Claims and System Audit Report

for

Nevada Public Employees’ Benefits Program

Health Matters.

Audit Period: PEBP Plan Year 2017, Quarter Four April, May and June 2017

Audited Vendor:

Submitted By:

Health Scope

Healthy People
Healthy Business
Healthy Futures

Health Claim Auditors, Inc.

August 2017
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The following categories are reviewed each quarterly audit, however, because of their constant properties, the detail of each category will only be displayed within the first quarter audit of the PEBP fiscal year unless a change or defect is detected:

* HSB System
* Eligibility
* Unbundling/Rebundling
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* Experimental/Cosmetic Proc
* Patterns of Care
* Duplicate Claim Edits
* Hospital Discounts
* Filing Limitation
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* Controlling Possible Fraud
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* HSB Policy/Procedure
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* Procedure, Diagnosis, Place of Service
* Medical Necessity Guidelines
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* Adjusted Claims
* Hospital Bills and Audits
* Unprocessed Claim Procedures
* Membership Procedures
* Provider Credentialing
* Medicare
* Security Access
* Internet Capabilities
* Banking and Cash Flow
* General System
EXECUTIVE SUMMARY

Audited Random Selection Data
Total number of claims: 500
Total Charge Value of random selection: $ 796,432.11
Total Paid Value of random selection: $ 268,254.91

 Paid Dollar Distribution

Performance Guaranteed Metric Results

<table>
<thead>
<tr>
<th>Metric</th>
<th>Guarantee Measurement</th>
<th>Actual</th>
<th>Pass/Fail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment Accuracy</td>
<td>≥ 97% of claims audited are to be paid accurately</td>
<td>99.0%</td>
<td>Pass</td>
</tr>
<tr>
<td>Financial Accuracy</td>
<td>≥ 99% of the dollars paid for the audited claims is to be paid accurately</td>
<td>99.66%</td>
<td>Pass</td>
</tr>
<tr>
<td>Claim Processing Turnaround Time</td>
<td>- 90% of all claims processed within 18 days.</td>
<td>99.15%</td>
<td>Pass</td>
</tr>
<tr>
<td></td>
<td>- 98% of all claims processed within 30 days.</td>
<td>99.93%</td>
<td>Pass</td>
</tr>
<tr>
<td>Customer Service</td>
<td>- Telephone Response Time: ≤ 30 seconds.</td>
<td>29.25sec.</td>
<td>Pass</td>
</tr>
<tr>
<td></td>
<td>- Telephone Abandonment Rate: ≤ 2%.</td>
<td>1.98%</td>
<td>Pass</td>
</tr>
<tr>
<td></td>
<td>- Member Problems documented w/in 2 days</td>
<td>99.88%</td>
<td>Pass</td>
</tr>
<tr>
<td></td>
<td>- Member Problem resolved within 10 days</td>
<td>95.85%</td>
<td>Pass</td>
</tr>
</tbody>
</table>

Previous Recommendation(s)
HCA is pleased to report that all previous recommendations accepted by the PEBP Board of Directors has been implemented and/or in the process of application.

Newly adopted/approved applied out-of-state allowable rates with Aetna network
PEBP has approved the use of the Aetna network rates adjudication for out-of-state claims effective 01 July 2016. The PEBP Executive Officer requested a focus audit of this authorization to ensure PEBP that the savings being obtained currently are greater than the previous out-of-state network rates used net of the Per Participant Per Month (PPPM) fees to access the network and in compliance with savings promised.

For the first year period of PEBP Plan Year 2017, claims in the billed amount of $12,907,928 were eligible to be adjudicated under the Aetna network. The average discount achieved for these claims was 49.5%. When this data is compared to the average discount of 32.1% achieved for the same period last year under the previous utilized network, the discounting of these claims increased by $2,243,082 for PEBP. Reporting this gain minus the Per Participant Per Month (PPPM) of the 959 eligible participants, nets an estimated greater savings amount of $2,053,200 for the PEBP plan during Plan Year 2017.
HTH Repriced non Hospital claims

All claims received by HealthSCOPE for PEBP members are sent to Hometown Health for repricing and application of the network negotiated rates for each provider. Claim data is sent back from Hometown Health to HealthSCOPE displaying the network rate or identified as non network. The non network claims are then processed by HealthSCOPE and identified as non network non-Preferred Provider Organization (PPO) with the Hometown Health, Sierra Healthcare Options (SHO) network, PEBP PPO contract or any PEBP related network.

HealthSCOPE has possession of hospital contracts which are utilized during the audit process by HCA and internal large dollar reviews by HealthSCOPE; however, do not possess non hospital contracts and rely completely on Hometown Health repricing. Previous audits have identified errors with hospital contract rate applications, so the PEBP Executive Officer expanded the audit to include a selection of non hospital claims to be audited against the negotiated PPO contract(s). Approximately 15% of the claims repriced by Hometown Health within the valid random selection were audited for accuracy, of which, will be increased in subsequent audits.

The results in this focus audit detected no exceptions; however, identified an issue associated with the method in which the Hometown Health claims are repriced. Many contracts are priced on a case rate or global basis meaning that if a provider renders any level or volume of services, the contract rate is a set financial allowable amount. When Hometown Health reprices claims such as these, they apply the full global allowable in proportion to each line of the services rendered. It is HealthSCOPE’s responsibility to apply reductions for multiple surgical guidelines, inclusive services, etc. as per American Medical Association and Medicare guideline rules. When a situation occurs where the reduction is applied to a global fee, the claim is underpaid as was illustrated in HCA reference no. 404. In this situation, the provider is contracted to be paid $100 for any and all services rendered unless they charge less than the contract rate. HealthSCOPE provided their duty by not allowing the allowable for inclusive charges (service codes that were unbundled and are a part of the principal service code) and thereby reduces the total allowable by the inclusive service portion and creates an underpayment.

EXAMPLE (Ref. No. 404):
CPT service 97140, charged $118.00, repriced at $81.38
CPT service 97010, charged $27.00, repriced at $18.62

The total repriced by Hometown Health at $100.00 as per the network contract for the negotiated global rate; however, when HealthSCOPE reduces the 97010 service for inclusive edit, they will only allow $81.38 versus the $100 as per the network contract.

HCA recommends that this methodology be reviewed and the correction be implemented. The correction can be conducted in multiple ways; however, the most probable best solution would be to apply the global fee to the primary service so the HealthSCOPE edits do not reduce the allowable(s) less than contract fee.
**Trends/Issues**

The audit revealed the following issues or trends detected from the random selection and bias selected claims. Please note: the reference numbers in **bold type** are claims from the random selection and are included within the statistical calculations. Reference numbers in normal type were identified as issues in bias claims as defined earlier and are not included within the statistical calculations of this audit. Specific information regarding supporting reference numbers can be found in the Audit Results Section in numerical sequence, which begins on page 15.

**Incorrect rate;** Supporting reference no. 135 and 502

**Incorrect rate with large dollar error;** Supporting reference no. 502

**Incorrect rate due to retroactive updated HTH re-pricing;**
Supporting reference nos. 174 and 318

**Incorrect rate due to receipt of retroactive updated SHO contract;**
Supporting reference nos. 191 and 451

**Paid preventive/wellness service as medical;** Supporting ref. nos. 241 and 389

**Incorrect rate due to re-pricer;** Supporting reference nos. 379 and 404

**Paid under incorrect patient;** Supporting reference no. 051

**Non-covered service paid in error;** Supporting reference no. 136

**Paid medical charge as routine/preventive;** Supporting reference no. 149

**Routine lab charge not adjusted after receipt of routine office visit claim;** Supporting reference no. 153

**Corrected diagnosis code not entered during claim adjustment;**
Supporting reference no. 295

**Dental deductible taken in error;** Supporting reference no. 365

The audit revealed the following issues, which appear to be administered properly by HSB, but should be brought to client attention for proper notification or verification. Specific information regarding supporting reference numbers can be found in the Audit Results Section in numerical sequence, which begins on page 15.

**Dependent eligibility sent to HSB twice with name differences resulting in dependent being added twice;** Supporting reference no. 051

**Routine lab services from independent lab not paid unless system finds routine office visit within 10 days prior or after lab date in order to validate routine diagnosis;** Supporting reference no. 153
HTH re-pricing global fee with an allowed amount for each procedure code billed; Supporting reference no. 404

2016 HCA Hospitals contract with HTH extended due to continuation of negotiation for 2017 contract; Supporting reference no. 503

CLAIM PROCEDURES/SYSTEM CAPABILITIES/SUPPORT DATA

Introduction

In July 2017, Health Claim Auditors, Inc. (HCA) performed a Claims and System Audit of HealthSCOPE Benefits (HealthSCOPE) located in Little Rock, Arkansas on behalf of The State of Nevada Public Employees’ Benefits Program (PEBP).

This audit was performed by collecting information to assure that HealthSCOPE is doing an effective job of controlling claim costs while paying claims accurately within a reasonable period of time.

This report was presented to HealthSCOPE for any additional comments and responses on 25 July 2017.

Breakdown of Claims Audited

The individual claims audited were randomly selected from PEBP’s claims listings as supplied by HealthSCOPE. These claims had dates of service ranging from January 2016 to June 2017 and were processed by HealthSCOPE from 01 April 2017 through 30 June 2017 (PEBP’s Fourth Quarter Plan Year 2017). These claims were stratified by dollar volume to assure that HCA audited all types of claims. The audit also includes large dollar paid amounts that are considered as bias* selected claims.

*Bias claims are not part of the random selection but were audited by HCA because of some “out of the ordinary” characteristic of the claim. There are multiple criteria to identify the “out of the ordinary” characteristics. Examples are duplicates, CPT up coding, exceeding benefit limits, etc.

The breakdown of the 500 random selected claims audited is as follows:

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Charge Amount</th>
<th>Paid Amount</th>
<th>Paid Distribution</th>
<th>No. of Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>$179,084.04</td>
<td>$66,507.15</td>
<td>24.8%</td>
<td>318</td>
</tr>
<tr>
<td>Outpt. Hospital</td>
<td>$242,684.41</td>
<td>$55,637.01</td>
<td>20.7%</td>
<td>66</td>
</tr>
<tr>
<td>Inpt. Hospital</td>
<td>$322,037.66</td>
<td>$121,658.53</td>
<td>45.4%</td>
<td>7</td>
</tr>
<tr>
<td>Dental</td>
<td>$52,626.00</td>
<td>$24,452.22</td>
<td>9.1%</td>
<td>109</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$796,432.11</td>
<td>$268,254.91</td>
<td>100%</td>
<td>500</td>
</tr>
</tbody>
</table>
Payment Accuracy

Per PEBP, the Service Performance Standards and Financial Guarantees Agreement for the payment accuracy is to be 97% or above of claims adjudicated are to be paid correctly or a penalty of 2.5% of Quarterly Administration Fees for each percentage (%) point, or fraction thereof, below performance guarantee is to be applied. Payment Accuracy is calculated by dividing the total number of claims not containing payment errors in the audit period by the number of claims audited within the random selection.

The Payment Accuracy Percentage of the number of claims paid correctly from the HealthSCOPE random selection for this audited quarter is 99.0%.

| Number of claims: | 500 |
| Number of claims paid incorrectly: | 5 |
| Percentage of claims paid incorrectly: | 1.0% |
| Number of claims paid correctly: | 495 |
| Percentage of claims paid correctly: | 99.0% |

![Payment Accuracy for the past four quarters](image)

Financial Accuracy

Per PEBP, the Service Performance Standards and Financial Guarantees Agreement for the financial accuracy of the total dollars paid for claims adjudicated is to be paid correctly at 99% or above or a penalty of 2.5% of Quarterly Administration Fees for each percentage (%) point, or fraction thereof, below performance guarantee is to be applied. Financial Accuracy is calculated by dividing the total audited dollars paid correctly by the total audited dollars processed within the random selection.

The Financial Accuracy Percentage of paid dollars remitted correctly on the HealthSCOPE claims selected randomly for this audited quarter is 99.66%.

This audit reflected eighty-nine and nine tenths percent (89.9%) of the audited errors within the valid random selection were overpayments.

| Paid dollars audited | $268,254.91 |
| Amount of paid dollars remitted incorrectly | $915.67 |
| Percentage of Dollars paid incorrectly | 0.34% |
| Paid Dollars of claims paid correctly | $267,339.24 |
| Percentage of Dollars Paid correctly | 99.66% |
Financial Accuracy for the past four quarters

Historical Statistical Data of Performance Guarantees

The following reflects the historical statistical data since the origin of PEBP medical claims administration by HealthSCOPE. The entries designated in **bold red type** are measurable categories with underperformance of the Service Performance Guarantees Agreement.

<table>
<thead>
<tr>
<th>Period Audited</th>
<th>Payment Accuracy</th>
<th>Financial Accuracy</th>
<th>Turnaround Time</th>
<th>Telephone Response</th>
<th>Telephone Abandon Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Qtr PY 2012</td>
<td>95.7%</td>
<td>98.6%</td>
<td>7.6 days</td>
<td>:17</td>
<td>1.43%</td>
</tr>
<tr>
<td>2nd Qtr PY 2012</td>
<td><strong>93.3%</strong></td>
<td><strong>97.3%</strong></td>
<td>12.7 days</td>
<td>:12</td>
<td>1.16%</td>
</tr>
<tr>
<td>3rd Qtr PY 2012</td>
<td><strong>96.8%</strong></td>
<td><strong>98.6%</strong></td>
<td>3.7 days</td>
<td>:18</td>
<td>1.32%</td>
</tr>
<tr>
<td>4th Qtr PY 2012</td>
<td><strong>95.8%</strong></td>
<td>99.5%</td>
<td>11.4 days</td>
<td>:14</td>
<td>0.93%</td>
</tr>
<tr>
<td>1st Qtr PY 2013</td>
<td>97.2%</td>
<td>99.4%</td>
<td>10.4 days</td>
<td>:20</td>
<td>1.06%</td>
</tr>
<tr>
<td>2nd Qtr PY 2013</td>
<td>98.5%</td>
<td>99.3%</td>
<td>7.3 days</td>
<td>:11</td>
<td>0.87%</td>
</tr>
<tr>
<td>3rd Qtr PY 2013</td>
<td>98.0%</td>
<td><strong>95.7%</strong></td>
<td>6.4 days</td>
<td>:25</td>
<td>1.98%</td>
</tr>
<tr>
<td>4th Qtr PY 2013</td>
<td>98.4%</td>
<td>99.7%</td>
<td>6.2 days</td>
<td>:29</td>
<td>1.61%</td>
</tr>
<tr>
<td>1st Qtr PY 2014</td>
<td>98.8%</td>
<td>99.6%</td>
<td>5.4 days</td>
<td>:14</td>
<td>0.84%</td>
</tr>
<tr>
<td>2nd Qtr PY 2014</td>
<td>99.2%</td>
<td>99.2%</td>
<td>5.9 days</td>
<td>:29</td>
<td>1.96%</td>
</tr>
<tr>
<td>3rd Qtr PY 2014</td>
<td>98.0%</td>
<td><strong>98.5%</strong></td>
<td>5.2 days</td>
<td>:30.5</td>
<td>1.92%</td>
</tr>
<tr>
<td>4th Qtr PY 2014</td>
<td>99.0%</td>
<td>99.8%</td>
<td>4.4 days</td>
<td>:28</td>
<td>1.96%</td>
</tr>
<tr>
<td>1st Qtr PY 2015</td>
<td>98.8%</td>
<td>99.27%</td>
<td>4.9 days</td>
<td>:29.4</td>
<td>1.94%</td>
</tr>
<tr>
<td>2nd Qtr PY 2015</td>
<td>99.0%</td>
<td>99.35%</td>
<td>8.1 days</td>
<td>:22</td>
<td>1.18%</td>
</tr>
<tr>
<td>3rd Qtr PY 2015</td>
<td>98.6%</td>
<td>99.8%</td>
<td>5.9 days</td>
<td>:29.7</td>
<td>1.97%</td>
</tr>
<tr>
<td>4th Qtr PY 2015</td>
<td>99.6%</td>
<td><strong>95.6%</strong></td>
<td>4.9 days</td>
<td>:29.4</td>
<td>1.91%</td>
</tr>
<tr>
<td>1st Qtr PY 2016</td>
<td>99.0%</td>
<td><strong>98.9%</strong></td>
<td>4.8 days</td>
<td>:29.1</td>
<td>1.94%</td>
</tr>
<tr>
<td>2nd Qtr PY 2016</td>
<td>98.6%</td>
<td>99.7%</td>
<td>3.5 days</td>
<td>:24.0</td>
<td>1.14%</td>
</tr>
<tr>
<td>3rd Qtr PY 2016</td>
<td>98.8%</td>
<td><strong>98.53%</strong></td>
<td>5.3 days</td>
<td>:29.0</td>
<td>1.96%</td>
</tr>
<tr>
<td>4th Qtr PY 2016</td>
<td>99.0%</td>
<td>99.52%</td>
<td>6.3 days</td>
<td>:29.5</td>
<td>1.98%</td>
</tr>
<tr>
<td>1st Qtr 2017</td>
<td>99.0%</td>
<td>99.23%</td>
<td>6.6 days</td>
<td>:29.8</td>
<td>1.93%</td>
</tr>
<tr>
<td>2nd Qtr 2017</td>
<td>99.6%</td>
<td>99.78%</td>
<td>4.3 days</td>
<td>:29.3</td>
<td>1.96%</td>
</tr>
<tr>
<td>3rd Qtr 2017</td>
<td>98.2%</td>
<td><strong>93.83%</strong></td>
<td>3.7 days</td>
<td>:29.8</td>
<td>1.97%</td>
</tr>
<tr>
<td>4th Qtr 2017</td>
<td><strong>99.0%</strong></td>
<td><strong>99.66%</strong></td>
<td>4.6 days</td>
<td>:29.3</td>
<td><strong>1.98%</strong></td>
</tr>
</tbody>
</table>
**Turnaround Time**

Per the Service Performance Standards and Financial Guarantees Agreement, the turnaround time for payments of claims is measured in calendar days from the date HealthSCOPE receives the claim until the date of process. Ninety percent (90%) of all claims are to be processed within eighteen (18) calendar days and ninety nine percent (99%) are to be processed within thirty (30) calendar days or a penalty of two percent (2.0%) of Quarterly Administration fees for each percentage point or fraction thereof in non-compliance per level is to be applied. HCA had requested the report that reflects the measurement of this issue. This report reflected that 99.15% of “clean” claims were processed within 18 calendar days and 99.93% of “clean” claims were processed within 30 calendar days, in compliance with the performance guarantee. This report also displayed the total turnaround process time for all claims at 4.6 days.

**Turnaround Time Measurements**

<table>
<thead>
<tr>
<th></th>
<th>80</th>
<th>85</th>
<th>90</th>
<th>95</th>
<th>100</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 day TAT</td>
<td>90</td>
<td>91</td>
<td>92</td>
<td>93</td>
<td>94</td>
</tr>
<tr>
<td>30 day TAT</td>
<td>99</td>
<td>99</td>
<td>99</td>
<td>97</td>
<td>96</td>
</tr>
<tr>
<td>% of claims processed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance Guarantee</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The turnaround time, measured only from the random selected claims, for Medical claims was 8.7 calendar days, Out Patient Hospital claims was 10.3 calendar days, In Patient Hospital claims was 16.0 calendar days and Dental claims was 1.4 calendar days.

During the audit period of 01 April 2017 to 30 June 2017, HealthSCOPE had received 529 PEBP e-mail inquiries for information via the internet. The average turnaround time for these inquiries was less than 24 hours (24:00) with the exclusion of those received on a holiday and/or weekend day.

**Customer Service Satisfaction**

Per the Service Performance Standards and Financial Guarantees Agreement, the telephone response time reflects all calls must be answered within thirty (30) seconds or a penalty of one percent (1%) of Quarterly Administration fees for each second or fraction thereof in non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP fourth fiscal quarter Plan Year 2017, which revealed the average incoming answer speed to be 29.25 seconds (0:29.25). The telephone response time was 23 seconds for April 2017, 25 seconds for May 2017 and 39 seconds for April 2017.
Per the Service Performance Standards and Financial Guarantees Agreement, the abandonment rate must be under two percent (2%) of total calls or a penalty of one percent (1%) of Quarterly Administration fees for each percentage point or fraction thereof in non-compliance is to be applied. Please note: this performance measurement was changed from 3% as the measured benchmark for previous plan years. HCA has reviewed the appropriate report for the PEBP fourth fiscal quarter Plan Year 2017, which revealed the abandoned calls ratio to be 1.98%. The telephone abandonment rate was 1.66% for April 2017, 1.67% for May 2017 and 2.55% for April 2017.

### Telephone Abandonment Rate

<table>
<thead>
<tr>
<th>Percentage of Calls Abandoned</th>
<th>Performance Guarantee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.98</td>
</tr>
</tbody>
</table>

Per the Service Performance Standards and Financial Guarantees Agreement, ninety five percent (95%) of incoming PEBP member problems must be documented within two (2) business days and resolved within ten (10) business days or a penalty of one percent (1%) of Quarterly Administration fees for each percentage point or fraction thereof in non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP fourth fiscal quarter Plan Year 2017, which revealed that HealthSCOPE documented 99.88% of problems within two business days and resolved 95.85% of problems within ten business days.

HealthSCOPE has eighty plus (80+) Customer Service Reps (CSRs), of which, the majority are in the Little Rock office with an average of eight (8) years experience. HealthSCOPE currently has eighteen (18) CSRs dedicated to the PEBP plan.

HealthSCOPE stated that customer service hours of operation will be applied to PEBP direction for proper service levels.

Benefit data is supplied by electronic documentation so that the analyst may explain benefit information to clients, members and providers by HealthSCOPE.

HealthSCOPE stated that the customer service representatives will not have the ability to make system changes.

HealthSCOPE’s telephone conversations are documented for future reference.

HealthSCOPE does have an audit process for Customer Service Representatives.

HealthSCOPE is able to monitor trends/errors found through Customer Service.

HealthSCOPE can conduct customer service satisfaction surveys to determine employee satisfaction of claims administration and service upon client request.
Soft Denied Claims

The audit identifies the volume of claims adjudicated and placed in a “soft denied” status. HCA recognizes and respects the need to place certain claims in a soft denied status such as claims that require additional information or special calculation of payment. It is HCA’s opinion that these amounts are the result of HealthSCOPE conducting due diligence and resolution of the issues and trends including those previously detected in previous audits. It is important to include this data within this report to disclose the outstanding unpaid claims that could create an artificial debit/savings during the time that these claims were adjudicated. Note: The measurement of this data was provided as a “snapshot” report. The report reflected the “soft edit” amounts as they were reported on the specific day that the report was recorded.

The report for the current claims placed in a “soft denied” status reflect a total of 4,768 claims representing $20,217,736.28. This quarter incurred an increase in large dollar claims (42 greater than $100,000.00 representing $9,184,051) all requiring legitimate reasons for a “soft pend” status.

<table>
<thead>
<tr>
<th>Audit Period</th>
<th>Total Number of Claims</th>
<th>Charge Amount Value of Soft Edits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Qtr PY 2012</td>
<td>2,607</td>
<td>$7,544,177.55</td>
</tr>
<tr>
<td>2nd Qtr PY 2012</td>
<td>4,068</td>
<td>$10,697,954.53</td>
</tr>
<tr>
<td>3rd Qtr PY 2012</td>
<td>1,536</td>
<td>$6,472,249.56</td>
</tr>
<tr>
<td>4th Qtr PY 2012</td>
<td>559</td>
<td>$2,205,318.16</td>
</tr>
<tr>
<td>1st Qtr PY 2013</td>
<td>1,053</td>
<td>$3,413,738.12</td>
</tr>
<tr>
<td>2nd Qtr PY 2013</td>
<td>1,107</td>
<td>$5,019,961.70</td>
</tr>
<tr>
<td>3rd Qtr PY 2013</td>
<td>1,023</td>
<td>$4,179,542.34</td>
</tr>
<tr>
<td>4th Qtr PY 2013</td>
<td>1,094</td>
<td>$3,049,481.74</td>
</tr>
<tr>
<td>1st Qtr PY 2014</td>
<td>1,389</td>
<td>$3,853,629.07</td>
</tr>
<tr>
<td>2nd Qtr PY 2014</td>
<td>1,157</td>
<td>$2,510,539.33</td>
</tr>
<tr>
<td>3rd Qtr PY 2014</td>
<td>1,621</td>
<td>$7,873,432.21</td>
</tr>
<tr>
<td>4th Qtr PY 2014</td>
<td>1,487</td>
<td>$4,665,197.77</td>
</tr>
<tr>
<td>1st Qtr PY 2015</td>
<td>1,404</td>
<td>$5,901,903.17</td>
</tr>
<tr>
<td>2nd Qtr PY 2015</td>
<td>1,668</td>
<td>$6,930,288.41</td>
</tr>
<tr>
<td>3rd Qtr PY 2015</td>
<td>2,897</td>
<td>$10,800,874.08</td>
</tr>
<tr>
<td>4th Qtr PY 2015</td>
<td>2,498</td>
<td>$10,685,255.24</td>
</tr>
<tr>
<td>1st Qtr PY 2016</td>
<td>3,071</td>
<td>$13,027,717.82</td>
</tr>
<tr>
<td>2nd Qtr PY 2016</td>
<td>2,543</td>
<td>$13,547,682.34</td>
</tr>
<tr>
<td>3rd Qtr PY 2016</td>
<td>2,871</td>
<td>$10,360,017.78</td>
</tr>
<tr>
<td>4th Qtr PY 2016</td>
<td>3,107</td>
<td>$15,262,995.27</td>
</tr>
<tr>
<td>1st Qtr PY 2017</td>
<td>2,580</td>
<td>$8,558,641.28</td>
</tr>
<tr>
<td>2nd Qtr PY 2017</td>
<td>3,876</td>
<td>$15,960,661.94</td>
</tr>
<tr>
<td>3rd Qtr PY 2017</td>
<td>3,696</td>
<td>$18,864,824.74</td>
</tr>
<tr>
<td>4th Qtr PY 2017</td>
<td>4,768</td>
<td>$20,217,736.28</td>
</tr>
</tbody>
</table>
Overpayments

The previous PEBP health plan administrator (UMR) provided HealthSCOPE with a report displaying the outstanding identified overpayments reflecting a grand total of outstanding overpayments at $1,751,949.42. HealthSCOPE conducted much research on these overpayments and found that 507 of these claims were deemed as no longer valid due to providers showing items that were already paid to UMR, corrected claims were sent to resolve the issue, etc. As of this audit, these aged overpayments (overpayments aged in excess of four years) remain “on the books” as active, however, are not displayed and reported as current overpayments.

HCA requested an overpayment report that reflects the identified current outstanding overpayments incurred since the beginning of the contract period with HealthSCOPE. This report reflected a current total of 3,905 (a decrease of 382 from the previous report) overpayments with a potential recovery value of $1,618,381.82 (a decrease of $69,478.25) for HealthSCOPE. Detailed information regarding outstanding overpayments can be reviewed in a separate Supplemental Report, which for confidentiality purposes is not included in this report but is made available to PEBP staff should they request it.

HSB’s policy is to keep all identified overpayments active for potential recoupment(s), however, for reporting purposes, PEBP authorized that this report will display the “open” overpayments for the past four (4) years to the present time. The breakout of overpayments identified by the year paid are as follows:

<table>
<thead>
<tr>
<th>Period</th>
<th># of Claims</th>
<th>Due/Potential Recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Year 2012</td>
<td>207</td>
<td>$70,589.53</td>
</tr>
<tr>
<td>Fiscal Year 2013</td>
<td>756</td>
<td>$239,848.24</td>
</tr>
<tr>
<td>Fiscal Year 2014</td>
<td>518</td>
<td>$113,721.59</td>
</tr>
<tr>
<td>Fiscal Year 2015</td>
<td>498</td>
<td>$179,945.19</td>
</tr>
<tr>
<td>Fiscal Year 2016</td>
<td>762</td>
<td>$421,351.23</td>
</tr>
<tr>
<td>Fiscal Year 2017</td>
<td>1,164</td>
<td>$592,926.04</td>
</tr>
<tr>
<td>TOTAL</td>
<td>3,905</td>
<td>$1,618,381.82</td>
</tr>
</tbody>
</table>

Overpayments $ Value (last four quarters)
Of the 1,164 current (Fiscal Year 2017) identified outstanding overpayments (HSB only), 52.9% were found to be caused by external sources that are not a cause of the HealthSCOPE adjudication processes. Breakout of the HealthSCOPE’s most current (PY17) overpayments (by claim count) are listed by reason as follows:

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>27.81%</td>
<td>Corrected SHO Network Pricing/Feed</td>
</tr>
<tr>
<td>20.34%</td>
<td>Incorrect Benefit Applied</td>
</tr>
<tr>
<td>9.10%</td>
<td>Provider caused, rebilled, charges billed in error, corrected EOB</td>
</tr>
<tr>
<td>6.95%</td>
<td>Incorrect Rate Applied</td>
</tr>
<tr>
<td>6.35%</td>
<td>No COB on file</td>
</tr>
<tr>
<td>5.67%</td>
<td>Duplicate</td>
</tr>
<tr>
<td>4.29%</td>
<td>COB incorrectly calculated or not applied</td>
</tr>
<tr>
<td>3.78%</td>
<td>Corrected HTH Network Pricing</td>
</tr>
<tr>
<td>3.26%</td>
<td>Service not covered</td>
</tr>
<tr>
<td>2.92%</td>
<td>Retro termination</td>
</tr>
<tr>
<td>2.49%</td>
<td>Corrected Network pricing</td>
</tr>
<tr>
<td>1.29%</td>
<td>Adjusted after medical review</td>
</tr>
<tr>
<td>1.12%</td>
<td>Industrial and/or possible Workers Compensation claim</td>
</tr>
<tr>
<td>0.94%</td>
<td>Processed under the incorrect provider</td>
</tr>
<tr>
<td>0.86%</td>
<td>Processed under incorrect patient</td>
</tr>
<tr>
<td>0.52%</td>
<td>Paid NON PPO provider as PPO</td>
</tr>
<tr>
<td>0.43%</td>
<td>Exceeded maximum benefit limits</td>
</tr>
<tr>
<td>0.43%</td>
<td>Multiple Surgical Guidelines not applied</td>
</tr>
<tr>
<td>0.34%</td>
<td>Subrogation error</td>
</tr>
<tr>
<td>0.26%</td>
<td>Paid PPO provider as NON PPO</td>
</tr>
<tr>
<td>0.26%</td>
<td>First Health Pricing Adjustment</td>
</tr>
<tr>
<td>0.26%</td>
<td>Incorrect assignment applied</td>
</tr>
<tr>
<td>0.09%</td>
<td>Exception/Appeal</td>
</tr>
<tr>
<td>0.09%</td>
<td>Pharmacy claim deductible/Co-Insurance error</td>
</tr>
<tr>
<td>0.09%</td>
<td>Updated Wellness level</td>
</tr>
<tr>
<td>0.09%</td>
<td>Beechstreet Adjusted Pricing</td>
</tr>
</tbody>
</table>
Subrogation

HCA requested a subrogation report that can be reviewed in a separate Supplemental Report, which for confidentiality purposes is not included in this report. It is made available to PEBP staff should they request it.

This report reflects open subrogation claims representing a current potential recovery amount of $2,985,427.08; a decrease of $681,810.59 from the previous quarter.

Reports received from HealthSCOPE reflect that subrogation recoveries for the audited period was $119,024.38. After contingency fees were paid, PEBP received $89,268.29.

HealthSCOPE system will apply a pursue and pay subrogation policy as directed by PEBP. Per HealthSCOPE, subrogation is determined and pursued on all claims where the total amount paid equals to or exceeds $1000 (one thousand).

HealthSCOPE does identify possible subrogation cases internally. HealthSCOPE utilizes a third party vendor for recovery of monies. Vendors are paid a contingency of which the administrator receives a portion of and disclosed within RFP 1983 for Third Party Claims Administration.

HealthSCOPE does not conduct auditing of outstanding subrogation cases sent to their vendors, but sends any cases not picked up by the main vendor to another vendor for review.

HealthSCOPE depends on the external vendors to conduct the appropriate International Classification of Diseases (ICD) sweep checks for subrogation detections. HealthSCOPE is currently utilizing the new ICD-10 conversions and the coding has been completed within their system.

Per HealthSCOPE, claims related to Worker’s Compensation are denied.

Recoupment and payments for subrogation claims are assigned as directed by PEBP.
High Dollar Claimants

Per the request of PEBP staff, HCA has requested a report to identify the number of active, retiree or COBRA elected participants or dependents who have obtained a plan paid level of $750,000.00 or greater.

This report reflected fifty (50) members and sixteen (16) dependents for a total of 66 active participants, who have obtained this level of plan payment participation representing an accrued dollar paid amount of $86,565,270.82.

Personnel

The audit included a review of the HealthSCOPE personnel dedicated or assigned to PEBP. There were no changes from the previous quarter. The current Organization Chart for individuals assigned to the PEBP plan, is as follows:

- State of Nevada Manager;
- Vice President – Quality Assurance;
- Sr. Vice President Operations Customer Care;
- Executive Account Manager;
- Client Relations Manager;
- Financial Operations Director;
- Provider Maintenance Specialist;
- Financial Analysts, 3 individuals;
- Funding Supervisor;
- Claims Administration Director;
- Claims Administration Supervisors; 2 individuals;
- Claims Analysts, 12 individuals;
- Eligibility Director;
- Eligibility Supervisor;
- Customer Service Vice President;
- Customer Service Director;
- Customer Service Representatives, 18 individuals;
- Scanning Services Manager;
- Recoveries Manager;
- Recoveries Specialists, 2 individuals;
- Vice President Data Services;
- Senior Data Analyst;
- Chief Information Officer;
- Data Architect
- Computer Domain Hosting (CDH) Services Manager;
- Sr. Vice President-Legal and Compliance;
- COBRA Service Manager;
- Customer Care Supervisor;
- Customer Care Representatives, 3 individuals.
**HealthSCOPE System Overview**

This section details the HealthSCOPE adjudication system capabilities and operations as they pertain to the PEBP Health Plan. These operations typically do not change on a regular basis and remain redundant within subsequent audit reports, thereby, will only be displayed within the first quarterly audit report for the fiscal year. The quarterly audit includes the review of the following operations, however, if any changes or defects are identified, they will be reported immediately within the audited period report:

- HealthSCOPE Policy/Procedures
- Eligibility
- Deductibles, Out-of-Pocket and Benefit Maximums
- Unbundling/Rebundling
- Concurrent Care
- Code Creeping
- Procedure, Diagnosis and Place of Service
- Experimental and Cosmetic Procedures
- Medical Necessity/Potential Abuse Guidelines and Procedures
- Patterns of Care and Treatment for Physicians
- Mandatory Outpatient/Inpatient Procedures
- Duplicate Claim Edits
- Adjusted Claims
- Hospital and Other Discounts
- Hospital Bills (UB-92) and Audits
- Filing Limitations
- Unprocessed Claims Procedures
- Reasonable/Customary and Maximum Allowances
- Membership Procedures
- COBRA Administration
- Provider Credentialing
- Coordination of Benefits
- Medicare
- Controlling Possible Fraudulent Claims and Security Access
- Quality Control and Internal Audit
- Internet Capabilities
- Communication between Utilization Review (UR) and Claims Department
- Claim Repricing Capabilities
- Banking and Cash Flow
- Reporting Capabilities
- General System
- Security
HCA CLAIM AUDIT PROCEDURES

HCA selects a random sampling of claims from the client's current detailed claims listings. The third party administrator is advised of the audit and requested to provide either limited system access or paper reproduction of the entire file associated with each random claim.

Each random claim and file is reviewed comparing eligibility and benefits to information provided by the client. Third party administrator personnel are questioned regarding any discrepancies. Entire files are reviewed to assure the client that deductibles, out-of-pockets benefit maximums and related claims are processed correctly. This allows HCA to verify all details of the client's benefit plan.

Audit statistics involve only those claims chosen in the random selection. If a randomly selected claim HealthSCOPE been recalculated or corrected prior to our audit, an error was not charged for the original miscalculation. HCA will, at its opinion, comment on any claim in the random claim history to illustrate situations it feels the client should be aware of or specific areas requiring definition.

A payment error is charged when an error identified in claim processing results in an under/overpayment or a check being paid to the wrong party. Assignment errors are considered payment errors since the plan could be liable for payment to the correct party.

In situations where there is disagreement between HCA and the third party administrator as to what constitutes an error, both sides are presented in the report. Final determination of error rests with the client.

AUDIT RESULTS

Listed below are the errors or issues of discussion found by this audit while processing the claims for PEBP.

Ref. No. 051 Medical HSB claim no.

Overpayment - $299.04

1) Claim being paid under member but claim is actually for baby boy pd as:

DOS 3/28 99232 allow 106.80 pd 85.44

3/29 99232 106.80 85.44

3/30 99238 160.20 128.16

Shouldn't this claim have been paid under patient baby boy?

2) Appears per dependent listing that the baby boy has been entered twice. Claims have been paid under both files & some claims have been denied. Shouldn't these 2 files be combined into one file for the dependent?

HSB response: 1) Claim processed under mother in error. Claim will be moved. No overpayment. 2) PEBP sent dependent twice. Once without "Jr" and once with "Jr". Files will be revised and combined once PEBP advises which is correct.
Ref. No. 135  Medical  HSB claim no.
Overpayment - $272.00
DOS 4/14  99223  chg 825.00  allow 0.00  timely filing
  4/15  99233  425.00  185.00
  4/16  99233  425.00  185.00
  4/17  99233  425.00  185.00
  4/18  99233  425.00  185.00
Shouldn't allowed be $100.00 versus $185.00 for each 99233 service?
99233 services keyed as 99223 & allowed each at 99223 allowables
O/P $272.00?
HSB response: Agree. Keying error. This caused incorrect pricing. Claim is
overpaid $272.00.

Ref. No. 136  Medical  HSB claim no.
NOT charged in statistical calculation. Note to client for information only.
J0696  chg 31.36  allow 31.36  pd 31.36
S9500  395.00  0.00  0.00
This claim was adjusted on 6/4/17 to reverse the J0696 payment as
"services rendered are not covered under your contract w/SHO".
Since the S9500 service was denied on original claim as a non covered
service, is there a system edit issue that still allowed the payment of the
J code?
HSB response: These services are not covered under contract for POS 12.
This is provider write off per SHO. During QA, this was identified and
reports ran to correct issue.

Ref. No. 149  Medical  HSB claim no.
Overpayment - $252.01
81241  chg 330.00  allow 100.01
85230  261.00  24.30
85303  196.00  14.13
85306  250.00  15.26
86147  414.00  98.31
        1451.00  252.01
These services were originally denied for physician statement of medical
necessity. Claim paid at 100%, OOP not met, not routine, etc. Please
explain why claim paid at 100%?
HSB response: Original denial incorrect. Claim reprocessed and should
have paid under illness. Overpaid $252.01.
Ref. No. 153  Medical          HSB claim no.
Underpayment - $21.04
DX: Z0000 Routine Exam
80050  chg 262.64  allow 48.32
80061  155.22  18.24
81001  47.59  4.32
84439  176.96  12.28
87086  31.65  11.00
87088  31.73  11.03
705.79  105.19
Claim paid at 80% = 84.15 paid
File has claim xxxxxx, Carson Med Grp for DOS 4/27/17, 99397 - routine exam
Should audited claim have been adjusted to pay at 100% under routine versus 80% coinsurance?
HSB response: Original claim received 4/19/17 and paid correctly as not routine as no OV in history. When OV claim received 5/2/17 analyst failed to review history to have claim corrected. Underpaid $21.04.

Ref. No. 174  Medical          HSB claim no.
NOT charged in statistical calculation. Note to client for information only.
HTH electronically repriced on 4/10/17 99214 with allow of 165.77 under claim xxxxxx pd 2/1/17.
Updated repricing from HTH received 4/25/17 to now reprice at 176.00. Additional 8.18 paid on audited claim.
Appears incorrect repricing received from HTH.
HSB response: Corrected HTH pricing was received to allow additional $8.18.

Ref. No. 191  Outpatient Hospital  HSB claim no.
NOT charged in statistical calculation. Note to client for information only.
Provider: UMC
ER claim (99285) - audited claim is original processing allow 1927.00
Claim adjusted under xxxxxx on 6/22/17 to allow 2072.00 and pay additional 116.00
When was updated contract for effective 4/1/17 received?
HSB response: Updated contract from SHO received 6/13/17. No error.
Ref. No. 241  Outpatient Hospital       HSB claim no.
Underpayment - $71.58
Claim for ultrasound w/pregnancy DX
REV 402, CPT 7601 pd at 80% allow 357.90 (pd 286.32)
1) Shouldn't this ultrasound have been paid at 100% versus 80%?
NOT charged in statistical calculation. Note to client for information only.
2) Should claim xxxxxx for reading 76815-26 have been then paid at 100%
versus going to ded? (38.50 to ded)
HSB response: 1) Agree. This should pay at 100% of allowable. Underpaid $71.58. 2) Agree. If ultrasound reconsidered at 100% then reading should also be 100%. Underpaid $38.50.

Ref. No. 295  Medical                HSB claim no.
NOT charged in statistical calculation. Note to client for information only.
99214  chg 145.00  allow 94.86
Claim originally paid at 80% after ded on 3/20/17  paid 70.14
Provider rebilled w/Z12.83 DX added. Claim was adjusted & paid on
5/18/17 at 100% however shouldn't the Z12.83 DX code appear in the
system?
HSB response: Corrected claim received with HM diagnosis. Claim
corrected on Txxxxxx but dx Z12.83 was not entered on claim.
Procedural error.

Ref. No. 318  Medical                HSB claim no.
NOT charged in statistical calculation. Note to client for information only.
Original paid under xxxxxx on 2/10/17 paying 332.20
Adjusted on audited claim on 5/23/17 paying additional 68.40
Per Trans Msg appears that HT pricing updated 4/28/17?
HSB response: Yes.

Ref. No. 365  Dental                  HSB claim no.
NOT charged in statistical calculation. Note to client for information only.
Claim originally paid 23.20 on 6/2/17 (audited claim w/$100 ded applied)
Claim adjusted on 7/7/17 to pay additional 76.00 as $95.00 of deductible
had been met for plan year under different ID. System notes reflect a
fast load due to effective date.
HSB response: That is correct. Claim was received and paid before accums had been moved.
Ref. No. 379  Medical  HSB claim no.
NOT charged in statistical calculation. Note to client for information only.
Claim xxxxxx  DOS 5/22-5/23/17  Provider Renown Reg Med Ctr
Chg 26,313.25  allow 18,352.40  (HTH pricing found on portal)
DRG 621 = 15,692 for 1st day/applicable per diem thereafter
REV 636 = 220.00 x 42% = 92.40
Surg add-on = 2,568.00
Due that the claim is DRG 621 & case rate for 1st day = $15,692 (pt in
one day) plus Rev 636 at 42% allowable
Is the surgical add-on to be applied when case rate DRG is used?
HSB response: Per HTH, no surgical add on should not be reimbursed
separately.

Ref. No. 389  Outpatient Hospital  HSB claim no.
NOT charged in statistical calculation. Note to client for information only.
Claim xxxxxx is surgeon's bill
58563  chg 3580.00  allow 177.32
58671.51  710.00  468.06
4290.00  645.38  645.38 applied to ded
If 58671 service is routine & paid at 100% on facility bill, shouldn't the
surgeon's charge for this service also be paid at 100% versus applied to
ded?
HSB response: Yes – surgeon’s fee for CPT 58671 is subject to preventive
benefit at 100%. Claim will be reconsidered.

Ref. No. 404  Medical  HSB claim no.
NOT charged in statistical calculation. Note to client for information only.
Provider: Custom Physical Therapy
Per HTH contract allowable is "bundled rate of $100 per member visit,
limited to one visit per day"
Per Electronic/scanned service detail screen allows show as:
97140  chg 118.00  allow 81.38
97010  27.00  18.62
145.00  100.00
HSB paid claim bundling CPT 97010 into 97140 and only allowing 81.38
at 80% = 65.10
1) Does the allowed amounts on Elec/scanned detail screen come from
HTH or is this screen populated by HSB?
2) Since contract rate is $100 per visit, shouldn't claim have paid as:
100.00 x 80% = 80.00 versus 81.38 x 80% = 65.10?
(Note: There are 23 claims from this provider in this member's file)
HSB response: 1) Yes. Amounts come from HTH. 2) HTH portal
repricing attached.
HCA Note: Portal re-pricing reflects same as Electronic/scanned service
detail screen as shown above.
Ref. No. 451  Medical  HSB claim no.
NOT charged in statistical calculation. Note to client for information only.
Provider: UMC
Original paid on 4/26/17 under xxxxxx paying as:
99202  chg 326.73  allow 194.00  pd 155.20
Audited claim is adjustment on 6/16/17 to pay additional 11.20 as SHO
allow corrected to 208.00
When was updated/corrected allowed amount received from SHO?
HSB response: Initial claim processed on 4-6-17, Txxxxxx.
Reconsidered on audited trans due to contract update for provider
received 6/13/17.

Ref. No. 502  Inpatient Hospital  HSB claim no.
NOT charged in statistical calculation. Note to client for information only.
Provider: UCLA
Original bill for DOS 1/20-2/2/17 claim xxxxxx pd on 2/28/17:
chg 198,172.82  paid 78,063.97
Audited is adjustment to pay additional charges for DOS 1/20-2/14/17
chg 339,543.82  paid additional 112,114.22 on 4/4/17
1) Shouldn't claim have paid as:
REV 206 ICU per diem 5416.00 x 9 days = 48,744.00
REV 278  2525.91 x 34.5% = 871.44
Stoploss  194,817.19 x 80% = 155,583.19
15,291.00
Appears claim is underpaid $15,291.00 utilizing ICU 206 revenue service codes

Communication from SHO to HSB: I finally spoke to the provider and I will email
the information to her. I am not sure why. As far as I know there is no revenue for
DOU. I wanted to review with them before sending the pricing but you stated that
you needed this ASAP. The allowable may change based on additional
information from the provider. If it does change, I will correct the pricing and send
you a corrected pricing sheet.

HSB response received on 28 July 2017: We disagree with the amount you
identified as the underpayment. We have reviewed with SHO. This is another
unusual contract, and they had to reach out to the provider. SHO has indicated an
underpayment of $404.73. We are working with SHO on how to better understand
their intensions when little used provisions come into play.

HCA note: DOU = Definitive Observation Unit, which would be utilized for
patients who are less critical than ICU. As much as the reduction and allowance of
the lower level of service is positive, the network contract makes no allowance for
this level of services. The charges received reflected ICU revenue codes and
without a proper designation within the UB92 documents, it would be extremely
difficult for the administrator to reprice accurately.
Ref. No. 503     Inpatient Hospital     HSB claim no.
NOT charged in statistical calculation. Note to client for information only.
Provider: Sunrise Hospital     Chg 373,888.77 paid 58,497.60
Repriced as: Rev 121 x 12 = 32,235.27
             200 x 4 = 15204.73
360/361 add on surg = 2682.00
390 1778.50 x 20% = 355.70
636 20049.75 x .40 = 8019.90
      58,497.60

Based on 2016 contract:
2824.00 x 12 = 33,888.00   3388.00 x 4 = 13,552.00
add-on       = 2,682.00   Rev 390      = 355.70
Rev 636      = 8,019.90
      58,497.60

Please have HTH supply HSB updated HCA 2017 contract. On file goes to 2016, Dec 31. Claim matches 2016 rates
HSB response: Per HTH - 2016 rates are still applicable. They are still negotiating rates.