Claims and System Audit Report

for

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

Audit Period: PEBP Plan Year 2020, Quarter Four
April, May and June 2020

Audited Vendor:

HealthSCOPE BENEFITS

Healthy People
Healthy Business
Healthy Futures

Submitted By:
Health Claim Auditors, Inc.
August 2020

TABLE OF CONTENTS

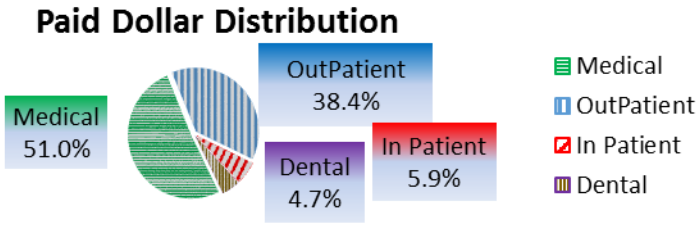
The following categories are reviewed each quarterly audit, however, because of their constant properties, the detail of each category will only be displayed within the first quarter audit of the PEBP fiscal year unless a change or defect is detected:

*HSB System	*HSB Policy/Procedure
*Eligibility	*Deductibles, Benefit Maximums
*Unbundling/Rebundling	*Concurrent Care
*Code Creeping	*Procedure, Diagnosis, Place of Service
*Experimental/Cosmetic Proc	*Medical Necessity Guidelines
*Patterns of Care	*Mandatory Outpatient/Inpatient Procedures
*Duplicate Claim Edits	*Adjusted Claims
*Hospital Discounts	*Hospital Bills and Audits
*Filing Limitation	*Unprocessed Claim Procedures
*R&C/Maximum Allowance	*Membership Procedures
*COBRA	*Provider Credentialing
*Coordination of Benefits	*Medicare
*Controlling Possible Fraud	*Security Access
*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: $1,147,834.68
Total Paid Value of random selection: $ 272,389.23



Performance Guaranteed Metric Results

Metric	Guarantee Measurement	Actual	Pass/Fail
Payment Accuracy	≥ 98% of claims audited are to be paid accurately	98.6%	Pass
Financial Accuracy	≥ 99% of the dollars paid for the audited claims is to be paid accurately	99.8%	Pass
Claim Processing Turnaround Time	- 99% of all claims are to be processed within 30 days.	99.8%	Pass
Customer Service	-Telephone Response Time: ≤ 30 seconds. -Telephone Abandonment Rate: ≤ 2%. -First Call Resolution: ≥ 95%	5 sec. 0.11% 97.45%	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 rate due to network re-pricing;
Supporting reference nos. 120, 160, 165, 217, 278, 417, 428, 443, 450 and 508

Incorrect copay applied;
Supporting reference nos. **070** and 417

Claim/charge denied in error;
Supporting reference nos. 167 and **415**

Incorrect allowable applied;
Supporting reference nos. **277** and **291**

Discount not applied;
Supporting reference no. **034**

Copay applied in error;
Supporting reference no. **046**

DOS not verified on corrected claim before making adjustment;
Supporting reference no. **273**

CLAIM PROCEDURES/SYSTEM CAPABILITIES/SUPPORT DATA

Introduction

In July 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 03 August 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 February 2019 to June 2020 and were processed by HealthSCOPE from 01 April 2020 through 30 June 2020 (PEBP's Fourth 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	$ 445,364.06	$ 139,066.42	51.0%	379
Outpt. Hospital	$ 626,946.72	$ 104,414.56	38.4%	58
Inpt. Hospital	$ 38,837.25	$ 16,130.02	5.9%	1
Dental	$ 36,686.65	$ 12,778.23	4.7%	62
TOTAL	**$1,147,834.68**	**$ 272,389.23**	**100%**	**500**

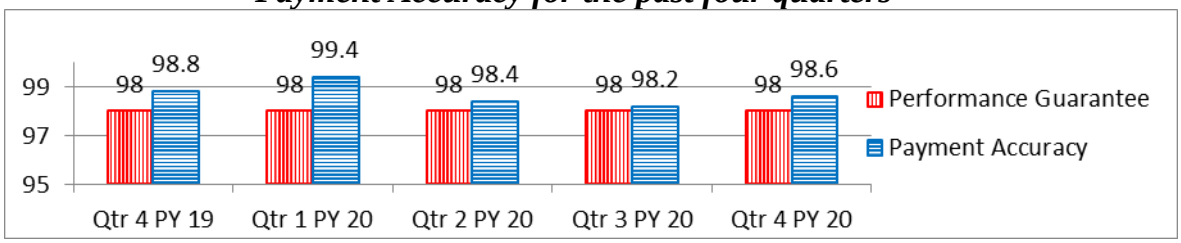
Payment Accuracy

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 98.6%.

Number of claims:	500
Number of claims paid incorrectly:	7
Percentage of claims paid incorrectly:	1.4%
Number of claims paid correctly:	493
Percentage of claims paid correctly:	98.6%

Payment Accuracy for the past four quarters



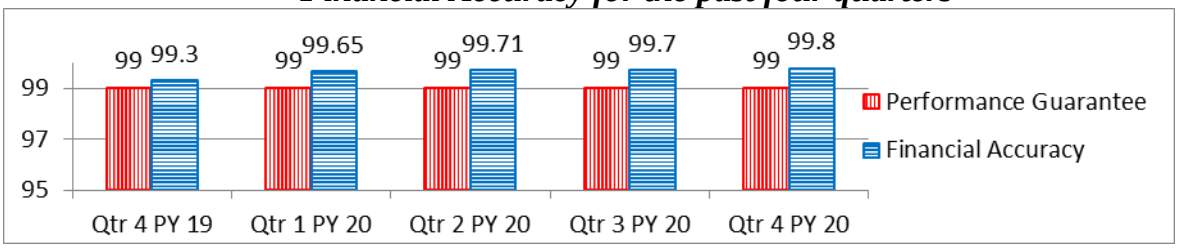
Financial Accuracy

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 99.8%. This audit reflected forty-six and two tenths percent (46.2%) of the audited errors within the valid random selection were overpayments.

Paid dollars audited	$ 272,389.23
Amount of paid dollars remitted incorrectly	$ 298.41
Percentage of Dollars paid incorrectly	0.2%
Paid Dollars of claims paid correctly	$ 272,090.82
Percentage of Dollars Paid correctly	99.8%

Financial Accuracy for the past four quarters



Historical Statistical Data of Performance Guarantees

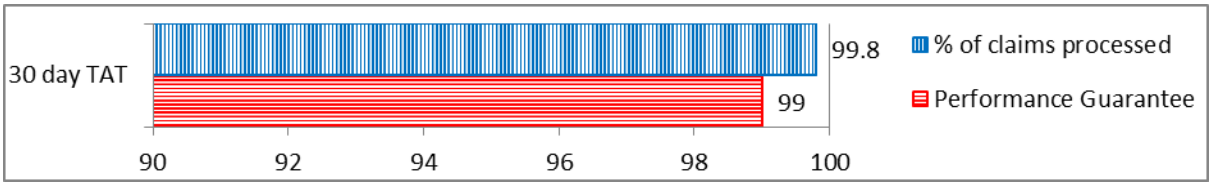
The following reflects the historical statistical data since the origin of PEBP medical claims administration by HealthSCOPE. The entries designated in **bold red type** are measurable categories with underperformance of the Service Performance Guarantees.

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%
4th Qtr PY 2020	**98.6%**	**99.8%**	**3.7 days**	**:05.0**	**0.11%**	**97.45%**

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 99.8% 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 3.7 days.

Turnaround Time Measurements



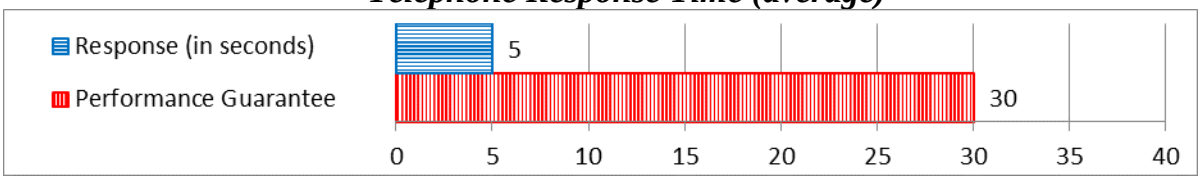
The turnaround time, measured only from the random selected claims, for Medical claims 6.9 calendar days, Out Patient Hospital claims was 7.7 calendar days, In Patient Hospital claims was 4.0 calendar days and Dental claims was 1.5 calendar days.

During the audit period of 01 April 2020 – 30 June 2020, HealthSCOPE had received 1,033 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

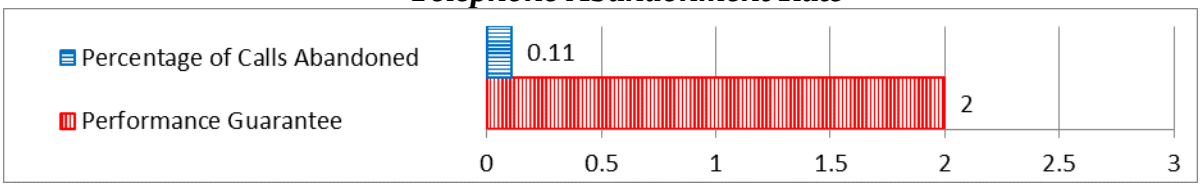
Per the Service Performance Standards and Financial Guarantees Agreement, the telephone response time reflects all calls must be answered within thirty (30) seconds or a penalty of one percent (1%) of Quarterly Administration fees for each second in non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP fourth fiscal quarter Plan Year 2020, which revealed the average incoming answer speed to be 5 seconds (0:05.0). The telephone response time was 3 seconds for April 2020, 4 seconds for May 2020 and 7 seconds for June 2020.

Telephone Response Time (average)



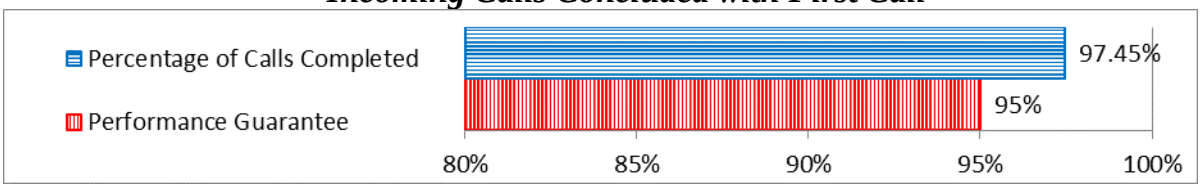
Per the Service Performance Standards and Financial Guarantees Agreement, the abandonment rate must be under two percent (2%) of total calls or a penalty of one percent (1%) of Quarterly Administration fees for each percentage point or fraction thereof in non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP fourth fiscal quarter Plan Year 2020, which revealed the abandoned calls ratio to be 0.11%. The telephone abandonment rate was 0% for April 2020, 0.07% for May 2020 and 0.22% for June 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 fourth fiscal quarter Plan Year 2020, which revealed that HealthSCOPE documented 97.45% 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 3,909 claims representing $ 17,472,693.36.

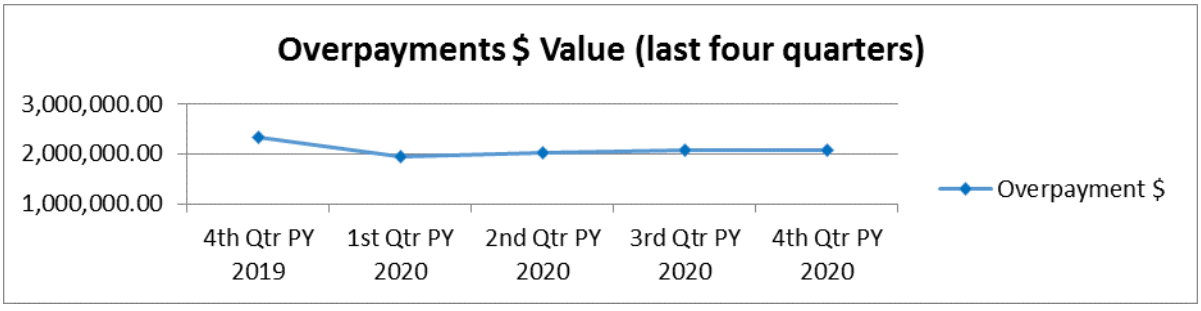
Audit Period	Total Number of Claims	Charge Amount Value of Soft Edits
1st Qtr PY 2012	2,607	$ 7,544,177.55
2nd Qtr PY 2012	4,068	$10,697,954.53
3rd Qtr PY 2012	1,536	$ 6,472,249.56
4th Qtr PY 2012	559	$ 2,205,318.16
1st Qtr PY 2013	1,053	$ 3,413,738.12
2nd Qtr PY 2013	1,107	$ 5,019,961.70
3rd Qtr PY 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
4th Qtr PY 2020	**3,909**	**$17,472,693.36**

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 $2,059,471.76 (a decrease of $16,991.77). 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	$ 101,877.77
- Fiscal Year 2013	$ 140,505.35
- Fiscal Year 2014	$ 60,215.17
- Fiscal Year 2015	$ 131,758.66
- Fiscal Year 2016	$ 182,092.61
- Fiscal Year 2017	$ 99,535.36
- Fiscal Year 2018	$ 328,171.58
- Fiscal Year 2019	$ 141,160.13
- Fiscal Year 2020 (to date)	$ 874,155.13
TOTAL	$2,059,471.76



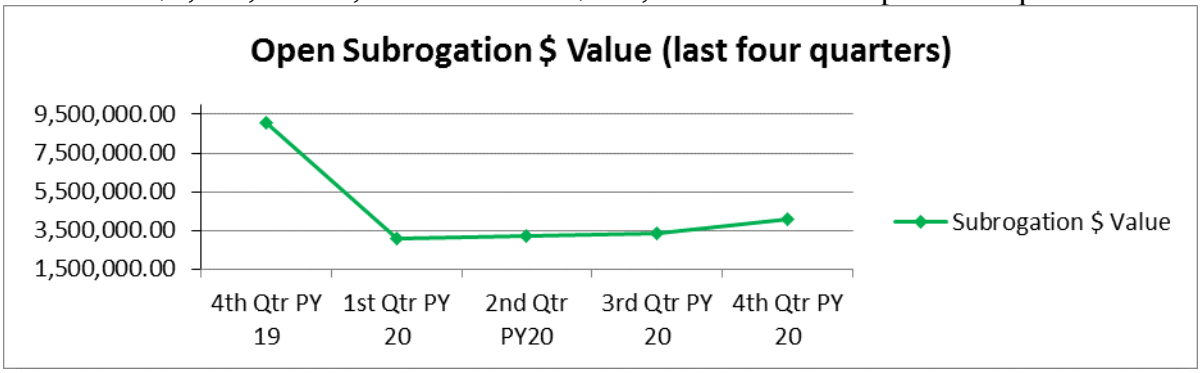
Of the 1,098 most current (Plan Year 2020) identified outstanding overpayments (HSB only), 52% were found to be caused by external sources that are not a cause of the HealthSCOPE adjudication processes. Breakout of the HealthSCOPE's most current overpayments (by claim count) are listed by reason as follows:

15.66%	Incorrect Benefit Applied
15.48%	No COB on file
15.29%	Incorrect Rate Applied
14.75%	Provider caused, rebilled, charges billed in error, corrected EOB
13.93%	Corrected HTH Network Pricing
3.92%	Retro termination
3.55%	Duplicate
3.46%	SHO Pricing Correction
3.10%	COB incorrectly calculated or not applied
1.55%	Previous Information Received
1.09%	Processed under the incorrect provider
0.91%	Paid NON PPO as PPO
0.91%	Service not covered
0.82%	Adjusted after Medical Review
0.64%	Processed under incorrect patient
0.64%	Pharmacy Deductible Error
0.55%	Category error
0.46%	Benefit Clarification
0.46%	Subrogation error
0.46%	Same Day Void
0.36%	Entry Error
0.36%	Pre-Certification Error
0.27%	Paid PPO provider as NON PPO
0.27%	Incorrect Assignment Applied
0.18%	Aetna network Pricing
0.18%	Paid over Maximum
0.18%	System Error
0.18%	Undefined Code
0.09%	Workers Compensation Claim
0.09%	Stop Payment
0.09%	Eligibility 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 $4,049,321.26; an increase of $689,247.78 from the previous quarter.



Reports received from HealthSCOPE reflect that subrogation recoveries for the audited period was $188,509.24. After contingency fees were paid, PEBP received $139,561.92.

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-seven (47) active members and thirty-one (31) dependents for a total of 78 active participants, who have obtained this level of plan payment participation representing an accrued dollar paid amount of $102,000,273.27.

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 Supervisors; **CHANGED**,1 individual added for a total of 2 individuals;
- Claims Analysts, 15 individuals;
- Eligibility Director;
- Eligibility Specialists; 2 individuals;
- Customer Service Vice President;
- Customer Service Director;
- Customer Service Representatives, 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. 034 Medical HSB claim no.

Overpayment - $37.95

99396 chg/allow/pd 253.00

Repricing of 215.05 shown. Appears claim overpaid 37.95.

HSB response: Yes, claim is overpaid by $37.95.

Ref. No. 046 Outpatient Hospital HSB claim no.

Overpayment - $12.43

Rev 300 (36415) allow 1.13 copay 1.13 paid 0.00

305 (85025) 11.30 11.30 0.00

920 (93971) 303.60 75.00 228.60

Since lines 1 & 2 are for lab services shouldn't no copay have been applied?

HSB response: Yes, a $75.00 copay should apply for OP diagnostics, not $87.43.

Ref. No. 070 Medical HSB claim no.

Underpayment - $20.00

90837 allow 163.77 copay 40.00 paid 123.77

Claim paid under category GR & taking $40 copay. DX F411, F641

Shouldn't this have paid as MN taking $20 copay?

(Note all claims in history this provider paid under category GR)

HSB response: Yes, claim should take a $20 copay.

Ref. No. 120 Medical HSB claim no.

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

Claim originally paid 2/13/20 under xxxxxx as:

97803 allow/paid 33.36

Audited is adjustment done 4/17/20 to pay additional 116.64

97803 chg/allow/pd 150.00

Appears HTH sent corrected pricing?

HSB response: Yes, HTH did send corrected pricing.

Ref. No. 160 Medical HSB claim no.

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

Claim xxxxxx paid 3/18/20 – COB info needed

Audited paid 4/24/20 as: 00170-AA-P1 allow/paid 567.84

Claim xxxxxx paid 5/19/20 corrected pricing:

Allow 590.52, paid additional 22.68

Appears HTH corrected pricing?

HSB response: Yes, HTH did send corrected pricing.

Ref. No. 165 Medical HSB claim no.

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

Claim originally paid 2/26/20 under xxxxxx as:

Allow/paid 444.00

Audited claim paid 4/27/20 as:

Allow 684.66, additional 240.66 paid

Appears HTH corrected pricing?

HSB response: Yes, HTH did send corrected pricing.

Ref. No. 167 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
COB w/Medicare
Claim originally processed 4/16/20 under xxxxxx – denied requesting OI info – Medicare info came in with claim
Audited is now paying on 4/29/20 COB's with Medicare
Shouldn't we have paid the claim when originally received versus denying?
HSB response: Yes, original claim xxxxxx should have been paid with Medicare information received on claim.

Ref. No. 217 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim originally paid 2/17/20 under xxxxxx as:
01214 allow 1054.56 paid 843.65
Audited paid 5/4/20 is adjustment to now allow 1096.68, paying an additional 33.69
Appears HTH provided corrected pricing?
HSB response: Yes, HTH submitted corrected pricing for 01214.

Ref. No. 273 Medical HSB claim no.

Over/Underpayment - $0.00

DOS	5/6	99233	chg 165	allow 0.00	paid 0.00
	5/6	99233	165	50.11	40.09
	5/7	99233	165	50.11	40.09

Claim xxxxxx paid 6/15/20 is adjustment per trns msg provider corrected DOS. Paid now as:

DOS	3/8	99233	allow 50.11	pd 40.09
	5/6	99233	50.11	40.09
	5/6	99233	50.11	50.11

Does not appear per history review that member was inpatient in March 2020. Hospital bill in history for DOS 5/4-5/6/20.
Shouldn't DOS have been confirmed with provider before adjusting?
HSB response: Original claim xxxxxx paid on 5/16/20 paid correctly at the time of receipt. Yes, charges on corrected claim should have been verified prior to making adjustment under claim xxxxxx.

Ref. No. 277 Outpatient Hospital HSB claim no.

Underpayment - $53.39

Provider – Flamingo Surgery Center

Claim paid as: 29848 case rate = 1129.00

25115 742.52 at 50% = 371.26

1500.26 x 80% = 1200.21 paid

Shouldn't allowable have been: 29848 case rate = 1129.00

Grp 4 25115 = 925 x 50% = 462.50

1591.50 x 80% = 1273.20

HSB response: 29848 case rate = $1129.00

25115 grp 3 (876 x 50%) = $438.00

Total allow $1567.00 x 80% = $1253.60

Underpaid $53.39

HCA note: Per CMS, CPT 25115 = ASC grouper 4 but XXXX contract does display CPT 25115 as grouper 4 for this plan.

Ref. No. 278 Medical HSB claim no.

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

Originally claim paid 3/17/20 under xxxxxx as:

01996 allow/paid 243.36

Audited paid 5/14/20 is adjustment to now pay as:

Allow 253.08 – additional 9.72 paid

HSB response: Yes, HTH submitted corrected pricing for 01996.

Ref. No. 291 Outpatient Hospital HSB claim no.

Overpayment - $96.72

Provider – Henderson Surgery Center

Per suspense memo 43239 allow = 435.32

Why was claim paid with allow of 556.23?

HSB response: Agree. Allowable should be $435.32.

Ref. No. 320 Outpatient Hospital HSB claim no.

Provider – Sunrise

Claim paid as CPT 37243 case rate = 3684.00

Rev 278 (w/C2616) = 19984.00

23,668.00

Appears rates used are HCA Children's Trauma Rates

** Additional Question – Contracts under Mountain View and Southern Hills show standard HCA contract rates which are different then the rates shown for the contract listed in Nevada Auditors file for Sunrise.

Sunrise does have a children's hospital and rates by contract are usually higher than for adults.

Attached pg. 20 & 23 from contract sent with response clearly states "HCA Children's Trauma Rate Attachment".

Should the rates at Sunrise for adults be the same as the rates shown on contracts for Mountain View & Southern Hills?

HSB response: I have confirmed that this Sunrise Agreement is not just a Children's Trauma Agreement. It is the Sunrise Agreement but is sometimes known as a Children's Hospital as well.

Ref. No. 415 Outpatient Hospital HSB claim no.

Underpayment - $78.12

Provider – Carson Tahoe

Paid as: allow 7629.84 n/c 186.00

Rev 278 1548.00 x 42% = 650.16

636 568.20 x 42% = 238.64

13757.20 x 49% = 6741.04

7629.84

1) Why were Rev 636 charges 66.70 & 119.30 not covered?

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

2) Surgeon & facility (audited claim) claims paid. Claim xxxxxx same DOS for anesthesia was denied 6/3/20. Shouldn't this claim have been paid?

HSB response: 1) REV 636 for $66.70 & $119.30 should have been paid.

2) Claim xxxxxx for anesthesia should have been paid.

Ref. No. 417 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider – Renown
Claim paid on 6/12/20 as: allow 1792.41 – copay 286.13 = 1506.28
Claim adjusted on 7/17/20 under xxxxxx to now pay as:
Allow 933.36 – copay 250.00 = 683.36
1) Appears HTH pricing incorrect on audited claim?
2) Why was copay of 286.13 originally applied?
HSB response: 1) HTH repriced the claim. 2) Examiner applied the allowable for REV 255 to copay incorrectly.

Ref. No. 428 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider – Renown
Audited is original claim paid 6/13/20 as:
Rev 761 1048 x 32% = 335.36 x 80% = 268.29
Claim adjusted on 7/21/20 under xxxxxx as:
1048.00 x 28% = 293.44
Appears HTH corrected pricing?
HSB response: Yes, HTH repriced the claim.

Ref. No. 443 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider – Renown
Rev 343 chg 828.00 allow 389.16 paid 311.33
404 7216.00 4257.44 3405.95
3717.28 paid 6/16/20
Claim adjusted under xxxxxx on 7/20/20 as:
Rev 343 allow 389.16 paid 311.33
404 2020.48 1616.38
1927.71
Appears that HTH corrected pricing?
HSB response: Yes, HTH repriced the claim

Ref. No. 450 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim xxxxxx paid 6/23/20 from Renown as:
chg 33983.75 allow 13743.44 coins 1714.71 paid 12028.73
Claim adjusted 7/22/20 under xxxxxx as:
allow 12931.00 coins 1714.71 paid 11,216.29
HSB response: HTH repriced claim.

Ref. No. 508 Inpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider – Carson Tahoe (DRG 462)
Original claim paid on 3/31/20 under xxxxxx not paying for implants –
Allow 11,304.96 copay 500 paid 10804.96
Audited is to now pay implants on 5/5/20 as:
R278 $27154.00 x 42% = 11,404.68
Please explain how total allow of 22,709.64 was calculated
HCA calculates allow as:
R110 2 days x 2694.22 = 5388.44
278 27154.00 x 42% = 11404.68
16793.12
HSB response: HTH Recon xxxxx. Per attached from HTH, pricing incorrect and will be returned.
HCA Note: Per attached from HTH: "We are in receipt of your request for review of the linked claim. This review has determined the claim was re-priced incorrectly. Hometown Health contract calculation is as follows: Inpatient Medical per diem 2826.24 x 2 = 5652.48, Surgical add-on 2826.24 this should only be one surgery add on line, 278 27154.00 x 42% = 11404.68."

27 Corporate Hill
Little Rock, AR 72205

August 25, 2020

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

Subject: Audit Results April 1, 2020 – June 30, 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 fourth quarter of Plan Year 2020. The audit included 500 claims with paid amounts totaling $272,389.23.

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 an additional $1.7M through non-network negotiations, subrogation and claims edit savings in the fourth 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