Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employees' Benefits Program Plans

Administered by HealthSCOPE Benefits

Audit Period: January 1, 2021 through March 31, 2021
Audit Number 1.FY21.Q3

Presented to

State of Nevada Public Employees' Benefits Program

Revised March 9, 2022

CLAIM TECHNOLOGIES
INCORPORATED

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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 January 1, 2021 through March 31, 2021 (quarter 3 (Q3) 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	$56,776,162
Total Number of Claims Paid/Denied/Adjusted	206,359
Health Reimbursement Arrangement (HRA)	
Total Paid Amount	$1,239,023
Total Number of Claims Paid/Denied/Adjusted	13,330

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 improved its Financial Accuracy measurement in Q3 FY2021 and no penalty is owed.
2. HealthSCOPE should:
    - Review the 100% Electronic Screening with Targeted Sample results and focus on the most material findings in Paid Greater than Charged, Spinal Region Upcoding, and Duplicate Claims Payments.
    - Review the Random Sample Audit results and focus on providing coaching and feedback to examiners to prevent similar manual errors going forward.

Summary of HealthSCOPE's Guarantee Measurements

Based on CTI's Random Sample Audit results, HealthSCOPE met both claims processing measurements for the PEBP in Q3 FY2021.

Quarterly Guarantee	Measure	Met/Not Met	Penalty
Financial Accuracy	99%	Met – 99.88%	None.
Payment Accuracy	98%	Met – 99.00%	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 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 Q3 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.	99.88%	Met
Payment Accuracy	98% or greater of medical/dental claims audited are paid accurately.	99.00%	Met
Claim Processing Turnaround	99% of all medical/dental claims are to be processed within 30 days	99.92%	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%	9 Seconds Less than .01% 99.58%	Met Met Met
Data Reporting	• 100% of standard reports within 10 business days • Annual/Regulatory Documents within 10 business days of the Plan Year	Delivered 5/14/21. 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:** Q3 FY2021				
Category	**Number of Service Codes**	**Number of Members**	**Billed Charge**	**Allowed***
Paid Greater than Charged	11	5	$3,597	$8,925
Fraud, Waste and Abuse				
Spinal Region Upcoding – Number of spinal regions treated does not match number of spinal regions billed and allowed.	1,108	368	$76,788	$32,685

**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 Detail Report					
QID	**Category**	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
24	Paid Greater Than Charged	$4,789.98	Disagree. The claim was paid with Aetna contracted pricing.	Procedural deficiency and overpayments remain. HealthSCOPE paid more than billed charges on this claim and should consider adding lessor of language to its provider contracts.	☐ M ☒ S
25		$158.40	Agree. This claim should have been considered with the Medicare coinsurance due of $34.00. The overpayment amount would be $158.40. This claim has not been reconsidered to request refund as of yet.		☐ M ☒ S

Fraud, Waste, and Abuse Detail Report					
QID	**Category**	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
41	Spinal Region Upcoding	$17.03	Disagree. The claim was adjudicated based on the plan guidelines for Chiropractic care based on the agreement with Hometown Health. This was not investigated, there were no 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 procedure are spinal region driven and should be billed with appropriate diagnosis codes to support billing.	☐ M ☒ S
42		$27.87			☐ 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:** Q3 FY2021				
Category	**Number of Service Codes**	**Number of Members**	**Billed Charge**	**Allowed***
Duplicate Payments				
Providers and/or Employees	303	41	$551,147	$210,289

**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 Payments Detail Report				
QID	**Under/ Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
35	$972.00	Agree. NEV.XXXX3321 has not been corrected under the account.	Procedural deficiency and overpayment remain. HealthSCOPE paid duplicate charges.	☒ M ☐ S

There were no errors found under the dental benefit plan.

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.

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 $500.00 in underpayments and $26.88 in overpayments, for an absolute value variance of $526.88.

The weighted Financial Accuracy rate was 99.88%.

Financial Accuracy Detail Report						
Error Description	**Audit No.**	**Under/ Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**	
Copay Calculation	1035	$500.00 – Under	Agree. Claim should have been considered at 100% of the PPO allowed with no copayment.	Procedural error and underpayment remain. This COVID-19 claim should have no cost-share.	☒ M ☐ S	
Subtotal	**1**					
Coinsurance	1050	$26.88 – Over	Agree. Claim was manually adjudicated incorrectly. The maximum out of pocket was not met.	Procedural error and overpayment remain. The out of pocket was not met and cost share should have been applied.	☒ M ☐ S	
Subtotal	**2**					
TOTALS	**2**	**VARIANCE $526.88**			**M: 2**	**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 2 incorrectly paid claims and 198 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	1	99.00%

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	
198	0	2	99.00%

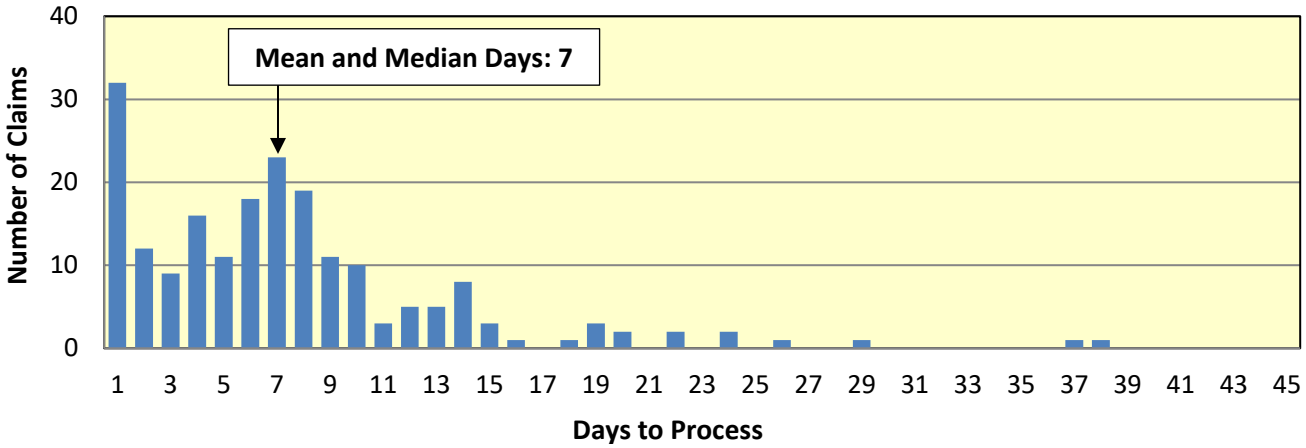
Accurate Processing Detail Report				
Error Description	**Audit No.**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
Managed Care				
Copay Calculation	1035	Agree. Claim should have been considered at 100% of the PPO allowed with no copayment.	Procedural error remains. This COVID-19 claim should have no cost-share.	☒ M ☐ S
Policy Provision				
Coinsurance	1050	Agree. Claim was manually adjudicated incorrectly. The maximum out of pocket was not met.	Procedural error remains. The out of pocket was not met and cost share should have been applied.	☒ 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 is denying any claim with a diagnosis code range of M70 – M79.9 (other soft tissue disorders sometimes associated with an accident) pending completion of an accident report. In this instance, the diagnosis code of M79.7 (fibromyalgia) was listed in the 9th diagnostic position. The primary diagnosis and the reason the patient was being seen was for malignant neoplasm of the rectum. This is clearly not due to an accident.	1031
HealthSCOPE is denying any claim with a diagnosis code range of M46.0 – M54.9 (back pain) pending completion of an accident report. In this instance, the diagnosis code of M54.42 and M54.41 (lumbago with sciatica) was listed in the 9th and 10th diagnostic positions. The primary diagnosis and the reason the patient was being seen was for a chronic ulcer of the right ankle. This is clearly not due to an accident.	1059
HealthSCOPE is denying any claim with a diagnosis code range of S00 – T88.9 (Injury, poisoning and certain other consequences of external causes) pending completion of an accident report. In this instance, the diagnosis code of T86.5 (complications of stem cell transplant) was listed in the 6th diagnostic position. The primary diagnosis and the reason the patient was being seen was for systemic sclerosis, unspecified. This is clearly not due to an accident.	1098

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 one observation 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
A claim was received via the Consumer Portal. The claim was processed correctly, but the examiner did not document the dates of service, provider name, or amount per the training procedures.	HRA1017

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.

Paid Dates 1/1/2021 through 3/31/2021				
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Total of All Claims				
Claim Type	**Allowed Amount**	**Provider Discount**		**Plan Paid**
Ancillary	$3,355,416	$2,385,617	41.6%	$2,956,809
Non-Facility	$28,480,314	$29,832,564	51.2%	$20,670,342
Facility Inpatient	$13,180,176	$30,673,189	69.9%	$12,621,593
Facility Outpatient	$16,399,471	$33,193,455	66.9%	$13,584,457
Total	**$61,415,377**	**$96,084,825**	**61.0%**	**$49,833,200**
In-Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Plan Paid**
Ancillary	$3,290,759	$2,381,839	42.0%	$2,934,174
Non-Facility	$26,305,617	$29,747,095	53.1%	$19,154,538
Facility Inpatient	$13,123,617	$30,620,673	70.0%	$12,586,884
Facility Outpatient	$16,161,986	$32,818,170	67.0%	$13,427,300
Total In-Network	**$58,881,980**	**$95,567,776**	**61.9%**	**$48,102,896**
% of Eligible Charge - 95.9%		% Claim Frequency - 86.5%		
Out of Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Plan Paid**
Ancillary	$64,657	$3,778	5.5%	$22,635
Non-Facility	$2,174,697	$85,470	3.8%	$1,515,804
Facility Inpatient	$56,558	$52,516	48.1%	$34,709
Facility Outpatient	$237,485	$375,285	61.2%	$157,156
Total Out of Network	**$2,533,397**	**$517,049**	**16.9%**	**$1,730,305**
% of Eligible Charge - 4.1%		% Claim Frequency - 13.5%		

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

PEBP's members had utilization of network or secondary network medical providers at 95.9% of all allowed charges and 86.5% 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 no sanctioned providers were identified as receiving payment from the administrator during the audit period.

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 95.51% of the procedure codes identified as preventive services were paid by HealthSCOPE at 100% when provided in-network. A detailed list of the other 4.49% 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 1/1/2021 - 3/31/2021
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	%
HHS	Breastfeeding support and counseling - women	36	1	19	$4,523	0	$0	10	$431	6	$1,204	17.14%
USPSTF-B	Depression screening - >18	37	0	12	$142	5	$30	7	$20	13	$141	35.14%
USPSTF-B	BRCA screening counseling - women	37	1	10	$6,463	3	$120	10	$1,791	13	$14,144	36.11%
USPSTF-B	Alcohol misuse - screening and counseling	12	0	4	$79	0	$0	3	$9	5	$158	41.67%
USPSTF-A,B	Rh incompatibility screening - pregnant women	139	8	40	$2,043	2	$281	30	$339	59	$984	45.04%
USPSTF-A	HIV screening - pregnant women	40	1	16	$551	1	$17	4	$22	18	$868	46.15%
USPSTF-A	Phenylketonuria (PKU) screening 0-90 days	6	0	1	$11	0	$0	2	$3	3	$32	50.00%
USPSTF-B	Healthy diet counseling	260	1	30	$2,917	34	$1,341	26	$484	169	$17,906	65.25%
USPSTF-A	Urinary tract infection screening - pregnant women	118	0	24	$1,073	3	$84	13	$114	78	$1,177	66.10%
USPSTF-A	Syphillis screening	43	4	11	$80	0	$0	2	$2	26	$138	66.67%
USPSTF-B	Breast cancer chemoprevention counseling- >17	9	0	1	$48	0	$0	2	$19	6	$948	66.67%
HHS	Gestational Diabetes Mellitus screening - women	160	0	40	$314	0	$0	13	$30	107	$834	66.88%
USPSTF-A	Syphilis screening - pregnant women	144	2	38	$360	0	$0	8	$10	96	$689	67.61%
USPSTF-B	Gonorrhea screening - female	351	3	83	$4,323	0	$0	25	$261	240	$11,194	68.97%
USPSTF-A,B	Chlamydia infection screening - women	355	3	84	$4,131	0	$0	25	$258	243	$11,084	69.03%
USPSTF-A	HIV screening - >14	169	9	36	$1,051	0	$0	12	$69	112	$3,467	70.00%
USPSTF-B	Tobacco use counseling - >18	35	3	6	$194	0	$0	3	$11	23	$564	71.88%
USPSTF-A	Hepatitis B screening - women	67	3	11	$228	1	$11	5	$8	47	$999	73.44%
USPSTF-A,B	Cholesterol abnormalities screening - women >19	667	1	117	$2,090	0	$0	48	$182	501	$9,138	75.23%
USPSTF-A	Cholesterol abnormalities screening - men 35-75	523	12	92	$1,716	0	$0	21	$68	398	$6,171	77.89%
USPSTF-B	Depression screening - 12-18	37	0	7	$89	0	$0	1	$8	29	$179	78.38%
USPSTF-B	Hepatitis C Virus (HCV) Screening	203	10	25	$416	0	$0	11	$35	157	$2,348	81.35%
Bright Futures	Hearing Screening 0-21 yrs	169	9	5	$458	1	$11	10	$285	144	$3,016	90.00%
Bright Futures	Dyslipidemia screening - 2-20	48	0	1	$18	0	$0	3	$11	44	$652	91.67%
Bright Futures	Tuberculin testing - <21	13	0	1	$6	0	$0	0	$0	12	$119	92.31%
USPSTF-B	Hearing loss screening - 0 - 90 days	40	0	2	$652	0	$0	1	$65	37	$9,371	92.50%
USPSTF-A	Colorectal cancer screening - 45-75	714	28	15	$926	1	$40	10	$177	660	$211,541	96.21%
USPSTF-A	Cervical Cancer Screening (Pap) - women	1,393	5	26	$860	1	$29	14	$108	1,347	$62,029	97.05%
HHS	Contraceptive methods - women	538	1	4	$885	3	$91	6	$1,043	524	$148,976	97.58%
ACIP	Immunizations - Pneumococcal >18	50	0	1	$72	0	$0	0	$0	49	$5,236	98.00%
HHS	Cervical Cancer Screening (HPV DNA) - women >29	863	2	14	$635	1	$39	2	$19	844	$35,290	98.03%
Bright Futures	Developmental Autism screening - <3	205	0	2	$42	1	$20	1	$5	201	$6,036	98.05%
USPSTF-B	Breast cancer mammography screening - >39	3,891	0	40	$2,589	4	$80	21	$244	3,826	$299,261	98.33%
ACIP	Immunizations - Influenza Age >18	496	5	4	$127	0	$0	3	$16	484	$9,666	98.57%
HHS	Wellness Examinations - >18	725	2	6	$423	2	$60	2	$46	713	$92,527	98.62%
ACIP	Immunizations - Herpes Zoster >59	276	1	3	$662	0	$0	0	$0	272	$39,444	98.91%
Bright Futures	Iron Supplement - <21	94	0	0	$0	1	$3	0	$0	93	$360	98.94%
HHS	Wellness Examinations - women	2,522	2	6	$486	2	$40	5	$449	2,507	$336,948	99.48%
ACIP	Immunizations - Influenza <19	551	1	1	$17	0	$0	1	$3	548	$11,012	99.64%
ACIP	Immunizations - DTP <19	626	1	1	$121	0	$0	0	$0	624	$42,551	99.84%
ACIP	Immunization Administration - >18	5,355	42	4	$258	1	$50	2	$6	5,306	$143,226	99.87%
HRSA/HHS	Wellness Examinations - <19	2,163	1	1	$25	0	$0	1	$21	2,160	$234,900	99.91%

PPACA Preventive Services Coverage Compliance Detail Report

QID	Error Description	Under/ Over Paid	HealthSCOPE Response	CTI Conclusion	Manual or System
11	Copayment Applied	$40.00 – under	Agree. Claim did take a $40 specialist copay for surgery in a specialist office in error.	Procedural deficiency and underpayment remain. HealthSCOPE applied a copayment to a preventive service.	☐ M ☒ S
10	Deductible Applied	$327.67 – under	Agree. NEV.XXXX2307 should have been considered preventive at 100%.		☐ M ☒ S
12	Coinsurance Applied	$52.16 – under	Agree. Hearing exam should have paid at 100%.		☐ M ☒ S

PPACA Preventive Services Coverage Compliance Detail Report					
QID	Error Description	Under/ Over Paid	HealthSCOPE Response	CTI Conclusion	Manual or System
15		$806.00 – under	Agree. Outpatient surgical center for sterilization processed with coinsurance in error.		☐ M ☒ S

Preventive Care Services Compliance Review Paid at 100%

PEBP - HealthSCOPE

Audit Period 1/1/2021 - 3/31/2021

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	Immunization Administration - <19	2,779	12	0	$0	0	$0	0	$0	2,767	$106,786	100.00%
ACIP	Immunizations - Rotavirus <19	258	0	0	$0	0	$0	0	$0	258	$27,847	100.00%
ACIP	Immunizations - Human papillomavirus	233	0	0	$0	0	$0	0	$0	233	$52,422	100.00%
ACIP	Immunizations - Hepatitis A <19	232	1	0	$0	0	$0	0	$0	231	$8,991	100.00%
ACIP	Immunizations - Meningococcal <19	188	0	0	$0	0	$0	0	$0	188	$24,903	100.00%
ACIP	Immunizations - Measles, Mumps, Rubella <19	144	0	0	$0	0	$0	0	$0	144	$32,889	100.00%
ACIP	Immunizations - Meningococcal >18	127	0	0	$0	0	$0	0	$0	127	$21,692	100.00%
USPSTF-B	Vision screening - 3- 5	119	11	0	$0	0	$0	0	$0	108	$2,852	100.00%
ACIP	Immunizations - Varicella <19	91	0	0	$0	0	$0	0	$0	91	$14,626	100.00%
ACIP	Immunizations - Hepatitis B <19	79	1	0	$0	0	$0	0	$0	78	$2,110	100.00%
ACIP	Immunizations - Hepatitis B >18	31	2	0	$0	0	$0	0	$0	29	$2,062	100.00%
ACIP	Immunizations - Inactivated Poliovirus <19	30	0	0	$0	0	$0	0	$0	30	$1,508	100.00%
Bright Futures	Lead screening - <21	25	6	0	$0	0	$0	0	$0	19	$287	100.00%
ACIP	Immunizations - Hepatitis A >18	9	0	0	$0	0	$0	0	$0	9	$849	100.00%
ACIP	Immunizations - Varicella >18	9	0	0	$0	0	$0	0	$0	9	$1,322	100.00%
ACIP	Immunizations adult - Influenza Age (FluMist) 19-49	2	0	0	$0	0	$0	0	$0	2	$47	100.00%
ACIP	Immunizations - Pneumococcal <19	2	0	0	$0	0	$0	0	$0	2	$144	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.

Outpatient Hospital Services (facility claims with codes not designated inpatient)								
Primary		Secondary			Primary Description	Secondary Description	Line	Allowable
Code	Mod	Code	Mod	Mod Use			Count	Benefit
78803	TC	C2616		YES	Radiopharmaceutical localization of tumor, infla	BRACHYTX, NON-STR,YTTRIUM-90	1	$20,790
					Misuse of column two code with column one code			
C9600		93454		YES	Percutaneous transcatheter placement of drug elu	CORONARY ARTERY ANGIO S&I	1	$11,002
					CPT Manual or CMS manual coding instructions			
37243		75726	TC	YES	Vascular embolization or occlusion	ARTERY X-RAYS ABDOMEN	1	$9,652
					CPT Manual or CMS manual coding instructions			
74177	TC	96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	13	$4,168
					Standards of medical / surgical practice			
70553		70544		YES	Mri brain stem w/o & w/dye	MR ANGIOGRAPHY HEAD W/O DYE	1	$3,653
					Misuse of column two code with column one code			
22551		95939	TC	YES	NECK SPINE FUSE&REMOV BEL C2	C MOTOR EVOKED UPR&LWR LIMBS	2	$3,021
					Misuse of column two code with column one code			
22853		22845		YES	INSJ BIOMCHN DEV INTERVERTEBRAL DSC SPC W/A	INSERT SPINE FIXATION DEVICE	1	$2,864
					HCPCS/CPT procedure code definition			
76857		93975		YES	US EXAM PELVIC LIMITED	VASCULAR STUDY	2	$2,331
					Misuse of column two code with column one code			
96374		96372		YES	THER/PROPH/DIAG INJ IV PUSH	THER/PROPH/DIAG INJ SC/IM	12	$2,243
					CPT Manual or CMS manual coding instructions			
74176		74160		YES	CT ABD & PELVIS	CT ABDOMEN W/DYE	1	$1,524
					CPT Manual or CMS manual coding instructions			
						Top 10 TOTAL	**35**	**$61,249**
						GRAND TOTAL	**554**	**$126,281**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)								
Primary		Secondary			Primary Description	Secondary Description	Line	Secondary
Code	Mod	Code	Mod	Mod Use			Count	Allowable
95865	26	95868	26	YES	MUSCLE TEST LARYNX	MUSCLE TEST CRAN NERVE BILAT	1	$1,137
					Mutually exclusive procedures			
22842		76000	26	YES	INSERT SPINE FIXATION DEVICE	FLUOROSCOPE EXAMINATION	1	$750
					Standards of medical / surgical practice			
63030	80	63056	80	YES	LOW BACK DISK SURGERY	Decompress spinal cord lmbr	1	$680
					Mutually exclusive procedures			
90471		99396		YES	IMMUNIZATION ADMIN	PREV VISIT EST AGE 40-64	6	$551
					CPT Manual or CMS manual coding instructions			
22612		69990		NO	LUMBAR SPINE FUSION	MICROSURGERY ADD-ON	1	$477
					Misuse of column two code with column one code			
22551	59	69990		NO	NECK SPINE FUSE&REMOV BEL C2	MICROSURGERY ADD-ON	1	$467
					Misuse of column two code with column one code			
00537	AA,P3	95955	26,59	NO	ANESTH CARDIAC ELECTROPHYS	EEG DURING SURGERY	1	$450
					Standard preparation / monitoring services for anesthesia			
94760		99213		YES	MEASURE BLOOD OXYGEN LEVEL	Office/outpatient visit for E&M of estab pat	3	$345
					CPT Manual or CMS manual coding instructions			
63056	80	63707	80	YES	Decompress spinal cord lmbr	REPAIR SPINAL FLUID LEAKAGE	1	$320
					Standards of medical / surgical practice			
63030		99223		YES	LOW BACK DISK SURGERY	INITIAL HOSPITAL CARE	1	$279
					CPT Manual or CMS manual coding instructions			
						Top 10 TOTAL	**17**	**$5,456**
						GRAND TOTAL	**114**	**$9,813**

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

Outpatient Hospital Services (facility claims with codes not designated inpatient)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line Count Exceeding Limit**	**Gross Benefit Allowed**
90999	1	DIALYSIS PROCEDURE	81	$325,374
		Rationale: Clinical: Data		
93580	1	TRANSCATH CLOSURE OF ASD	1	$23,833
		Rationale: Anatomic Consideration		
C1880	2	VENA CAVA FILTER	1	$20,337
		Rationale: Clinical: Data		
14301	2	Tis trnfr any 30.1-60 sq cm	1	$14,968
		Rationale: Clinical: Data		
C1732	3	CATH, EP, DIAG/ABL, 3D/VECT	2	$14,642
		Rationale: Clinical: Data		
57425	1	LAPAROSCOPY SURG COLPOPEXY	1	$10,779
		Rationale: Anatomic Consideration		
27447	1	TOTAL KNEE ARTHROPLASTY	1	$9,933
		Rationale: CMS Policy		
A9520	1	TECHNETIUMTC-99M SULFUR CLLD	2	$8,923
		Rationale: Clinical: Society Comment		
29806	1	SHOULDER ARTHROSCOPY/SURGERY	1	$8,138
		Rationale: CMS Policy		
23430	1	REPAIR BICEPS TENDON	1	$8,138
		Rationale: CMS Policy		
		Top 10 TOTAL	**92**	**$445,065**
		GRAND TOTAL	**351**	**$551,125**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line Count Exceeding Limit**	**Gross Benefit Allowed**
J9355	105	INJ TRASTUZUMAB EXCL BIOSIMI	3	$43,341
		Rationale: CMS Policy		
97799	1	PHYSICAL MEDICINE PROCEDURE	23	$17,680
		Rationale: Clinical: Data		
64714	1	REVISE LOW BACK NERVE(S)	1	$7,620
		Rationale: CMS Policy		
95165	30	ANTIGEN THERAPY SERVICES	5	$6,140
		Rationale: Clinical: Data		
88374	5	Morphometric analysis, in situ hybridization (quantitativ	8	$5,756
		Rationale: Clinical: Data		
97155	24	ADAPT BHV TX PRTCL MODIFICAJ PHYS/QHP EA 15 MIN	5	$4,170
		Rationale: Clinical: Society Comment		
31298	1	Nasal/sinus endoscopy, w dilation (balloon dilation) fro	1	$3,254
		Rationale: CMS Policy		
J0475	8	BACLOFEN 10 MG INJECTION	2	$2,234
		Rationale: Prescribing Information		
99494	2	Initial or subsequent psychiatric collaborative care mana	4	$2,150
		Rationale: Clinical: Data		
97151	8	BEHAVIOR ID ASSESSMENT BY PHYS/QHP EA 15 MIN	3	$1,630
		Rationale: Clinical: CMS Workgroup		
		Top 10 TOTAL	**55**	**$93,975**
		GRAND TOTAL	**161**	**$108,383**

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
E0465	2	Home ventilator, any type, used with invasive interface, (e	12	$14,306
		Rationale: Nature of Equipment		
E0466	2	Home ventilator, any type, used with non-invasive interfa	5	$7,581
		Rationale: Nature of Equipment		
E0471	1	RAD W/BACKUP NON INV INTRFC	1	$2,212
		Rationale: Nature of Equipment		
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	16	$2,145
		Rationale: Nature of Equipment		
E0443	1	PORTABLE 02 CONTENTS, GAS	19	$1,966
		Rationale: Code Descriptor / CPT Instruction		
E0470	1	RAD W/O BACKUP NON-INV INTFC	1	$1,127
		Rationale: Nature of Equipment		
B4035	1	ENTERAL FEED SUPP PUMP PER D	2	$824
		Rationale: Code Descriptor / CPT Instruction		
E0601	1	CONT AIRWAY PRESSURE DEVICE	1	$540
		Rationale: Nature of Equipment		
K0001	1	STANDARD WHEELCHAIR	10	$382
		Rationale: Nature of Equipment		
E0630	1	PATIENT LIFT HYDRAULIC	1	$171
		Rationale: Nature of Equipment		
		Top 10 TOTAL	**68**	**$31,253**
		GRAND TOTAL	**92**	**$32,281**

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.

Audit Period 1/1/2021 - 3/31/2021									
Provider Id	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	
	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
880103557	268	$118,664	33	11.0%	$4,921	20	$1,273	12	$900
860800150	4	$2,450	4	50.0%	$2,254	1	$188	3	$716
880310956	20	$10,652	2	9.1%	$2,044	1	$169	1	$297
208628418	42	$21,019	10	19.2%	$5,588	9	$1,785	1	$240
770465765	13	$23,422	2	13.3%	$7,899	0	$0	1	$239
260816957	3	$1,265	2	40.0%	$149	0	$0	2	$232
880236758	35	$5,799	2	5.4%	$455	1	$183	1	$148
203395567	150	$28,797	2	1.3%	$179	1	$191	1	$120
880382265	1	$43	2	66.7%	$119	1	$51	1	$113
880060272	0	$0	1	100.0%	$58	0	$0	1	$101
Top 10	**536**	**$212,112**	**60**	**10.1%**	**$23,667**	**34**	**$3,841**	**24**	**$3,107**
Overall Total	**3,311**	**$1,125,304**	**512**	**13.4%**	**$105,792**	**445**	**$45,470**	**28**	**$3,383**

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

January 18, 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.

HealthSCOPE Benefits has reviewed the Q3 draft report and would like to add the response to the conclusions within the audit report.

TARGETED SAMPLE ANALYSIS:

Invalid Procedures Codes Detail Report:

QID 19 – HSB does not agree with CTI conclusion. No overpayment on the member account. Case management was performed by American Health Holding on case # [redacted].

QID 20 - HSB does not agree with CTI conclusion. No overpayment on the member account. High dollar policy and procedures were followed, and this high dollar claim did go through the review process and released by VP of claims. Case management was performed on case # [redacted].

QID 21- HSB does not agree with CTI conclusion. No overpayment on the member account. First day of dialysis was on 05/17/2017. Medicare ESRD coverage was investigated and the dates are identified under the member account. The plan is primary during the coordination period.

QID 22 - HSB does not agree with CTI conclusion. No overpayment on the member account. The claim was reviewed by LNL (subrogation vendor) and no third party liability for this date of service.

QID 23 - HSB does not agree with CTI conclusion. No overpayment on the member account. Accident detail information reviewed by LNL (subrogation vendor) and this is not work related and no third party liability.

QID 24 - HSB does not agree with CTI conclusion. No overpayment on the member account. Claim was paid with the pricing under the Aetna contract.

QID 25 - HSB does agree with CTI conclusion. The overpayment on this account should be $158.40. The claim was coordinated incorrectly.

QID 26 - HSB does not agree with CTI conclusion. No overpayment on the member account. Claim was paid based on the agreement with Hometown Health.

QID 27 - HSB does not agree with CTI conclusion. No overpayment on the member account. This member was out of the country and rendered services in Turkey. The documentation was provided on the response to CTI for QID 27.

QID 28 - HSB does not agree with CTI conclusion. No overpayment on the member account. This claim was paid under the dental benefits under root canal treatment per the MPD.

QID 29 - HSB does not agree with CTI conclusion. No overpayment on the member account. The member was inpatient for 37 days in ICU. Authorization on file for the member and services rendered.

QID 30 - HSB does not agree with CTI conclusion. No overpayment on the member account. This claim was paid under the dental benefits under oral surgery per the MPD.

QID 31 - HSB does not agree with CTI conclusion. No overpayment on the member account. This claim was paid under the dental benefits under prosthodontics per the MPD.

QID 32 - HSB does not agree with CTI conclusion. No overpayment on the member account. This claim was paid under the dental benefits under oral surgery per the MPD.

QID 33 - HSB does not agree with CTI conclusion. No overpayment on the member account. This claim was paid under the dental benefits under oral surgery per the MPD.

Fraud, Waste, and Abuse Detail Report:

QID 40 - HSB does not agree with CTI conclusion. No overpayment on the member account. The claim was adjudicated based on plan guidelines and based on the agreement with Hometown Health. The authorization number # 5399492 on file for services.

QID 41 – HSB does not agree with CTI conclusion. No overpayment on the member account. The claim was adjudicated based on the plan guidelines for Chiropractic care based on the agreement with Hometown Health.

QID 42 – HSB does not agree with CTI conclusion. No overpayment on the member account. The claim was adjudicated based on the plan guidelines for Chiropractic care based on the agreement with Hometown Health.

QID 43 – HSB does not agree with CTI conclusion. No overpayment on the member account. The provider is contracted under the Aetna network and adjudicated based on the Aetna agreement for service rendered.

Duplicate Payment Detail Report:

QID 34 – HSB does not agree with CTI conclusion. No overpayment on the member account. This is not a duplicate claim. Claim [redacted]1574 was a corrected claim that was received.

QID 35 - HSB does agree with CTI conclusion. Duplicate claim on file and paid. [redacted]3321 has not been corrected under the account.

QID 36 – HSB does not agree with CTI conclusion. Claim NEV.10394358 was billed with J0878 and S9494 and [redacted]8272 was billed with J1335 and S9494.

QID 37 – HSB does not agree with CTI conclusion. No overpayment on the member account. This is not a duplicate claim. Claim [redacted]9729 was a reconsideration of [redacted]1902.

QID 38 – HSB does not agree with CTI conclusion. No overpayment on the member account. This is not a duplicate claim. Claim [redacted]9507 was a reconsideration due to a corrected claim that was received.

QID 39 - HSB does not agree with CTI conclusion. No overpayment on the member account. This claim was a reconsideration with corrected pricing.

Plan Limitations Detail Report:

QID 16 – HSB does not agree with CTI conclusion. No overpayment on the member account. The claim was paid per the COVID-19 timely filing guidelines.

QID 17 – HSB does not agree with CTI conclusion. No overpayment on the member account. The claim was paid per the COVID-19 timely filing guidelines.

QID 18 – HSB does not agree with CTI conclusion. No overpayment on the member account. The claim was paid per the COVID-19 timely filing guidelines.

Plan Exclusion Detail Report:

QID 44 – HSB does not agree with CTI conclusion. No overpayment on the member account. The claim was considered with CDT D9951 for an occlusal adjustment. The exclusion is for expenses for *athletic* mouth guards and associated devices.

QID 45 – HSB does not agree with CTI conclusion. No overpayment on the member account. The claim was considered with CDT D9943 for an occlusal adjustment. The exclusion is for expenses for *athletic* mouth guards and associated devices.

QID 46 - HSB does not agree with CTI conclusion. No overpayment on the member account. Medical necessity was requested and received and provided to CTI regarding acquired deformities of foot/feet.

QID 47 – HSB does not agree with CTI conclusion. No overpayment on the member account. Services were investigated based on plan guidelines. These services are covered under the MPD.

QID 48 - HSB does not agree with CTI conclusion. No overpayment on the member account. Services were investigated based on plan guidelines. There is an authorization number # 5536967 on file for services.

QID 49 – HSB does agree with CTI conclusion. The analyst should review plan guidelines and review procedures as well as records received for services. The operative report was provided to CTI as an attachment.

QID 50 - HSB does not agree with CTI conclusion. No overpayment on the member account. Services were investigated based on plan guidelines. There is an authorization number # 5539902 on file for services. Operative records were provided to CTI as an attachment.

RANDOM SAMPLE AUDIT:

Financial Accuracy and Accurate payment Detail Report:

Audit No. 1035 – HSB does agree with CTI conclusion. The claim should have been considered at 100% of PPO allowed amount with no copayment.

Audit No. 1050 - HSB does agree with CTI conclusion. The claim was manually adjudicated incorrectly.

Accurate Processing Detail Report:

Audit No. 1035 – HSB does agree with CTI conclusion. The claim should have been considered at 100% of PPO allowed amount with no copayment.

Audit No. 1050 - HSB does agree with CTI conclusion. The claim was manually adjudicated incorrectly.

PPACA Preventive Services Coverage Compliance Detail Report:

QID 9 - HSB does not agree with CTI conclusion. No overpayment on the member account. Nutritional therapy was considered based on the information in the MPD. This wellness/preventive benefit is limited to three (3) Health Diet/Physical Activity Counseling or Obesity Screening/Counseling sessions per Plan yea.

QID 10 - HSB does agree with CTI conclusion. Claim [redacted]2307 should have been considered preventive at 100% per plan guidelines.

QID 11 - HSB does agree with CTI conclusion. Claim [redacted]3392 did take a $40 specialist copay for surgery in a specialist office in error.

QID 12 - HSB does agree with CTI conclusion. Claim should have paid at 100% for Hearing exam per the plan guidelines.

QID 13 - HSB does not agree with CTI conclusion. No overpayment on the member account. Claim [redacted]9965 was reversed on 05/21/2021 to pay at 100% without deductible or copayment.

QID 14 - HSB does not agree with CTI conclusion. No overpayment on the member account. Claim was billed with diagnosis of 099281, E039, 099511 and Z3A13.

QID 15 - HSB does agree with CTI conclusion. The outpatient claim was manually adjudicated with coinsurance in error.

Procedure to Procedure Edits Detail Report:

QID 4 - HSB does not agree with CTI conclusion. No overpayment on the member account. Claim was paid based on the agreement with Hometown Health.

QID 5 - HSB does not agree with CTI conclusion. No overpayment on the member account. Provider did submit modifier 59 with CPT code 95868 correctly.

QID 6 - HSB does not agree with CTI conclusion. No overpayment on the member account. Claim was paid based on the pricing under the Aetna contract.

Medically Unlikely Edits Detail Report:

QID 1 - HSB does not agree with CTI conclusion. No overpayment on the member account. Durable medical equipment was considered with rental up to purchase price per MPD DME guidelines.

QID 2 - HSB does not agree with CTI conclusion. No overpayment on the member account. Claim was paid based on the pricing under the Aetna contracted case rate.

QID 3 - HSB does not agree with CTI conclusion. No overpayment on the member account. Claim was paid based on plan guidelines and based on the agreement with Hometown Health. The authorization number # 5626720 on file for services.

Global Surgery Prohibited Fee Period Evaluation and Management Service Detail Report:

QID 7 - HSB does not agree with CTI conclusion. No overpayment on the member account. The claim numbers referenced on QID 7 does have two different claim numbers and two different providers. [redacted]2449 was billed by [redacted], Hematology, Internal Medicine, Medical Oncology. Claim [redacted]2450 was billed by [redacted], General Surgery, Obstetrics & Gynecology.

QID 8 - HSB does not agree with CTI conclusion. No overpayment on the member account. Claim [redacted]6760 was billed as part of a free standing ER visit. The initial visit and services provider by the ER Physician.

Thank you,

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

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