Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employees Benefit Program Plans

Administered by HealthSCOPE Benefits

Audit Period: July 1, 2021 through September 30, 2021
Audit Number 1.FY22.Q1

Presented to

State of Nevada Public Employees Benefit Program

Revised May 4, 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 Benefit 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 July 1, 2021 through September 30, 2021 (quarter 1 (Q1) for Fiscal Year (FY) 2022). The population of claims and amount paid during the audit period reported by HealthSCOPE Benefits:

Medical and Dental	
Total Paid Amount	$62,465,813
Total Number of Claims Paid/Denied/Adjusted	211,811
Health Reimbursement Arrangement (HRA)	
Total Paid Amount	$1,642,330
Total Number of Claims Paid/Denied/Adjusted	16,827

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 met both its Financial and Payment Accuracy measures in Q1 FY2022.
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 of CTI's claims processing measurements for the PEBP in Q1 FY2022.

Quarterly Guarantee	Measure	Met/Not Met	Penalty
Financial Accuracy	99%	Met – 99.29%	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 Benefit 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 Q1 FY2022 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.	99.29%	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	99.88%	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% 97.67%	Met Met Met
Data Reporting	• 100% of standard reports within 10 business days • Annual/Regulatory Documents within 10 business days of the Plan Year	No exceptions noted NA – Annual Report	Met NA
Disclosure of Subcontractors	• Report access of PEBP data within 30 calendar days • Removal of PEBP member PHI within 3 business days after knowledge	No exceptions noted No exceptions noted	Met Met

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

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

Scope

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

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

Methodology

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

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

Findings

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

Categories for Process Improvement

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

Process Improvement Summary Report				
Client: PEBP **Screening Period:** Q1 FY2022				
Category	**Number of Service Codes**	**Number of Members**	**Billed Charge**	**Allowed***
Fraud, Waste and Abuse				
Spinal Region Upcoding – Number of spinal regions treated does not match number of spinal regions billed and allowed.	1,215	448	$80,326	$42,848

**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 FY2022 report.

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

Fraud, Waste, and Abuse Detail Report					
QID	**Category**	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
27	Spinal Region Upcoding	$55.00	Disagree. Claim was paid according to the plan benefits.	Procedural deficiency and overpayment remain. The description for CPT codes for chiropractic care includes the number of regions of the spine or extraspinal regions treated and should be supported by the diagnosis. The provider billed five or more spinal regions treated; however, the diagnosis billed supported treatment of only two spinal regions. These procedures are spinal region driven and should be billed with appropriate diagnosis codes to support billing.	☐ M ☒ S
28		$136.00			☒ 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:** Q1 FY2022				
Category	**Number of Service Codes**	**Number of Members**	**Billed Charge**	**Allowed***
Duplicate Payment				
Providers and/or Employees	304	63	$113,369	$38,669
Exclusions				
Dental, General Anesthesia	458	238	$108,572	$91,253
Dental, Orthodontia	2	2	$809	$731
Dental, Other Services	116	92	$40,277	$22,686
Dental, Other Surgical Procedures	184	158	$125,931	$88,334
Dental, TMJ	4	3	$2,555	$1,916
Orthopedic Shoes	3	3	$668	$409

**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**
18	$500.00	Agree. The refund has not been received.	Procedural deficiency and overpayment remain. HealthSCOPE paid duplicate charges.	☒ M ☐ S
19	$147.48			☒ M ☐ S
22	$458.10			☒ M ☐ S
23	$201.72			☒ M ☐ S
24	$1,371.60			☒ M ☐ S
25	$690.00			☒ M ☐ S

Exclusion Detail Report				
QID	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
43	$189.60	Agree. Claim would suspend for analyst review. Analyst should have denied to request medical records.	Procedural deficiency and overpayment remain. HealthSCOPE should have denied charges and requested medical records.	☒ M ☐ S

There were also nine errors found under the dental benefit plan for excluded services paid. CTI's review indicated five "Other Dental Surgical Procedures" paid for a total of $2,631.00 including:

- two Sinus Augmentation claims;
- two Bone Replacement Graft for Ridge Preservation; and
- one Osseous, Osteoperiosteal, or Cartilage of the Mandible or Facial Bones.

The remaining four dental claims paid for excluded services include:

- one TMJ for $1,174.20;
- one Other Services for $692.61;
- one Orthodontia for $337.60;
- one General Anesthesia for $142.66.

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 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 $177.81 in underpayments and no overpayments, for an absolute value variance of $177.81.

The weighted Financial Accuracy rate was 99.29%.

Financial Accuracy Detail Report						
Error Description	**Audit No.**	**Under Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**	
Copay Calculation	1020	$14.01	Agree with the error. The claim should have paid at 100%.	As agreed, procedural error and underpayment remain.	☐ M ☒ S	
Subtotal	**1**					
Other Error	1053	$163.80	Agree with the error. This claim should have paid under the correct category with no cost share.	As agreed, procedural error and underpayment remain.	☐ M ☒ S	
Subtotal	**1**					
TOTALS	**2**	**VARIANCE $177.81**			**M: 0**	**S: 2**

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	2	0	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	
195	2	3	97.50%

Accurate Processing Detail Report				
Error Description	**Audit No.**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
Managed Care				
Copay Calculation	1020	Agree with the error. The claim should have paid at 100%.	As agreed, procedural error remains.	☐ M ☒ S
Other Error	1113	***Initial Response:*** Agree. The EOB comment code 64 should have been removed. ***Draft Response:*** HSB does not agree with CTI conclusion. The claim was paid correctly for the newborn per MPD. The EOB comment code 64 should have been removed.	As agreed, procedural error remains.	☒ M ☐ S
Policy Provision				
Other Error	1053	Agree with the error. This claim should have paid under the correct category with no cost share.	As agreed, procedural error remains.	☐ M ☒ S
	1111	***Initial Response:*** Agree. Used incorrect EOB comment code on the denial.	As agreed, procedural error remains.	☒ M ☐ S

Accurate Processing Detail Report				
Error Description	**Audit No.**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
		Draft Response: HSB does not agree with CTI conclusion. The claim did not have pricing from HTH and was a NICU claim. The incorrect EOB comment was used.		
	2015	***Initial Response:*** Agree with the error. NEV.11054607 was denied as a duplicate in error. ***Draft Response:*** The claim denied as a duplicate in error. HSB does agree with the procedural error for the denial of the claim.	As agreed, procedural error remains.	☒ M ☐ S

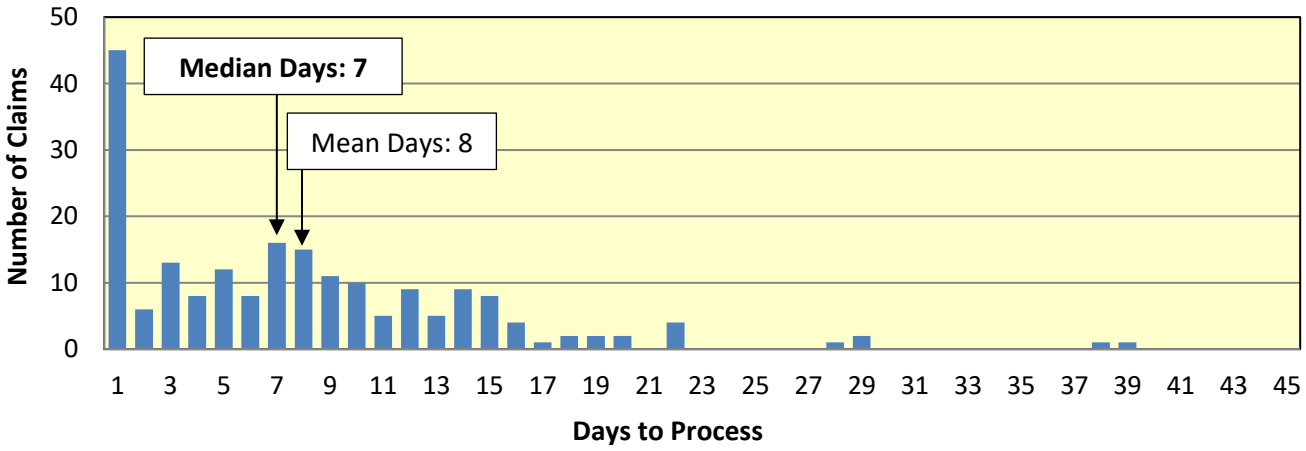
**Note that Accurate Processing Frequency is for PEBP's information only. It is not a performance guarantee measure that must be met by HealthScope.*

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



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
No doctors note included with receipt for an air purifier. Per policy documentation, it is required.	HRA1032

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.

Provider Discount Review PEBP - HealthSCOPE				
Paid Dates 7/1/2021 through 9/30/2021				
Proprietary and Confidential Information. Do not reproduce without express permission of Claim Technologies Inc.				
Total of All Claims				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$3,395,187	$3,617,372	51.6%	$2,818,819
Non-Facility	$29,863,023	$31,390,993	51.2%	$19,352,618
Facility Inpatient	$19,021,283	$33,045,581	63.5%	$18,233,860
Facility Outpatient	$18,812,106	$39,684,251	67.8%	$14,859,956
Total	**$71,091,599**	**$107,738,197**	**60.2%**	**$55,265,253**
In-Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$3,292,507	$3,602,707	52.2%	$2,787,520
Non-Facility	$28,577,940	$31,388,166	52.3%	$18,910,018
Facility Inpatient	$18,957,498	$32,904,987	63.4%	$18,202,475
Facility Outpatient	$18,635,512	$38,936,397	67.6%	$14,754,959
Total In-Network	**$69,463,457**	**$106,832,257**	**60.6%**	**$54,654,972**
% of Eligible Charge -	97.7%	% Claim Frequency -	85.3%	
Out of Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$102,680	$14,665	12.5%	$31,299
Non-Facility	$1,285,083	$2,827	0.2%	$442,599
Facility Inpatient	$63,785	$140,594	68.8%	$31,385
Facility Outpatient	$176,594	$747,855	80.9%	$104,997
Total Out of Network	**$1,628,142**	**$905,940**	**35.8%**	**$610,281**
% of Eligible Charge -	2.3%	% Claim Frequency -	14.7%	

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

PEBP's members had utilization of network or secondary network medical providers at 97.7% of all allowed charges and 85.3% 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 95.22% of the procedure codes identified as preventive services were paid by HealthSCOPE at 100% when provided in-network. A detailed list of the other 4.78% 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 7/1/2021 - 9/30/2021

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**	**%**
USPSTF-A	Ambulatory blood pressure screening - adult	2	0	2	$626	0	$0	0	$0	0	$0	.00%
ACIP	Immunizations - DTP >18	1	1	0	$0	0	$0	0	$0	0	$0	.00%
HHS	Breastfeeding support and counseling - women	33	0	16	$3,750	7	$330	3	$151	7	$1,113	21.21%
USPSTF-B	Breast cancer chemoprevention counseling- >17	8	0	3	$248	3	$150	0	$0	2	$164	25.00%
USPSTF-A,B	Rh incompatibility screening - pregnant women	104	11	31	$1,055	14	$639	22	$170	26	$166	27.96%
USPSTF-A	HIV screening - pregnant women	16	0	9	$578	0	$0	2	$48	5	$216	31.25%
USPSTF-B	BRCA screening counseling - women	30	2	5	$1,884	8	$330	3	$153	12	$8,411	42.86%
USPSTF-A	Hepatitis B screening - women	43	2	16	$337	0	$0	6	$41	19	$678	46.34%
USPSTF-A	Urinary tract infection screening - pregnant women	88	4	30	$601	1	$114	12	$234	41	$474	48.81%
USPSTF-B	Hearing loss screening - 0 - 90 days	2	0	0	$0	0	$0	1	$8	1	$326	50.00%
USPSTF-B	Tobacco use counseling - >18	46	5	12	$204	1	$19	6	$33	22	$446	53.66%
USPSTF-A	Syphilis screening - pregnant women	155	0	53	$371	0	$0	11	$42	91	$377	58.71%
USPSTF-A	Syphillis screening	65	4	20	$80	0	$0	5	$4	36	$148	59.02%
USPSTF-A	Phenylketonuria (PKU) screening 0-90 days	9	1	2	$15	0	$0	1	$1	5	$35	62.50%
USPSTF-A	HIV screening - >14	188	7	57	$1,178	2	$71	8	$43	114	$2,647	62.98%
USPSTF-B	Depression screening - >18	39	1	10	$145	3	$17	1	$1	24	$420	63.16%
USPSTF-B	Depression screening - 12-18	108	0	29	$204	8	$100	1	$1	70	$545	64.81%
HHS	Gestational Diabetes Mellitus screening - women	155	7	41	$432	0	$0	10	$12	97	$684	65.54%
USPSTF-B	Hepatitis C Virus (HCV) Screening	211	7	46	$605	0	$0	17	$59	141	$2,260	69.12%
USPSTF-A,B	Chlamydia infection screening - women	293	2	65	$2,256	1	$94	13	$113	212	$8,153	72.85%
USPSTF-B	Gonorrhea screening - female	283	2	60	$2,324	1	$94	14	$195	206	$7,794	73.31%
Bright Futures	Tuberculin testing - <21	19	0	4	$38	0	$0	1	$2	14	$191	73.68%
USPSTF-A,B	Cholesterol abnormalities screening - women >19	719	1	153	$1,843	0	$0	18	$89	547	$7,558	76.18%
USPSTF-A	Cholesterol abnormalities screening - men 35-75	528	11	90	$1,508	2	$42	15	$60	410	$5,518	79.30%
USPSTF-B	Alcohol misuse - screening and counseling	18	2	2	$37	1	$20	0	$0	13	$234	81.25%
USPSTF-B	Healthy diet counseling	202	3	12	$635	13	$712	8	$203	166	$20,538	83.42%
Bright Futures	Dyslipidemia screening - 2-20	71	2	4	$46	0	$0	1	$4	64	$709	92.75%
ACIP	Immunizations - Hepatitis B >18	45	4	0	$0	0	$0	2	$53	39	$3,846	95.12%
ACIP	Immunizations - Hepatitis A >18	21	0	1	$117	0	$0	0	$0	20	$1,721	95.24%
Bright Futures	Lead screening - <21	24	1	1	$11	0	$0	0	$0	22	$409	95.65%
HHS	Contraceptive methods - women	477	1	11	$2,629	1	$20	4	$111	460	$155,785	96.64%
USPSTF-A	Colorectal cancer screening - 45-75	684	15	13	$1,707	2	$100	6	$187	648	$278,099	96.86%
Bright Futures	Iron Supplement - <21	112	1	1	$2	0	$0	2	$1	108	$386	97.30%
ACIP	Immunizations - Herpes Zoster >59	304	3	3	$654	0	$0	4	$176	294	$78,483	97.67%
HHS	Wellness Examinations - >18	923	4	12	$817	0	$0	9	$98	898	$139,945	97.71%
USPSTF-A	Cervical Cancer Screening (Pap) - women	1,321	5	18	$629	1	$29	11	$64	1,286	$41,212	97.72%
Bright Futures	Hearing Screening 0-21 yrs	238	15	1	$32	0	$0	4	$42	218	$7,511	97.76%
USPSTF-B	Breast cancer mammography screening - >39	4,065	2	69	$5,325	4	$80	11	$269	3,979	$381,607	97.93%
ACIP	Immunization Administration - >18	1,718	43	7	$301	0	$0	10	$102	1,658	$72,465	98.99%
HHS	Wellness Examinations - women	2,796	6	10	$945	3	$85	0	$0	2,777	$438,439	99.53%
Bright Futures	Developmental Autism screening - <3	216	0	1	$10	0	$0	0	$0	215	$3,819	99.54%
ACIP	Immunizations - Human papillomavirus	420	3	0	$0	0	$0	1	$36	416	$138,939	99.76%
HHS	Cervical Cancer Screening (HPV DNA) - women >29	862	0	1	$39	0	$0	1	$10	860	$31,540	99.77%
HRSA/HHS	Wellness Examinations - <19	2,817	6	2	$61	0	$0	2	$24	2,807	$336,645	99.86%

PPACA Preventive Services Coverage Compliance Detail Report

QID	Error Description	Under Paid	HealthSCOPE Response	CTI Conclusion	Manual or System
1	Deductible Applied	$481.67	Agree. Claim should have been paid at 100% of PPO allowed amount.	As agreed, procedural deficiency and	☒ M ☐ S

PPACA Preventive Services Coverage Compliance Detail Report					
QID	**Error Description**	**Under Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
2	Coinsurance Applied	$185.57	Agree. Claim should have been paid at 100% of PPO allowed amount.	underpayment remain.	☒ M ☐ S
7	Copay Applied	$50.00	Agree. Claim should have been paid at 100% of PPO allowed amount.		☒ M ☐ S

Preventive Care Services Compliance Review Paid at 100%

PEBP - HealthSCOPE

Audit Period 7/1/2021 - 9/30/2021

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	Immunization Administration - <19	3,026	24	0	$0	0	$0	0	$0	3,002	$113,963	100.00%
ACIP	Immunizations - DTP <19	813	5	0	$0	0	$0	0	$0	808	$64,595	100.00%
ACIP	Immunizations - Meningococcal <19	377	1	0	$0	0	$0	0	$0	376	$72,884	100.00%
ACIP	Immunizations - Rotavirus <19	264	2	0	$0	0	$0	0	$0	262	$37,186	100.00%
ACIP	Immunizations - Hepatitis A <19	232	1	0	$0	0	$0	0	$0	231	$12,351	100.00%
ACIP	Immunizations - Meningococcal >18	163	0	0	$0	0	$0	0	$0	163	$39,650	100.00%
USPSTF-B	Vision screening - 3- 5	159	11	0	$0	0	$0	0	$0	148	$1,634	100.00%
ACIP	Immunizations - Measles, Mumps, Rubella <19	156	0	0	$0	0	$0	0	$0	156	$61,719	100.00%
FDA/CDC	Immunizations - Covid19	151	0	0	$0	0	$0	0	$0	151	$8,618	100.00%
ACIP	Immunizations - Varicella <19	105	0	0	$0	0	$0	0	$0	105	$16,138	100.00%
ACIP	Immunizations - Hepatitis B <19	102	0	0	$0	0	$0	0	$0	102	$5,322	100.00%
ACIP	Immunizations - Influenza <19	78	0	0	$0	0	$0	0	$0	78	$1,684	100.00%
ACIP	Immunizations - Pneumococcal >18	62	1	0	$0	0	$0	0	$0	61	$10,680	100.00%
ACIP	Immunizations - Influenza Age >18	58	1	0	$0	0	$0	0	$0	57	$1,447	100.00%
ACIP	Immunizations - Inactivated Poliovirus <19	32	0	0	$0	0	$0	0	$0	32	$1,399	100.00%
ACIP	Immunizations - Varicella >18	9	1	0	$0	0	$0	0	$0	8	$1,811	100.00%
USPSTF-B	Pre-Diabetes/Type 2 Diabetes	1	0	0	$0	0	$0	0	$0	1	$184	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	Secondary
Code	Mod	Code	Mod	Mod Use			Count	Allowable Benefit
74177	TC	96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	19	$11,100
					Standards of medical / surgical practice			
96374		96372		YES	THER/PROPH/DIAG INJ IV PUSH	THER/PROPH/DIAG INJ SC/IM	10	$7,108
					CPT Manual or CMS manual coding instructions			
63081		22551		YES	Remove vert body dcmprn crvl	NECK SPINE FUSE&REMOV BEL C2	2	$6,891
					More extensive procedure			
29880	LT	29877	XS,LT	NO	KNEE ARTHROSCOPY/SURGERY	KNEE ARTHROSCOPY/SURGERY	1	$4,153
					Misuse of column two code with column one code			
74177	TC	96365		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG IV INF INIT	7	$3,751
					Standards of medical / surgical practice			
92526	GN	97110	GP	YES	ORAL FUNCTION THERAPY	THERAPEUTIC EXERCISES	14	$2,979
					Misuse of column two code with column one code			
93351		93306		YES	STRESS TTE COMPLETE	TTE W/DOPPLER COMPLETE	1	$2,725
					HCPCS/CPT procedure code definition			
74177		96365		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG IV INF INIT	8	$2,587
					Standards of medical / surgical practice			
71275	TC	96374		YES	CT ANGIOGRAPHY CHEST	THER/PROPH/DIAG INJ IV PUSH	4	$2,570
					Standards of medical / surgical practice			
96372		99204		YES	THER/PROPH/DIAG INJ SC/IM	Office/outpatient visit for E&M of new patie	2	$2,500
					Standards of medical / surgical practice			
						Top 10 TOTAL	**68**	**$46,366**
						GRAND TOTAL	**552**	**$126,896**

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 Benefit
29880	RT	29877	RT	NO	KNEE ARTHROSCOPY/SURGERY	KNEE ARTHROSCOPY/SURGERY	2	$2,019
					Misuse of column two code with column one code			
22853	AS	22845	AS	YES	INSJ BIOMCHN DEV INTERVERTEBRAL DSC SPC W/AI	INSERT SPINE FIXATION DEVICE	4	$1,428
					HCPCS/CPT procedure code definition			
40805		00170	P1	NO	REMOVAL FOREIGN BODY MOUTH	ANESTH PROCEDURE ON MOUTH	5	$804
					Anesthesia service included in surgical procedure			
45378		00812	QS,QZ	NO	DIAGNOSTIC COLONOSCOPY	Anesthesia for lower intestinal endoscopic	5	$750
					Anesthesia service included in surgical procedure			
43239		00731	QS,QZ,P2	NO	UPPER GI ENDOSCOPY BIOPSY	Anesthesia for upper gastrointestinal endos	1	$662
					Anesthesia service included in surgical procedure			
45380	33	00812	QS,QZ	NO	COLONOSCOPY AND BIOPSY	Anesthesia for lower intestinal endoscopic	4	$583
					Anesthesia service included in surgical procedure			
90471		99396		YES	IMMUNIZATION ADMIN	PREV VISIT EST AGE 40-64	4	$512
					CPT Manual or CMS manual coding instructions			
00400	AA,P3	95955	26,59	NO	ANESTH SKIN EXT/PER/ATRUNK	EEG DURING SURGERY	1	$450
					Standard preparation / monitoring services for anesthesia			
63047		69990	59	NO	Remove spine lamina 1 lmbr	MICROSURGERY ADD-ON	1	$422
					Misuse of column two code with column one code			
90460		99394		YES	IM ADMIN 1ST/ONLY COMPONENT	PREV VISIT EST AGE 12-17	2	$418
					CPT Manual or CMS manual coding instructions			
						Top 10 TOTAL	**29**	**$8,048**
						GRAND TOTAL	**122**	**$14,160**

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	9	$32,022
		Rationale: Clinical: CMS Workgroup		
29827	1	ARTHROSCOP ROTATOR CUFF REPR	1	$20,236
		Rationale: CMS Policy		
93657	2	Tx l/r atrial fib addl	1	$15,955
		Rationale: Clinical: Data		
C2630	3	CATH, EP, COOL-TIP	1	$13,320
		Rationale: Clinical: Data		
23430	1	REPAIR BICEPS TENDON	1	$10,118
		Rationale: CMS Policy		
97799	1	PHYSICAL MEDICINE PROCEDURE	16	$9,824
		Rationale: Clinical: CMS Workgroup		
J9070	55	CYCLOPHOSPHAMIDE 100 MG INJ	1	$6,998
		Rationale: Clinical: Data		
96372	5	THER/PROPH/DIAG INJ SC/IM	2	$5,235
		Rationale: Clinical: Data		
99218	1	INITIAL OBSERVATION CARE	13	$5,115
		Rationale: Code Descriptor / CPT Instruction		
88185	35	FLOWCYTOMETRY/TC ADD-ON	2	$4,941
		Rationale: Clinical: Data		
		Top 10 TOTAL	**47**	**$123,765**
		GRAND TOTAL	**266**	**$223,486**

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	$55,034
		Rationale: CMS Policy		
95165	30	ANTIGEN THERAPY SERVICES	10	$10,880
		Rationale: Clinical: Data		
97155	24	ADAPT BHV TX PRTCL MODIFICAJ PHYS/QHP EA 15 MIN	6	$4,200
		Rationale: Clinical: Society Comment		
88341	13	Immunohistochemistry or immunocytochemistry, per spe	4	$2,881
		Rationale: Clinical: Data		
87799	3	DETECT AGENT NOS DNA QUANT	3	$2,534
		Rationale: Clinical: Data		
J0475	8	BACLOFEN 10 MG INJECTION	1	$2,368
		Rationale: Prescribing Information		
63045	1	Remove spine lamina 1 crvl	2	$2,075
		Rationale: Anatomic Consideration		
88305	16	TISSUE EXAM BY PATHOLOGIST	1	$2,053
		Rationale: Clinical: Data		
95079	2	Ingest challenge addl 60 min	4	$1,709
		Rationale: Clinical: Society Comment		
97151	8	BEHAVIOR ID ASSESSMENT BY PHYS/QHP EA 15 MIN	2	$1,680
		Rationale: Clinical: CMS Workgroup		
		Top 10 TOTAL	**37**	**$85,414**
		GRAND TOTAL	**161**	**$109,229**

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	7	$20,689
		Rationale: Nature of Equipment		
E0466	2	Home ventilator, any type, used with non-invasive interfa	3	$5,400
		Rationale: Nature of Equipment		
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	18	$2,178
		Rationale: Nature of Equipment		
E0601	1	CONT AIRWAY PRESSURE DEVICE	2	$1,389
		Rationale: Nature of Equipment		
V2521	2	CNTCT LENS HYDROPHILIC TORIC	9	$878
		Rationale: Anatomic Consideration		
V2520	2	CONTACT LENS HYDROPHILIC	7	$720
		Rationale: Anatomic Consideration		
B4035	1	ENTERAL FEED SUPP PUMP PER D	2	$635
		Rationale: Code Descriptor / CPT Instruction		
E0260	1	HOSP BED SEMI-ELECTR W/ MATT	3	$542
		Rationale: Nature of Equipment		
K0001	1	STANDARD WHEELCHAIR	4	$362
		Rationale: Nature of Equipment		
E0265	1	HOSP BED TOTAL ELECTR W/ MAT	1	$340
		Rationale: Nature of Equipment		
		Top 10 TOTAL	**56**	**$33,133**
		GRAND TOTAL	**86**	**$34,910**

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 7/1/2021 - 9/30/2021									
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		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
362193608	4	$13,435	1	20.0%	$508	0	$0	1	$216
203516398	0	$0	2	100.0%	$620	0	$0	2	$200
850955444	1	$180	1	50.0%	$180	0	$0	1	$192
474436324	48	$9,600	3	5.9%	$485	1	$100	1	$187
330423270	0	$0	1	100.0%	$694	0	$0	1	$170
910858192	80	$27,279	32	28.6%	$4,525	29	$3,001	1	$169
880133501	151	$59,394	33	17.9%	$8,330	33	$4,792	1	$164
020566741	29	$10,759	8	21.6%	$608	6	$905	1	$133
203416144	1	$163	1	50.0%	$139	1	$69	0	$0
203395567	95	$22,754	6	5.9%	$6,815	5	$1,134	0	$0
Top 10	**409**	**$143,564**	**88**	**17.7%**	**$22,905**	**75**	**$10,001**	**9**	**$1,431**
Overall Total	**2,774**	**$809,086**	**477**	**14.7%**	**$94,408**	**457**	**$57,537**	**9**	**$1,431**

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

April 8, 2022
Amended on May 2, 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 Audit Number 1.FY22.Q1 draft report and would like to add the response to the conclusions within the audit report.

Summary of HealthSCOPE's Guarantee Measurements:
Quarterly Guarantee: Financial Accuracy:
HealthSCOPE Benefits would like to request CTI to review the financial accuracy and guarantee definition per the PEBP contract with HealthSCOPE Benefits. Please confirm the CTI calculation on the financial accuracy and percentage identified on the draft response report.

TARGETED SAMPLE ANALYSIS:

Fraud, Waste, and Abuse Detail Report:

QID 27 – HSB does not agree with CTI conclusion. The claim was considered according to the plan benefits.

QID 28 - HSB does not agree with CTI conclusion. The claim was considered according to the plan benefits.

Duplicate Payment Detail Report:

QID 18- HSB does agree with CTI conclusion. Duplicate claim was paid in error.

QID 19 - HSB does agree with CTI conclusion. Duplicate claim was paid in error.

QID 22 - HSB does agree with CTI conclusion. Duplicate claim was paid in error.

QID 23 – HSB does agree with CTI conclusion. Duplicate claim was paid in error.

QID 24 - HSB does agree with CTI conclusion. Duplicate claim was paid in error.

QID 25 - HSB does agree with CTI conclusion. Duplicate claim was paid in error.

Exclusion Detail Report:

QID 43 - HSB does agree with CTI conclusion. The claim should have denied to request medical records.

RANDOM SAMPLE AUDIT:

Financial Accuracy Detail Report:

Audit No. 1020 – HSB does agree with CTI conclusion. The outpatient lab should have been paid at 100%.

Audit No. 2015 – HSB does agree with CTI conclusion. The claim denied as a duplicate in error. HSB does agree with the procedural error for the denial of the claim.
Update on the financial error charged for $332.00 underpayment. HSB does not agree with the financial error charged based on the maximum dental benefit of $1500.00. The claim would not have paid anything out as the dental maximum was met prior to Audit No. 2015 was processed.

Audit No. 1053 – HSB does agree with CTI conclusion. The office exam related to COVID testing should have paid with no cost share.

Accurate Processing Detail Report:

Audit No. 1020 – HSB does agree with CTI conclusion. The outpatient lab should have been paid at 100%.

Audit No. 1113 – HSB does not agree with CTI conclusion. The claim was paid correctly for the newborn per MPD. The EOB comment code 64 should have been removed.

Audit No. 2015 – HSB does agree with CTI conclusion. The claim denied as a duplicate in error.

Audit No. 1053 – HSB does agree with CTI conclusion. The office exam related to COVID testing should have paid with no cost share.

Audit No. 1111 – HSB does not agree with CTI conclusion. The claim did not have pricing from HTH and was a NICU claim. The incorrect EOB comment code was used.

Observation HRA:

Audit No. HRA1032 – 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 1 – HSB does agree that the claim should have paid at 100% of the PPO allowed amount.

QID 4 – QID 3 and QID 4 are the same claim as outline on the ESAS. HSB does not agree with the error. Claim NEV.11160409 was reconsidered on 11/23/2021 to pay at 100% prior to the audit.

QID 6 – HSB does not agree with the error. Claim NEV.11160041 was reconsidered on 10/19/2021 to pay at 100% prior to the audit.

QID 2 – HSB does agree that the claim should have paid at 100% of the PPO allowed amount.

QID 7 – HSB does agree that the claim should have paid at 100% of the PPO allowed amount.

Thank you,

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

CLAIM TECHNOLOGIES INCORPORATED

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