Claims and System Audit Report

for

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

Audit Period: PEBP Plan Year 2020, Quarter Two
October, November and December 2019

Audited Vendor:

HealthSCOPE BENEFITS

Healthy People
Healthy Business
Healthy Futures

Submitted By:
Health Claim Auditors, Inc.
February 2020

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The following categories are reviewed each quarterly audit, however, because of their constant properties, the detail of each category will only be displayed within the first quarter audit of the PEBP fiscal year unless a change or defect is detected:

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*Unbundling/Rebundling	*Concurrent Care
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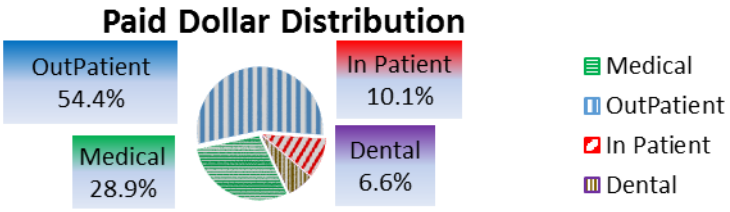
*Communication, U/R and Claims Depts.	
*Claim Repricing	*Banking and Cash Flow
*Reporting Capabilities	*General System

EXECUTIVE SUMMARY

Audited Random Selection Data

Total number of claims: 500
Total Charge Value of random selection: $1,095,532.25
Total Paid Value of random selection: $ 266,150.68



Performance Guaranteed Metric Results

Metric	Guarantee Measurement	Actual	Pass/Fail
Payment Accuracy	≥ 98% of claims audited are to be paid accurately	98.4%	Pass
Financial Accuracy	≥ 99% of the dollars paid for the audited claims is to be paid accurately	99.71%	Pass
Claim Processing Turnaround Time	- 99% of all claims are to be processed within 30 days.	99.41%	Pass
Customer Service	-Telephone Response Time: ≤ 30 seconds. -Telephone Abandonment Rate: ≤ 2%. -First Call Resolution: ≥ 95%	17 sec. 1.44% 95.89%	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.

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 14.

Preventive claim/service paid as medical;
Supporting reference nos. 128, 187, 229, **354** and 367

Incorrect allowable applied; Supporting ref. nos. **156, 194,** 205, 206 and **376**

Medical claim/service paid as preventive; Supporting ref. nos. 062, 186 and 193

Incorrect rate due to network re-pricing; Supporting ref. nos. 383, 504 and 508

Pre-certification penalty not applied; Supporting reference nos. 021 and 076

Incorrect copay applied; Supporting reference nos. **330** and **433**

Duplicate paid; Supporting reference nos. 289 and **490**

Paid at incorrect coinsurance; Supporting reference no. 105

Provider repriced as non-par by network in error; Supporting ref. no. 166

Claim paid at 80% due to RX copay assist; Supporting reference no. 204

Incorrect calculation for bilateral surgery; Supporting reference no. 220

Unbundled lab; Supporting reference no. **351**

Incorrect network used; Supporting reference no. 359

Pre-certification penalty applied in error; Supporting reference no. 431

Claim not reprocessed after requested information received;
Supporting reference no. 480

The audit revealed the following issues, which appear to be administered properly by HSB but should be brought to client attention for proper notification or verification. Specific information regarding supporting reference numbers can be found in the Audit Results Section in numerical sequence, which begins on page 14.

UCS pricing used on VAMC claims if pricing received;
Supporting reference no. 206

CLAIM PROCEDURES/SYSTEM CAPABILITIES/SUPPORT DATA

Introduction

In January 2020, 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 11 February 2020.

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 September 2018 to December 2019 and were processed by HealthSCOPE from 01 October 2019 through 31 December 2019 (PEBP's Second 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	$ 279,359.18	$ 76,837.32	28.9%	349
Outpt. Hospital	$ 553,245.13	$ 144,769.49	54.4%	57
Inpt. Hospital	$ 222,698.75	$ 26,973.52	10.1%	4
Dental	$ 40,229.19	$ 17,570.35	6.6%	90
TOTAL	**$1,095,532.25**	**$ 266,150.68**	**100%**	**500**

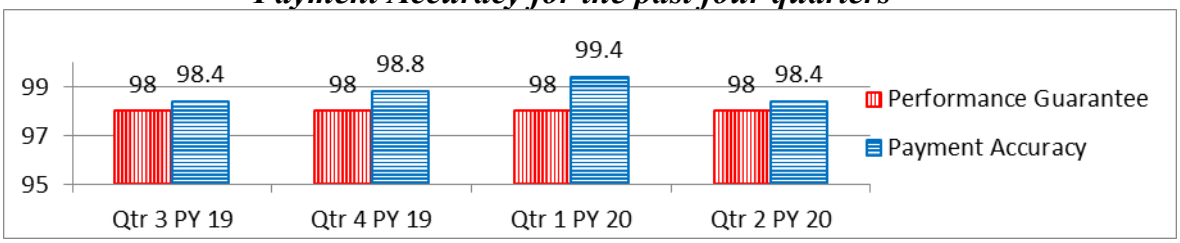
Payment Accuracy

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 98.4%.

Number of claims:	500
Number of claims paid incorrectly:	8
Percentage of claims paid incorrectly:	1.6%
Number of claims paid correctly:	492
Percentage of claims paid correctly:	98.4%

Payment Accuracy for the past four quarters



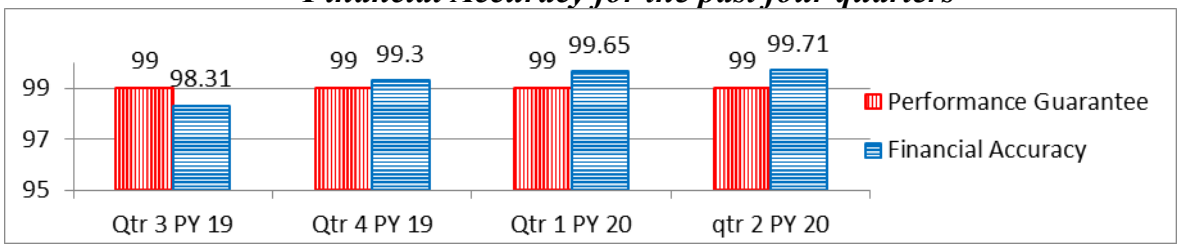
Financial Accuracy

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 99.71%. This audit reflected seventy-five and two tenths percent (75.2%) of the audited errors within the valid random selection were overpayments.

Paid dollars audited	$ 266,150.68
Amount of paid dollars remitted incorrectly	$ 774.67
Percentage of Dollars paid incorrectly	0.29%
Paid Dollars of claims paid correctly	$ 265,376.01
Percentage of Dollars Paid correctly	99.71%

Financial Accuracy for the past four quarters



Historical Statistical Data of Performance Guarantees

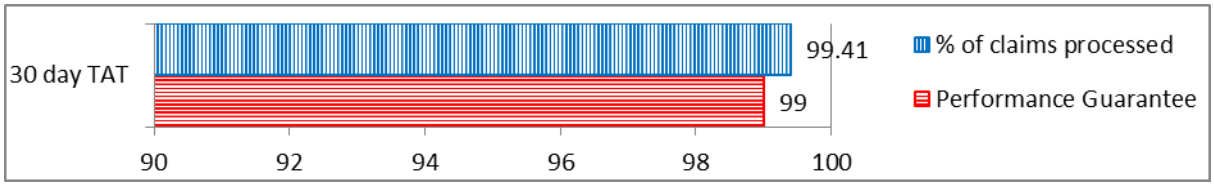
The following reflects the historical statistical data since the origin of PEBP medical claims administration by HealthSCOPE. The entries designated in **bold red type** are measurable categories with underperformance of the Service Performance Guarantees Agreement.

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%
2nd Qtr PY 2020	**98.4%**	**99.71%**	**5.0 days**	**:17.0**	**1.44%**	**95.89%**

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 99.41% 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 5.0 days.

Turnaround Time Measurements



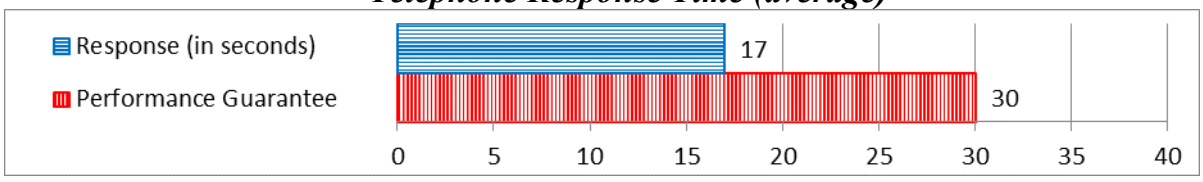
The turnaround time, measured only from the random selected claims, for Medical claims 10.8 calendar days, Out Patient Hospital claims was 10.4 calendar days, In Patient Hospital claims was 1.8 calendar days and Dental claims was 1.6 calendar days.

During the audit period of 01 October 2019 to 31 December 2019, HealthSCOPE had received 1,475 PEBP e-mail inquiries for information via the internet. The average turnaround time for these inquiries was calculated at approximately 7.5 hours.

Customer Service Satisfaction

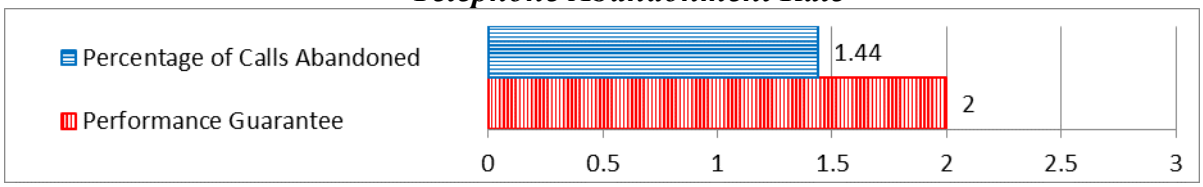
Per the Service Performance Standards and Financial Guarantees Agreement, the telephone response time reflects all calls must be answered within thirty (30) seconds or a penalty of one percent (1%) of Quarterly Administration fees for each second in non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP second fiscal quarter Plan Year 2020, which revealed the average incoming answer speed to be 17.0 seconds (0:20.0). The telephone response time was 14 seconds for October 2019, 23 seconds for November 2019 and 15 seconds for December 2019.

Telephone Response Time (average)



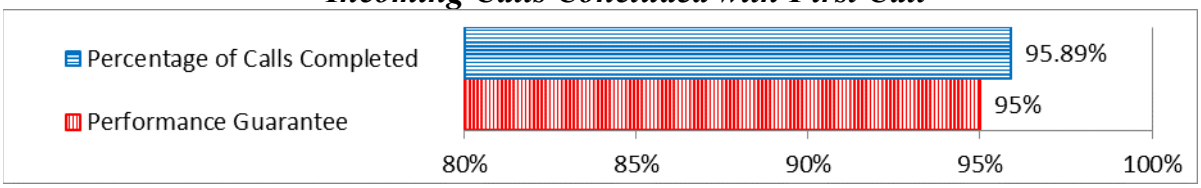
Per the Service Performance Standards and Financial Guarantees Agreement, the abandonment rate must be under two percent (2%) of total calls or a penalty of one percent (1%) of Quarterly Administration fees for each percentage point or fraction thereof in non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP second fiscal quarter Plan Year 2020, which revealed the abandoned calls ratio to be 1.44%. The telephone abandonment rate was 1.22% for October 2019, 1.94% for November 2019 and 1.22% for December 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 second fiscal quarter Plan Year 2020, which revealed that HealthSCOPE documented 95.89% 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 4,275 claims representing $ 22,248,300.62.

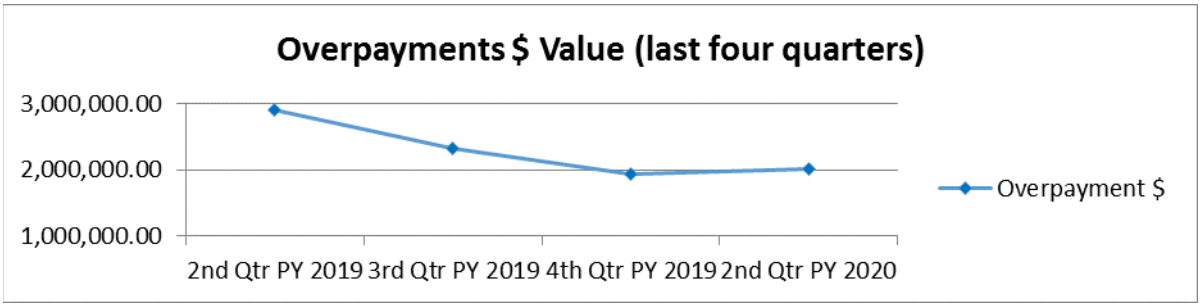
Audit Period	Total Number of Claims	Charge Amount Value of Soft Edits
1st Qtr PY 2012	2,607	$ 7,544,177.55
2nd Qtr PY 2012	4,068	$10,697,954.53
3rd Qtr PY 2012	1,536	$ 6,472,249.56
4th Qtr PY 2012	559	$ 2,205,318.16
1st Qtr PY 2013	1,053	$ 3,413,738.12
2nd Qtr PY 2013	1,107	$ 5,019,961.70
3rd Qtr PY 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
2nd Qtr PY 2020	**4,275**	**$22,248,300.62**

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 $2,015,568.37 (an increase of $74,637.49). 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	$ 104,209.00
- Fiscal Year 2013	$ 143,390.29
- Fiscal Year 2014	$ 61,856.00
- Fiscal Year 2015	$ 152,744.70
- Fiscal Year 2016	$ 181,327.34
- Fiscal Year 2017	$ 104,485.08
- Fiscal Year 2018	$ 342,730.79
- Fiscal Year 2019	$ 178,903.53
- Fiscal Year 2020 (to date)	$ 745,921.64
TOTAL	$2,015,568.37



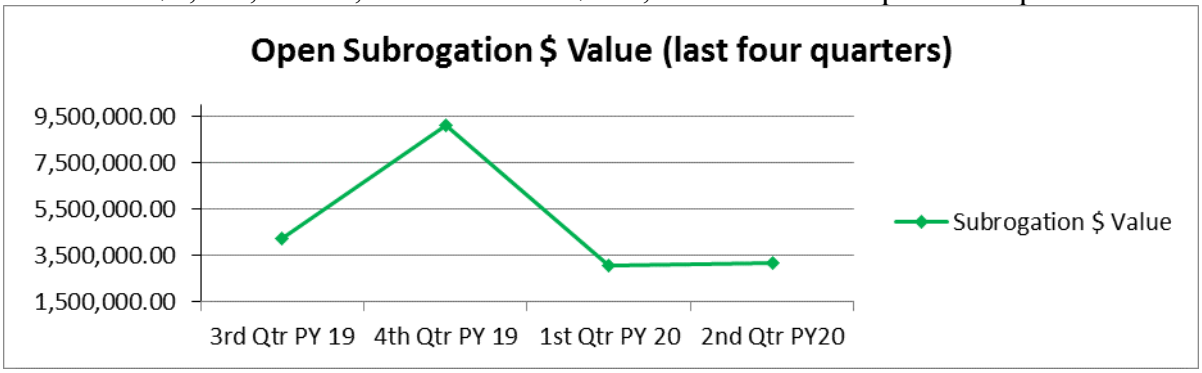
Of the 1,004 most current (Plan Year 2020) identified outstanding overpayments (HSB only), 66% were found to be caused by external sources that are not a cause of the HealthSCOPE adjudication processes. Breakout of the HealthSCOPE's most current overpayments (by claim count) are listed by reason as follows:

34.40%	Corrected HTH Network Pricing
13.56%	Incorrect Benefit Applied
13.06%	Incorrect Rate Applied
11.76%	Provider caused, rebilled, charges billed in error, corrected EOB
8.00%	Retro termination
8.77%	No COB on file
2.09%	Duplicate
1.99%	COB incorrectly calculated or not applied
1.50%	SHO Pricing Correction
1.20%	Previous Information Received
0.70%	Service not covered
0.60%	Category error
0.40%	Processed under incorrect patient
0.30%	Paid NON PPO as PPO
0.30%	Stop Payment
0.30%	Benefit Clarification
0.30%	Subrogation error
0.20%	Processed under the incorrect provider
0.20%	Paid PPO provider as NON PPO
0.20%	Aetna network Pricing
0.10%	Denied in Error
0.10%	Entry Error
0.10%	Multiple Surgery Reduction not applied
0.10%	Incorrect Copayment
0.10%	Pharmacy Deductible Error

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 $3,188,870.28; an increase of $139,543.93 from the previous quarter.



Reports received from HealthSCOPE reflect that subrogation recoveries for the audited period was $263,812.58. After contingency fees were paid, PEBP received $197,859.45.

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 forty-three (43) active members and thirty (30) dependents for a total of 73 active participants, who have obtained this level of plan payment participation representing an accrued dollar paid amount of $100,279,810.91.

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, **CHANGED;**
- 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, **CHANGED**, 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, **CHANGED**;
- Customer Care Supervisor;
- Customer Care Representatives, 3 individuals.

HealthSCOPE POLICY/PROCEDURES/SYSTEM CAPABILITIES

This section details the HealthSCOPE adjudication system capabilities and operations as they pertain to the PEBP Health Plan. These operations typically do not change on a regular basis and remain redundant within subsequent audit reports, thereby, are only displayed within the first quarterly audit report for the fiscal year. The quarterly audit includes the review of the following operations, however, if any changes or defects are identified, they will be reported immediately within the audited period report:

- HealthSCOPE Policy/Procedures
- Eligibility
- Deductibles, Out-of-Pocket and Benefit Maximums
- Unbundling/Rebundling
- Concurrent Care
- Code Creeping
- Procedure, Diagnosis and Place of Service
- Experimental and Cosmetic Procedures
- Medical Necessity/Potential Abuse Guidelines and Procedures
- Patterns of Care and Treatment for Physicians
- Mandatory Outpatient/Inpatient Procedures
- Duplicate Claim Edits
- Adjusted Claims
- Hospital and Other Discounts
- Hospital Bills (UB-92) and Audits
- Filing Limitations
- Unprocessed Claims Procedures
- Reasonable/Customary and Maximum Allowances
- Membership Procedures
- COBRA Administration
- Provider Credentialing
- Coordination of Benefits
- Medicare
- Controlling Possible Fraudulent Claims and Security Access
- Quality Control and Internal Audit
- Internet Capabilities
- Communication between Utilization Review (UR) and Claims Department
- Claim Repricing Capabilities
- Banking and Cash Flow
- Reporting Capabilities
- General System
- Security

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. 021 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Audited claim paid as: allow 15002.46 – pre-cert penalty 7501.26 – ded 335.25 = 7165.95 x 80% = 5732.75 pd
All other claims (xxxxx ass't surg), (xxxxx surg), (xxxxx lab), (xxxxx anes) did not take pre-cert penalty.
Shouldn't penalty have applied to these four claims?
HSB response: Surgeon – xxxxx is incorrect. Should have assessed pre-cert penalty. Assess penalty on surgeon & facility claims per email attached.
HCA Note: Email dated May 13, 2019 from client states: "Restating our intent regarding precertification penalty: The precert penalty should only apply to the surgeon and facility. The penalty will NOT apply to ancillary services when those services are billed separately."

Ref. No. 062 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.

Audited: Code HM CPT 77063-26 chg 108.00 allow/pd 36.85
HM 77067-26 274.00 46.82

Claim xxxxx same DOS, same provider pd as:

76641-26-LT	chg 114.00	allow/ded 45.08	pd 0.00
76641-26-RT	114.00	45.08	0.00
76376-26-59	32.00	12.14	0.00

Claim xxxxx for facility fee paid as:

REV 402	CPT 76641-TC	chg 562.00	allow/pd 252.90
403	77063-TC	64.00	10.24
403	77067	1011.00	161.76

Should REV 402, CPT 76641-TC have been paid at 80% versus 100% since it is not a routine service? (OOP not met)

HSB response: REV 402, 76641-TC should have been paid at 80% not 100%.

Ref. No. 076 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.

77263	chg 480.00	allow 319.31	penalty 159.66	pd 159.65
77290-26	457.00	155.92	77.96	77.96
77334-26	137.00	115.11	57.56	57.55

Pre-cert penalty applied

Claim xxxxx same DOS for facility services w/CPTs 77290 & 77334 (plus other codes & DOS 10/1-10/29) pd as:

chg 80,734.00 allow/pd 32,293.60

If penalty on audited claim is correct, should facility have had a pre-cert penalty also?

HSB response: Biased claim should have paid w/penalty due to Renown Regional auth on file at time of claim adjudication did not specify radiation therapy.

Ref. No. 105 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.

97803 chg/allow/pd 60.00 DX – E669

1) System does not indicate Obesity Care Mgmt. Why is claim being paid at 100%?

2) Claim xxxxx DOS 10/22/19 for 97803 chg/a/pd 180.00 paid on 10/26/19 would be the 4th visit. Shouldn't this claim have gone to deductible versus paid at 100%?

HSB response: 1) Per page 65 & 66 of MPD services covered as wellness/preventive for up to 3 visits per plan year. Processed correctly.

2) Xxxxx should have applied to deductible. Programming issue that has been corrected.

Ref. No. 128 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Audited: 77067-26 chg 94.67 allow/pd 80.47
77063-26 51.26 51.26
Claim xxxxx same DOS for hospital charges pd as:
chg 5769.40 allow 4027.04 ded 1574.63 (x80%) pd 1961.93
Claim contains: REV 403, 77063 chg 37.20
403, 77067 360.50
Shouldn't these 2 services have been paid at 100%?
HSB response: 77063 & 77067 billed under claim xxxxx should pay at 100% of PPO and allow as wellness.

Ref. No. 156 Medical HSB claim no.

Overpayment - $235.11
Provider – Reno VAMC
58300 chg/allow/pd 264.17
Claim has been adjusted on 1/27/20 to pay using UCS pricing.
Now paid as: allow/pd 29.06
Why wasn't UCS pricing used on original processing?
HSB response: Analyst error. Internal audit ran on 12-31-19 and claim was corrected under xxxxx based on report.

Ref. No. 166 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Originally paid on 9/4/19 as: 74177-26 chg 236.00 ded 236.00
HTH priced as non-par
Audited is adjusted due to corrected HTH pricing:
74177-26 allow/pd 126.24 (OOP now met)
Appears HTH incorrectly identified provider as non-par.
HSB response: HTH originally returned claim as non-par. HTH repriced claim on 9-30-19.

Ref. No. 186 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Audited for routine gyn exam
Claim xxxxx from LabCorp same DOS w/DX R5383 pd as:
83001 chg 136.34 allow/pd 20.91
84443 112.33 16.39
85025 46.33 11.30
Since DX for these services is not routine shouldn't these have gone to deductible? (Note: claim xxxxx same DOS from LabCorp has routine DX – pd at 100% correctly)
HSB response: Yes, xxxxx should have applied to deductible.

Ref. No. 187 Medical HSB claim no.
NOT charged in statistical calculation. Note to client for information only.
Audited - DX Z0000, CPT 36415 chg 21.00 allow/pd 13.00
Claim xxxxx same DOS from LabCorp, same DX allow of 48.59 went to deductible.
Shouldn't this have been paid at 100% since we had a claim from the physician for a venipuncture that we paid at 100%?
HSB response: Claim xxxxx should pay at 100% of PPO allowed.

Ref. No. 193 Outpatient Hospital HSB claim no.
NOT charged in statistical calculation. Note to client for information only.
Code HM REV 490 45380 chg 6286.00 allow/pd 2961.99
HM 490 S9999 296.20 0.00
1) Claim adjusted under xxxxx on 1/2/20 to now pay as SU as:
REV 490 45380 allow 2961.99 (x80%) pd 2369.59
490 S9999 0.00 0.00
Why was claim originally paid at 100% since DX was illness?
2) Claim xxxxx same DOS for lab charge paid at 100% on 1/16/20.
Should this have been paid at 80% due to medical DX?
REV 312 88305 chg 552.00 allow/pd 276.00
HSB response: 1) Should be illness corrected under xxxxx on 1/2/20.
2) Claim xxxxx should pay under SU.

Ref. No. 194 Outpatient Hospital HSB claim no.
Underpayment - $37.98 Provider – LV VAMC
Original is audited claim pd as: allow 153.12 x 80% = 122.50 pd
Claim adjusted under xxxxx on 1/27/20 to pay w/UCS pricing:
allow 200.59 x 80% = 160.48 – 122.50 = 37.98 additional paid
Why wasn't UCS pricing applied on original processing?
HSB response: Analyst error. UCS pricing from xxxxx should have been used. Report ran on 12/31/19 to identify VAMC claims to reconsider and claim corrected on 1/27/20 under xxxxx.

Ref. No. 204 Medical HSB claim no.
NOT charged in statistical calculation. Note to client for information only.
Clm xxxxx DOS 1/21/20 paid 1/27/20, xxxxx DOS 1/14/20 paid 1/27/20, xxxxx DOS 12/17/19 paid 12/26/19, xxxxx DOS 12/10/19 paid 12/19/19, and xxxxx DOS 12/3/19 paid 12/12/19 all paid at 80%
Clm xxxxx DOS 11/19/19 paid 11/28/19, xxxxx DOS 11/5/19 paid 11/18, audited DOS 10/15/19 paid 11/14/19, and xxxxx DOS 10/22/19 paid 10/31
All claims from same provider.
Why are claims prior to DOS 12/3/19 being paid at 100% versus 80%?
HSB response: Claims xxxxx, xxxxx, xxxxx & xxxxx paid at 100% of PPO allowed as a result of RX integration for copay assist. RX claims xxxxx & xxxxx, ESI did not apply the Copays assist until 12/3/19, which negatively affected the member's accumulators.

Ref. No. 205 Outpatient Hospital HSB claim no.
NOT charged in statistical calculation. Note to client for information only.
Provider – Reno VAMC
Chg 127.02 allow/pd 5.24
Claim adjusted under xxxxx on 1/13/20 to pay w/UCS pricing as:
allow/pd 13.97, paying an additional 8.73
Why wasn't UCS pricing used on original processing?
HSB response: Analyst error. UCS pricing from xxxxx should have been used. Report ran on 12/31/19 to identify VAMC claims to reconsider and claim corrected on 1/13/20. Claim corrected prior to audit pull and random extract submitted to HSB on 1/21/20.

Ref. No. 206 Outpatient Hospital HSB claim no.
NOT charged in statistical calculation. Note to client for information only.
Provider – Reno VAMC
Audited claim pd as: allow/pd 48.63
Claim now adjusted under xxxxx on 1/15/20 to now use UCS pricing as:
allow/pd 104.22, with additional 55.59 paid
1) Why wasn't UCS pricing used on original processing?
2) When was it decided to use UCS pricing?
HSB response: 1) Analyst error. UCS pricing from xxxxx should have been used. Report ran on 12/31/19 to identify VAMC claims to reconsider and claim corrected on1/15/20. Claim corrected prior to audit pull and random extract submitted on 1/21/20. 2) On 11/25/19 confirmed to use UCS pricing for DOS prior to 10/1/19 if pricing had been received.

Ref. No. 220 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Paid as: allow 2642.58 – penalty 388.31 – ded 33.27 – coins 444.21 = 1776.79 paid

CPT 30140 allow 214.37
30520 1012.89
31257 359.03
31267 319.97
31276 456.64
61782 279.68

Claim adjusted for appended auth & apply no penalty under claim xxxxx paying additional 454.27 on 12/23/19 now allowing 2822.10:

CPT 30140 allow 214.37
30520 1012.89
31257 538.55
31267 319.97
31276 456.64
61782 279.68

Appears incorrect calculation of allow for CPT 31257 done on original processing?
HSB response: Yes, 31257-59-50 had the incorrect allowed amount on original claim. Claim corrected under xxxxx on 12/23/19 once retroactive authorization received from UM vendor.

Ref. No. 229 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim xxxxx same DOS lab charges w/same DX Z125

REV 300 36415 chg 23.00 allow 1.13 ded 1.13 pd 0.00
301 84153 170.00 16.95 16.95

Why wasn't 36415 venipuncture paid at 100%?
HSB response: 36415 should have paid at 100% of PPO allowed.
Analyst error.

Ref. No. 289 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim xxxxx same DOS, services & provider paid on 12/31/19 also paying 60.31 after COB w/Medicare.
This claim appears to be a dup of audited claim & should have been denied.
HSB response: Claim paid in error.

Ref. No. 330 Outpatient Hospital HSB claim no.

Underpayment - $100.00

Provider – Renown

REV 255		chg 5.00	allow 2.45
255		31.00	15.19
320	CPT 77002-RT	190.00	79.80
610	73222-RT	1729.00	1556.10
761		291.00	90.21
			1743.75

Claim paid as: allow 1743.75 – 350.00 copay = 1393.75 pd

Per MPD copay for MRI should be $250.00. Appears incorrect copay taken & claim is underpaid $100.00.

HSB response: Agree, claim should have assessed $250 copay.

Ref. No. 351 Medical HSB claim no.

Overpaid $3.17

Claim from Quest contains:

85025	chg 45.50	allow 10.66 (x80%)	pd 8.53
80053	88.07	18.58 "	14.86
84443	130.49	23.05	18.44
		52.29	41.83

1) Shouldn't CPTs 85025, 80053 & 84443 have been rebundled & paid as 80050?

2) Please advise what allowable would be for 80050 for this DOS

HSB response: 1) Yes, it should bundle to 80050. 2) Allowed amount for 80050 = $48.32.

Ref. No. 354 Outpatient Hospital HSB claim no.

Underpayment - $34.40

REV 402	CPT 76641-TC	chg 562.00	allow 252.90	(x80%)	pd 202.32
403	77063-TC	64.00	10.24	"	8.19
403	77067	1011.00	161.76	"	129.41

REV 403 codes 77063 & 77067 for routine mammography for screening Shouldn't these service have been paid at 100% versus 80%? Appears claim underpaid 34.40.

(Note: claim xxxxx for reading was paid at 100%)

HSB response: Yes, 77063-TC and 77067 should have reimbursed at 100% of PPO allowed.

Ref. No. 359 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Audited paid as: A7031-NU-KX chg 56.83 allow/pd 28.02
Claim adjusted on 1/10/20 under xxxxx to now pay as: allow/pd 55.90 – an additional 27.88 paid
Appears incorrect discount applied on original (audited) processing?
HSB response: During internal QA audit, EPO claim identified as paying with Aetna in error. Claim corrected on 1/10/20 under xxxxx with correct pricing prior to receipt of random audit extract.

Ref. No. 367 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Labs with DX Z113 paid at 100%
Claim xxxxx same DOS & DX for OV 99213 – 102.60 going to ded
Should this have been paid at 100% same as labs?
HSB response: Yes, xxxxx should have paid at 100% of PPO allowed per MPD page 65. Per USPSTF grade B recommendation counseling services related to sexually transmitted infection is allowed as wellness.

Ref. No. 376 Inpatient Hospital HSB claim no.

Overpayment - $232.01
Provider – Summerlin
3 day vaginal delivery
Claim paid as: allow 7880.00 x 80% = 6304.01 paid
Per my calculation shouldn't allowable have been:
Mat (non Csec) 1st day = 2704.00
Add'l day 2443 x 2 = 4886.00
Allow 7590.00 x 80% = 6072.00
Appears claim overpaid 232.01?
HSB response: Agree, $232.01 overpayment, analyst error.

Ref. No. 383 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider – Renown
Please explain how allowable of 12,131.87 was calculated
(allow 12,131.87 coins 2245.89 pd 9885.98)
Per Renown hospital rates effective 5/1/19 through 12/31/19 calculation reflects allow of $12,047.94

REV 250 $74.00 x 46% = 34.04
255 $65.25 x 49% = 31.97
260 $936.00 x 38% = 355.68
260 $756.00 x 38% = 287.28
CPT 36415 = 1.13
80053 = 15.82
80061 = 15.82
80307 = 7.18
83880 = 16.95
84484 = 11.30
84484-91 = 0.00
86140 = 7.35
85025 = 11.30
85379 = 9.61
85610 = 3.39
85730 = 5.65

REV 324 $623.00 x 30% = 186.90
352 $2017 x 90% = 1815.30
352 $2017 x 90% = 1815.30
450 $4202 x 42% = 1764.84
636 $87.75 x 42% = 36.86
730 $1008 x 88% = 887.04
762 133.55 x 25 units = 3338.75
250 $38.00 x 46% = 17.48
CPT 36415 = 1.13
86140 = 7.35
85652 = 4.52
REV 483 w/CPT 93360-TC = 1358.00

Should have paid as: 12,047.94 – coins 2245.89 = 9802.05. Overpaid 83.93.
HSB response: Lab service fee schedule, multiple rev code priced at % of billed charges, corresponding with amounts indicated in the contract. Observation is a $133.55 per unit. Diagnostic cardiology Rev 433 $1358 per visit when billed with 93306 or 93017.

Ref. No. 431 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Original pd 8/30/18 under xxxxx as:
REV 510, CPT 99214 allow 469.02 penalty 469.02 pd 0.00
Audited is adjustment to now pay as: allow 136.43 copay 45 pd 91.43
Why was penalty applied on original claim?
HSB response: Analyst error.

Ref. No. 433 Medical HSB claim no.

Underpayment - $20.00
90791 – psychiatric diagnostic eval
Claim pd as: allow 161.61 copay 40.00 pd 121.61
Should copay have only been $20 for mental health outpatient office visit?
HSB response: Yes. Analyst error.

Ref. No. 480 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Audited claim reprocessed after subro info received
Claim xxxxx same DOS for assistant surgeon was also denied for subro info however this claim has not been reprocessed.
Shouldn't it have also been reconsidered as others in history were at the time requested info was received?
HSB response: Yes, claim xxxxx should have been corrected when xxxxx was corrected.

Ref. No. 490 Dental HSB claim no.

Overpayment - $112.00
Provider – Whitney Bryant, DDS, claim pd 12/19/19

Non-PPO pd as:	D0120	chg 41.00	allow 32.00	(x80%)	pd 25.60
	D0274	52.00	39.00	"	31.20
	D1110	77.00	69.00	"	55.20

Claim xxxxx paid 12/16/19 provider Regina Crowley, DDS same DOS & exact same services & charges pd as:

D0120	chg/allow/pd 41.00
D0274	52.00
D1110	77.00

These claims appear to be duplicates. Providers are at same address. Review of history shows only Dr. Crowley as dentist.
HSB response: Records indicate that the provider reached out to DDS and HSB on 1/22/20 to advise that their billing office had submitted claims under incorrect TIN for DOS prior to 2/1/20. A report was ran identifying impacted claims and they are in line for reconsideration.

Ref. No. 504 Inpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider – Mountain View
HTH repriced & claim processed with allow of 103,708.00
Shouldn't allowable have been:

DRG 219 case rate (1-6 days)	= 55,370.00
1 additional day	= 3,113.00
REV 278 95194.00 x 40%	= 38,077.60
REV 636 10476.00 x 40%	= 4,190.40
	100,751.00

Appears HTH also allowed sur add-on of 2957.00 which would not apply on case rates. Claim overpaid 2957.00
HSB response: HTH response indicating claim priced incorrectly. Yes they did allow addt'l $2957 as indicated. Corrected pricing returned with total allow of $100,751.00.

Ref. No. 508 Inpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.

Provider – Mountain View

HCA calculation:

DRG 791 – 197401.00 x 46% = 90,804.46

REV 636 10589.00 x 40% = 4235.60

95,040.06

We allowed & paid 95,050.06. appears claim overpaid $10.00.

HSB response: Agree, over allowed/paid $10.00.

27 Corporate Hill
Little Rock, AR 72205

February 27, 2020

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

Subject: Audit Results October 1, 2019 –December 31, 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 second quarter of Plan Year 2020. The audit included 500 claims with paid amounts totaling $266,150.68

HealthSCOPE Benefits is extremely 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 an additional $1.5M through non-network negotiations, subrogation, clinical edits and transplant savings in the second quarter of PY2020.

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