Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employees' Benefits Program Plans

Administered by HealthSCOPE Benefits

Audit Period: October 1, 2020 through December 31, 2020
Audit Number 1.FY21.Q2

Presented to

State of Nevada Public Employees' Benefits Program

Revised March 9, 2022

CLAIM TECHNOLOGIES INCORPORATED

TABLE OF CONTENTS

EXECUTIVE SUMMARY

This ***Quarterly Findings Report*** is a compilation of the detailed information, findings, and conclusions drawn from Claim Technologies Incorporated's (CTI's) audit of HealthSCOPE Benefits' (HealthSCOPE) administration of the State of Nevada Public Employees' Benefits Program's (PEBP) medical, dental, and health reimbursement arrangement (HRA) plan.

Scope

CTI performed an audit of HealthSCOPE's administration of the PEBP's medical, dental and HRA for the period of October 1, 2020 through December 31, 2020 (quarter 2 (Q2) for Fiscal Year (FY) 2021). The population of claims and amount paid during the audit period reported by HealthSCOPE Benefits:

Medical and Dental	
Total Paid Amount	$50,948,921
Total Number of Claims Paid/Denied/Adjusted	208,793
Health Reimbursement Arrangement (HRA)	
Total Paid Amount	$1,655,551
Total Number of Claims Paid/Denied/Adjusted	17,483

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

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

Auditor's Opinion

Based on these findings, and in our opinion:

1. HealthSCOPE provided good customer service to PEBP's members by exceeding telephone response time, abandonment rate, and first call resolution.
2. HealthSCOPE should:
    - Review the 100% Electronic Screening with Targeted Sampled results and focus on the most material findings in Spinal Region Upcoding, Duplicate Claims Payments, Air Ambulance Prior Authorization Requirements, Timely Filing of Claims, and Dental Plan Exclusions.
    - Review the Random Sample Audit results and focus on making system improvements and/or providing coaching and feedback to examiners to prevent similar errors going forward. This will improve performance guarantee results and prevent future penalties from being owed to PEBP.

Summary of HealthSCOPE's Guarantee Measurements

Based on CTI's Random Sample Audit results, HealthSCOPE met both claims processing measurements for PEBP in Q2 FY2021.

Quarterly Guarantee	Measure	Met/Not Met	Penalty
Financial Accuracy	99%	Met – 99.80%	None.
Payment Accuracy	98%	Met – 98.00%	None.

AUDIT OBJECTIVES

This report contains CTI's findings from our audit of HealthSCOPE Benefits' (HealthSCOPE) administration of the State of Nevada Public Employees' Benefits Program (PEBP) plans. We provide this report to PEBP, the plan sponsor, and HealthSCOPE, the claim administrator. A copy of HealthSCOPE's response to these findings can be found in the Appendix of this report.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and information provided by PEBP and HealthSCOPE. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to obtain a reasonable assurance claims were adjudicated according to the terms of the contract between HealthSCOPE and PEBP.

CTI would like to note that per Attachment AA4 of the Service Performance Standards, Service Guarantees and Financial Penalties document provided to CTI and executed by HealthSCOPE and PEBP in January 2011, under Service Performance Standards I and II, bullet four, sub-bullet two – *If the claim is corrected by Vendor prior to the date (as determined by the health plan auditor) on which PEBP's health plan auditor sends to Vendor a list of claims to be included in the random sample, the error will not be included in the calculation of the Claim Payment Accuracy and/or Financial Accuracy metrics.* Claims identified that fall into this category are noted under the Additional Observations section of our findings reports and would have otherwise been counted as errors against HealthSCOPE's financial and claim payment accuracy results based on CTI's existing audit methodology and continuous quality improvement philosophy.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of policies, procedures, and systems HealthSCOPE used to pay PEBP's claims during the audit period. While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

The objectives of CTI's audit of HealthSCOPE's claim administration were to determine whether:

- HealthSCOPE followed the terms of its contract with PEBP;
- HealthSCOPE paid claims according to the provisions of the plan documents and if those provisions were clear and consistent; and
- members were eligible and covered by PEBP's plans at the time a service paid by HealthSCOPE was incurred.

OPERATIONAL REVIEW PERFORMANCE GUARANTEES

Performance Guarantees

As part of CTI's quarterly audit of PEBP, we reviewed the Performance Guarantees included in its contract with HealthSCOPE. The results for Q2 FY2021 follow.

Metric	Guarantee Measurement	Actual	Met/ Not Met
Financial Accuracy	99% or greater of the dollars paid for the audited medical/dental claims to be paid accurately.	99.80%	Met
Payment Accuracy	98% or greater of medical/dental claims audited are paid accurately.	98.00%	Met
Claim Processing Turnaround	99% of all medical/dental claims are to be processed within 30 days	99.89%	Met
Customer Service	• Telephone Response Time less than 30 seconds for inbound calls. • Telephone Abandonment Rate less than 3% First call Resolution greater or equal to 95%	6 Seconds Less than .5% 97.82%	Met Met Met
Data Reporting	• 100% of standard reports within 10 business days • Annual/Regulatory Documents within 10 business days of the Plan Year	No exceptions noted. NA – Annual Report	Met NA
Disclosure of Subcontractors	• Report access of PEBP data within 30 calendar days • Removal of PEBP member PHI within 3 business days after knowledge	No exceptions noted. No exceptions noted.	Met Met

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

CTI's Electronic Screening and Analysis System (ESAS) software identified and quantified potential claim administration payment errors. PEBP and HealthSCOPE should discuss any verified under- or overpayments to determine the appropriate actions to correct the errors.

Scope

CTI electronically screened 100% of the service lines processed by HealthSCOPE during the audit period for both medical and dental claims. The accuracy and completeness of HealthSCOPE's data directly impacted the screening categories we completed and the integrity of our findings. We screened the following high-level ESAS categories to identify potential amounts at risk:

- Duplicate payments to providers and/or employees
- Plan exclusions and limitations
- Multiple surgical procedures

Methodology

We used ESAS to analyze claim payment accuracy as well as any opportunities for system and process improvement. Using the data file provided by HealthSCOPE, we readjudicated each line on every claim the plan paid or denied during the audit period against the plan's benefits. Our Technical Lead Auditor tested a targeted sample of claims to provide insight into HealthSCOPE's claim administration as well as operational policies and procedures. We followed these procedures to complete our ESAS process:

- ***Electronic Screening Parameters Set*** – We used your plan document provisions to set the parameters in ESAS.
- ***Data Conversion*** – We converted and validated your claim data, reconciled it against control totals, and checked it for reasonableness.
- ***Electronic Screening*** – We systematically screened 100% of the service lines processed and flagged claims not administered according to plan parameters.
- ***Auditor Analysis*** – If claims within an ESAS screening category represented a material amount, our auditors analyzed the findings to confirm results were valid. Note than using ESAS could lead to false positives if there was incomplete claim data. CTI auditors made every effort to identify and remove false positives.
- ***Targeted Sample Analysis*** – From the categories identified with material amounts at risk, we selected the best examples of potential under- or overpayments to test. As cases were not randomly selected, we cannot extrapolate results. We selected 50 cases and sent your administrator a questionnaire for each. Targeted samples verified if the claim data supported our finding and if our understanding of plan provisions matched HealthSCOPE's administration.
- ***Audit of Administrator Response and Documentation*** – We reviewed the responses and redacted the responses to eliminate personal health information. Based on the responses and further analysis of the findings, we removed false positives identified from the potential amounts at risk.

Findings

We are confident in the accuracy of our ESAS results. It should be noted that the dollar amounts associated with the results represent potential payment errors and process improvement opportunities. We would have to perform additional testing to substantiate the findings that could then provide the basis for remedial action planning or reimbursement.

Categories for Process Improvement

The following detail report shows, by category, the number of line items or claimants with process improvement opportunities remaining after our analysis and removal of verified false positives. A CTI auditor reviewed the responses and supporting documentation. The administrator responses are copied directly from HealthSCOPE's reply to audit findings.

Process Improvement Summary Report				
Client: PEBP **Screening Period:** Q2 FY2021				
Category	**Number of Service Codes**	**Number of Members**	**Billed Charge**	**Allowed***
Fraud, Waste and Abuse				
Spinal Region Upcoding – Number of spinal regions treated does not match number of spinal regions billed and allowed.	1,217	424	$81,866	$37,668

**Allowed equals total paid by plan and member combined.*

Electronic screening of all service lines processed revealed the potential for incorrectly paid claims. Analysis confirmed the opportunity for process improvement and further testing is recommended. For each potential error, we sent an ESAS Questionnaire (QID) to HealthSCOPE for written response. After review of the response and additional information provided, CTI confirmed the potential for process improvement. Note that all recommendations for HealthSCOPE process improvements will also be included in the Q4 FY2021 report.

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

Paid Greater Than Charged – HealthSCOPE paid six service codes for four members for a total allowed amount of $986.00.

Paid Greater than Charged Detail Report				
QID	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
M8	$208.40	Agree. Plan pays according to Medicare allowed amount. Claim is from a rural health clinic; Medicare pays more than billed charge. Allowed should have been $86.00 with a $17.20 payment. This claim has not been adjusted.	Procedural deficiency and overpayment remain. HealthSCOPE paid $225.60 and should have only paid $17.20.	☒ M ☐ S

Fraud, Waste, and Abuse (FWA) Detail Report					
QID	**Category**	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
M27	Spinal Region Upcoding	$35.00	Disagree. The claim was adjudicated based on the plan guidelines for Chiropractic care based on the agreement with Sierra Healthcare Options. This was in investigated, there were not clinical edits and the claim was paid according to the plan guidelines.	Procedural deficiency and overpayment remain. The description for CPT codes for chiropractic care includes the number of regions of the spine or extraspinal regions treated and should be supported by the diagnosis. The provider billed five or more spinal regions treated; however, the diagnosis billed supported treatment of only two spinal regions. These procedures are spinal region driven and should be billed with appropriate diagnosis codes to support billing.	☐ M ☒ S
M28		$30.97	Disagree. The claim was adjudicated based on the plan guidelines for Chiropractic care based on the agreement with Hometown Healthcare. This was in investigated, there were not clinical edits and the claim was paid according to the plan guidelines.		☐ M ☒ S
M29		$23.65			☐ M ☒ S

Categories for Potential Amount at Risk

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

Categories for Potential Amount at Risk				
Client: PEBP **Screening Period:** Q2 FY2021				
Category	**Number of Service Codes**	**Number of Members**	**Billed Charge**	**Allowed***
Duplicate Payments				
Providers and/or Employees	205	49	$205,141	$48,679
Plan Limitations				
Air Ambulance Pre-Authorization Required	7	4	$280,523	$51,193
Hearing Aids $1,500/Device Every 3 Years	6	4	$20,025	$6,657
TMJ In-Network Limited to 50%	54	23	$7,980	$3,612
Timely Filing	1,738	313	$3,725,301	$1,237,705
Plan Exclusions				
Dental, Other Surgical Procedures	173	157	$115,766	$54,477
Dental, TMJ	4	3	$3,535	$1,783

**Allowed equals total paid by plan and member combined.*

Electronic screening of all service lines processed revealed the potential for incorrectly paid claims. Analysis confirmed the opportunity for process improvement and further testing is recommended.

Duplicate Payment Detail Report				
QID	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
M11	$45.99	Agree. Claim has not been adjusted.	Procedural deficiency and overpayment remain. Provider was paid twice for date of service 06/01/20.	☒ M ☐ S
M16	$335.35	Agree. Auto recoupment of overpayment on 08/30/21.	Procedural deficiency and overpayment remain. Duplicate payment as agreed. Overpayment recouped 08/30/21.	☒ M ☐ S
M17	$1,298.99			☒ M ☐ S
M18	$1,323.32			☒ M ☐ S
M19	$8,511.60			☒ M ☐ S
M20	$3,474.67			☒ M ☐ S
M23	$334.31	Agree. Claim has not been adjusted.	Procedural deficiency and overpayment remain. Duplicate payment as agreed.	☒ M ☐ S
M24	$193.05			☒ M ☐ S

Plan Limitations Detail Report					
QID	**Category**	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
D1	Timely Filing – within 12 months from the date of service	$453.50	Disagree. Original claim XXX.XXX3620 was received on 09/10/19. Claim was reconsidered to pay D2740.	Procedural deficiency and overpayment remain. The date of service was 7/10/19 and the claim was initially received on 7/15/19 and paid. The claim was then resubmitted three times on 9/10/19, 3/28/20, and 4/2/20 and each time the claim was denied as a duplicate. The claim was then submitted on 10/27/20 with additional information for reconsideration and an additional $50 was paid out to the provider on 10/29/20.	☒ M ☐ S
D2		$63.20	Disagree. Original claim was received on 04/17/19 and denied for periodontal charting. Provider faxed perio-chart requesting reconsideration on 09/22/20.	Procedural deficiency and overpayment remain. The date of service was 2/27/19 and the claim was initially received on 3/18/19. The claim was denied for periodontal charting. The provider resubmitted the claim a second time without the requested charting on 4/17/19 and was denied again. The claim was received a third and final time on 9/22/20 with the claim adjusted and paid on 11/17/20.	☒ M ☐ S
M3		$40,065.00	Disagree. Original claim XXX.XXX9773 received on 03.16.20 and denied for EOMB. The EOMB received and claim adjusted on	Procedural deficiency and overpayment remain. The date of service was 6/13/19 and the claim was initially received on 11/13/19. The claim was denied	☒ M ☐ S

Plan Limitations Detail Report					
QID	**Category**	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
			11/30/20. Claim was manually processed.	for an Explanation of Medicare Benefits (EMOB). The provider resubmitted the claim a second time without the EMOB on 3/16/2020 and was denied again. The claim was received a third and final time on 11/25/20 with the claim adjusted and paid on 11/30/20.	
M33	Hearing Aids $1,500/Device Every Three Years	$887.13	Agree. Claim did exceed the plan limitation. Provider refund check number 90340 received 02/23/21.	Procedural deficiency and overpayment remain. Paid over the plan limit of $3,000.	☒ M ☐ S
M34	TMJ In-Network Limited to 50%	$25.13	Agree. The claim should have paid at 50% of the PPO allowed amount after the deductible. Records were received to support the medical necessity for services. Claim was manually processed.	Procedural deficiency and overpayment remain. After deductible, the plan pays 50%. HealthSCOPE paid $67.01 and should have paid $41.88.	☐ M ☒ S
M35		$10.08	Disagree. Claim was paid based on the physical therapy benefit as described in the plan benefits.	Procedural deficiency and overpayment remain. Claim was incorrectly paid under the physical therapy benefit. The primary diagnosis was left temporomandibular joint disorder, unspecified – which is not considered physical therapy. Benefit should have been 50% after deductible.	☒ M ☐ S
M37	Air Ambulance Pre-Authorization Required	$9,452.66	Waiting for documentation of approval from client (PEBP).	Procedural deficiency and overpayment remain. HealthSCOPE paid for services prior to approval.	☒ M ☐ S

There were also six errors found under the dental benefit plan for excluded services paid. CTI's review indicated four "Other Dental Surgical Procedures" paid for a total of $949.30 including:

- two Sinus Augmentation claims;
- one Collection and Application of Autologous, Blood Concentrate Product claim; and
- one Frenectomy claim.

The remaining two dental claims paid for excluded services were for TMJ and totaled $611.80 including:

- one Arthrocentesis, joint aspiration claim; and
- one reposition of teeth grafting claim.

In CTI's experience the PEBP's dental plan document is vague and/or silent on a number of dental services. We recommend that the language be updated to indicate specifically which services are covered and which are excluded. This will eliminate the option for medical necessity which means any claim currently submitted is being paid.

Additional Observations

During the ESAS review, our auditor observed the following procedures or situations that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

Observation	QID Number
HealthSCOPE paid more than billed charge. It should consider including lesser of language in its provider contracts to prevent paying more than billed charge.	M9

RANDOM SAMPLE AUDIT

Objectives

The objectives of our Random Sample Audit were to determine if medical and dental claims were paid according to plan specifications and the administrative agreement, to measure and benchmark process quality, and to prioritize areas of administrative deficiency for further review and remediation.

Scope

CTI's statistically valid Random Sample Audit included a stratified random samples of 200 paid or denied claims. HealthSCOPE's performance was measured using the following key performance indicators:

- Financial Accuracy
- Accurate Payment
- Accurate Processing

We also measured claim turnaround time, a commonly relied upon performance measure.

In addition, CTI sampled 50 health reimbursement arrangement (HRA) claims to ensure payment and processing accuracy.

Methodology

Our Random Sample Audit ensures a high degree of consistency in methodology and is based upon the principles of statistical process control with a management philosophy of continuous quality improvement. Our auditors reviewed each sample claim selected to ensure it conformed to plan specifications, agreements, and negotiated discounts. We recorded our findings in our proprietary audit system.

When applicable, we cited claim payment and processing errors identified by comparing the way a selected claim was paid and the information HealthSCOPE had available at the time the transaction was processed**. It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so you can discuss how to reduce errors and re-work in the future with your administrator.**

CTI communicated with HealthSCOPE in writing about any errors or observations using system-generated response forms. We sent HealthSCOPE a preliminary report for its review and written response. We considered HealthSCOPE's written response, as found in the Appendix, when producing our final reports. Note that the administrator responses have been copied directly from HealthSCOPE's reply.

Financial Accuracy

CTI defines Financial Accuracy as the total correct claim payments made compared to the total dollars of correct claim payments that should have been made for the audit sample.

The claims sampled and reviewed revealed $33.03 in underpayments and $655.05 in overpayments, for an absolute value variance of $688.08.

The weighted Financial Accuracy rate was 99.80%.

Financial Accuracy and Accurate Payment Detail Report						
Error Description	**Audit No.**	**Under/ Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**	
Coinsurance	M1082	$632.90 – Over	Agree. The claim was paid with the wellness benefit.	Procedural error and overpayment remain. The out-of-pocket maximum was not satisfied.	☒ M ☐ S	
	M1138	$22.15 – Over	Agree the CPT 17110 should have been considered with coinsurance. The overpayment amount should be $22.15. CPT 99202-25 paid correctly at 100% per guidelines.	Procedural error and overpayment remain. CPT 17110 should have been considered with coinsurance.	☒ M ☐ S	
Subtotal	**2**					
Deductible Error	M1143	$33.03 – Under	Agree. Claim should have paid 100% of PPO allowed amount per plan guidelines.	Procedural error and underpayment remain. HIV screening in adults aged 15 – 65 is a considered preventive.	☒ M ☐ S	
Subtotal	**1**					
TOTALS	**3**	**VARIANCE $688.08**			**M: 3**	**S: 0**

Accurate Payment

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

The audit sample revealed 3 incorrectly paid claims and 197 correctly paid claims. Note CTI only uses adequately documented claims for this calculation.

Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid Claims	Overpaid Claims	
200	1	2	98.00%

Accurate Processing

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

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
196	0	4	98.00%

Accurate Processing Detail Report				
Error Description	**Audit No.**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
Policy Provision				
Coinsurance Error	M1082	Agree.	Procedural error remains. The out-of-pocket maximum was not satisfied.	☒ M ☐ S
	M1138	Agree the CPT 17110 should have been considered with coinsurance. The overpayment amount should be $22.15. CPT 99202-25 paid correctly at 100% per guidelines.	Procedural error remains for both billed services. CPT 17110 as agreed, as well as CPT 99205-25 with the diagnosis billed would not be considered preventive at 100%.	☒ M ☐ S

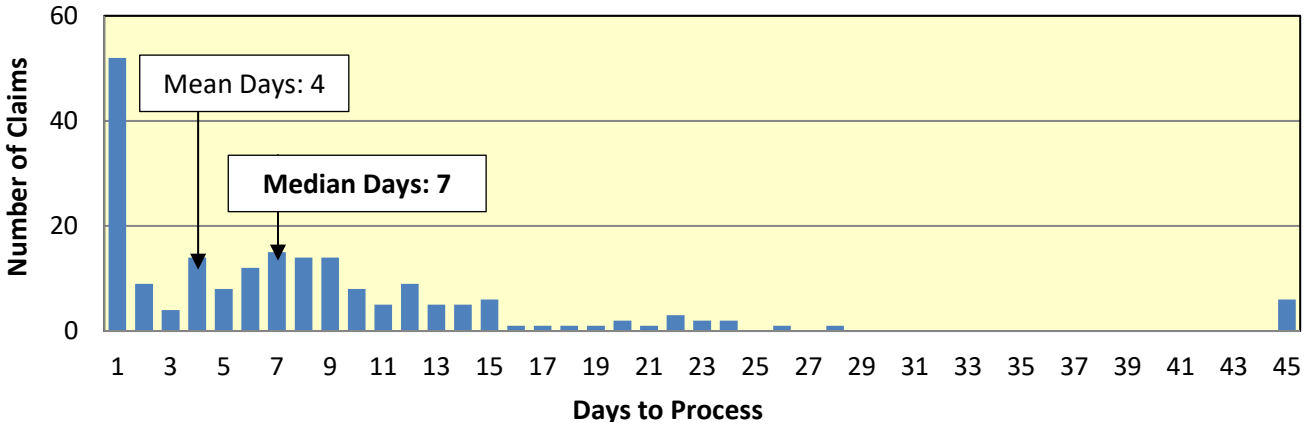
Accurate Processing Detail Report				
Error Description	**Audit No.**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
Deductible Error	M1143	Agree. Claim should have paid 100% of PPO allowed amount per plan guidelines.	Procedural error remains as agreed. HIV screening in adults aged 15 – 65 is a considered preventive.	☒ M ☐ S
Charting Inconsistency	D2049	Disagree. Paper claim submitted with tooth F. This is the only claim in file for oral surgery for this patient. The system would edit if there were other oral surgery claims for this patient.	Procedural error remains. Claim was submitted for tooth F and the tooth chart received was not reflected to show tooth F; it reflected all teeth when processed.	☒ M ☐ S

Claim Turnaround

CTI defines Claim Turnaround as the number of calendar days required to process a claim – from the date the claim was received by the administrator to the date a payment, denial, or additional information request was processed – expressed as both the Median and Mean for the audit sample.

Claim administrators commonly measure claim turnaround time in mean days. Median days, however, is a more meaningful measure for administrators to focus on when analyzing claim turnaround because it prevents one or just a few claims with extended turnaround time from distorting the true performance picture.

Median and Mean Claim Turnaround



Additional Observations

During the Random Sample Audit, our auditor observed the following procedures or situations that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

Observation	Audit Number
HealthSCOPE did not take a diagnostic test copay on this out-of-sample claim, and one should have been taken. This resulted in a $75.00 overpayment for the plan.	M1020
PEBP should be aware that HealthSCOPE incorrectly denied a $1,741.65 eligible expense on this sampled claim on 10/19/20, indicating there was no prior authorization. There was, however, an authorization on file dated 7/24/20 for these services. The claim was reconsidered on 12/3/2020, prior to CTI pulling the audit sample. Therefore, per Attachment AA4 of the Service Performance Standards, Service Guarantees and Financial Penalties document provided to CTI and initially executed by HealthSCOPE and PEBP in January 2011, no financial or payment accuracy error can be assessed.	M1089

Health Reimbursement Arrangement (HRA) Findings

CTI also reviewed 50 HRA claims as part of our random sample. We communicated with HealthSCOPE in writing about any errors or observations found using response forms. In addition, we sent HealthSCOPE a preliminary report for its review and written response. We considered HealthSCOPE's written response, as found in the Appendix, when producing our final reports.

Of the 50 claims reviewed, our audit revealed two observations of procedures or situations that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

Observation	Audit Number
Though the member provided the receipt for the service, the scanned file copy was not completely legible. HealthSCOPE agreed but indicated the original document was no longer accessible.	H1008
The order for durable medical equipment was placed on 10/27/20; however, the items were shipped were 11/05/20, 12/03/20, and 12/97/20. There was no note in the file indicating the order date and shipped dates were different to avoid duplication of payments. HealthSCOPE indicated they would talk to claim processors to ensure the service and delivery dates were noted in the claim file.	H1040

DATA ANALYTICS

Medical Findings

This component of our audit used your electronic claim data to identify improvement opportunities and potential recoveries. The informational categories we analyzed include:

- Network Provider Utilization and Discount Savings;
- Sanctioned Provider Identification;
- Patient Protection and Affordable Care Act (PPACA) Preventive Services Payment Compliance;
- National Correct Coding Initiative (NCCI) Editing Compliance; and
- Global Surgery Prohibited Fee Period Analysis.

The following pages provide the scope and report for each data analytic to enable more-informed decisions about ways PEBP can maximize benefit plan administration and performance.

Network Provider Utilization and Discount Savings

The Network Provider Utilization and Discount Savings report provides an evaluation of provider network discounts obtained during the audit period. Since discounts can be calculated differently by administrators, carriers, and benefit consultants, we believe calculating discounts in the same manner for all our clients will allow for more meaningful comparisons to be made.

Scope

CTI compared submitted charges to allowable charges for all claims paid during the audit period. The review was divided into three subsets:

- In-network
- Out-of-network
- Secondary networks

Each of these subsets was further delineated into four subgroups:

- Ancillary services – such as durable medical equipment
- Non-facility services – such as an office visit
- Facility inpatient – such as services received at a hospital
- Facility outpatient – such as services received at a surgical center

Report

The following report relied on the data and data fields provided by your administrator. We made no assumptions when requested data fields were not provided.

Medical Provider Discount Review Paid Dates 10/1/2020 through 12/31/2020				
Proprietary and Confidential Information. Do not reproduce without express permission of Claim Technologies Inc.				
Total of All Claims				
Claim Type	**Allowed Amount**	**Provider Discount**		**Plan Paid**
Ancillary	$3,160,247	$1,539,223	32.8%	$2,679,453
Non-Facility	$27,159,028	$29,890,633	52.4%	$18,272,186
Facility Inpatient	$11,440,265	$28,523,783	71.4%	$10,531,736
Facility Outpatient	$16,855,395	$32,833,875	66.1%	$13,795,587
Total	**$58,614,935**	**$92,787,515**	**61.3%**	**$45,278,962**
In-Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Plan Paid**
Ancillary	$3,101,456	$1,538,878	33.2%	$2,664,421
Non-Facility	$26,172,222	$29,886,934	53.3%	$17,930,608
Facility Inpatient	$11,320,640	$28,443,235	71.5%	$10,494,721
Facility Outpatient	$16,613,724	$32,509,757	66.2%	$13,612,883
Total In-Network	**$57,208,042**	**$92,378,804**	**61.8%**	**$44,702,633**
% of Eligible Charge -	97.6%	% Claim Frequency -	84.2%	
Out of Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Plan Paid**
Ancillary	$58,791	$345	0.6%	$15,032
Non-Facility	$986,806	$3,699	0.4%	$341,579
Facility Inpatient	$119,625	$80,548	40.2%	$37,015
Facility Outpatient	$241,672	$324,118	57.3%	$182,704
Total Out of Network	**$1,406,894**	**$408,711**	**22.5%**	**$576,330**
% of Eligible Charge -	2.4%	% Claim Frequency -	15.8%	

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

PEBP's members had utilization of network or secondary network medical providers at 97.6% of all allowed charges and 84.2% of all claims.

Sanctioned Provider Identification

The Sanctioned Provider Identification report identifies services rendered by providers on the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE). OIG's LEIE provides information to the healthcare industry, patients, and the public about individuals and entities currently excluded from participation in Medicare, Medicaid, and all other federal health care programs.

Scope

We received and converted an electronic data file of all claims processed during the audit period. The claims screened included all medical (not including prescription drug) and dental claims paid or denied during the audit period. Through electronic screening, we identified all claims in the audit universe that were non-facility claims, i.e., claims submitted by providers of service other than hospitals, nursing, or skilled care facilities, or durable medical equipment suppliers. These claims predominantly include physician and other medical professional claims.

Report

We screened 100% of non-facility claims against OIG's LEIE and identified the following providers as sanctioned. Our screening indicated the following providers received payment from the administrator during the audit period.

NPI	Exclusion Date	Reinstatement Date	Exclusion Type	Provider Name	Claim Count	Total Charged	Total Allowed	Total Paid
1104912278	20191219	N/A	1128a4	JAMES SHELBY	5	$3,106	$3,099	$1,607
				Totals	**5**	**$3,106**	**$3,099**	**$1,607**

According to the OIG, James Shelby was excluded on December 19, 2019 with for a felony-controlled substance conviction.

PPACA Preventive Services Coverage Compliance

The Preventive Services Coverage Compliance report confirms that the administrator processed preventive services as required by PPACA and as regulated by the Department of Health and Human Services (HHS). The federal PPACA mandate for all health plans (unless grandfathered) requires that certain preventive services, if performed by a network provider, must be covered at 100% without copayment, coinsurance, or deductible. Our review analyzed in-network preventive care services to determine if your administrator paid services in compliance with PPACA guidelines.

Scope

Our review included all in-network services we believe should be categorized as preventive and paid at 100%. The guidance provided by HHS for the definition of preventive services is somewhat vague, leaving it up to individual health plans to define their own system edits. In addition to the U.S. Preventive Services Task Force recommendations, CTI researched best practices of major health plan administrators to develop a compliance review we believe reflects the industry's most comprehensive overview of procedures to be paid at 100%.

Our review did not include services:

- performed by an out-of-network provider;
- adjusted or paid more than once (duplicate payments) during the audit period; or
- for which PPACA requirements suggest a frequency limitation such as one per year.

Our data analytics parameters relied upon the published recommendations from the sources HHS used to create the list of preventive services for which it has mandated coverage.

Reports

We analyzed the payments to determine if they were compliant. Types of services for which we identified non-compliance (if any) are listed first and the percentage of allowed charge paid is in the last column. To demonstrate full compliance with PPACA's requirements, the last column of this report should show 100% of services performed by network providers were paid and that no deductible, coinsurance, or copayment was applied.

Because services may be denied for reasons other than exclusion or limitation of non-covered services (e.g., a service could be denied because the patient was ineligible at the time it was performed), less than 100% of the preventive services may be paid.

The preventive services compliance review shows the frequency of claims paid at less than required benefit levels (i.e., claims reduced payment due to the application of deductibles, coinsurance, and/or copayments). We electronically screened 78 categories of preventive services that match the preventive care services specified by HHS including immunizations, women's health, tobacco use

counseling, cholesterol and cancer screenings, and wellness examinations. This review either confirms compliance with PPACA or highlights areas for improvement.

CTI's analysis also found that 96.33% of the procedure codes identified as preventive services were paid by HealthSCOPE at 100% when provided in-network. A detailed list of the other 3.67% is available upon request.

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

Preventive Care Services Compliance Review Paid at Less than 100%

PEBP - HealthSCOPE

Audit Period 10/1/2020 - 12/31/2020

Plans: All

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

		Claim Lines Submitted	Denied	Applied Deductible		Applied Copay		Applied Coinsurance		Paid @100%		
Edit Guideline	Preventive Service Benefit	#	#	#	Amount	#	Amount	#	Amount	#	Amount	%
USPSTF-A	Hypothyroidism screening - 0-90 days	1	0	1	$20	0	$0	0	$0	0	$0	.00%
USPSTF-B	Breast cancer chemoprevention counseling- >17	9	0	5	$346	1	$40	2	$53	1	$159	11.11%
USPSTF-B	BRCA screening counseling - women	29	2	11	$7,456	3	$120	9	$2,228	4	$4,784	14.81%
ACIP	Immunizations - DTP >18	4	0	0	$0	0	$0	3	$18	1	$30	25.00%
HHS	Breastfeeding support and counseling - women	40	0	23	$4,875	1	$40	3	$96	13	$2,568	32.50%
USPSTF-A,B	Rh incompatibility screening - pregnant women	71	0	26	$1,284	12	$622	9	$125	24	$1,439	33.80%
USPSTF-A	HIV screening - pregnant women	27	1	16	$542	0	$0	1	$45	9	$204	34.62%
USPSTF-B	Alcohol misuse - screening and counseling	8	0	5	$118	0	$0	0	$0	3	$47	37.50%
USPSTF-B	Depression screening - >18	25	0	12	$142	0	$0	3	$8	10	$133	40.00%
USPSTF-A	Syphillis screening	51	2	20	$108	0	$0	6	$7	23	$165	46.94%
USPSTF-B	Tobacco use counseling - >18	32	3	11	$174	0	$0	2	$11	16	$391	55.17%
HHS	Gestational Diabetes Mellitus screening - women	171	4	53	$723	0	$0	10	$14	104	$828	62.28%
USPSTF-B	Depression screening - 12-18	33	0	10	$59	0	$0	2	$2	21	$123	63.64%
USPSTF-A	Hepatitis B screening - women	39	0	13	$271	0	$0	0	$0	26	$282	66.67%
USPSTF-A	Syphilis screening - pregnant women	154	2	44	$538	0	$0	6	$6	102	$556	67.11%
USPSTF-A	Urinary tract infection screening - pregnant women	91	2	18	$566	4	$122	5	$55	62	$666	69.66%
USPSTF-B	Hepatitis C Virus (HCV) Screening	235	3	52	$768	0	$0	18	$60	162	$2,436	69.83%
USPSTF-B	Gonorrhea screening - female	375	0	95	$4,764	1	$0	17	$189	262	$11,620	69.87%
USPSTF-A,B	Chlamydia infection screening - women	379	0	95	$4,438	1	$75	17	$184	266	$12,021	70.18%
USPSTF-A	Phenylketonuria (PKU) screening 0-90 days	7	0	1	$8	0	$0	1	$13	5	$67	71.43%
USPSTF-A	HIV screening - >14	185	7	41	$1,442	0	$0	8	$44	129	$3,655	72.47%
USPSTF-B	Healthy diet counseling	293	2	34	$1,776	25	$1,000	18	$373	214	$24,117	73.54%
USPSTF-A	Cholesterol abnormalities screening - men 35-75	594	3	119	$1,774	0	$0	12	$36	460	$8,130	77.83%
USPSTF-A,B	Cholesterol abnormalities screening - women >19	704	1	117	$2,162	0	$0	22	$83	564	$10,500	80.23%
Bright Futures	Tuberculin testing - <21	14	0	2	$35	0	$0	0	$0	12	$187	85.71%
USPSTF-B	Hearing loss screening - 0 - 90 days	36	0	2	$219	0	$0	2	$43	32	$5,017	88.89%
ACIP	Immunizations - Hepatitis A >18	18	0	1	$117	0	$0	0	$0	17	$1,305	94.44%
ACIP	Immunizations - Pneumococcal >18	74	1	2	$158	0	$0	2	$56	69	$8,644	94.52%
Bright Futures	Lead screening - <21	28	7	1	$17	0	$0	0	$0	20	$302	95.24%
Bright Futures	Dyslipidemia screening - 2-20	67	0	3	$35	0	$0	0	$0	64	$1,110	95.52%
Bright Futures	Iron Supplement - <21	130	0	3	$12	0	$0	1	$1	126	$485	96.92%
USPSTF-A	Colorectal cancer screening - 45-75	554	25	13	$790	0	$0	2	$7	514	$184,664	97.16%
USPSTF-B	Breast cancer mammography screening - >39	4,240	2	98	$6,100	12	$240	6	$52	4,122	$325,412	97.26%
ACIP	Immunizations - Herpes Zoster >59	328	1	7	$1,544	0	$0	1	$44	319	$46,155	97.55%
HHS	Contraceptive methods - women	605	5	3	$597	3	$100	3	$1,391	591	$190,821	98.50%
ACIP	Immunizations - Influenza Age >18	2,849	25	11	$360	6	$125	10	$58	2,797	$54,294	99.04%
HHS	Cervical Cancer Screening (HPV DNA) - women >29	804	1	5	$220	0	$0	2	$17	796	$33,867	99.13%
USPSTF-A	Cervical Cancer Screening (Pap) - women	1,377	3	8	$245	0	$0	2	$9	1,364	$63,108	99.27%
HHS	Wellness Examinations - women	2,638	9	10	$1,834	0	$0	3	$92	2,616	$344,562	99.51%
Bright Futures	Developmental Autism screening - <3	235	0	1	$20	0	$0	0	$0	234	$7,347	99.57%
HHS	Wellness Examinations - >18	800	5	2	$175	0	$0	1	$5	792	$101,779	99.62%
ACIP	Immunization Administration - >18	4,066	79	3	$189	3	$90	1	$2	3,980	$104,872	99.82%
ACIP	Immunizations - DTP <19	732	6	1	$58	0	$0	0	$0	725	$48,358	99.86%
HRSA/HHS	Wellness Examinations - <19	2,616	4	2	$229	0	$0	1	$19	2,609	$284,243	99.89%
ACIP	Immunizations - Influenza <19	2,637	4	0	$0	0	$0	2	$7	2,631	$50,991	99.92%
ACIP	Immunization Administration - <19	4,952	34	1	$59	0	$0	0	$0	4,917	$168,889	99.98%

Preventive Care Services Compliance Review Paid at 100%												
PEBP - HealthSCOPE												
Audit Period 10/1/2020 - 12/31/2020												
Plans: All												
Filters: Exclude - out of network, adjustments, edits with frequency limits, claimants 65 or older												
		Claim Lines Submitted	Denied	Applied Deductible		Applied Copay		Applied Coinsurance		Paid @100%		
Edit Guideline	Preventive Service Benefit	#	#	#	Amount	#	Amount	#	Amount	#	Amount	%
ACIP	Immunizations - Human papillomavirus	295	1	0	$0	0	$0	0	$0	294	$65,140	100.00%
ACIP	Immunizations - Meningococcal <19	275	1	0	$0	0	$0	0	$0	274	$35,319	100.00%
ACIP	Immunizations - Rotavirus <19	272	2	0	$0	0	$0	0	$0	270	$27,484	100.00%
ACIP	Immunizations - Hepatitis A <19	262	1	0	$0	0	$0	0	$0	261	$9,635	100.00%
Bright Futures	Hearing Screening 0-21 yrs	191	19	0	$0	0	$0	0	$0	172	$3,349	100.00%
USPSTF-B	Vision screening - 3- 5	165	13	0	$0	0	$0	0	$0	152	$3,789	100.00%
ACIP	Immunizations - Measles, Mumps, Rubella <19	149	2	0	$0	0	$0	0	$0	147	$32,128	100.00%
ACIP	Immunizations - Meningococcal >18	135	0	0	$0	0	$0	0	$0	135	$22,871	100.00%
ACIP	Immunizations - Varicella <19	121	0	0	$0	0	$0	0	$0	121	$18,370	100.00%
ACIP	Immunizations - Hepatitis B <19	80	0	0	$0	0	$0	0	$0	80	$2,367	100.00%
ACIP	Immunizations - Hepatitis B >18	35	2	0	$0	0	$0	0	$0	33	$5,959	100.00%
ACIP	Immunizations - Inactivated Poliovirus <19	24	0	0	$0	0	$0	0	$0	24	$1,183	100.00%
ACIP	Immunizations - Varicella >18	8	0	0	$0	0	$0	0	$0	8	$1,107	100.00%
ACIP	Immunizations adult - Influenza Age (FluMist) 19-4	4	2	0	$0	0	$0	0	$0	2	$47	100.00%
ACIP	Immunizations - Pneumococcal <19	1	0	0	$0	0	$0	0	$0	1	$107	100.00%

NCCI Editing Compliance

While there are no universally accepted correct coding guidelines among private insurers and administrators, the Centers for Medicare & Medicaid Services (CMS), the nation's largest payer for health care, took the initiative to provide valuable guidance for medical benefit plans. Implementation of NCCI mandated several initiatives to prevent improperly billed claims from being paid under Medicare and Medicaid.

Scope

The two NCCI initiatives that can offer the greatest return benefit to self-funded employee benefit plans are the Procedure-to-Procedure (PTP) Edits and Medically Unlikely Edits (MUEs).

Our claim system code editing analysis identified services submitted to the plan and paid by HealthSCOPE that Medicare and Medicaid would have denied. **Since HealthSCOPE paid the billed charges, the payments represent a potential savings opportunity to PEBP.**

It is difficult to establish the extent to which administrators and carriers use NCCI edits; however, CTI recommends these reports be discussed with your administrator to determine the extent to which they incorporate CMS edits. Using these edits typically reduces claim expense and furthers efforts toward achieving standardized code-editing systems for all payers.

PTP Edits Reports

PTP Edits compare procedure codes from multiple claim lines on the same day to identify when procedures submitted on the same claim cannot be billed together. Our reports are grouped by outpatient hospital services and non-facility claims using CMS' quarterly updated data. If your administrator is not currently using these CMS edits, CTI's reports will help you evaluate the savings you would have realized had the PTP Edits been in place.

Procedure to Procedure Edits								
PEBP - HealthSCOPE								
Based on Paid Dates 10/1/2020 through 12/31/2020								
Outpatient Hospital Services (facility claims with codes not designated inpatient)								
Primary		**Secondary**		**Mod**	**Primary Description**	**Secondary Description**	**Line**	**Secondary**
Code	**Mod**	**Code**	**Mod**	**Use**			**Count**	**Allowable Benefit**
63081		22551		YES	Remove vert body dcmprn crvl	NECK SPINE FUSE&REMOV BEL C2	1	$6,874
					More extensive procedure			
70496		70450		YES	CT ANGIOGRAPHY HEAD	CT HEAD/BRAIN W/O DYE	6	$3,622
					Misuse of column two code with column one code			
37241		75831	TC	YES	Vascular embolization or occlusion	VEIN X-RAY KIDNEY	1	$2,633
					CPT Manual or CMS manual coding instructions			
74177	TC	96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	7	$2,509
					Standards of medical / surgical practice			
93975		76770		YES	VASCULAR STUDY	US EXAM ABDO BACK WALL COMP	2	$2,355
					Misuse of column two code with column one code			
93975		76856		YES	VASCULAR STUDY	US EXAM PELVIC COMPLETE	5	$2,308
					Misuse of column two code with column one code			
77280	TC	77336		YES	SET RADIATION THERAPY FIELD	RADIATION PHYSICS CONSULT	4	$1,970
					Misuse of column two code with column one code			
29876	SG	29877	SG,59	NO	KNEE ARTHROSCOPY/SURGERY	KNEE ARTHROSCOPY/SURGERY	2	$1,841
					Misuse of column two code with column one code			
74177	TC	96365		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG IV INF INIT	5	$1,792
					Standards of medical / surgical practice			
74177		96365		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG IV INF INIT	4	$1,537
					Standards of medical / surgical practice			
						Top 10 TOTAL	**37**	**$27,440**
						GRAND TOTAL	**638**	**$95,373**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)								
Primary		**Secondary**		**Mod**	**Primary Description**	**Secondary Description**	**Line**	**Secondary**
Code	**Mod**	**Code**	**Mod**	**Use**			**Count**	**Allowable Benefit**
90471		99396		YES	IMMUNIZATION ADMIN	PREV VISIT EST AGE 40-64	11	$1,014
					CPT Manual or CMS manual coding instructions			
90471		99214		YES	IMMUNIZATION ADMIN	Office/outpatient visit for E&M of	8	$930
					CPT Manual or CMS manual coding instructions			
63030		69990	59	NO	LOW BACK DISK SURGERY	MICROSURGERY ADD-ON	1	$617
					Misuse of column two code with column one code			
22551		69990		NO	NECK SPINE FUSE&REMOV BEL C2	MICROSURGERY ADD-ON	1	$467
					Misuse of column two code with column one code			
90460		99211	25	NO	IM ADMIN 1ST/ONLY COMPONENT	OFFICE/OUTPATIENT VISIT EST	16	$414
					CPT Manual or CMS manual coding instructions			
00790	AA,P3	95955	26,59	NO	ANESTH SURG UPPER ABDOMEN	EEG DURING SURGERY	2	$308
					Standard preparation / monitoring services for anesthesia			
01400	AA	95955	26,59	NO	ANESTH KNEE JOINT SURGERY	EEG DURING SURGERY	2	$308
					Standard preparation / monitoring services for anesthesia			
63047		69990		NO	Remove spine lamina 1 lmbr	MICROSURGERY ADD-ON	1	$300
					Misuse of column two code with column one code			
90471		99203		YES	IMMUNIZATION ADMIN	Office/outpatient visit for E&M of	2	$275
					CPT Manual or CMS manual coding instructions			
96372		99204		YES	THER/PROPH/DIAG INJ SC/IM	Office/outpatient visit for E&M of	1	$219
					Standards of medical / surgical practice			
						Top 10 TOTAL	**45**	**$4,853**
						GRAND TOTAL	**165**	**$9,180**

MUE Reports

An MUE is an edit that tests claim lines for the same beneficiary, procedure code, date of service, and billing provider against a maximum allowable number of service units. The MUE rule for a given code is the maximum number of service units a provider should report for a single day of service. MUE errors could be caused by incorrect coding, inappropriate services performed, or fraud. MUEs do not require Medicare contractors to perform a manual review or suspend claims; rather, claim lines are denied and must be correctly resubmitted by providers, typically with a lesser payment amount.

CTI's MUE analyses are grouped into three separate reports:

- Outpatient hospital
- Non-facility
- Ancillary

NCCI MUE Edits				
PEBP - HealthSCOPE				
Based on Paid Dates 10/1/2020 through 12/31/2020				
Outpatient Hospital Services (facility claims with codes not designated inpatient)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line Count Exceeding Limit**	**Gross Benefit Allowed**
C1880	2	VENA CAVA FILTER	1	$19,570
		Rationale: Clinical: Data		
29823	1	debridement, extensive, 3 or more discrete	1	$9,852
		Rationale: CMS Policy		
90999	1	DIALYSIS PROCEDURE	3	$7,124
		Rationale: Clinical: CMS Workgroup		
90945	1	DIALYSIS ONE EVALUATION	10	$6,838
		Rationale: Nature of Service/Procedure		
36558	2	INSERT TUNNELED CV CATH	1	$6,161
		Rationale: Clinical: Data		
69436	1	CREATE EARDRUM OPENING	1	$4,918
		Rationale: CMS Policy		
99152	2	MOD SED SAME PHYS/QHP INITIAL 15	28	$4,893
		Rationale: Nature of Service/Procedure		
10140	2	DRAINAGE OF HEMATOMA/FLUID	1	$4,638
		Rationale: Clinical: Data		
99153	12	MOD SED SAME PHYS/QHP EACH ADDL 15	18	$4,430
		Rationale: Clinical: CMS Workgroup		
80307	1	DRUG TEST PRSMV INSTRMNT CHEMISTRY	4	$3,854
		Rationale: Code Descriptor / CPT Instruction		
		Top 10 TOTAL	**68**	**$72,278**
		GRAND TOTAL	**167**	**$118,998**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)				
Procedure Code	Service Unit Limit	Procedure Description	Line Count Exceeding Limit	Gross Benefit Allowed
95165	30	ANTIGEN THERAPY SERVICES	13	$15,701
		Rationale: Clinical: Data		
97155	24	ADAPT BHV TX PRTCL MODIFICAJ	11	$10,290
		Rationale: Clinical: Society Comment		
97157	16	MULTIPLE FAM GROUP BHV TX GDN	6	$9,375
		Rationale: Clinical: CMS Workgroup		
97799	1	PHYSICAL MEDICINE PROCEDURE	13	$9,052
		Rationale: Clinical: Data		
97156	16	FAMILY ADAPT BHV TX GDN PHYS/QHP EA	7	$7,310
		Rationale: Clinical: CMS Workgroup		
88374	5	Morphometric analysis, in situ	6	$2,811
		Rationale: Clinical: Data		
95004	80	PERCUT ALLERGY SKIN TESTS	4	$2,789
		Rationale: Clinical: CMS Workgroup		
88377	5	Morphometric analysis, in situ	1	$2,398
		Rationale: Clinical: Data		
88307	8	TISSUE EXAM BY PATHOLOGIST	2	$2,317
		Rationale: Clinical: Data		
56515	1	DESTROY VULVA LESION/S COMPL	1	$2,141
		Rationale: Anatomic Consideration		
		Top 10 TOTAL	**64**	**$64,184**
		GRAND TOTAL	**165**	**$90,128**

Ancillary (All other claims not flagged Inpatient, Outpatient Hospital, or non-facility)				
Procedure Code	Service Unit Limit	Procedure Description	Line Count Exceeding Limit	Gross Benefit Allowed
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	23	$2,617
		Rationale: Nature of Equipment		
K0001	1	STANDARD WHEELCHAIR	26	$1,185
		Rationale: Nature of Equipment		
E0443	1	PORTABLE 02 CONTENTS, GAS	7	$1,094
		Rationale: Code Descriptor / CPT Instruction		
E0465	2	Home ventilator, any type, used with	1	$887
		Rationale: Nature of Equipment		
E0730	1	TENS FOUR LEAD	1	$697
		Rationale: Nature of Equipment		
A7520	1	TRACH/LARYN TUBE NON-CUFFED	3	$662
		Rationale: Published Contractor Policy		
E0601	1	CONT AIRWAY PRESSURE DEVICE	2	$630
		Rationale: Nature of Equipment		
E0202	1	PHOTOTHERAPY LIGHT W/ PHOTOM	2	$450
		Rationale: Nature of Equipment		
B4035	1	ENTERAL FEED SUPP PUMP PER D	1	$412
		Rationale: Code Descriptor / CPT Instruction		
A5114	3	FOAM/FABRIC LEG STRAP	3	$231
		Rationale: Clinical: CMS Workgroup		
		Top 10 TOTAL	**69**	**$8,865**
		GRAND TOTAL	**113**	**$10,711**

Global Surgery Prohibited Fee Period Analysis

CMS created the definition of global surgical package to make payments for services provided by a surgeon before, during, and after procedures. The objective of CTI's Global Surgery Prohibited Fee Period Analysis is to compare paid surgical claims to Medicare's payment guidelines and identify instances of unbundling and improper use of evaluation and management (E/M) coding.

Scope

The scope of the Global Surgery Prohibited Fee Period Analysis is surgery charges provided in any setting, including inpatient hospital, outpatient hospital, ambulatory surgical center (ASC), and physician's office. Claims for surgeon visits in intensive care or critical care units are also included in the global surgical package. Our analysis encompasses the three types of procedures with global surgical packages: simple, minor, and major. Each type has specific global periods:

- Simple – One day
- Minor – Ten days
- Major – Ninety days

CMS allows providers to bill for an E/M service after surgery if the patient's condition required a significant, separately identifiable E/M service beyond the usual pre-operative and post-operative care. When this occurs, the provider can add a modifier 24, 25, or 57 to the E/M service procedure code but must submit supporting documentation with the claim.

Report

The following report provides a summary of:

- top 10 providers with and without E/M charges during prohibited periods and associated charges;
- analysis of same providers' surgeries with modifier 24, 25, or 57 when Medicare would have required supporting documentation before payment; and
- analysis of the same providers' surgeries without modifier 24, 25, or 57 when Medicare would have denied payment.

Payment of unbundled, post-surgical E/M services during the global fee period increases the cost of a claim. While there are no universally accepted guidelines for global surgery fee periods with 24, 25, or 57 modifiers, some states and groups mandate providers accept assignment of benefits on those claims. This mitigates the financial impact of unbundling and improper coding. When we discuss our findings, we will help you identify strategies to monitor and eliminate unbundling within your plan.

PEBP - HealthSCOPE									
Audit Period 10/1/2020 - 12/31/2020									
	Surgeries with 'CMS Defined' Prohibited Global Fee Periods					Evaluation and Management Services using Same ID as Surgeon and Within Prohibited Global Fee Period			
	Surgeries without E/M Procedures during Prohibited Global Fee Periods		Surgery with E/M Charge during Prohibited Global Fee Periods			E/M Procedure Codes with Modifier 24, 25, or 57		E/M Procedure Codes without Modifier 24, 25, or 57	
Provider Id	Count	Allowed Charge	Count	% Surgeries with E/M Charges during Prohibited Global Fee Periods	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge
880176637	1	$310	4	80.0%	$5,456	0	$0	12	$2,400
880103557	244	$106,315	29	10.6%	$2,387	16	$855	12	$922
946004062	6	$2,451	2	25.0%	$1,608	1	$173	1	$302
300520570	12	$1,199	2	14.3%	$1,389	1	$106	3	$225
880502320	0	$0	2	100.0%	$206	1	$71	2	$172
880133501	111	$38,272	23	17.2%	$4,242	20	$1,697	2	$172
880310956	32	$9,520	3	8.6%	$394	3	$361	1	$47
880341714	47	$20,778	4	7.8%	$908	3	$205	1	$44
880454760	11	$2,402	2	15.4%	$53	0	$0	1	$32
910858192	41	$19,396	23	35.9%	$2,106	22	$1,669	1	$32
Top 10	**505**	**$200,642**	**94**	**15.7%**	**$18,749**	**67**	**$5,136**	**36**	**$4,349**
Overall Total	**2,989**	**$1,027,970**	**507**	**14.5%**	**$96,875**	**458**	**$44,353**	**36**	**$4,349**

CONCLUSION

We consider it a privilege to have worked for, and with, your staff and administrator. Thank you again for choosing CTI.

APPENDIX – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Your administrator's response to the draft report follows.

27 Corporate Hill Drive
Little Rock, AR 72205

December 17, 2021
Amended on February 25, 2022

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

Dear Ms. Nisius,

Thank you for the opportunity to work with CTI on our mutual client State of Nevada Public Employees' Benefit Program.

Appendix – Administrator's Response to Draft Report for State of Nevada Public Employees' Benefit Program.

Performance Guarantees: Administrator's Response to the Draft Report regarding the State of Nevada Public Employees' Benefit program.
Metrics

- Payment Accuracy Q2– 96.5% - **HSB Response**: Disagree with CTI conclusion regarding the payment accuracy detail information. There are errors that are calculated in the detail that should be re-evaluated based on the documentation and information provided to CTI.
- Financial Accuracy Q2– 97.51% - **HSB Response**: Disagree with CTI conclusion regarding the financial accuracy detail information. There are errors that are calculated in the detail that should be re-evaluated based on the documentation and information provided to CTI.
- Claim Processing Turnaround Q2– 98% - **HSB Response**: The original implementation with the State of Nevada Public Employees' Benefit Program, HealthSCOPE Benefits and the PEBP appointed auditor, agreed that HealthSCOPE Benefits would self-report turnaround time results using reporting from the HealthSCOPE claims processing system. HealthSCOPE Benefits has been providing the quarterly turnaround time reports since inception of the plan to the State of Nevada as well as the PEBP appointed auditor.
- Data Reporting Q2– **HSB Response**: Disagree with CTI conclusion regarding the data reporting was not met. February 14, 2021 falls on a Sunday and the reports were delivered to the State of Nevada the following business day which was Monday February 15, 2021.

HealthSCOPE Benefits has reviewed the draft report and would like to add the additional information due to the conclusions within the audit report.

TARGETED SAMPLE ANALYSIS:

Invalid Procedures Codes Detail Report:

QID M10 – HSB does not agree with CTI conclusion. The invoice received is a payment for a covered Breast Pump. Per the MPD * Contact the third-party Claims Administrator for the purchase of covered breast pumps.
Commit Developers LLC, dba Breast Pump Direct which is a Breast Pump vendor that is utilized to purchase Breast Pumps. HealthSCOPE Benefits does have a contract with the vendor.

Fraud, Waste, and Abuse Detail Report:

QID M27 - HSB does not agree with CTI conclusion. The claim was adjudicated based on the plan guidelines for Chiropractic care based on the agreement with Sierra Healthcare Options.

QID M28 – HSB does not agree with CTI conclusion. The claim was adjudicated based on the plan guidelines for Chiropractic care based on the agreement with Hometown health.

QID M29 – HSB does not agree with CTI conclusion. The claim was adjudicated based on the plan guidelines for Chiropractic care based on the agreement with Hometown health.

Duplicate Payment Detail Report:

QID M16 – HSB does not agree with CTI conclusion. There is not an outstanding overpayment on the account for QID M16. The overpayment was satisfied on 08/30/2021 on the account.

QID M17 - HSB does not agree with CTI conclusion. There is not an outstanding overpayment on the account for QID M17. The overpayment was satisfied on 08/30/2021 on the account. **M17** is the same claim number as **M16**.

QID M18 – HSB does not agree with CTI conclusion. There is not an outstanding overpayment on the account for QID M18. The overpayment was satisfied on 08/30/2021 on the account. **M18** is the same claim number as **M16**.

QID M19 – HSB does not agree with CTI conclusion. There is not an outstanding overpayment on the account for QID M19. The overpayment was satisfied on 08/30/2021 on the account. **M19** is the same claim number as **M16**.

QID M20 – HSB does not agree with CTI conclusion. There is not an outstanding overpayment on the account for QID M20. The overpayment was satisfied on 08/30/2021 on the account. **M20** is the same claim number as **M16**.

Plan Limitations Detail Report:

QID D1 – HSB does not agree with CTI conclusion. There is not an outstanding overpayment on the account for QID D1. The claim was received prior to the timely filing deadline per the MPD guidelines. This claim was a reconsideration of the original claim.

QID D2 – HSB does not agree with CTI conclusion. There is not an outstanding overpayment on the account for QID D2. The claim was received prior to the timely filing deadline per the MPD guidelines. This claim was a reconsideration with additional information that was requested.

QID M3 – HSB does not agree with CTI conclusion. Update response for QID M3. Original claim was received prior to the timely filing deadline per the MPD. The claim was denied to investigate Medicare coverage for this member. Provider submitted a new claim with information and this claim was a reconsideration of the original claim.

QID M33 – HSB does not agree with CTI conclusion. There is not an outstanding overpayment on the account for QID M33. The provider submitted refund check # 90340 that was received 02/23/2021 and applied to the account and satisfied the amount due on the account.

QID M35 - HSB does not agree with CTI conclusion. The claim had additional diagnosis code to include cervicalgia.

QID M37 – HSB does not agree with CTI conclusion. Client did provide verbal approval to pay the claim according to the Hometown Health contract. The client did not want the member to be balanced billed for any service due to the critical treatment for the member.

Plan Exclusion Detail Report:

QID D3 – HSB does not agree with CTI conclusion. There is not an outstanding overpayment on the account for QID D3. The services were billed due to code D7240 which is removal of impacted tooth – completely bony.

QID D4 – HSB does not agree with CTI conclusion. There is not an outstanding overpayment on the account for QID D4. Code D7952 is augmentation of the sinus to increase alveolar height by vertical access through the ridge crest by raising the floor of the sinus and grafting as necessary. This includes obtaining the bone or bone substitutes due to code D7210 which is a surgical removal of erupted tooth requiring removal of bone and/or sectioning of the tooth.

QID D5 - HSB does not agree with CTI conclusion. There is not an outstanding overpayment on the account for QID D5. Code D7951 is augmentation of the sinus and includes obtaining the bone or bone substitutes due to code D7210 which is a surgical removal of erupted tooth requiring removal of bone and/or sectioning of the tooth.

QID D6 – HSB does not agree with CTI conclusion. The claim, procedure notes as well as a copy of the x-rays were provided with the response on QID D6 for D7960.

QID D8 - HSB does not agree with CTI conclusion. Code D7870 is a procedure to remove the synovial fluid accumulated around the joints.

QID D10 – HSB does not agree with CTI conclusion. The procedure code D7290 is surgical repositioning of teeth due to bone replacement graft.

Observation:

QID M9 – Claim was considered and priced based on the Aetna contracted pricing. Aetna confirmed the pricing per the contracted rate and that the pricing is correct. Per Aetna, PPO contract does not have lesser of language.

RANDOM SAMPLE AUDIT:

Financial Accuracy and Accurate payment Detail Report: HealthSCOPE Benefit will request that CTI review the additional information on the following audits and re-evaluate the Financial Accuracy for the State of Nevada Q2 audit findings.

Audit No. 1089 – HSB update for response on final draft. M1089 was identified during an internal audit and the claim was reconsidered on 12/03/2020. This claim was reconsidered prior to the CTI audit.

Audit No. M1106 – HSB does not agree with CTI conclusion. This claim was processed correctly per client's directive. Primary diagnosis is routine, and this is the first EKG of the year.

Audit No. M1136 - HSB does not agree with CTI conclusion. The plan has allowed screening mammograms for women under the age of 40 with a diagnosis billed as family history of malignant cancer.

Audit No. M1105 – HSB does not agree with CTI conclusion. Due to the National Emergency declared on March 1, 2020, the Employee Benefits Security Administration, Department of Labor, Internal Revenue Service and the Department of the Treasury extended certain timeframes to ease the burden of maintaining benefits and compliance with notice obligations. To help providers and members meet timely filing rules the period from March 1, 2020, to 60 days after the announced end of the National Emergency will not count towards timely filing requirements. Currently, there is no end date. There was an extension to the timely filing period. The claim does fall into the extension and was processed correctly.

Accurate Processing Detail Report:

Audit No. M1106 – HSB does not agree with CTI conclusion. This claim was processed correctly per client's directive. Primary diagnosis is routine, and this is the first EKG of the year.

Audit No. M1136 - HSB does not agree with CTI conclusion. The plan has allowed screening mammograms for women under the age of 40 with a diagnosis billed as family history of malignant cancer.

Audit No. D2049 - HSB does not agree with CTI conclusion. The paper claim that was submitted does reflect tooth number/letter F. The current system is set to edit for possible duplicates based on the parameters provided to CTI. The system will look at Date of service, Tax ID, Procedure Code, Modifiers, Tooth numbers.

Audit No. M1105 – HSB does not agree with CTI conclusion. Due to the National Emergency declared on March 1, 2020, the Employee Benefits Security Administration, Department of Labor, Internal Revenue Service and the Department of the Treasury extended certain timeframes to ease the burden of maintaining benefits and compliance with notice obligations. To help providers and members meet timely filing rules the period from March 1, 2020, to 60 days after the announced end of the National Emergency will not count towards timely filing requirements. Currently, there is no end date. There was an extension to the timely filing period. The claim does fall into the extension and was processed correctly.

Thank you,

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

CLAIM TECHNOLOGIES INCORPORATED

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

(515) 244-7322 • claimtechnologies.com