Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employees' Benefits Program Plans

Administered by HealthSCOPE Benefits

Audit Period: April 1, 2021 through June 30, 2021
Audit Number 1.FY21.Q4

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 (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 April 1, 2021 through June 30, 2021 (quarter 4 (Q4) 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	$54,896,231
Total Number of Claims Paid/Denied/Adjusted	208,088
Health Reimbursement Arrangement (HRA)	
Total Paid Amount	$1,105,972
Total Number of Claims Paid/Denied/Adjusted	11,152

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

- Operational Review and Performance Guarantees Validation
- 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 Q4 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.
    - Of the Electronic Screening Results, 13 of the 15 errors were manually processed. HealthSCOPE should confirm processor coaching, feedback, and retraining has occurred to prevent similar errors in the future.

Summary of HealthSCOPE's Guarantee Measurements

Based on CTI's Random Sample Audit results, HealthSCOPE met both claims processing measurements for PEBP in Q4 FY2021.

Quarterly Guarantee	Measure	Met/Not Met	Penalty
Financial Accuracy	99%	Met – 99.73%	None.
Payment Accuracy	98%	Met – 99.50%	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 AND PERFORMANCE GUARANTEE VALIDATION

Objective

CTI's Operational Review evaluates HealthSCOPE's claim administration systems, staffing, and procedures to identify any deficiencies that materially affect its ability to control risk and pay claims accurately on behalf of the plans.

Scope

The scope of the Operational Review included:

- Claim administrator information
    - Insurance and bonding
    - Conflicts of interest
    - Internal audit
    - Financial reporting
    - Business continuity planning
    - Claim payment system and coding protocols
    - Data and system security
    - Staffing
- Claim funding:
    - Claim funding mechanism
    - Check processing and security
    - COBRA/direct pay premium collections
- Claim adjudication, customer service, and eligibility maintenance procedures:
    - Exception claim processing
    - Eligibility maintenance and investigation
    - Overpayment recovery
    - Customer service call and inquiry handling
    - Network utilization
    - Utilization review, case management, and disease management
    - Appeals processing
- HIPAA compliance

Methodology

CTI used an Operational Review Questionnaire to gather information from HealthSCOPE. We modeled our questionnaire after the audit tool used by certified public accounting firms when conducting an SSAE 18 audit of a service administrator. We modified that tool to elicit information specific to the administration of your plans.

We reviewed HealthSCOPE's responses and any supporting documentation supplied to gain an understanding of the procedures, staffing, and systems used to administer PEBP's plans. This allowed us to conduct the audit more effectively.

In addition to the questionnaire, we used our proprietary Electronic Screening and Analysis System (ESAS®) software to identify the best cases to test operational processes. We selected a targeted sample of 50 cases and provided a substantive testing questionnaire to HealthSCOPE to collect information for each. We used the responses provided to validate that HealthSCOPE followed procedures to control risk and accurately pay claims.

Following is a list of sample screening categories used to identify candidate cases for operational testing:

ESAS Screening Categories
Fraud, Waste, and Abuse
Subrogation/Right of Recovery from Third Party
Workers' Compensation
Coordination of Benefits (COB)
Large Claim Review
Case Management
Specific Reinsurance Reimbursements

Findings

Claim Administrator Information

CTI reviewed information about HealthSCOPE including:

- Background information
- Financial reports
- Insurance protection types and levels
- Dedicated staffing
- Systems and software
- Fee and commission disclosure
- Performance standards
- Internal audit practices

We observed the following:

- HealthSCOPE provided the following insurance coverage information:

Coverage	Amount
Errors and Omissions	Not provided
Crime	$5,000,000
Cyber Liability	$10,000,000

- HealthSCOPE indicated it had been audited by BDO USA, L.L.P (BDO), for compliance with the standards of the American Institute of Certified Public Accountants through the issuance of a Service Organization Controls (SOC) 1 Report. Under the SOC1, the administrator is required to provide a description of its system, and controls, which the service auditor validates. CTI received a copy of the report from the period of November 1, 2019, to October 31, 2020. There were no exceptions noted.

  HealthSCOPE also provided CTI a second SOC report audited by BDO USA, L.L.P (BDO) dated November 1, 2020, to October 31, 2021. There were four exceptions noted in the report.

Claim Funding
CTI reviewed HealthSCOPE's claim check controls and procedures for:

- Claim funding
- Fund reconciliation
- Refund and returned check handling
- Large check approval
- Security
- Stale check disposition
- Audit trail reports
- COBRA and retiree/direct pay premium collection

We observed the following:

- HealthSCOPE reports it honors assignment of benefits for non-network providers which allows non-network providers to receive payment directly from HealthSCOPE versus having to pay the member who would then have to pay the non-network provider. This is a best practice.

Claim Adjudication, Customer Service, and Eligibility Maintenance Procedures
CTI reviewed HealthSCOPE's enrollment, eligibility maintenance, and claim processing controls and procedures. We observed the following:

- HealthSCOPE had adequately documented training, workflow, procedures, and systems.
- Verification of initial or continued COB was not required by HealthSCOPE.
- HealthSCOPE reported 80% of claims were received electronically during the audit period and 63.5% of claims were auto adjudicated.
- HealthSCOPE reported it did not have a minimum dollar amount to recoup an overpayment and has the ability to automatically recoup a refund from the next payment made to the same provider.
- The overpayment report provided by HealthSCOPE for FY 2021, shows $91,939.67 potential recovery.
- HealthSCOPE outsourced subrogation recovery to Luper Neidenthal & Logan. The vendor worked directly with PEBP on authority limits to reduce or waive a lien. Its fee was 18% of recovery amounts.
- HealthSCOPE provided a subrogation report titled Quarterly Subrogation Case Report for Nevada Public Employees' Benefit Program for FY 2021. The report indicated 549 open and 248 closed cases. HealthSCOPE reported total recoveries of $2,263,565.44 of $2,912,061.06 for a 77.73% recovery rate.
- The minimum amount to prompt a subrogation investigation was $1,000 in aggregate claim payments. HealthSCOPE stated recoveries did not result in claim adjustments.
- HealthSCOPE provided a member appeals report for Q2 and Q3 of FY 2021. This report showed a total of 42 member appeals – 12 in Q2 and 30 in Q3. Of those appeals, 30 were processed timely while 12 took greater than 20 days to close. According to HealthSCOPE all member

appeals should have a decision within 20 days of receipt to correspond to Nevada's state statute.

- HealthSCOPE provided a second appeals report and while this report did not include received, assigned, or closed dates, it did indicate a total of 38 PEBP member appeals in Q4 2021.
- HealthSCOPE reported it used software specifically designed to identify potential provider fraud but did not use external resources to identify providers who have been sanctioned for having committed fraud. It also reported it worked with its PPO networks to identify provider fraud.
- 100% of rebates received for processing specialty drugs are shared with PEBP.
- HealthSCOPE indicated the plan never allows more than billed charges. However, in Q2 and Q3 there were sampled claims in which HealthSCOPE paid more than billed charge.

HIPAA Compliance

CTI reviewed information about the systems and processes HealthSCOPE had in place to maintain compliance with HIPAA regulations. The objective was to determine if the administrator was aware of the HIPAA regulations and was compliant at the time of the audit. We observed the following:

- HealthSCOPE indicated HIPAA training is provided by the compliance department and training is provided annually to its employees.

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 Q4 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	99.73%	Met
Payment Accuracy	98% or greater of medical/dental claims audited are paid accurately	99.50%	Met
Claim Processing Turnaround	99% of all medical/dental claims are to be processed within 30 days	99.98%	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% 98.71%	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 8/16/21 Delivered 12/6/21	Met Met
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 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.
- ***Eligibility Verification of Every Claim by Date of Service*** – We used ESAS to compare service dates against the eligibility periods provided to us to look for claims paid for ineligible members.

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. **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.**

Process Improvement Summary Report				
Client: PEBP **Screening Period:** Q4 FY2021				
Category	**Number of Service Codes**	**Number of Members**	**Billed Charge**	**Allowed***
Paid Greater than Charged	9	5	$1,899	$2,432
Fraud, Waste and Abuse				
Spinal Region Upcoding – Number of spinal regions treated does not match number of spinal regions billed and allowed.	1,164	419	$78,715	$37,041
Large Payment to Member	504	274	$86,978	$41,683

**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.

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**
25	Paid Greater Than Charged	$203.20	Agree. We should have allowed billed charges and paid $22.80 coinsurance assessed by Medicare.	Procedural deficiency and overpayments remain.	☒ M ☐ S

Fraud, Waste, and Abuse Detail Report					
QID	**Category**	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
37	Spinal Region Upcoding	$55.00	Disagree. Reviewed for medical necessity.	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	☐ M ☒ S
38		$55.00			☐ M ☒ S

Fraud, Waste, and Abuse Detail Report					
QID	**Category**	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
				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.	
35	Large Payment to Member	$669.87	Agree. This was a pre-treatment estimate and payment should not have been issued. Refund was requested from member and received on 06/09/21, check number 223332567.	Procedural deficiency and overpayments remain.	☒ 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:** Q4 FY2021				
Category	**Number of Service Codes**	**Number of Members**	**Billed Charge**	**Allowed***
Duplicate Payments				
Providers and/or Employees	314	77	$332,102	$66,828
Exclusions				
Dental, Other Surgical Procedures	120	109	$71,517	$50,516
Dental, TMJ	1	1	$240	$180
Limitations				
Timely Filing	1,306	295	$3,344,468	$1,166,438

**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	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
31	$1,215.00	Agree. XXX.XXXX6511 pending reconsideration to request $1,215.00 refund of duplicate payment.	Procedural deficiency and overpayment remain. HealthSCOPE paid duplicate charges.	☒ M ☐ S
32	$300.00	Agree. XXX.XXXX6511 pending reconsideration to request $300.00 refund of duplicate payment.		☒ M ☐ S
33	$634.00	Agree. XXX.XXXX1664 pending reconsideration to request $634.00 refund of duplicate payment.		☒ M ☐ S

Timely Filing Detail Report				
QID	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
18	$1,346.75	Disagree. Original claim was received on XXX.XXX0699 on 02/12/2019. The claim denied to request accident details. The subrogation vendor LNL sent out original letter in 03/06/2019, then follow-ups were submitted on 03/26/2019 and 04/18/2019. The member contacted the subrogation vendor on 05/07/2021 in response to the accident questionnaire. Claim was reconsidered after notification received from LNL that there was no SUBRO and to apply plan benefits.	Procedural deficiency and overpayment remain. Claim was processed 28 months after the service date.	☒ M ☐ S
19	$3,864.00	Disagree. Claim originally received on 02/28/2018 and denied requesting additional information regarding possible other health insurance. The transplant network provided this information, along with proof of timely filing on 05/14/21. Claim was then reconsidered at that time.	Procedural deficiency and overpayment remain. Claim was processed 49 months after service date. Did not provide reasons why timely filing should be extended.	☒ M ☐ S

There were also four errors found under the dental benefit plan for services paid. CTI's review indicated four "Dental Surgical Procedures" paid for a total of $234.20 including:

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

One additional dental claim paid for excluded services for TMJ and totaled $144.00.

In CTI's experience the PEBP 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.

Eligibility Verification

CTI electronically compared dates of service for FY21 Q2, Q3, and Q4 and PEBP's electronic eligibility file revealed that some services were paid during the audit period for potentially ineligible claimants. At this time, potentially overpaid amounts have been flagged into one of the following categories:

Employee Eligibility Screening Subcategory	Amount Paid
No Identification Match to Any Eligible Employee	$1,621,216
Payments Prior to Effective Date	$1,775,583
Payments During Gaps in Coverage	$2,893
After Termination Date of Employee's Coverage	$72,444
Subtotal	$3,472,136
Dependent Eligibility Screening Subcategory	**Amount Paid**
No Identification Match to Any Eligible Employee	$932,380
Payments Prior to Effective Date	$239,684
Payments During Gaps in Coverage	$1,155
After Termination Date of Employee's Coverage	$87,748
Subtotal	$1,260,967
COMBINED TOTAL*	**$4,733,103**

**CTI notes that 2.9% of the PEBP's total medical spend processed by HealthSCOPE was identified as paid for members who may not have been eligible for coverage. These results are high compared to the less than 1% CTI generally reports.*

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 sample 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 $250.00 in underpayments and no overpayments, for an absolute value variance of $250.00.

The weighted Financial Accuracy rate was 99.73%.

Financial Accuracy Detail Report						
Error Description	**Audit No.**	**Under Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**	
Copay Calculation	1036	$250.00	Agree. Claim should have only one $250 copayment.	Procedural error and underpayment remain.	☐ M ☒ S	
TOTALS	**1**	**VARIANCE $250.00**			**M: 0**	**S: 1**

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 1 incorrectly paid claims and 199 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	0	99.50%

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	
199	1	0	99.50%

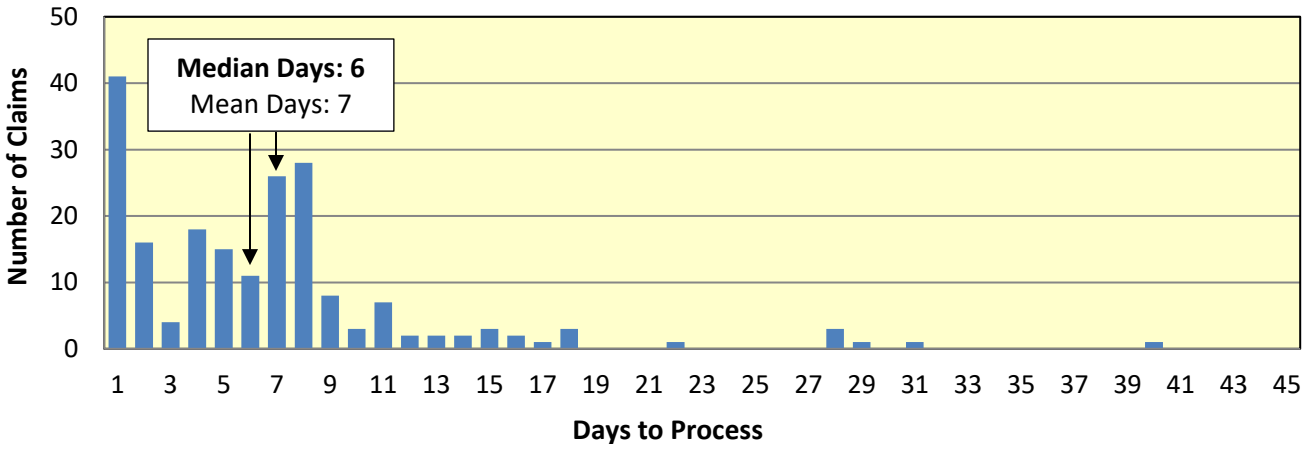
Accurate Processing Detail Report				
Error Description	**Audit No.**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
Managed Care				
Copay Calculation	1036	Agree. Claim should have only one $250 copayment.	Procedural error remains.	☐ M ☒ S

Claim Turnarounds

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 remove a remark code stating a COVID-19 test was 100% covered on the Explanation of Benefits (EOB) when in fact, the member was no longer covered and the test was not paid for.	1070

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.

Our audit revealed no procedures or situations that may have caused an error on the sampled claim.

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 4/1/2021 through 6/30/2021				
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	$3,100,919	$2,385,912	43.5%	$2,825,261
Non-Facility	$28,585,095	$31,575,791	52.5%	$21,270,216
Facility Inpatient	$10,532,712	$23,993,676	69.5%	$9,923,749
Facility Outpatient	$15,521,006	$33,939,861	68.6%	$13,250,504
Total	**$57,739,732**	**$91,895,240**	**61.4%**	**$47,269,729**
In-Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Plan Paid**
Ancillary	$3,027,986	$2,385,912	44.1%	$2,773,776
Non-Facility	$27,594,677	$31,570,202	53.4%	$20,909,408
Facility Inpatient	$10,518,434	$23,926,034	69.5%	$9,917,439
Facility Outpatient	$15,455,734	$33,689,083	68.6%	$13,210,347
Total In-Network	**$56,596,832**	**$91,571,231**	**61.8%**	**$46,810,970**
% of Eligible Charge -	98.0%	% Claim Frequency -	87.7%	
Out of Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Plan Paid**
Ancillary	$72,933	$0	0.0%	$51,485
Non-Facility	$990,418	$5,589	0.6%	$360,808
Facility Inpatient	$14,277	$67,642	82.6%	$6,309
Facility Outpatient	$65,272	$250,778	79.3%	$40,157
Total Out of Network	**$1,142,900**	**$324,008**	**22.1%**	**$458,759**
% of Eligible Charge -	2.0%	% Claim Frequency -	12.3%	

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

PEBP's members had utilization of network or secondary network medical providers at 98.00% of all allowed charges and 87.70% 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	3	$1,253	$1,253	$264
				Totals	**3**	**$1,253**	**$1,253**	**$264**

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 95.23% of the procedure codes identified as preventive services were paid by HealthSCOPE at 100% when provided in-network. A detailed list of the other 4.77% 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 4/1/2021 - 6/30/2021

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	49	1	17	$3,523	2	$80	18	$798	11	$2,722	22.92%
USPSTF-B	Depression screening - >18	69	0	18	$127	15	$90	8	$18	28	$323	40.58%
USPSTF-A,B	Rh incompatibility screening - pregnant women	120	2	32	$1,121	4	$411	31	$350	51	$1,458	43.22%
USPSTF-B	Breast cancer chemoprevention counseling- >17	11	0	4	$362	0	$0	2	$16	5	$831	45.45%
USPSTF-B	Tobacco use counseling - >18	23	1	6	$141	0	$0	5	$10	11	$277	50.00%
USPSTF-B	BRCA screening counseling - women	18	2	1	$1,825	2	$40	5	$855	8	$4,452	50.00%
USPSTF-A	HIV screening - pregnant women	28	2	8	$356	0	$0	4	$21	14	$391	53.85%
USPSTF-A	Syphillis screening	40	2	13	$76	0	$0	3	$3	22	$134	57.89%
USPSTF-A	HIV screening - >14	172	5	46	$1,401	0	$0	20	$147	101	$2,828	60.48%
USPSTF-B	Healthy diet counseling	296	0	33	$2,199	36	$1,422	28	$691	199	$21,558	67.23%
USPSTF-A	Urinary tract infection screening - pregnant women	101	0	15	$224	2	$75	16	$228	68	$733	67.33%
USPSTF-A	Hepatitis B screening - women	62	2	13	$552	1	$2	5	$10	41	$411	68.33%
USPSTF-A,B	Chlamydia infection screening - women	307	3	65	$3,608	2	$114	22	$226	215	$9,675	70.72%
USPSTF-A	Syphilis screening - pregnant women	133	3	30	$196	0	$0	8	$13	92	$646	70.77%
USPSTF-B	Gonorrhea screening - female	305	3	65	$3,641	1	$36	20	$200	216	$9,874	71.52%
USPSTF-B	Hepatitis C Virus (HCV) Screening	224	3	34	$572	0	$0	25	$92	162	$2,615	73.30%
HHS	Gestational Diabetes Mellitus screening - women	164	2	21	$173	0	$0	22	$111	119	$1,065	73.46%
USPSTF-B	Alcohol misuse - screening and counseling	17	1	2	$29	0	$0	2	$6	12	$314	75.00%
USPSTF-A	Phenylketonuria (PKU) screening 0-90 days	12	0	0	$0	0	$0	3	$5	9	$194	75.00%
USPSTF-B	Hearing loss screening - 0 - 90 days	4	0	0	$0	1	$40	0	$0	3	$841	75.00%
USPSTF-A	Cholesterol abnormalities screening - men 35-75	577	8	89	$1,680	2	$22	46	$124	432	$6,699	75.92%
USPSTF-A,B	Cholesterol abnormalities screening - women >19	713	1	113	$2,367	1	$19	47	$192	551	$10,088	77.39%
USPSTF-B	Depression screening - 12-18	49	0	7	$46	1	$9	3	$3	38	$395	77.55%
Bright Futures	Hearing Screening 0-21 yrs	230	6	10	$752	0	$0	22	$539	192	$6,474	85.71%
Bright Futures	Dyslipidemia screening - 2-20	39	1	0	$0	0	$0	4	$11	34	$546	89.47%
ACIP	Immunizations - Hepatitis A >18	11	0	1	$117	0	$0	0	$0	10	$738	90.91%
ACIP	Immunizations - Influenza Age >18	73	4	2	$89	0	$0	1	$8	66	$1,617	95.65%
ACIP	Immunizations - Pneumococcal >18	48	1	0	$0	1	$59	1	$18	45	$4,484	95.74%
ACIP	Immunizations - Hepatitis B >18	29	3	0	$0	0	$0	1	$16	25	$4,415	96.15%
USPSTF-A	Colorectal cancer screening - 45-75	713	33	13	$1,373	1	$20	10	$186	656	$240,799	96.47%
USPSTF-A	Cervical Cancer Screening (Pap) - women	1,357	4	32	$1,235	1	$29	13	$76	1,307	$60,838	96.60%
Bright Futures	Iron Supplement - <21	99	2	2	$7	0	$0	1	$1	94	$355	96.91%
ACIP	Immunizations - Herpes Zoster >59	235	1	1	$148	0	$0	4	$249	229	$31,578	97.86%
USPSTF-B	Breast cancer mammography screening - >39	3,499	2	20	$2,017	6	$160	23	$435	3,448	$283,348	98.60%
HHS	Cervical Cancer Screening (HPV DNA) - women >29	849	1	9	$564	0	$0	2	$18	837	$35,410	98.70%
HHS	Wellness Examinations - >18	847	2	5	$860	0	$0	4	$53	836	$108,791	98.93%
HHS	Contraceptive methods - women	537	5	2	$343	1	$40	1	$55	528	$141,839	99.25%
ACIP	Immunizations - DTP <19	616	2	1	$72	0	$0	2	$46	611	$42,029	99.51%
HHS	Wellness Examinations - women	2,572	4	3	$286	0	$0	5	$29	2,560	$345,825	99.69%
ACIP	Immunization Administration - >18	5,007	36	3	$134	0	$0	3	$44	4,965	$176,427	99.88%
HRSA/HHS	Wellness Examinations - <19	2,188	6	1	$25	0	$0	1	$5	2,180	$234,092	99.91%
ACIP	Immunization Administration - <19	2,386	8	0	$0	0	$0	1	$20	2,377	$96,005	99.96%

PPACA Preventive Services Coverage Compliance Detail Report					
QID	**Error Description**	**Under Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
8	Coinsurance Applied	$112.41	Agree. Preventive charge paid with coinsurance.	Procedural deficiency and underpayment remain.	☒ M ☐ S
10		$767.60	Claim should have paid at 100% of the PPO allowed for procedure 81162 based on diagnosis.		☒ M ☐ S
9	Copay Applied	$40.00	Agree. Copayment in error based on surgical procedure performed in specialty care physician's office.		☒ M ☐ S
11	Denied	$37.12	Agree. Procedure G0442 should have been paid at 100% of PPO allowed per ACA guidelines.		☒ M ☐ S

Preventive Care Services Compliance Review Paid at 100%

PEBP - HealthSCOPE

Audit Period 4/1/2021 - 6/30/2021

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	Immunizations - Human papillomavirus	266	0	0	$0	0	$0	0	$0	266	$62,354	100.00%
ACIP	Immunizations - Rotavirus <19	214	0	0	$0	0	$0	0	$0	214	$22,688	100.00%
ACIP	Immunizations - Meningococcal <19	207	0	0	$0	0	$0	0	$0	207	$28,894	100.00%
Bright Futures	Developmental Autism screening - <3	203	0	0	$0	0	$0	0	$0	203	$5,738	100.00%
ACIP	Immunizations - Hepatitis A <19	203	0	0	$0	0	$0	0	$0	203	$7,745	100.00%
USPSTF-B	Vision screening - 3- 5	136	15	0	$0	0	$0	0	$0	121	$2,985	100.00%
ACIP	Immunizations - Measles, Mumps, Rubella <19	126	0	0	$0	0	$0	0	$0	126	$29,361	100.00%
ACIP	Immunizations - Meningococcal >18	108	0	0	$0	0	$0	0	$0	108	$17,821	100.00%
ACIP	Immunizations - Hepatitis B <19	87	0	0	$0	0	$0	0	$0	87	$2,526	100.00%
ACIP	Immunizations - Varicella <19	87	0	0	$0	0	$0	0	$0	87	$14,122	100.00%
ACIP	Immunizations - Influenza <19	77	0	0	$0	0	$0	0	$0	77	$1,611	100.00%
Bright Futures	Lead screening - <21	21	3	0	$0	0	$0	0	$0	18	$297	100.00%
ACIP	Immunizations - Inactivated Poliovirus <19	18	1	0	$0	0	$0	0	$0	17	$690	100.00%
ACIP	Immunizations - Varicella >18	11	0	0	$0	0	$0	0	$0	11	$1,430	100.00%
Bright Futures	Tuberculin testing - <21	6	0	0	$0	0	$0	0	$0	6	$78	100.00%
	Totals	**26,599**	**181**	**737**	**$32,239**	**80**	**$2,668**	**442**	**$5,930**	**25,159**	**$2,092,478**	**95.23%**

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		Mod	Primary Description	Secondary Description	Line Count	Secondary Allowable Benefit
Code	Mod	Code	Mod	Use				
74177	TC	96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	15	$5,425
					Standards of medical / surgical practice			
29881	RT	29877	XS,RT	NO	KNEE ARTHROSCOPY/SURGERY	KNEE ARTHROSCOPY/SURGERY	1	$4,356
					Misuse of column two code with column one code			
63081		22551		YES	Remove vert body dcmprn crvl	NECK SPINE FUSE&REMOV BEL C2	1	$4,219
					More extensive procedure			
70553		70544		YES	Mri brain stem w/o & w/dye	MR ANGIOGRAPHY HEAD W/O DYE	1	$3,567
					Misuse of column two code with column one code			
92960		93005		YES	CARDIOVERSION ELECTRIC EXT	ELECTROCARDIOGRAM TRACING	6	$2,730
					Standards of medical / surgical practice			
22551		95939	TC	YES	NECK SPINE FUSE&REMOV BEL C2	C MOTOR EVOKED UPR&LWR LIMBS	4	$2,727
					Misuse of column two code with column one code			
70551		70544		YES	Mri brain stem w/o dye	MR ANGIOGRAPHY HEAD W/O DYE	2	$2,336
					Misuse of column two code with column one code			
70496		70450		YES	CT ANGIOGRAPHY HEAD	CT HEAD/BRAIN W/O DYE	1	$2,317
					Misuse of column two code with column one code			
51702		96366		YES	INSERT TEMP BLADDER CATH	THER/PROPH/DIAG IV INF ADDON	1	$2,153
					Misuse of column two code with column one code			
74177	TC	96365		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG IV INF INIT	4	$1,794
					Standards of medical / surgical practice			
						Top 10 TOTAL	**36**	**$31,624**
						GRAND TOTAL	**619**	**$121,086**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)								
Primary		Secondary		Mod	Primary Description	Secondary Description	Line Count	Secondary Allowable Benefit
Code	Mod	Code	Mod	Use				
95955	TC	95940		YES	EEG DURING SURGERY	Ionm in operatng room 15 min	1	$3,053
					CPT Manual or CMS manual coding instructions			
22853		22845		YES	INSJ BIOMCHN DEV INTERVERTEBRAL DSC SPC W/A	INSERT SPINE FIXATION DEVICE	1	$1,785
					HCPCS/CPT procedure code definition			
29875	RT	29877	59,RT	NO	KNEE ARTHROSCOPY/SURGERY	KNEE ARTHROSCOPY/SURGERY	1	$757
					Misuse of column two code with column one code			
22551		69990		NO	NECK SPINE FUSE&REMOV BEL C2	MICROSURGERY ADD-ON	2	$599
					Misuse of column two code with column one code			
00530	AA,P3	95955	26,59	NO	ANESTH PACEMAKER INSERTION	EEG DURING SURGERY	1	$450
					Standard preparation / monitoring services for anesthesia			
00537	AA,P3	95955	26,59	NO	ANESTH CARDIAC ELECTROPHYS	EEG DURING SURGERY	1	$450
					Standard preparation / monitoring services for anesthesia			
90471		99386		YES	IMMUNIZATION ADMIN	PREV VISIT NEW AGE 40-64	3	$449
					CPT Manual or CMS manual coding instructions			
29882	51	29877	59,51	NO	KNEE ARTHROSCOPY/SURGERY	KNEE ARTHROSCOPY/SURGERY	1	$382
					Misuse of column two code with column one code			
29882		29877		NO	KNEE ARTHROSCOPY/SURGERY	KNEE ARTHROSCOPY/SURGERY	2	$374
					Misuse of column two code with column one code			
99205	25	97802		NO	Office/outpatient visit for E&M of new patient. 60	MEDICAL NUTRITION INDIV IN	6	$259
					Misuse of column two code with column one code			
						Top 10 TOTAL	**19**	**$8,559**
						GRAND TOTAL	**126**	**$14,172**

Procedure to Procedure Detail Report					
QID	**Error Description**	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
4	Non-Facility	$3,052.80	Agree. Claim should have been denied based on system edits. Refund of $3,052.80 has been requested.	Procedural deficiency and overpayment remain.	☒ M ☐ S
5	Outpatient	$1,088.95.	Agree. Claim was calculated incorrectly, and benefit exceeded is $1,088.95.	Procedural deficiency and overpayment remain.	☒ M ☐ S

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	59	$265,111
		Rationale: Clinical: CMS Workgroup		
20999	1	MUSCULOSKELETAL SURGERY	1	$20,551
		Rationale: Clinical: CMS Workgroup		
A9588	10	FLUCICLOVINE F-18	2	$19,928
		Rationale: Prescribing Information		
20680	3	REMOVAL OF SUPPORT IMPLANT	2	$17,062
		Rationale: Clinical: Data		
97799	1	PHYSICAL MEDICINE PROCEDURE	20	$11,534
		Rationale: Clinical: CMS Workgroup		
C1732	3	CATH, EP, DIAG/ABL, 3D/VECT	1	$7,071
		Rationale: Clinical: Data		
J9070	55	CYCLOPHOSPHAMIDE 100 MG INJ	1	$6,998
		Rationale: Clinical: Data		
27870	1	FUSION OF ANKLE JOINT OPEN	1	$5,389
		Rationale: CMS Policy		
J0585	600	INJECTION,ONABOTULINUMTOXINA	2	$5,352
		Rationale: Clinical: Data		
99152	2	MOD SED SAME PHYS/QHP INITIAL 15 MINS 5/> YRS	23	$4,768
		Rationale: Nature of Service/Procedure		
		Top 10 TOTAL	**112**	**$363,763**
		GRAND TOTAL	**299**	**$421,896**

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	4	$49,891
		Rationale: CMS Policy		
97799	1	PHYSICAL MEDICINE PROCEDURE	36	$23,100
		Rationale: Clinical: Data		
95165	30	ANTIGEN THERAPY SERVICES	10	$9,601
		Rationale: Clinical: Data		
88374	5	Morphometric analysis, in situ hybridization (quantitativ	10	$7,770
		Rationale: Clinical: Data		
87799	3	DETECT AGENT NOS DNA QUANT	5	$5,487
		Rationale: Clinical: Data		
88341	13	Immunohistochemistry or immunocytochemistry, per spe	5	$3,190
		Rationale: Clinical: Data		
97154	18	GROUP ADAPTIVE BHV TX BY PROTOCOL TECH EA 15 MIN	5	$2,831
		Rationale: Clinical: CMS Workgroup		
99494	2	Initial or subsequent psychiatric collaborative care mana	11	$2,321
		Rationale: Clinical: Data		
J0475	8	BACLOFEN 10 MG INJECTION	1	$2,313
		Rationale: Prescribing Information		
96127	2	Brief emotional/behavioral assessment (eg, depression in	19	$1,695
		Rationale: Nature of Service/Procedure		
		Top 10 TOTAL	**106**	**$108,200**
		GRAND TOTAL	**203**	**$128,866**

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
E0466	2	Home ventilator, any type, used with non-invasive interfa	10	$13,742
		Rationale: Nature of Equipment		
E0465	2	Home ventilator, any type, used with invasive interface, (e	7	$8,045
		Rationale: Nature of Equipment		
E1390	1	OXYGEN CONCENTRATOR	1	$2,881
		Rationale: Nature of Equipment		
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	16	$2,052
		Rationale: Nature of Equipment		
E0956	4	W/C LATERAL TRUNK/HIP SUPPOR	3	$566
		Rationale: Nature of Equipment		
K0001	1	STANDARD WHEELCHAIR	8	$407
		Rationale: Nature of Equipment		
V2520	2	CONTACT LENS HYDROPHILIC	3	$288
		Rationale: Anatomic Consideration		
E0260	1	HOSP BED SEMI-ELECTR W/ MATT	3	$192
		Rationale: Nature of Equipment		
V2521	2	CNTCT LENS HYDROPHILIC TORIC	1	$110
		Rationale: Anatomic Consideration		
V2522	2	CNTCT LENS HYDROPHIL BIFOCL	1	$110
		Rationale: Anatomic Consideration		
		Top 10 TOTAL	**53**	**$28,393**
		GRAND TOTAL	**63**	**$28,801**

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 4/1/2021 - 6/30/2021									
	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		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
880103557	289	$164,071	34	10.5%	$2,532	26	$1,291	8	$590
330571597	1	$327	2	66.7%	$5,933	0	$0	1	$507
680334324	12	$5,287	1	7.7%	$283	0	$0	1	$461
860800150	3	$2,300	2	40.0%	$1,074	1	$172	1	$404
910858192	49	$15,720	26	34.7%	$1,827	22	$1,760	2	$246
880313907	20	$3,107	14	41.2%	$1,648	13	$1,730	1	$139
416011702	5	$5,239	3	37.5%	$3,033	0	$0	1	$129
880310956	24	$9,368	2	7.7%	$1,908	0	$0	1	$122
270028866	47	$85,837	9	16.1%	$7,671	7	$1,248	1	$117
880454760	15	$975	2	11.8%	$53	0	$0	2	$111
Top 10	**465**	**$292,231**	**95**	**17.0%**	**$25,963**	**69**	**$6,202**	**19**	**$2,827**
Overall Total	**3,476**	**$1,229,616**	**572**	**14.1%**	**$119,924**	**515**	**$54,310**	**34**	**$3,808**

Q2, Q3, and Q4 FY2021 RECOMMENDATIONS

CTI has the following recommendations:

1. HealthSCOPE should review each of the financial errors identified in our Q2, Q3, and Q4 FY2021 random sample audits and determine if system changes or examiner training could help reduce or eliminate errors of a similar nature in the future. It should focus specifically on steps necessary to improve Financial Accuracy, Accurate Payment Frequency, and Accurate Processing Frequency.
2. HealthSCOPE should conduct a focused analysis of the errors identified through ESAS to determine if overpayment recovery and/or system improvements are possible and to reduce or eliminate similar errors going forward. For the issues identified by ESAS, CTI can prepare claim detail for HealthSCOPE to use in its analysis.
3. PEBP should carefully review any new contract signed with its administrators to ensure its ability to audit is not limited by restrictive conditions such as errors adjusted prior to date of audit or lesser than a certain dollar amount.
4. Based on Q3 2021 findings, PEBP and HealthSCOPE should discuss which diagnosis codes and diagnosis positions should trigger an accident questionnaire to be sent to the member. Member claims are currently being denied until a questionnaire is returned for an illness that is clearly not accident related. This is causing member disruption.
5. HealthSCOPE should adjust impacted claims when subrogation recoveries are received. This is not currently taking place and it is impacting member total out-of-pocket limits.
6. PEBP should review the results of the eligibility screening and perform causal analysis to identify workflow and/or system improvements to reduce or eliminate paying claims on ineligible claimants.
7. PEBP should talk to HealthSCOPE about its Coordination of Benefits (COB) processes and procedures. HealthSCOPE indicated it is not currently part of their service to review any COB indicators on a submitted claim.
8. HealthSCOPE's self-reported auto-adjudication rate is 63.5%. In CTI's experience, this is very low. We typically see 80% - 85% auto-adjudication. HealthSCOPE should consider ways to automate claims processing. This will also help reduce the number of manual errors that are occurring with HealthSCOPE's current adjudication.
9. In CTI's experience 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.
10. PEBP should request regular member appeal reports that include the reason for appeal, as well as received and closed dates. Currently it appears that HealthSCOPE is calculating appeal decision dates based on when the appeal was assigned, not when the appeal was received as stated on page 101 of PEBP's Consumer Driven Health Plan Master Plan for Plan Year 2021.
11. When generating PEBP's overpayment report, HealthSCOPE should specify the reason for overpayments. Tracking the reason for overpayments will allow both PEBP and HealthSCOPE to understand why overpayments occur and help determine the steps necessary to prevent them going forward.

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

February 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 Q4 draft report and would like to add the response to the conclusions within the audit report.

Performance Guarantees: HSB provided CTI with the copy of the email notification to the State of Nevada regarding the Annual/Regulatory Documents.

TARGETED SAMPLE ANALYSIS:

Paid Greater Thank Charged Detail Report:

QID 25 – HSB does agree with CTI conclusion. The claim was coordinated incorrectly.

Fraud, Waste, and Abuse Detail Report:

QID 37 - HSB does not agree with CTI conclusion. The claim was reviewed for medical necessity and records were provided to CTI with the audit.

QID 38- HSB does not agree with CTI conclusion. The claim was reviewed for medical necessity and records were provided to CTI with the audit.

QID 35 - HSB does not agree with CTI conclusion regarding an outstanding overpayment on this account. This was a pre-treatment estimate and the payment was issued. The refund check was received on 06/09/2021 to satisfy the account.

Duplicate Payment Detail Report:

QID 31 - HSB does agree with CTI conclusion. [redacted]6511 pending reconsideration to request a refund on the account. [redacted]6511 is a duplicate payment to [redacted]2031.

QID 32 – Questionnaire ID 32 is the same as QID 31. [redacted]6511 pending reconsideration to request a refund on the account. [redacted]6511 is a duplicate payment to [redacted]2031.

QID 33 - HSB does agree with CTI conclusion. Claim pending reconsideration to request refund of duplicate payment.

Timely Filing Detail Report:

QID 18 - HSB does not agree with CTI conclusion. The original claim was received with in the timely filing guidelines. The accident questionnaire was sent to the member from the subrogation vendor LNL. The member contacted LNL regarding the status of this information. The claim was reconsidered after notification from LNL that there was no third party liability and to apply plan benefits.

QID 19 - HSB does not agree with CTI conclusion. No overpayment on the member account. The original claim was received and denied requesting additional information regarding possible other health insurance. The transplant network provided this information to include proof of timely filing. The claim was reconsidered with the proof of timely filing.

RANDOM SAMPLE AUDIT:

Financial Accuracy Detail Report:

Audit No. 1036 – HSB does agree with CTI conclusion. The claim should have only one $250 copayment.

Accurate Processing Detail Report:

Audit No. 1036 – HSB does agree with CTI conclusion. The claim should have only one $250 copayment.

Observation:

Audit No. 1070 – The claim was denied correctly on the account. The EOB comment code should have been removed from the claim.

PPACA Preventive Services Coverage Compliance Detail Report:

QID 8 – HSB does agree that claim lines 2-3 were paid at coinsurance in error.

QID 10 – HSB does agree that the claim should have paid at 100% of the PPO allowed for procedure 81162 based on diagnosis billed.

QID 9 – HSB does agree that this claim was paid with a copayment in error based on the surgical procedure performed in a specialty care physician's office.

QID 11 – HSB does agree that procedure G0442 should have been paid at 100% of PPO allowed amount.

Procedure to Procedure Detail Report:

QID 4 - HSB does agree the claim was originally paid incorrectly. The claim was reconsidered with the appropriate NCCI edits and refund was requested.

QID 5 - HSB does agree that the claim was considered incorrectly. The claim was calculated incorrectly, and the overpayment should be $1088.95.

RECOMMENDATIONS:

HealthSCOPE has reviewed the recommendations from CTI as outlined. HealthSCOPE will continue to review each of the errors identified in the CTI FY 2021 random sample audits and continue to use the samples for training opportunities as well as system enhancements. The HealthSCOPE team will meet internally to discuss any open items or issues to continue focusing on accuracy as well as training. The claim management team will have a copy of the full audit for FY 2021 to evaluate any areas of concern.

HealthSCOPE has requested the list of open cases from LNL for FY 2021. Once the report is received this will be submitted to CTI for review.

HealthSCOPE did provide CTI the appeals report that is also submitted to the PEBP's Quality Control Officer for their appeal and complaints summary vendor report requirement. The summary report provided does go back to 01/01/2020.

Thank you,

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

CLAIM TECHNOLOGIES INCORPORATED

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