSCOPE will pay all related charges of an inpatient stay at the network level if a network hospital is utilized if the benefit plan dictates. This will be performed on a manual basis by HealthSCOPE.

HealthSCOPE is utilizing a form of R&C for Non-PPO Durable Medical Equipment (DME) claims when applicable.

In situations where the PEBP member has claims adjudicated under the PEBP Preferred Provider Organization (PPO) Exception Rule (50 mile rule), HealthSCOPE will identify these exceptions at the time of adjudication and pay within the Exception Rule per the PEBP Master Plan Document.

Membership Procedures

HealthSCOPE has the capabilities of electronic enrollment and re-enrollments. HealthSCOPE will add or cancel employee information onto their system within twenty four (24) hours.

Per HealthSCOPE, claims received for newborns can be paid and history tracked under their own name.

The HealthSCOPE system analysts have inquiry capability to view eligibility files only. They do not have the capability to make changes to eligibility information.

If an employee is terminated, the HealthSCOPE system will deny claims as not covered. An explanation of benefits is generated every time a claim is received after this date. HealthSCOPE will check for claims paid after this termination date.

Current historical eligibility information is stored on the HealthSCOPE system indefinitely.

COBRA Administration

COBRA administration is being done by PEBP. If elected, determination for benefits elected by individuals under COBRA administration rules can be done by HealthSCOPE.

The HealthSCOPE system can maintain an eligibility date that coincides with the premium "paid to" COBRA date. If the system detects an exception to the date, it forces human intervention. If the member is found to be terminated from COBRA, the claim is denied. The HealthSCOPE COBRA system is integrated with the claims administration system.

Provider Credentialing

Currently, providers are monitored by the PPO for credentialing. Claims received by providers not in the PPO network are verified as legitimate by HealthSCOPE.

HealthSCOPE will check legitimacy of the provider through the internet and alternate resources before payments are released.

Coordination of Benefits

Coordination of Benefits (COB) information is obtained via enrollment applications and claims displaying positive COB by HealthSCOPE.

HealthSCOPE states that all claims are investigated for COB information. HealthSCOPE's procedure for COB is to pursue then pay for all possible COB claims. Claims are denied until requested information is received. If a claim form displays that a spouse is employed, HealthSCOPE will send a COB questionnaire.

The HealthSCOPE system utilizes COB indicators, which will cause a warning edit to alert the processor to the presence of other insurance.

The HealthSCOPE system utilizes separate COB indicators for different lines of business, i.e. medical, dental, etc.

The HealthSCOPE system has electronic split indicators to assure the proper payment of claims received out of sequence and multiple positive COB periods.

Per HealthSCOPE, COB processing is performed by all claim processors.

The HealthSCOPE system can process claims utilizing a COB Credit Reserve program on a calendar year basis if required.

HealthSCOPE will utilize the primary carrier's discount when the discount is greater than the client's if by Plan design.

HealthSCOPE policies are to recover overpayments of past paid claims when COB is discovered after the fact.

Medicare

The HealthSCOPE system will alert the Processor when a member or dependent may be eligible for Medicare benefits. If an individual is age sixty-five (65) or older and Medicare may exist, active employment may be verified.

HealthSCOPE can present a report specific to active participants for verification to eligibility files when requested.

Controlling Possible Fraudulent Claims and Security Access

HealthSCOPE claims analysts have a payment authority of $15,000.00. HealthSCOPE Team Lead has an authority of $35,000.00 and the HealthSCOPE Claims Manager has an authority of $75,000.00. HealthSCOPE directors review claim payments in excess of $75,000.00.

Security logs are created and monitored by HealthSCOPE. HealthSCOPE system utilizes passwords, is monitored to restrict the use of certain system operations and can lockout unauthorized users.

The HealthSCOPE system can track activity by individuals to identify who handled a claim.

HealthSCOPE does currently offer website access to be used by clients for eligibility purposes.

Quality Control and Internal Audit

HealthSCOPE has a total of 125+ claim analysts in their Little Rock location. HealthSCOPE has 15 claims analysts dedicated to the PEBP account.

HealthSCOPE Claims Managers and Directors were found to be knowledgeable and possess extensive training. Discussions and tests of their working knowledge of adjudication processes and policies and procedures were positive. They were found to possess the ability to identify and defeat many adjudication potential "problem areas" defined with billing practices within the nation.

HealthSCOPE does not have internal audit personnel. They utilize an outside vendor that conducts a review of no less than 2% of their claims.

HealthSCOPE has formal training programs, where policies and procedures are taught. HealthSCOPE stated their training lasts four (4) weeks from the start. HealthSCOPE offers consistent ongoing training and identifies needs of specific individual training. Any needs are identified and supplied on an ongoing basis.

HealthSCOPE conducts audits on all processors. HealthSCOPE audits new analysts at 100% during their probationary period.

HealthSCOPE stated that experienced claim analysts will have the PEBP performance guarantee levels met for claims per person per month audited.

Records for all analysts are kept on a database for performance reference by HealthSCOPE.

HealthSCOPE has internal accuracy and production standards. HealthSCOPE's internal financial accuracy standard is 99.2% of paid claims and payment accuracy is 98%.

The production standard for HealthSCOPE experienced claims analysts is 150 - 175 medical/dental claims per day.

Internet Capabilities

HealthSCOPE does have internet capabilities to further extend membership and administrative service levels.

HealthSCOPE has internet sites provided for member information. These sites provide claim information, network provider identification and contact data.

HealthSCOPE internet sites were user friendly and easy to access. HealthSCOPE's site was checked for security processes of data protection and was found to be protected by member supplied passwords, etc.

HealthSCOPE has an internet site available for vendor information. These sites provide claim and benefit information, network rates and contact data.

Communication between Utilization Review (UR) and Claims Department

HealthSCOPE can currently accept communication between the UR and the claims department via electronic source. Information received regarding pre-certification, PCP references and Case Management can be entered on the system when received.

Precertification penalties for non-compliance will be manually applied by HealthSCOPE.

HealthSCOPE will apply the proper cutbacks to UR authorized number of service days if different than the number of billing days on a manual basis. HealthSCOPE verified that they will apply authorized number of service days according to PEBP's methodology.

HealthSCOPE analysts are trained to identify potential catastrophic cases and refer them to a Case Management program.

The HealthSCOPE system has the ability to communicate special instructions or negotiate arrangements/ discounts to the analysts through the notes.

PEBP's policy allows for a three (3) Level Appeal process. HealthSCOPE stated that they can apply this policy.

Claim Repricing Capabilities

HealthSCOPE is currently receiving network fee schedules and provider maintenance data electronically for internal claims repricing. HealthSCOPE has data loaded into their adjudication system within 24 hours of receiving.

HealthSCOPE currently is participating with multiple networks for repricing via the Electronic Data Interface (EDI) methodology.

Banking and Cash Flow

HealthSCOPE stated that they can accommodate PEBP's requirement for payment release frequency. HealthSCOPE stated that they could release payment checks the same date of final adjudication if before 10:00 AM.

HealthSCOPE is utilizing bulk checks for provider payments.

Reporting Capabilities

In addition to the standard AD HOC reporting, HealthSCOPE has the capability to develop and produce client-requested reports based on any information captured on the system.

HealthSCOPE stated that no additional charge would be applied for any requested report which is in the standard reporting.

General System

HealthSCOPE has been using the current system for twenty plus (20+) years. The current system has undergone many updates since its inception.

HealthSCOPE has the controls in place for the application of source coding enabling them to make client specific adjustments as necessary.

HealthSCOPE has written procedures in place for a formal Disaster Recovery program.

HealthSCOPE conducts daily system data backups, which are stored in a secure location off site.

HealthSCOPE stated that they have not experienced any significant downtime.

Security

This audit reviewed building security, the handling and security of sensitive documents and materials and the proper disposal of data for any potential data breaches. The audit also reviewed internal processes and potential exposure to possible fraudulent activity.

The HealthSCOPE office located in Little Rock, Arkansas was found to be secure. All external ingress and egress locations were secured and locked. Entrance was made available to HealthSCOPE personnel by electronic pass keys. HCA entry beyond the reception area required assistance from official personnel. The facility work areas are monitored and recorded twenty four hours per day.

Sensitive data, specifically, member Personnel Health Information (PHI) of HealthSCOPE's clients was reviewed for security exposure practices. Any paper was found to be in secured areas and/or file cabinets when not in use.

Per Agreement, HealthSCOPE must provide all subcontractors that have access to PEBP member Personal Health Information (PHI) within 30 calendar days of said access or a penalty of 5.0% of rolling 12 months of administration fees will be applied for each violation.

Per Agreement, HealthSCOPE must remove PEBP member PHI from unauthorized/designated servers within 3 business days after they know or should have known using commercial reasonable efforts or a penalty of 5.0% of rolling 3 months of administration fees will be applied.

A review of the system server equipment for HealthSCOPE noted it was secured in a separate area under locked environments with appropriate fire suppression protections. Every attempt to access the adjudication system required appropriate security measures such as passcodes, etc.

HCA CLAIM AUDIT PROCEDURES

HCA selects a valid random sampling of claims from the client's current detailed claims listings. The third party administrator is advised of the audit and requested to provide either limited system access or paper reproduction of the entire file associated with each random claim.

Each random claim and file is reviewed comparing eligibility and benefits to information provided by the client. Third party administrator personnel are questioned regarding any discrepancies. Entire files are reviewed to assure the client that deductibles, out-of-pockets benefit maximums and related claims are processed correctly. This allows HCA to verify all details of the client's benefit plan.

Audit statistics involve only those claims chosen in the random selection. If a randomly selected claim HealthSCOPE been recalculated or corrected prior to the release of the random selection for the audit, an error was not charged for the original miscalculation. HCA will, at its opinion, comment on any claim in the random claim history to illustrate situations it feels the client should be aware of or specific areas requiring definition.

A payment error is charged when an error identified in claim processing results in an under/ overpayment or a check being paid to the wrong party. Assignment errors are considered payment errors since the plan could be liable for payment to the correct party.

In situations where there is disagreement between HCA and the third party administrator as to what constitutes an error, both sides are presented in the report. Final determination of error rests with the client.

AUDIT RESULTS

Listed below are the errors or issues of discussion found by this audit while processing the claims for PEBP.

Ref. No. 001 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Per Trans Msg "Pending HTH pricing 3/27/19" then "resubmitted request via email to HTH for pricing status check 6/18/19"
Did HTH give any explanation on why repricing was not done in March?
HSB response: Per HTH claim released as non-par in error. Provider's contracted rates were under review and should have been held. Claim processed w/HTH pricing provided on 6-26-19. No error.

Ref. No. 012 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider - Renown
Originally paid 7/3/19 allow/paying 68.93 (audited)
Adjusted 9/25/19 now allowing 68.90
Appears HTH corrected repricing?
HSB response: Yes, we received corrected pricing from HTH. We have overpayment on file for $.03. No error.

Ref. No. 014 Medical HSB claim no.

Underpayment - $122.98
Claim paid as: allow 496.74 x 50% = 248.37 at 80% (59514-80-51)
1) According to electronic service detail claim came in as 59514-80.
Why was -51 modifier included in calculation?
2) Shouldn't allowable for assistant surgeon have been no more than 20%
Of surgeon allow or 2010.49 x 20% = 402.10?
HSB response: Appears McKesson edit read the surgeon's bill and applied 51 modifier. Analyst did override this. Allowable was calculated from $2483.71 on Txxxxxx instead of surgeon's bill Txxxxxx and was cut second time by system. Underpaid $122.98.

Ref. No. 091 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Originally paid under claim xxxxxx on 5/14/19 paying: allow 331.74 and paying 286.74 as:

11102.59	chg 121.00	allow 42.35	ded 42.35	pd 0.00
11103	65.00	45.50	2.65	42.85
17000-59	116.00	38.30		38.30
17110	153.00	110.73		110.73
99214-25	145.00	94.86		94.86
		331.74	copay 45	286.74

1) MPR applied to 11102 and 17000 and 17003 bundled into 17110. Claim adjusted under audited to pay 17003 separately and pay an additional 12.62. Appears 17003 was bundled incorrectly?
2) Claim then adjusted 9/5/19 due to corrected HTH repricing and now paying additional 18.05.
HSB response: 1) 17003 is an add on code to 17000 & should not have bundled to 17110. 2) HTH returned corrected pricing on claim & it was adjusted correctly.

Ref. No. 102 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider - Renown
Audited claim paid as: allow 1716.44 copay 300
Claim adjusted on 10/1/19 to correct allow to 1820.96 with an additional 104.52 paid.
Appears claim priced at incorrect rate by HTH?
HSB response: HTH originally priced incorrectly. Updated pricing was provided by HTH w/allow amt of $1820.96 on 9/3/19 on report received 9/4-9/5.

Ref. No. 149 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim xxxxxx paid 8/26/19 as: allow/pd 506.94
Claim xxxxxx paid 7/19/19 denied same charges as on claim xxxxxx plus code J0702 as "Dep children are not covered for this diagnosis." Appears charges were originally denied in error?
HSB response: Claim xxxxxx was denied correctly. Services billed are not mandated to pay as wellness per ACA. Claim xxxxxx should have denied as a duplicate.

Ref. No. 163 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider – Carson Tahoe
Claim originally paid 8/16/16 as:
Observation w/cap allow 2577.37 ded 2518.45 pd 47.14
Audited is adjustment to now pay as: REV 636 at 42%, rest at 49%
Allow 10,890.66 ded 2518.45 pd 6697.76 – 47.14 prev pd = 6650.62
1) Appears HTH priced incorrectly on original processing?
2) Why did it take 3 years for this to be identified?
HSB response: 1) Appears HTH priced incorrectly originally.
2) Recon xxxxx submitted on 3-13-19 based on call from provider on 3-8-19 disputing pricing. HTH replied 3-13-19 indicating priced correctly. Provider apparently appealed to HTH directly regarding pricing dispute and they repriced claim on 7-24-19. No error. Processed correctly.

Ref. No. 237 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Per review of history claims xxxxxx DOS 6/14/19, xxxxxx DOS 6/28/19 and xxxxxx DOS 7/3/19 have not been reprocessed. Should they have been? (audited claim for 6/21/19 was reprocessed)
HSB response: Audited claim paid correctly. Biased claims should be processed and allowed.

Ref. No. 246 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim xxxxxx DOS 7/26/19 same services as audited denied for info 8/21/19. Shouldn't this have been reprocessed?
HSB response: Claim xxxxxx should have been paid.

Ref. No. 248 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim xxxxxx pd 8/22/19 same DOS, DX for surgeon pd as:
45385 chg 1119.00 allow 509.00 ded 509.00 pd 0.00
Trans msg states: "Paid under HM category once per plan year"
Claim xxxxxx (audited) is for facility (paid at 100%)
Shouldn't claim xxxxxx for surgeon have been pais at 100%?
HSB response: Claim xxxxxx should have paid as wellness.

Ref. No. 272 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Audited claim is for anesthesia for routine colonoscopy (paid at 100%)
Claim xxxxxx pd 8/23/19 same DOS, DX as audited is for facility paid as: allow 558.39 ded 558.39 pd 0.00
Shouldn't this claim have paid at 100% versus going to the deductible?
HSB response: Yes, claim xxxxxx should have paid at 100% of PPO allowable.

Ref. No. 308 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Originally processed under xxxxxx on 7/25/19 with no calculation
Audited is adjustment to now pay 138.68 x 80% = 110.94
What happened on original processing that prevented claim form being paid?
HSB response: Original claim xxxxxx was returned by HTH with no pricing as non-par. Recon request submitted to HTH on 7-25-19 (xxxxx) requesting repricing. HTH repriced claim on 7-29-19 and claim paid on 8-19-19 correctly under xxxxxx.

Ref. No. 344 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
If reading for 77080 is allowed at 100% should charge for 77080 on facility claim xxxxxx have been pulled out & paid at 100%?
HSB response: Claim xxxxxx facility claim 77080-TC only should have allowed as preventive – all other items subject to ded/coins.

Ref. No. 358 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim originally paid on 1/8/19 COBing and paying 271.25 on clm xxxxxx
Claim received again and denied as dup on 4/3/19 claim xxxxxx
Claim again received w/corrected OI EOB denied as dup again on 7/12/19 claim xxxxxx
Claim received 3 more times before correction to processing done on audited claim (now paying only 46.25)
1) Should claim have been corrected on claim xxxxxx when corrected EOB was received on 7/11/19?
2) Has refund for $225.00 been requested?
HSB response: 1) Claim xxxxxx should have been routed for adjustment when received on 7-11-19. 2) Yes, the $225.00 refund has been requested from provider.

Ref. No. 364 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim xxxxxx same DOS surgeon's bill for routine colonoscopy pd as:
chg 1125.00 allow 159.05 ded 159.05 pd 0.00
Shouldn't this claim have paid at 100% versus going to deductible?
HSB response: xxxxxx should have paid at 100% of PPO allowed.

Ref. No. 395 Outpatient Hospital HSB claim no.

Overpayment - $726.28
Provider – Mountain View
Claim for ER level 3 pd as: allow 3555.85 x 80% = 2844.68
Per 2019 HTH contract level 3 allow = 2648.00 x 80% = 2118.40
Appears claim overpaid 726.28.
HSB response: Analyst error, paid with SHO in error. Should be HTH.
OP $726.28.

Ref. No. 417 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim xxxxxx for same DOS, DX facility billing
Claim denied for subro. Since DX is M2012 – hallux valgus (acquired) something that is not caused by injury, shouldn't this claim have been paid same as audited was? (surgeon & anes both paid)
HSB response: Yes, facility claim xxxxxx should have been paid.

Ref. No. 431 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Member term'd 4/26/19. Claim xxxxxx for DOS 5/14/19 paid 111.55 on 9/3/19. Shouldn't this claim have been denied for after term?
HSB response: Provider billing newborn claims under mother's name. Claim should have been denied under mother and moved to child's coverage and paid. There would be no change in the payment amount so this is just a procedural error.

Ref. No. 448 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
88305 chg 265 allow/pd 91 as HM
Claim xxxxxx facility bill paid as SU category as per Trans Msg – "had screening in 2017. Should audited claim have paid at 80% versus 100%?
HSB response: xxxxxx should pay at 100%.

Ref. No. 458 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Originally paid on 8/29/19 paying 1853.97 (allow 2317.46 x 80%)
Audited is adjustment to pay additional 105.27 – now allowing 2449.06
Appears corrected HTH pricing received?
HSB response: Yes, HTH originally priced at $2317.43 and updated pricing to allow $2449.03 and claim adjusted.

Ref. No. 479 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Originally claim processed 7/20/19 w/zero pricing from HTH
Received again & processed 8/23/19 again w/zero pricing from HTH
Received again & processed 9/13/19 priced as 1413.64 & the adjusted on audited to pay.

Ref. No. 480 Medical HSB claim no.

Overpayment - $72.12
Originally paid under xxxxxx w/non-par status from HTH on 9/4/19
Adjusted on audited w/HTH repricing of 142.78
Claim was paid as 88305 chg/allow/pd 214.90
Shouldn't we have paid HTH repriced amount of 142.78?
HSB response: Analyst error. Should have used HTH corrected repricing of $142.78 – OP $71.22.
HCA Note: Claim originally paid 214.90 but should have paid 142.78 resulting in an overpayment of $72.12.

Ref. No. 488 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim originally under xxxxxx paid on 5/14/19 combining 99213 w/other codes and paying allow 575.15, paid 460.12 – modifier did not carry over to electronic detail from image.
Claim resubmitted under xxxxxx on 8/13/19 was processed as dup – electronic detail now showing modifier
Audited claim is adjustment on 9/25/19 to now pay additional 64.66 for CPT 99213-25.
Shouldn't claim have been adjusted when claim xxxxxx was received versus denying as dup?
HSB response: Yes, original claim should have been adjusted when claim xxxxxx was received even though provider did not bill with indicator of "7" in box 22 of claim form.

Ref. No. 492 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim xxxxxx same DOS for Dr. M CPT 99213 paid on 4/15/19 paying 125.09
Claim xxxxxx same DOS came in also for CPT 99213 but for Dr. A and was voided as dup to above claim
Claim was resubmitted received 5/14/19 under claim xxxxxx and was denied as dup
Audited claim is adjustment to pay claim for Dr. A
Appears claim xxxxxx was voided in error & should have been paid.
HSB response: Yes, claim xxxxxx was voided in error.

27 Corporate Hill
Little Rock, AR 72205

November 5, 2019

Public Employees' Benefits Program Board
State of Nevada
901 Stewart Street, Suite 1001
Carson City, NV 89701

Subject: Audit Results July 1, 2019 – September 30, 2019

Dear Public Employees' Benefits Program (PEBP) Board:

HealthSCOPE Benefits appreciates the opportunity to respond to the audit performed by Health Claim Auditors for the first quarter of Plan Year 2020. The audit included 500 claims with paid amounts totaling $259,647.98

HealthSCOPE Benefits is exceptionally pleased to have met all performance guarantees for this audit period.

We strive to have the highest possible quality and we continue to review improvement opportunities within our organization and our vendor partners.

We are very pleased with cost containment measures we are able to provide on the PEBP account. We saved PEBP an additional $2.4M through non-network negotiations, subrogation, clinical edits and transplant savings in the first quarter of Plan Year 2020.

We appreciate the quarterly audit process and the interaction between Health Claims Auditors, PEBP, and HealthSCOPE Benefits as it provides for continuous improvement in our service.

Sincerely,

Mary Catherine Person
President