Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employees Benefit Program Plans

Administered by HealthScope Benefits

Audit Period: October 1, 2021 through December 31, 2021
Audit Number 1.FY22.Q2

Presented to

State of Nevada Public Employees Benefit Program

May 13, 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 October 1, 2021 through December 31, 2021 (quarter 2 (Q2) 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	$51,106,258
Total Number of Claims Paid/Denied/Adjusted	202,245
Health Reimbursement Arrangement (HRA)	
Total Paid Amount	$1,203,011
Total Number of Claims Paid/Denied/Adjusted	12,796

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

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

Auditor's Opinion

Based on these findings, and in our opinion:

1. HealthSCOPE improved its Financial Accuracy measurement in Q2 FY2022 and no penalty is owed.
2. HealthSCOPE should:
    - Review the 100% Electronic Screening with Targeted Sample results and focus on the most material findings in Paid Greater than Charged, Spinal Region Upcoding, and Duplicate Claims Payments.
    - Review the Random Sample Audit results and discuss whether changes need to be made to reduce preventive services payment errors.

Summary of HealthSCOPE's Guarantee Measurements

Based on CTI's Random Sample Audit results, HealthSCOPE met both claims processing measurements for the PEBP in Q2 FY2022.

Quarterly Guarantee	Measure	Met/Not Met	Penalty
Financial Accuracy	99%	Met – 99.70%	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 Q2 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.	99.70%	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	99.95%	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%	11 Seconds Less than .01% 97.65%	Met Met Met
Data Reporting	• 100% of standard reports within 10 business days • Annual/Regulatory Documents within 10 business days of the Plan Year	No exceptions noted. NA – Annual Report	Met NA
Disclosure of Subcontractors	• Report access of PEBP data within 30 calendar days • Removal of PEBP member PHI within 3 business days after knowledge	No exceptions noted. No exceptions noted.	Met Met

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

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

Scope

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

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

Methodology

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

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

Findings

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

Categories for Process Improvement

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

Process Improvement Summary Report				
Client: PEBP **Screening Period:** Q2 FY2022				
Category	**Number of Service Codes**	**Number of Members**	**Billed Charge**	**Allowed***
Paid Greater than Charged	4	2	$644	$4,582
Invalid Procedure Codes	1,170	951	$132,188	$87,584
Fraud, Waste and Abuse				
Spinal Region Upcoding – Number of spinal regions treated does not match number of spinal regions billed and allowed.	1,105	419	$73,126	$39,022

**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 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.

Paid Greater Than Charged Detail Report					
QID	**Category**	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
22	Paid Greater Than Charged	$3,127.32	Agree. Claim was split and the Medicare allowed amount is incorrect.	As agreed, procedural deficiency and overpayments remain.	☒ M ☐ S
23		$158.41	Agree. Claim was not coordinated with Medicare correctly.		☒ M ☐ S

Invalid Procedure Codes Detail Report					
QID	**Category**	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
31	Invalid Procedure Codes	$10,764.25	Agree. Should have denied the service for medical necessity.	As agreed, procedural deficiency and overpayments remain.	☒ M ☐ S

Fraud, Waste, and Abuse Detail Report					
QID	**Category**	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
46	Spinal Region Upcoding	$28.51	Disagree. Claim was paid according to the Chiropractic Benefits per the MPD. Claim was not submitted for FWA.	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
47		$10.16			☒ M ☐ S
48		$28.70			☒ M ☐ S
49		$45.00			☒ 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:** Q2 FY2022				
Category	**Number of Service Codes**	**Number of Members**	**Billed Charge**	**Allowed***
Duplicate Payments				
Providers and/or Employees	179	51	$101,430	$19,406

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

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

Duplicate Payments Detail Report				
QID	**Under/ Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
37	$61.60	Agree. Provider submitted two claims with two different TAX ID numbers.	Procedural deficiency and overpayment remain.	☐ M ☒ S

There were also three errors found under the dental benefit plan for invalid procedure codes paid totaling $487.30 including:

- one Bone Graft in Conjunction with Periradicular Surgery;
- one Semi-Precision Abutment; and
- one Lingual Frenectomy.

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 $287.06 in underpayments and no overpayments, for an absolute value variance of $287.06.

The weighted Financial Accuracy rate was 99.70%.

Financial Accuracy Detail Report						
Error Description	**Audit No.**	**Under Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**	
Coinsurance	1088	$269.70	Agree. Claim should have been paid 100% of the PPO allowed amount.	As agreed, procedural error and underpayment remain. Claim should have been paid at 100% of the PPO allowed amount.	☐ M ☒ S	
Subtotal	**1**					
Deductible	1197	$17.36	Agree. CPT code 80061 and 83036 should have been paid at 100% of PPO allowable based on the diagnosis and procedure billed. CPT 80053 should apply to the deductible as it is not mandated under HCR to pay as preventive.	As agreed, procedural error and underpayment remain. CPT codes 80061 and 83036 should have been paid at 100%.	☐ M ☒ S	
Subtotal	**2**					
TOTALS	**2**	**VARIANCE $287.06**			**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	
198	2	0	99.00%

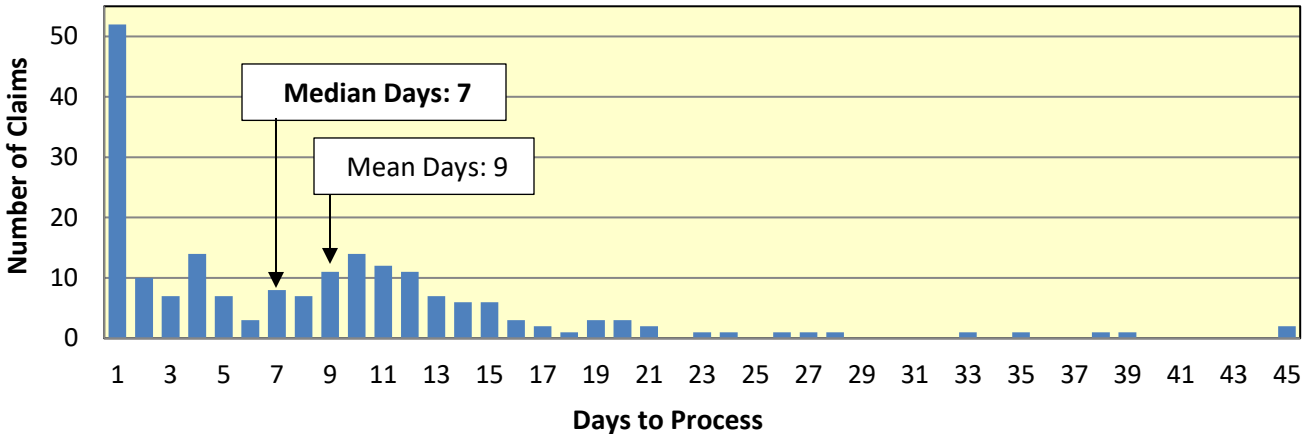
Accurate Processing Detail Report				
Error Description	**Audit No.**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
Managed Care				
Coinsurance	1088	Agree. Claim should have been paid 100% of the PPO allowed amount.	As agreed, procedural error remains. Claim should have been paid at 100% of the PPO allowed amount.	☐ M ☒ S
Policy Provision				
Deductible	1197	Agree. CPT code 80061 and 83036 should have been paid at 100% of PPO allowable based on the diagnosis and procedure billed. CPT 80053 should apply to the deductible as it is not mandated under HCR to pay as preventive.	As agreed, procedural error remains. CPT codes 80061 and 83036 should have been paid at 100%.	☐ M ☒ S

Claim Turnaround

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

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

Median and Mean Claim Turnaround



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
The member had two payments for the same provider, on the same day, and the same amount. System did not flag as a duplicate.	HRA 1041

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 10/1/2021 through 12/31/2021				
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	$3,298,970	$6,083,522	64.8%	$2,839,106
Non-Facility	$26,053,465	$27,607,851	51.4%	$17,359,527
Facility Inpatient	$16,335,124	$27,058,713	62.4%	$15,500,301
Facility Outpatient	$13,351,930	$31,130,993	70.0%	$10,274,328
Total	**$59,039,490**	**$91,881,079**	**60.9%**	**$45,973,262**
In-Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$3,134,104	$6,083,674	66.0%	$2,758,871
Non-Facility	$25,048,600	$27,607,980	52.4%	$17,015,346
Facility Inpatient	$16,165,119	$27,002,105	62.6%	$15,378,876
Facility Outpatient	$13,237,108	$30,054,129	69.4%	$10,198,543
Total In-Network	**$57,584,930**	**$90,747,887**	**61.2%**	**$45,351,637**
% of Eligible Charge -	97.5%	% Claim Frequency -	86.7%	
Out of Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$164,867	-$151	-0.1%	$80,235
Non-Facility	$1,004,865	-$129	0.0%	$344,181
Facility Inpatient	$170,005	$56,608	25.0%	$121,425
Facility Outpatient	$114,822	$1,076,865	90.4%	$75,784
Total Out of Network	**$1,454,560**	**$1,133,192**	**43.8%**	**$621,624**
% of Eligible Charge -	2.5%	% Claim Frequency -	13.3%	

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

PEBP's members had utilization of network or secondary network medical providers at 97.5% of all allowed charges and 86.7% 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 two sanctioned providers were identified as receiving 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	$1,780	$1,742	$928
1205023512	20180920	N/A	1128b5	ROOZBEH BADII	2	$705	$214	$214
				Totals	**5**	**$2,485**	**$1,956**	**$1,142**

According to the OIG, James Shelby was excluded on December 19, 2019, with a felony-controlled substance conviction and Roozbeh Badii was excluded on September 20, 2018, with an exclusion or suspension under the federal or state health care program.

PPACA Preventive Services Coverage Compliance

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

Scope

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

Our review did not include services:

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

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

Reports

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

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

The preventive services compliance review shows the frequency of claims paid at less than required benefit levels (i.e., claims reduced payment due to the application of deductibles, coinsurance, and/or copayments). We electronically screened 78 categories of preventive services that match the preventive care services specified by HHS including immunizations, women's health, tobacco use counseling, cholesterol and cancer screenings, and wellness examinations. This review either confirms compliance with PPACA or highlights areas for improvement.

CTI's analysis also found that 96.24% of the procedure codes identified as preventive services were paid by HealthSCOPE at 100% when provided in-network. A detailed list of the other 3.76% is available upon request.

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

Preventive Care Services Compliance Review Paid at Less than 100%

PEBP - HealthSCOPE

Audit Period 10/1/2021 - 12/31/2021

Plans: All

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

		Claim Lines Submitted	Denied	Applied Deductible		Applied Copay		Applied Coinsurance		Paid @100%		
Edit Guideline	Preventive Service Benefit	#	#	#	Amount	#	Amount	#	Amount	#	Amount	%
USPSTF-B	Breast cancer chemoprevention counseling- >17	8	0	4	$682	1	$50	2	$34	1	$154	12.50%
HHS	Breastfeeding support and counseling - women	33	1	9	$1,879	14	$660	4	$183	5	$759	15.63%
USPSTF-A,B	Rh incompatibility screening - pregnant women	110	33	21	$907	4	$324	25	$106	27	$1,168	35.06%
USPSTF-B	BRCA screening counseling - women	19	1	4	$504	3	$130	3	$418	8	$2,688	44.44%
USPSTF-A	HIV screening - pregnant women	24	7	7	$342	0	$0	2	$17	8	$347	47.06%
USPSTF-B	Tobacco use counseling - >18	29	1	7	$128	1	$25	6	$20	14	$341	50.00%
USPSTF-B	Hearing loss screening - 0 - 90 days	4	0	1	$42	0	$0	1	$8	2	$231	50.00%
USPSTF-B	Pre-Diabetes/Type 2 Diabetes	2	0	1	$31	0	$0	0	$0	1	$184	50.00%
USPSTF-A	Hepatitis B screening - women	37	4	14	$552	0	$0	2	$7	17	$746	51.52%
HHS	Gestational Diabetes Mellitus screening - women	120	7	26	$340	0	$0	23	$33	64	$613	56.64%
USPSTF-A	Syphillis screening	40	0	12	$45	0	$0	5	$4	23	$87	57.50%
USPSTF-A	Urinary tract infection screening - pregnant women	82	4	14	$522	2	$19	13	$49	49	$727	62.82%
USPSTF-B	Hepatitis C Virus (HCV) Screening	185	5	41	$668	2	$100	15	$54	122	$1,825	67.78%
USPSTF-B	Depression screening - >18	61	1	11	$147	2	$17	6	$11	41	$690	68.33%
USPSTF-A	HIV screening - >14	201	2	51	$1,185	1	$70	9	$56	138	$3,342	69.35%
USPSTF-A	Phenylketonuria (PKU) screening 0-90 days	10	0	3	$12	0	$0	0	$0	7	$35	70.00%
USPSTF-A	Syphilis screening - pregnant women	146	2	30	$125	0	$0	13	$13	101	$775	70.14%
USPSTF-B	Depression screening - 12-18	71	0	14	$76	5	$52	2	$2	50	$340	70.42%
USPSTF-B	Gonorrhea screening - female	250	2	51	$1,959	1	$94	20	$165	176	$6,776	70.97%
USPSTF-A,B	Chlamydia infection screening - women	265	3	52	$2,039	1	$94	20	$170	189	$7,570	72.14%
Bright Futures	Tuberculin testing - <21	8	0	1	$18	0	$0	1	$2	6	$92	75.00%
USPSTF-A,B	Cholesterol abnormalities screening - women >19	672	0	155	$1,686	0	$0	8	$29	509	$6,467	75.74%
USPSTF-B	Healthy diet counseling	301	85	21	$1,865	3	$94	26	$744	166	$24,989	76.85%
USPSTF-A	Cholesterol abnormalities screening - men 35-75	523	6	89	$1,220	0	$0	11	$63	417	$5,779	80.66%
USPSTF-B	Alcohol misuse - screening and counseling	25	1	3	$56	1	$18	0	$0	20	$369	83.33%
Bright Futures	Hearing Screening 0-21 yrs	218	22	6	$159	0	$0	10	$76	180	$5,679	91.84%
Bright Futures	Iron Supplement - <21	98	0	4	$9	0	$0	1	$1	93	$227	94.90%
ACIP	Immunizations - Pneumococcal >18	50	1	2	$220	0	$0	0	$0	47	$7,883	95.92%
USPSTF-A	Colorectal cancer screening - 45-75	657	2	10	$1,091	7	$350	2	$69	636	$272,959	97.10%
Bright Futures	Dyslipidemia screening - 2-20	36	1	1	$9	0	$0	0	$0	34	$321	97.14%
HHS	Wellness Examinations - >18	820	1	11	$682	1	$30	7	$90	800	$131,267	97.68%
USPSTF-B	Breast cancer mammography screening - >39	3,881	7	50	$3,552	15	$440	21	$406	3,788	$364,052	97.78%
HHS	Contraceptive methods - women	450	3	8	$976	0	$0	1	$53	438	$151,622	97.99%
Bright Futures	Developmental Autism screening - <3	192	0	3	$30	0	$0	0	$0	189	$2,964	98.44%
USPSTF-A	Cervical Cancer Screening (Pap) - women	1,270	4	15	$484	1	$71	2	$8	1,248	$37,152	98.58%
HHS	Wellness Examinations - women	2,486	3	14	$1,302	1	$25	6	$202	2,462	$415,745	99.15%
ACIP	Immunizations - Influenza Age >18	1,733	6	9	$337	1	$37	4	$40	1,713	$61,208	99.19%
ACIP	Immunizations - Herpes Zoster >59	250	1	1	$175	0	$0	1	$33	247	$74,675	99.20%
HHS	Cervical Cancer Screening (HPV DNA) - women >29	819	0	4	$196	0	$0	1	$19	814	$29,048	99.39%
ACIP	Immunization Administration - >18	3,284	63	5	$475	1	$80	8	$130	3,207	$107,498	99.57%
HRSA/HHS	Wellness Examinations - <19	2,443	1	2	$225	1	$30	1	$6	2,438	$296,818	99.84%

PPACA Preventive Services Coverage Compliance Detail Report					
QID	**Error Description**	**Under payment**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
1	Coinsurance Applied	$66.03	Agree. Claim should have paid at the routine benefit.	As agreed, procedural deficiency and underpayments remain.	☒ M ☐ S
6		$213.14	Agree. Claim paid under the surgical category in error.		☒ M ☐ S
9		$377.60	Agree. CPT 81162-33 should have denied. The remaining test on the claim paid as illness as defined in the MPD correctly.		☒ M ☐ S
4	Deductible Applied	$508.87	Agree. Claim should have been paid at the routine benefit.		☐ M ☒ S
11		$102.68	Agree. Claim should have been paid at the routine benefit.		☒ M ☐ S
5	Copayment Applied	$224.50	Agree. Claim should have been paid under the routine benefit.		☒ M ☐ S
10		$71.23	Agree. Claim should have been paid under the routine benefit for 88175.		☒ M ☐ S

Preventive Care Services Compliance Review Paid at 100%

PEBP - HealthSCOPE

Audit Period 10/1/2021 - 12/31/2021

Plans: All

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

		Claim Lines Submitted	Denied	Applied Deductible		Applied Copay		Applied Coinsurance		Paid @100%		
Edit Guideline	**Preventive Service Benefit**	**#**	**#**	**#**	**Amount**	**#**	**Amount**	**#**	**Amount**	**#**	**Amount**	**%**
ACIP	Immunization Administration - <19	4,100	24	0	$0	0	$0	0	$0	4,076	$131,790	100.00%
ACIP	Immunizations - Influenza <19	2,044	1	0	$0	0	$0	0	$0	2,043	$55,136	100.00%
ACIP	Immunizations - DTP <19	639	2	0	$0	0	$0	0	$0	637	$72,427	100.00%
FDA/CDC	Immunizations - Covid19	315	0	0	$0	0	$0	0	$0	315	$13,605	100.00%
ACIP	Immunizations - Rotavirus <19	271	0	0	$0	0	$0	0	$0	271	$44,970	100.00%
ACIP	Immunizations - Human papillomavirus	241	0	0	$0	0	$0	0	$0	241	$84,612	100.00%
ACIP	Immunizations - Hepatitis A <19	213	1	0	$0	0	$0	0	$0	212	$11,777	100.00%
ACIP	Immunizations - Meningococcal <19	165	0	0	$0	0	$0	0	$0	165	$34,928	100.00%
ACIP	Immunizations - Measles, Mumps, Rubella <19	126	1	0	$0	0	$0	0	$0	125	$52,576	100.00%
USPSTF-B	Vision screening - 3- 5	115	1	0	$0	0	$0	0	$0	114	$915	100.00%
ACIP	Immunizations - Hepatitis B <19	104	0	0	$0	0	$0	0	$0	104	$5,756	100.00%
ACIP	Immunizations - Varicella <19	100	0	0	$0	0	$0	0	$0	100	$15,631	100.00%
ACIP	Immunizations - Meningococcal >18	98	0	0	$0	0	$0	0	$0	98	$24,579	100.00%
ACIP	Immunizations - Inactivated Poliovirus <19	31	0	0	$0	0	$0	0	$0	31	$1,643	100.00%
ACIP	Immunizations - Hepatitis B >18	30	1	0	$0	0	$0	0	$0	29	$2,288	100.00%
Bright Futures	Lead screening - <21	16	1	0	$0	0	$0	0	$0	15	$149	100.00%
ACIP	Immunizations - Hepatitis A >18	8	0	0	$0	0	$0	0	$0	8	$809	100.00%
ACIP	Immunizations - Varicella >18	8	0	0	$0	0	$0	0	$0	8	$1,368	100.00%
ACIP	Immunizations adult - Influenza Age (FluMist) 19-49	2	0	0	$0	0	$0	0	$0	2	$50	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 Count	Secondary Allowable Benefit
Code	Mod	Code	Mod	Mod Use				
74177	TC	96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	11	$6,003
					Standards of medical / surgical practice			
70553		70555	50	YES	Mri brain stem w/o & w/dye	FMRI BRAIN BY PHYS/PSYCH	1	$3,680
					CPT Manual or CMS manual coding instructions			
99151		99285		YES	MOD SED SAME PHYS/QHP INITIAL 15 MINS <5 YRS	EMERGENCY DEPT VISIT	1	$3,097
					Standards of medical / surgical practice			
74177	TC	96365		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG IV INF INIT	5	$2,630
					Standards of medical / surgical practice			
74340		43752		NO	X-RAY GUIDE FOR GI TUBE	NASAL/OROGASTRIC W/STENT	1	$2,357
					CPT Manual or CMS manual coding instructions			
74177		74176		YES	CT ABD & PELV W/CONTRAST	CT ABD & PELVIS	1	$2,083
					HCPCS/CPT procedure code definition			
45385		45390		YES	LESION REMOVAL COLONOSCOPY	Colonoscopy, flexible; with endoscopic muc	1	$2,011
					CPT Manual or CMS manual coding instructions			
92526	GN	97110	GP	YES	ORAL FUNCTION THERAPY	THERAPEUTIC EXERCISES	7	$1,857
					Misuse of column two code with column one code			
74177		96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	15	$1,605
					Standards of medical / surgical practice			
71275	TC	96374		YES	CT ANGIOGRAPHY CHEST	THER/PROPH/DIAG INJ IV PUSH	3	$1,507
					Standards of medical / surgical practice			
						Top 10 TOTAL	**46**	**$26,831**
						GRAND TOTAL	**349**	**$55,747**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)								
Primary		Secondary			Primary Description	Secondary Description	Line Count	Secondary Allowable Benefit
Code	Mod	Code	Mod	Mod Use				
90471		99396		YES	IMMUNIZATION ADMIN	PREV VISIT EST AGE 40-64	19	$2,643
					CPT Manual or CMS manual coding instructions			
90471		99396	0	YES	IMMUNIZATION ADMIN	PREV VISIT EST AGE 40-64	10	$2,273
					CPT Manual or CMS manual coding instructions			
90471		99214		YES	IMMUNIZATION ADMIN	Office/outpatient visit for E&M of estab pat	11	$2,062
					CPT Manual or CMS manual coding instructions			
96372		99214		YES	THER/PROPH/DIAG INJ SC/IM	Office/outpatient visit for E&M of estab pat	12	$1,882
					Standards of medical / surgical practice			
22853		22846		YES	INSJ BIOMCHN DEV INTERVERTEBRAL DSC SPC W/AI	INSERT SPINE FIXATION DEVICE	2	$1,636
					HCPCS/CPT procedure code definition			
90460		99392		YES	IM ADMIN 1ST/ONLY COMPONENT	PREV VISIT EST AGE 1-4	14	$1,452
					CPT Manual or CMS manual coding instructions			
29880		29876		YES	KNEE ARTHROSCOPY/SURGERY	KNEE ARTHROSCOPY/SURGERY	1	$1,358
					Standards of medical / surgical practice			
90471		99395		YES	IMMUNIZATION ADMIN	PREV VISIT EST AGE 18-39	7	$1,305
					CPT Manual or CMS manual coding instructions			
90471		99214	0	YES	IMMUNIZATION ADMIN	Office/outpatient visit for E&M of estab pat	6	$1,266
					CPT Manual or CMS manual coding instructions			
22853		22845		YES	INSJ BIOMCHN DEV INTERVERTEBRAL DSC SPC W/AI	INSERT SPINE FIXATION DEVICE	2	$1,208
					HCPCS/CPT procedure code definition			
						Top 10 TOTAL	**84**	**$17,084**
						GRAND TOTAL	**599**	**$52,914**

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
63030	1	LOW BACK DISK SURGERY	1	$22,070
		Rationale: CMS Policy		
29888	1	KNEE ARTHROSCOPY/SURGERY	1	$15,404
		Rationale: CMS Policy		
27446	1	REVISION OF KNEE JOINT	1	$11,449
		Rationale: CMS Policy		
93460	1	R&L HRT ART/VENTRICLE ANGIO	1	$5,822
		Rationale: Nature of Service/Procedure		
94640	1	AIRWAY INHALATION TREATMENT	5	$3,615
		Rationale: Clinical: Data		
99218	1	INITIAL OBSERVATION CARE	5	$3,218
		Rationale: Code Descriptor / CPT Instruction		
87635	2	Infectious agnt detection by nucleic acid; svre acute resp	1	$3,127
		Rationale: Nature of Analyte		
J9070	55	CYCLOPHOSPHAMIDE 100 MG INJ	1	$2,870
		Rationale: Clinical: Data		
88342	4	IMMUNOHISTOCHEMISTRY	2	$2,618
		Rationale: Clinical: Data		
99153	12	MOD SED SAME PHYS/QHP EACH ADDL 15 MINS	8	$2,319
		Rationale: Clinical: CMS Workgroup		
		Top 10 TOTAL	**26**	**$72,513**
		GRAND TOTAL	**125**	**$99,930**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)				
Procedure Code	Service Unit Limit	Procedure Description	Line Count Exceeding Limit	Gross Benefit Allowed
97153	32	ADAPTIVE BEHAVIOR TX BY PROTOCOL TECH EA 15 MIN	1,081	$262,764
		Rationale: Clinical: Society Comment		
J9355	105	INJ TRASTUZUMAB EXCL BIOSIMI	4	$57,175
		Rationale: CMS Policy		
15111	5	EPIDRM AUTOGRFT T/A/L ADD-ON	1	$3,824
		Rationale: Clinical: Data		
19316	1	SUSPENSION OF BREAST	1	$2,812
		Rationale: CMS Policy		
J0475	8	BACLOFEN 10 MG INJECTION	2	$2,538
		Rationale: Prescribing Information		
97155	24	ADAPT BHV TX PRTCL MODIFICAJ PHYS/QHP EA 15 MIN	8	$2,208
		Rationale: Clinical: Society Comment		
95165	30	ANTIGEN THERAPY SERVICES	1	$1,461
		Rationale: Clinical: Data		
J3480	40	INJ POTASSIUM CHLORIDE	9	$1,453
		Rationale: Clinical: Data		
97151	8	BEHAVIOR ID ASSESSMENT BY PHYS/QHP EA 15 MIN	3	$1,450
		Rationale: Clinical: CMS Workgroup		
31572	1	LARYNGOSCOPY FLEXIBLE ABLATJ DESTJ LESION(S) UNI	2	$1,338
		Rationale: CMS Policy		
		Top 10 TOTAL	**1,112**	**$337,022**
		GRAND TOTAL	**1,200**	**$352,074**

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	4	$11,495
		Rationale: Nature of Equipment		
E0486	1	ORAL DEVICE/APPLIANCE CUSFAB	1	$6,375
		Rationale: Nature of Equipment		
E0265	1	HOSP BED TOTAL ELECTR W/ MAT	7	$2,380
		Rationale: Nature of Equipment		
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	18	$1,913
		Rationale: Nature of Equipment		
E2402	1	NEG PRESS WOUND THERAPY PUMP	1	$679
		Rationale: Nature of Equipment		
V2520	2	CONTACT LENS HYDROPHILIC	7	$520
		Rationale: Anatomic Consideration		
E0443	1	PORTABLE 02 CONTENTS, GAS	5	$499
		Rationale: Code Descriptor / CPT Instruction		
K0001	1	STANDARD WHEELCHAIR	4	$448
		Rationale: Nature of Equipment		
E0260	1	HOSP BED SEMI-ELECTR W/ MATT	1	$239
		Rationale: Nature of Equipment		
K0003	1	LIGHTWEIGHT WHEELCHAIR	1	$168
		Rationale: Nature of Equipment		
		Top 10 TOTAL	**49**	**$24,716**
		GRAND TOTAL	**71**	**$25,750**

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 10/1/2021 - 12/31/2021									
Provider Id	Surgeries with 'CMS Defined' Prohibited Global Fee Periods					Evaluation and Management Services using Same ID as Surgeon and Within Prohibited Global Fee Period			
	Surgeries without E/M Procedures during Prohibited Global Fee Periods		Surgery with E/M Charge during Prohibited Global Fee Periods			E/M Procedure Codes with Modifier 24, 25, or 57		E/M Procedure Codes without Modifier 24, 25, or 57	
	Count	Allowed Charge	Count	% Surgeries with E/M Charges during Prohibited Global Fee Periods	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge
860800150	17	$46,951	3	15.0%	$17,934	1	$455	2	$897
680334324	16	$11,970	2	11.1%	$8,633	0	$0	1	$744
203395567	81	$39,963	7	8.0%	$7,758	7	$1,338	3	$728
880133501	142	$54,122	18	11.3%	$5,356	14	$1,819	3	$532
941709925	50	$31,241	41	45.1%	$7,377	37	$5,773	2	$448
680405220	11	$6,907	5	31.3%	$923	3	$406	2	$358
020566741	27	$8,532	9	25.0%	$3,787	7	$953	1	$266
880107997	38	$15,800	8	17.4%	$2,188	5	$437	2	$222
852187390	7	$684	5	41.7%	$1,167	2	$138	2	$194
471471596	0	$0	1	100.0%	$946	0	$0	1	$187
Top 10	**389**	**$216,168**	**99**	**20.3%**	**$56,068**	**76**	**$11,319**	**19**	**$4,576**
Overall Total	**2,554**	**$813,607**	**462**	**15.3%**	**$118,303**	**403**	**$47,558**	**39**	**$6,416**

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

May 6, 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.Q2 draft report and would like to add the response to the conclusions within the audit report.

OPERATIONAL REVIEW PERFORMANCE GUARANTEES:

HealthSCOPE Benefits would like to request CTI update the "Disclosure of Subcontractors" as the information was submitted to CTI.
The Master List for Disclosure of Subcontractors has not changed as we have not added any new subcontractors in the last year; therefore, this report will remain the same throughout the transition to the UMR platform.

TARGETED SAMPLE ANALYSIS:

Paid Greater Than Charged Detail Report:

QID 22 – HSB does agree with CTI conclusion. The claim was split and the Medicare allowed amount was calculated incorrectly.

QID 23 – HSB does agree with CTI conclusion. The claim was not coordinated with Medicare correctly.

Invalid Procedure Codes Detail Report:

QID 31 – HSB does agree with the CTI conclusion. Code 0656T/22899 was denied by the UM vendor for necessity. All other procedures were authorized for this date of service.

Fraud, Waste, and Abuse Detail Report:

QID 46 – HSB does not agree with CTI conclusion. The claim was considered according to the plan benefits.

QID 47 - HSB does not agree with CTI conclusion. The claim was considered according to the plan benefits.

QID 48 – HSB does not agree with CTI conclusion. The claim was considered according to the plan benefits.

QID 49 - HSB does not agree with CTI conclusion. The claim was considered according to the plan benefits.

Duplicate Payment Detail Report:

QID 37- HSB does agree with CTI conclusion. The provider billed under two separate TAX ID numbers.

RANDOM SAMPLE AUDIT:

Financial Accuracy Detail Report:

Audit No. 1088 – HSB does agree with CTI conclusion. The claim should have paid at 100% of the PPO allowed amount.

Audit No. 1197 – HSB does agree with CTI conclusion. CPT code 80061 and 83036 should have paid at 100% of the PPO allowable based on the diagnosis and procedure billed. There is an underpayment of $17.36.

Accurate Processing Detail Report:

Audit No. 1088 – HSB does agree with CTI conclusion. The claim should have paid at 100% of the PPO allowed amount.

Audit No. 1197 – HSB does agree with CTI conclusion. CPT code 80061 and 83036 should have paid at 100% of the PPO allowable based on the diagnosis and procedure billed. There is an underpayment of $17.36.

Observation:

Audit Number HRA 1041 – HRA department will verify with the member on the transaction in question. There have been situations that a member owes a provider for a previous expense and pays the provider/merchant at the same time for both transactions.

PPACA Preventive Services Coverage Compliance Detail Report:

QID 1 – HSB does agree with CTI conclusion. The claim should have paid at the routine benefit.

QID 6 – HSB does agree with CTI conclusion. The claim was paid under the incorrect benefit category.

QID 9 – HSB does agree with CTI conclusion. CPT 81162-33 should have denied.

QID 4 – HSB does agree with CTI conclusion. The claim should have paid at the routine benefit.

QID 11 – HSB does agree with CTI conclusion. The claim should have paid at the routine benefit.

QID 5 – HSB does agree with CTI conclusion. The claim should have paid at the routine benefit.

QID 10 - HSB does agree with CTI conclusion. CPT 88175 should have paid at the routine benefit.

Thank you,

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

CLAIM TECHNOLOGIES INCORPORATED

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