Claims and System Audit Report

for

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

Audit Period: PEBP Plan Year 2020, Quarter Three
January, February and March 2020

Audited Vendor:

HealthSCOPE BENEFITS

Healthy People
Healthy Business
Healthy Futures

Submitted By:
Health Claim Auditors, Inc.
May 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
*Code Creeping	*Procedure, Diagnosis, Place of Service
*Experimental/Cosmetic Proc	*Medical Necessity Guidelines
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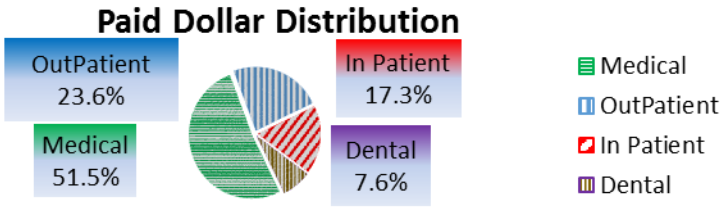
*Quality Control/Internal Audit	*Internet Capabilities
*Communication, U/R and Claims Depts.	
*Claim Repricing	*Banking and Cash Flow
*Reporting Capabilities	*General System

EXECUTIVE SUMMARY

Audited Random Selection Data

Total number of claims: 500
Total Charge Value of random selection: $ 895,979.46
Total Paid Value of random selection: $ 271,303.34



Performance Guaranteed Metric Results

Metric	Guarantee Measurement	Actual	Pass/Fail
Payment Accuracy	≥ 98% of claims audited are to be paid accurately	98.2%	Pass
Financial Accuracy	≥ 99% of the dollars paid for the audited claims is to be paid accurately	99.7%	Pass
Claim Processing Turnaround Time	- 99% of all claims are to be processed within 30 days.	99.16%	Pass
Customer Service	-Telephone Response Time: ≤ 30 seconds. -Telephone Abandonment Rate: ≤ 2%. -First Call Resolution: ≥ 95%	21 sec. 1.6% 96.25%	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.

Incorrect allowable applied;
Supporting reference nos. 066, 104, 200, **295, 350** and 409

Incorrect rate due to network re-pricing;
Supporting reference nos. 167, 507, 510 and 513

Preventive claim/service paid as medical;
Supporting reference nos. 059 and **092**

Claim not reprocessed after requested information received;
Supporting reference nos. 196 and 272

Copay not applied; Supporting reference no. **050**

Medical claim/service paid as preventive; Supporting reference no. **112**

Claim paid after timely filing limitation; Supporting reference no. **122**

Incorrect copay applied; Supporting reference no. **123**

Claim missed when repricing returned; Supporting reference no. 203

Claim adjusted in error; Supporting reference no. 244

Duplicate paid; Supporting reference no. **246**

Incorrect benefit paid for provider; Supporting reference no. **418**

Charge/service paid in error; Supporting reference no. 422

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.

System display issue causing incorrect fee schedule amounts to show in processing; Supporting reference nos. 075 and 250

VA claims no longer utilizing UCS pricing effective 01 October 2019:
Supporting reference no. 087

CLAIM PROCEDURES/SYSTEM CAPABILITIES/SUPPORT DATA

Introduction

In April 2020, Health Claim Auditors, Inc. (HCA) performed a Claims and System Audit of HealthSCOPE Benefits (HealthSCOPE) 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 30 April 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 January 2019 to March 2020 and were processed by HealthSCOPE from 01 January 2020 through 31 March 2020 (PEBP's Third 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	$ 376,613.48	$ 139,706.94	51.5%	368
Outpt. Hospital	$ 317,294.40	$ 64,054.03	23.6%	43
Inpt. Hospital	$ 166,791.26	$ 46,802.79	17.3%	3
Dental	$ 35,280.32	$ 20,739.58	7.6%	86
TOTAL	**$ 895,979.46**	**$ 271,303.34**	**100%**	**500**

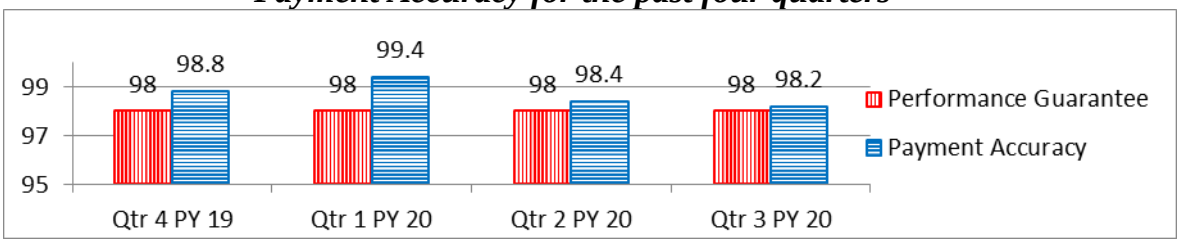
Payment Accuracy

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 98.2%.

Number of claims:	500
Number of claims paid incorrectly:	9
Percentage of claims paid incorrectly:	1.8%
Number of claims paid correctly:	491
Percentage of claims paid correctly:	98.2%

Payment Accuracy for the past four quarters



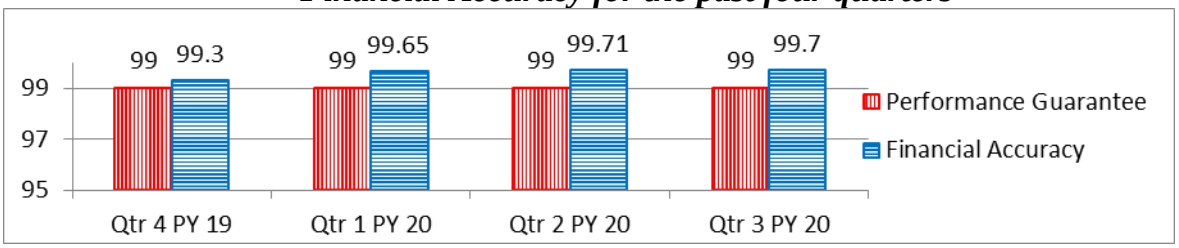
Financial Accuracy

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 99.7%. This audit reflected fifty-six and six tenths percent (56.6%) of the audited errors within the valid random selection were overpayments.

Paid dollars audited	$ 271,303.34
Amount of paid dollars remitted incorrectly	$ 722.18
Percentage of Dollars paid incorrectly	0.3%
Paid Dollars of claims paid correctly	$ 270,581.16
Percentage of Dollars Paid correctly	99.7%

Financial Accuracy for the past four quarters



Historical Statistical Data of Performance Guarantees

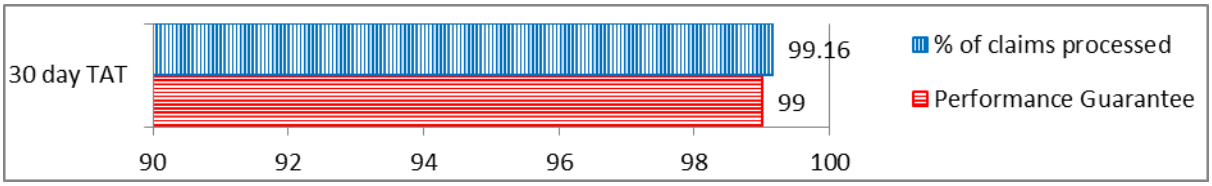
The following reflects the historical statistical data since the origin of PEBP medical claims administration by HealthSCOPE. The entries designated in **bold red type** are measurable categories with underperformance of the Service Performance Guarantees.

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%
3rd Qtr PY 2020	**98.2%**	**99.7%**	**4.1 days**	**:21.0**	**1.60%**	**96.25%**

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 99.16% 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 4.1 days.

Turnaround Time Measurements



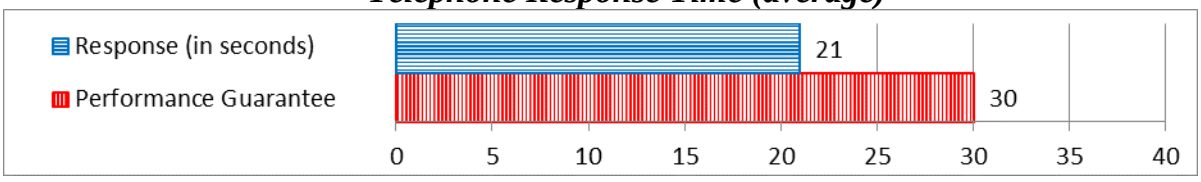
The turnaround time, measured only from the random selected claims, for Medical claims 10.0 calendar days, Out Patient Hospital claims was 9.5 calendar days, In Patient Hospital claims was 9.7 calendar days and Dental claims was 1.7 calendar days.

During the audit period of 01 January 2020 - 31 March 2020, HealthSCOPE had received 1,164 PEBP e-mail inquiries for information via the internet. The average turnaround time for these inquiries was calculated at approximately 6.5 hours.

Customer Service Satisfaction

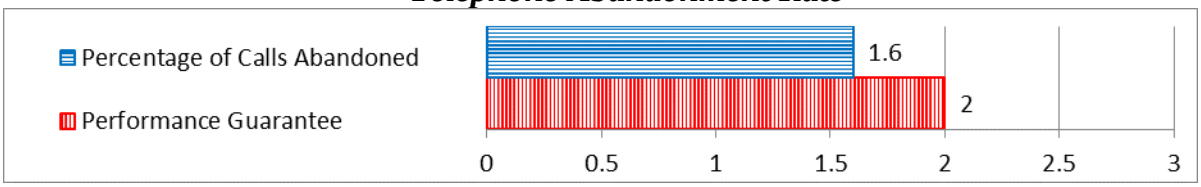
Per the Service Performance Standards and Financial Guarantees Agreement, the telephone response time reflects all calls must be answered within thirty (30) seconds or a penalty of one percent (1%) of Quarterly Administration fees for each second in non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP third fiscal quarter Plan Year 2020, which revealed the average incoming answer speed to be 21 seconds (0:21.0). The telephone response time was 37 seconds for January 2020, 17 seconds for February 2020 and 5 seconds for March 2020.

Telephone Response Time (average)



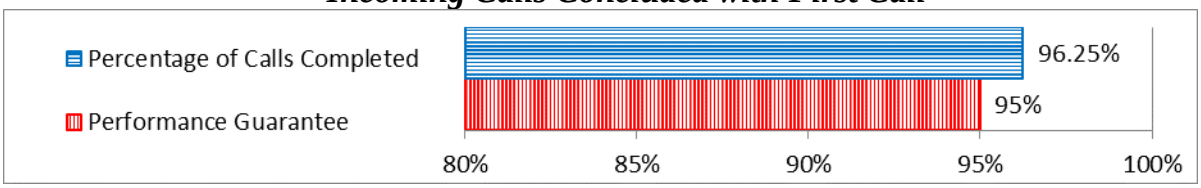
Per the Service Performance Standards and Financial Guarantees Agreement, the abandonment rate must be under two percent (2%) of total calls or a penalty of one percent (1%) of Quarterly Administration fees for each percentage point or fraction thereof in non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP third fiscal quarter Plan Year 2020, which revealed the abandoned calls ratio to be 1.6%. The telephone abandonment rate was 2.7% for Janaury 2020, 1.29% for February 2020 and 0.52% for March 2020.

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 third fiscal quarter Plan Year 2020, which revealed that HealthSCOPE documented 96.25% 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 4,521 claims representing $ 25,612,307.44.

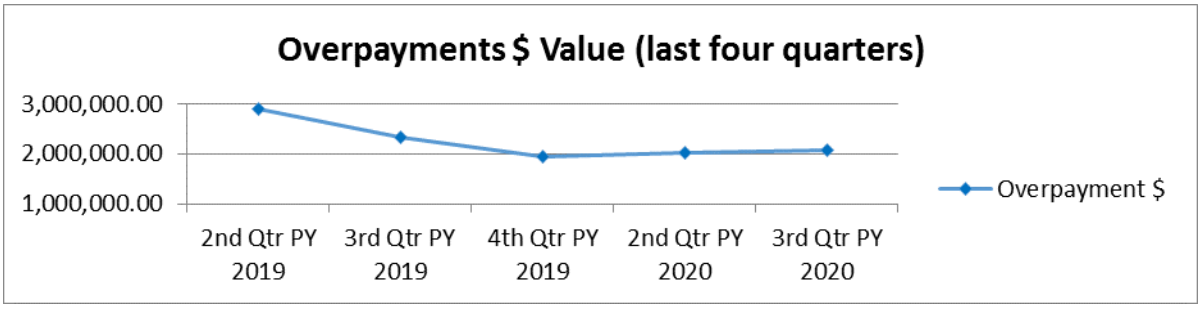
Audit Period	Total Number of Claims	Charge Amount Value of Soft Edits
1st Qtr PY 2012	2,607	$ 7,544,177.55
2nd Qtr PY 2012	4,068	$10,697,954.53
3rd Qtr PY 2012	1,536	$ 6,472,249.56
4th Qtr PY 2012	559	$ 2,205,318.16
1st Qtr PY 2013	1,053	$ 3,413,738.12
2nd Qtr PY 2013	1,107	$ 5,019,961.70
3rd Qtr PY 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
3rd Qtr PY 2020	**4,521**	**$25,612,307.44**

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 $2,076,463.53 (an increase of $60,895.16). 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	$ 102,674.34
- Fiscal Year 2013	$ 142,307.51
- Fiscal Year 2014	$ 60,502.98
- Fiscal Year 2015	$ 146,549.50
- Fiscal Year 2016	$ 182,297.94
- Fiscal Year 2017	$ 102,762.67
- Fiscal Year 2018	$ 342,494.82
- Fiscal Year 2019	$ 174,131.05
- Fiscal Year 2020 (to date)	$ 822,742.72
TOTAL	$2,076,463.53



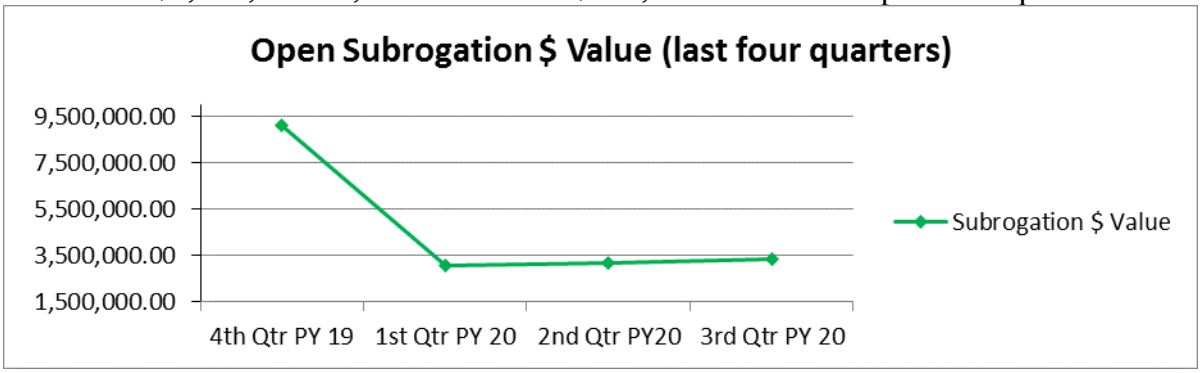
Of the 1,253 most current (Plan Year 2020) identified outstanding overpayments (HSB only), 55% were found to be caused by external sources that are not a cause of the HealthSCOPE adjudication processes. Breakout of the HealthSCOPE's most current overpayments (by claim count) are listed by reason as follows:

20.62%	Incorrect Rate Applied
18.55%	No COB on file
16.07%	Corrected HTH Network Pricing
12.07%	Provider caused, rebilled, charges billed in error, corrected EOB
11.35%	Incorrect Benefit Applied
4.72%	Retro termination
3.04%	Duplicate
2.72%	Paid NON PPO as PPO
2.32%	COB incorrectly calculated or not applied
1.36%	SHO Pricing Correction
1.36%	Previous Information Received
1.36%	Category error
0.64%	Service not covered
0.64%	Benefit Clarification
0.64%	Processed under the incorrect provider
0.40%	Adjusted after Medical Review
0.32%	Processed under incorrect patient
0.32%	Subrogation error
0.24%	Same Day Void
0.16%	Paid PPO provider as NON PPO
0.16%	Aetna network Pricing
0.16%	Workers Compensation Claim
0.08%	Stop Payment
0.08%	Entry Error
0.08%	Pharmacy Deductible Error
0.08%	Incorrect Assignment Applied
0.08%	Adjusted due to Appeal
0.08%	DME paid greater than Purchase Price
0.08%	Pre-Certification 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 $3,360,073.48; an increase of $171,203.20 from the previous quarter.



Reports received from HealthSCOPE reflect that subrogation recoveries for the audited period was $196,401.65. After contingency fees were paid, PEBP received $146,922.15.

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-four (44) active members and thirty-one (31) dependents for a total of 75 active participants, who have obtained this level of plan payment participation representing an accrued dollar paid amount of $100,666,396.91.

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;
- 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 Specialists; **CHANGED**, 2 individuals added and 2 removed for total of 2 individuals
- 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;
- 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. 050 Outpatient Hospital HSB claim no.

Overpayment - $75.00

REV 320	72050-TC	chg 295.00	allow 144.55			pd 144.55
612	72141-TC	890.00	436.10	copay 250		186.10

Per MPD "Non-Specialty Imaging & Diagnostic Testing (including x-rays & ultrasounds) – services provided in a hospital outpatient setting (except Specialty Imaging & Diagnostic testing as listed above) - $75 copay.

Should $75 copay have been applied to REV 320 (72050-TC)?

HSB response: Claim xxxxxx should have assessed an additional $75 copay. Examiner error.

Ref. No. 059 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Originally processed under xxxxxx on 9/13/19 as:

REV 490	chg 953	allow 558.39	penalty 279.20	ded 279.19	pd 0.00
270	18	0.00			0.00
270	20	0.00			0.00

Claim penalized for lack of pre-cert & ded applied
Audited claim is adjustment to now pay as: Chg 991.00 allow/pd 558.39
Claim for routine colonoscopy paid as medical in error applying ded & pre-cert penalty
HSB response: Original claim xxxxxx processed incorrectly. During a routine audit the claim was identified. Claim corrected on 1/6/20 under xxxxxx to pay preventive.

Ref. No. 066 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim originally paid under xxxxxx on 11/27/19 as:
62322-59 chg 1150.00 allow 88.78 (x 80%) pd 71.02
Repriced amount from HTH on this claim shows 575.00
Audited claim is adjusted to now pay as:
62322-59 chg 1150.00 allow 575.00 88.80 x 80% = 71.04

486.20 x 100% =	486.20
	557.24
prev pd	71.02
	486.22

Why was only 88.78 allowed on original processing?
HSB response: Examiner error.

Ref. No. 75 Outpatient Hospital HSB claim no.

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

REV 306	87081	chg 61.00	allow/pd 6.88
306	87150	325.00	36.63
			43.51

Per Renown Lab Fee Schedule 2018, shouldn't claim have pd as:

REV 306	87081	allow/pd 6.22
306	87150	37.29
		43.51

Please explain how allowables were calculated on this claim.
(Total allowable the same but allowed amounts for each service differ from schedule)
HSB response: Claim repriced correctly by HTH. There was a display issue in the PAID BY SERVICE field that was identified and correction completed on 4/9/20.

Ref. No. 087 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider – Reno VAMC
Audited claim paid as: 99283 chg/allow/pd 482.00
Claim xxxxxx DOS 8/29/19 same provider & service paid as:
99283 chg 482.00 allow/pd 53.02
Shouldn't audited claim have been cut back and paid as 53.02?
HSB response: Claim xxxxxx is for the facility ER fee. Claim xxxxxx is for physician charges for services provided during ER visit. The UCR for 99283 is $486, so claim allowed billed charges. Disagree, claim processed correctly.
Additional HSB response received 04 May 2020: PEBP stopped using UCS pricing as of 10/01/2019. This is the reason that the claim for DOS 12/01/2019 was processed correctly.

Ref. No. 092 Medical HSB claim no.

Underpayment - $84.00
Claim originally paid on 10/12/19 under claim xxxxxx as:
00811 chg 560.00 allow 420.00 ded 420.00 pd 0.00
Audited is adjusted claim to now pay as:
00811 chg 560.00 allow 420.00 (x80%) pd 336.00
Per Trans Msg category should have been changed to HM

Shouldn't adjustment have been paid as: 00811 chg 560 allow/pd 420.00
Appears underpaid 84.00
HSB response: Agree, adjusted claim should have paid at 100% of PPO allowed $420.00 Examiner error.

Ref. No. 104 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider: Reno VAMC
Originally paid on 10/28/19 under xxxxxx as:
REV 310 88302-TC allow/pd 38.54
Audited claim is adjustment to now pay as:
Allow/pd 50.17 – paying an additional 11.63
Appears incorrect allowed amount used on original processing?
HSB response: Yes original claim xxxxxx adjusted with updated pricing on 1/18/20 under claim xxxxxx. No error.

Ref. No. 112 Medical HSB claim no.

Overpayment – $44.53

80050	chg 193.50	allow/pd 30.51	
80061	104.50	15.82	
82306	294.50	40.68	
84153	116.50	16.95	(PSA test)
84402	201.50	36.73	
84403	171.50	33.90	
84439	143.50	8.48	
84481	236.50	24.30	
86376	112.43	18.08	
86800	109.57	14.13	

DX: R5383 – other fatigue, E785 hyperlipidemia, E559 Vit D deficiency, Z125 – encounter for screening malig neoplasm prostate

Shouldn't only 84153 have paid at 100% and the rest to ded & coins?

HSB response: Agree, only 84153 should have paid at 100% of the PPO allowed.

HCA Note: In calculating overpayment, HCA has assumed that the member has met their deductible. Claim therefore would have paid $16.95 x 100% plus $222.63 x 80% = $195.05 payable.

Ref. No. 122 Medical HSB claim no.

Overpayment - $27.01

COB w/Medicare

This is the first time this claim has been received. Claim submitted 15 months after DOS. Shouldn't the claim have been denied for timely filing? (Note – appears there may be others in history that were paid & should been denied for timely filing)

HSB response: Agree, claim should have denied timely filing.

Ref. No. 123 Medical HSB claim no.

Over/Underpayment - $0.00

Originally (audited) pd as: 99213 allow 88.16 copay 20 pd 68.16

Claim adjusted under xxxxxx on 4/17/20 as:

99213 allow 84.33 copay 40 pd 44.33

1) Per Trans Msg appears HTH corrected repricing?

2) Why is 40 copay now being applied on adjusted claim?

HSB response: 1) Audit claim xxxxxx was processed correctly with pricing by HTH at that time. 2) Examiner error assessing $40 copay on adjusted claim xxxxxx.

Ref. No. 167 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider: Sunrise
HTH repriced claim at 4649.60 – appears claim repricing calculated as:
CPT 15275 ungrp = 3502.00
Rev 636 2869 x 40% = 1147.60
4649.60
Shouldn't allowable have been:
CPT 15275 ungrp = 3502.00
15004 grp 2 = 1580.00
Rev 636 2869 x40% = 1147.60
6229.60 x 80% = 4983.68
HSB response: Claim repriced incorrectly. Per HTH corrected pricing attached.
HCA Note: Per attached form HTH: "Surgery codes are both ungrouped allowable was updated 3502 for each surgery and Rev code 636". Total allowable now shows as $8,151.60.

Ref. No. 196 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim xxxxxx same DOS for surgeon's charges denied for accident details on 1/22/20. Per member messages info received 2/14/20.
Shouldn't this claim have been reprocessed & paid?
HSB response: Yes should have been corrected at the same time.

Ref. No. 200 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
OOP met
Claim xxxxxx same DOS from Mountain View for ER services charge $38,643.00. Claim paid as: allow/paid 13,370.48
HCA calculates as:
Rev 450 chg 32,641.00 x 49.75% = 16,238.90
636 6002.00 x 31.4% = 1,886.63
18,125.53
Please show how claim was calculated to allow 13,370.48.
HSB response: Agree with auditor, allowed should be $18,125.53.

Ref. No. 203 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim xxxxxx received 1/28/20 for facility fee has BE date of 2/11/20.
Why has this claim not been paid?
HSB response: Examiner oversight, missed when she was working reports when repricing returned.

Ref. No. 244 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Originally claim paid 1/3/20 under xxxxxx paid 553.84

99285	chg 989.00	allow 692.30	pd 553.84
93010	54.00	0.00	0.00
99053	74.00	0.00	0.00

Audited is adjusted due to corrected billing:

99053	chg 74.00	allow 51.80	pd 41.44
99285	1043.00	692.30	553.84

595.28
-553.84 prev pd
41.44 additional paid

Claim then adjusted under xxxxxx on 4/9/20 to take back payment on audited claim
Appears audited claim paid in error?
HSB response: During a routine audit performed claim xxxxxx was identified as being paid incorrectly. Claim was corrected on 4/9/20 prior to receipt of audit extract.

Ref. No. 246 Medical HSB claim no.

Overpayment - $8.53

Audited claim:	36415	chg 22.50	allow 0.00	pd 0.00
	85025	45.50	10.66	8.53

Claim xxxxxx same provider, DOS & services also paid 8.53 on 12/12/19
Appears audited claim is exact duplicate to claim xxxxxx and audited
Claim should have been denied.
HSB response: Paid twice in error. Analyst error.

Ref. No. 250 Outpatient Hospital HSB claim no.

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

REV 300	36415	chg 23.00	allow/pd 2.62	
301	80053	98.00	11.82	
	80061	124.00	14.15	
	83036	90.00	10.27	
	84153	70.00	19.41	
			57.63	

Shouldn't claim have paid as:

36415	allow/pd 1.13	
80053		15.82
80061		15.82
83036		7.91
84153		16.95
		57.63

Total allowable the same but allowed amounts for each services differ from fee schedule. Why?

HSB response: Claim processed correctly with HTH allowed amount.

PAID BY SERVICE display issue was identified on 4/2/20 and corrected on 4/9/20.

Ref. No. 272 Outpatient Hospital HSB claim no.

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

Claims xxxxxx same DOS for surgeon and xxxxxx same DOS were denied for accident info. Accident info received 2/26/20.

Shouldn't these claims have been reprocessed?

HSB response: Yes claim xxxxxx should be adjusted.

Ref. No. 295 Outpatient Hospital HSB claim no.

Underpayment - $229.60

Provider: Spring Valley

Claim paid as: Rev 278	allow 118.51	(x80%)	pd 94.81	
Rev 361 (52332)	944.00	"	755.20	
790 (50590)	472.00	"	377.60	
	1534.51		1227.61	

Shouldn't claim have paid as: allow 1821.51/ paid 1457.21?

Rev 278	allow 118.51	(x80%)	pd 94.81
361	944.00	"	755.20
790	759.00	"	607.20

(Rev 790 CPT 50590 ungrp = 1518.00 x 50% MSG = 759.00)

HSB response: Agree with auditor's calculation.

Ref. No. 350 Inpatient Hospital HSB claim no.

Overpayment -$214.31

Provider: Northern NV

Claim paid as: allow 14,547.48 coins 694.37 pd 13,853.11

Per SHO memo dated 11/18/19 new percent of billed charge amount effective 1/1/20 is now 32.8%

Appears claim calculated using 2019 percent of BC 33.4%

Shouldn't claim have paid as:

Rev 120, 1 day x 2618.00 = 2618.00

278 35,659 x 32.8% = 11692.87

636 68.00 x 32.8% = 22.30

14,333.17 allow

-694.37 coins

13,638.80 payable

Overpaid 214.31

HSB response: Agree with auditor's calculation.

Ref. No. 409 Medical HSB claim no.

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

Claim xxxxxx same DOS for Southern Hills allow 3575.02/paid 2859.98

Shouldn't claim have paid as:

Rev 360 (47562) allow 2433.00

636, 3922 x 31.4% 1231.50

3664.51

HSB response: Agree, auditor's calculation is correct.

Ref. No. 418 Medical HSB claim no.

Overpayment - $39.20

Provider: Doctor on Demand

99212-GT chg 49.00 allow 49.00 (x80%) pd 39.20

MPD says "In-Network: You pay after deductible $49 for primary care visit"

Should we have paid anything on this claim?

HSB response: Member had already met deductible but not maximum OOP. Since deductible met member pays $9.80 coinsurance and plan pays $39.20.

HCA Note: MPD states "Telemedicine (All other telemedicine providers except Doctor on Demand) – Plan pays 80% after Plan Year Deductible". Since this provider is Doctor on Demand member should have paid $49 as deductible was met and plan should have paid zero.

Ref. No. 422 Dental HSB claim no.

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

Claim paid as:

D0170	chg 90.00	allow 70.00	ded 70.00	pd 0.00
D1354	25.00	0.00	0.00	0.00
D1354	25.00	0.00	0.00	0.00

Service D1354 coded with service code FL

Previous claim xxxxxx DOS 2/24/20 same provider for service D1354 coded as SN and paid 18.75 at 100%

Shouldn't D1354 on audited claim have been coded SN and paid 18.75 for each at 100%?

HSB response: D1354 for silver diamine fluoride application which fluoride is a type of fluoride treatment. Member's max benefit was met with claims xxxxxx & xxxxxx. Claim xxxxxx was processed in error to allow D1354. Audited claim xxxxxx processed correctly.

Ref. No. 507 Inpatient Hospital HSB claim no.

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

Provider – Mountain View

HTH allow 108,898.00 at 100%

Claim should have priced as:

Rev 128, 35 days x 3113.00 = 108,955.00

636, 41595.00 x 40% = 16,638.00

125,593.00

Appears incorrect allowed amount used in processing?

(Note: Trans Msg on claim dated 4/16/20 re: allowable)

HSB response: Per HTH priced incorrectly.

Ref. No. 510 Outpatient Hospital HSB claim no.

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

Provider: Mountain View

Originally paid 7/19/19 claim xxxxxx as allow/pd 3113.00

Audited is adjusted claim to now allow: 252,986.00

- 1402.00 rev 636

251,584.00 x 53% = 133,339.52

133,339.52 – prev pd 3113.00 = 130,226.52 additional paid

Appears incorrect HTH pricing on original claim?

HSB response: Original claim xxxxxx HTH repriced the claim with an allowed of $3113.00. HTH then came back with a repriced/adjusted for a total allowed of $133,339.52.

Ref. No. 513 Inpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider: Renown
Claim adjusted multiple times:
Paid 65,974.20 claim xxxxxx on 12/2/19 (HTH repriced = 67,156.95)
Paid 64,693.45 claim xxxxxx on 2/14/20
Paid 67,156.95 claim xxxxxx on 3/4/20
Audited paid 67,156.95 on 3/12/20
Appears allow amount should have been total charge as allow calculated by HCA would be:

Rev 171	1 day x 624.00	=	624.00
172	17 days x 3703.00	=	62,951.00
173	2 days x 3703.00	=	7406.00
278	210.00 x 42%	=	88.20
636	117.26 x 42%	=	49.25
			71,118.45

Shouldn't we have paid full charge amount of 67,346.76?
HSB response: Original claim priced incorrectly by HTH. Pulled pricing from portal. Corrected pricing provided on 4/24/20 – copay attached.
Attached from HTH states: "We are in receipt of your request for review of the linked claim. The review has determined the claim was re-priced correctly. Hometown Health contract calculation is as follow:
Rev 171 – 624.00
Rev 172 – 3703.00 x 17 = 62951.00
Rev 173 – 3703.00 x 2 = 7406.00
Rev 278 – 210.00 x 42% = 88.20
Rev 636 – 117.26 x 42% = 49.25
Total allow 71118.45
Allowable is greater then billed charges, claim allowed billed charges on all lines of service except for Rev 278 and Rev 636 these lines allowed at the 42% bc rate.
HCA Note: Since total allowed amount is greater than billed charges, the billed charges of $67,346.76 would then be the allowable. The member has met OOP so plan would then pay 100% of allowable or $67,346.76. Claim is therefore underpaid $189.81

27 Corporate Hill
Little Rock, AR 72205

May 1, 2020

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

Subject: Audit Results January 1, 2020 –March 31, 2020

Dear Public Employees' Benefits Program (PEBP) Board:

HealthSCOPE Benefits appreciates the opportunity to respond to the audit performed by Health Claim Auditors for the third quarter of Plan Year 2020. The audit included 500 claims with paid amounts totaling $271,303.34.

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 $1M through non-network negotiations, subrogation, clinical edits and transplant savings in the third 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