JOE LOMBARDO
Governor

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
3427 Goni Rd, Suite 109 | Carson City, Nevada 89706
Telephone 775-684-7000 | 702-486-3100 | 1-800-326-5496
www.pebp.state.nv.us

LAURA RICH
Executive Officer

JACK ROBB
Board Chair

Date: May 25, 2023

Item Number: X

Title: UMR Performance Guarantees Summary

SUMMARY

This report provides the PEBP Board and members of the public with supplemental information regarding CTI's audit of PEBP's Third-Party Administrator, UMR, and the performance guarantees that were not part of the Random Sample Audit results. The tables below illustrate additional penalties being assessed by PEBP for self-reported, unmet performance guarantees not captured in the second quarter audit for fiscal year 2023.

REPORT

Claims Administration

There are a total of nineteen (19) measurement categories of service and performance guarantees related to claims administration. In addition to any exceptions noted in the audited performance guarantees, there were six guarantees reported to be "Not Met" with penalties calculated against total fees of $1,292,524.65:

Performance Guarantee	Result	Fees at Risk	Calculated Penalty
1.4 Claim Adjustment Processing Time	NOT MET	1.0%	$12,925.25
1.5 (Customer Service) Telephone Service Factor	NOT MET	1.0%	$12,925.25
1.6 Call Abandonment Rate	NOT MET	1.0%	$12,925.25
1.7 First Call Resolution Rate	NOT MET	2.0%	$25,850.49
1.8 Open Inquiry Closure (98.00% within 5 Business Days)	NOT MET	1.0%	$12,925.25
1.9 CSR Audit	NOT MET	1.0%	$12,925.25
Total		**7.0%**	**$90,476.73**

Network Administration

There are a total of six (6) measurement categories of service and performance guarantees related to network administration. There was one (1) guarantee reported to be "Not Met" with penalties calculated against total fees of $664,856.00:

Performance Guarantee	Result	Fees at Risk	Calculated Penalty
2.1 EDI Claims Repricing Turnaround Time	NOT MET	2.0%	$13,297.12
Total			**$13,297.12**

Utilization Management and Case Management

There are a total of thirteen (13) measurement categories of service and performance guarantees related to Utilization Management and Case Management. There was one (1) guarantee reported to be "Not Met" with penalties calculated as the number of unreported high-cost claims (8 claims) against fees of $1,000.00 per occurrence:

Performance Guarantee	Result	Fees at Risk	Calculated Penalty
3.2 Notification of high-cost claims (per occurrence)	NOT MET	$1,000 per occurrence	$8,000.00
Total			**$8,000.00**

Summary

This is a brief summary of the performance guarantees where the measurements were determined to be "Not Met:"

Performance Guarantee	Calculated Penalty
1. Claims Administration	$90,476.73
2. Network Administration	$13,297.12
3. Utilization Management and Case Management	$8,000.00
Total	**$111,773.85**

The penalties, totaling $111,773.85, are administratively and automatically assessed by PEBP to the vendor. In conjunction with the audited penalties totaling $45,238.37, the calculated penalties for the period ending 12/31/2022 total **$157,012.22.**

DRAFT 05/15/2023

Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employees Benefit Plan

Administered by UMR Insurance Company

Audit Period: October 1, 2022 – December 31, 2022
Audit Number 1.FY23.Q2

Presented to

State of Nevada Public Employees Benefit Plan

May 25, 2023

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 UMR Insurance Company's (UMR's) administration of the State of Nevada Public Employees Benefit Plan (PEBP) medical and dental plans.

Scope

CTI performed an audit for the period of October 1, 2022 though December 31, 2022 (quarter 2 (Q2) for Fiscal Year (FY) 2023). The population of claims and amount paid during the audit period reported by UMR:

Medical and Dental	
Total Paid Amount	$49,649,252
Total Number of Claims Paid/Denied/Adjusted	187,175

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

- Quarterly Performance Guarantees Validation
- 100% Electronic Screening with Targeted Samples
- Random Sample Audit
- Data Analytics

Auditor's Opinion

Based on these findings, and in CTI's opinion:

1. UMR's Financial Accuracy, Overall Accuracy and Claim Turnaround Time did not meet the service objective and a penalty is owed (breakdown in summary below).
2. CTI recommends UMR should:
   - Review the financial errors identified in the random sample audit and determine if system changes or claim processor training could help reduce or eliminate errors of a similar nature in the future. Specific focus should be directed towards the identification of duplicate payments.
   - Review the 100% Electronic Screening with Targeted Sample results and focus on the most material findings.
   - Where appropriate, verify claim processor coaching, feedback, and retraining has occurred because most errors were manually processed.

Summary of UMR's Guarantee Measurements

Based on CTI's Random Sample Audit results, UMR did not meet the claims processing measurements for PEBP in Q2 FY2023 and a penalty is owed. Reported administrative fees for the quarter totaled $1,292,524.65.

Quarterly Metric	Guarantee	Met/Not Met	Penalty	Calculated Penalty
Financial Accuracy (p.16)	99.4%	Not Met – 97.95%	1.5%	$19,387.87
Overall Accuracy (p.17)	98%	Not Met – 97.0%	1%	$12,925.25
Turnaround Time	92% in 14 Days	Met – 92.9%	0%	$0
	99% in 30 Days	Not Met – 97.5%	1%	$12,925.25
		Total Penalty	3.5%	$45,238.37

AUDIT OBJECTIVES

This report contains CTI's findings from the audit of UMR Insurance Company's (UMR) administration of the State of Nevada Public Employees Benefit Plan (PEBP) plans. We provide this report to PEBP, the plan sponsor, and UMR, the claim administrator. A copy of UMR'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 the audit findings on the data and information provided by PEBP and UMR. The validity of those findings relies on the accuracy and completeness of that information. We planned and performed the audit to obtain reasonable assurance claims were adjudicated according to the terms of the contract between UMR 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 UMR used to pay PEBP's claims during the audit period. While performing the audit, CTI complied with 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 UMR's claim administration were to determine whether:

- UMR followed the terms of its contract with PEBP;
- UMR 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 UMR was incurred.

QUARTERLY PERFORMANCE GUARANTEE VALIDATION

As part of CTI's quarterly audit of PEBP, we reviewed the Performance Guarantees included in its contract and reports provided by UMR. The self-reported results for Q2 FY2023 are in the table below.

	Metric	Service Objective	Actual	Met/ Not Met
CLAIMS ADMINISTRATION – SERVICES AND PERFORMANCE GUARANTEES				
1.4	**Claim Adjustment Processing Time:** measured from the time a prior claim submission requiring an adjustment is identified through the date the claim adjustment is processed by service facility personnel.	95.00% 7 Calendar/ 5 Business Days	86.4%	Not Met
1.5	**Telephone Service Factor:** Defined as the percentage of the Client telephone inquiries answered by facility Customer Service Representatives (CSRs) within 30 seconds. Measured from the time the caller completes the prompts of the automated telephone system to the time the caller reaches a CSR.	85.00% Calls answered within 30 seconds	70.2%	Not Met
1.6	**Call Abandonment Rate:** total number of participant and provider calls abandoned, divided by the total number of calls received by the facility's customer service telephone system.	3.00%	5.7%	Not Met
1.7	**First Call Resolution Rate:** the percentage of telephone inquiries completely resolved within a 'window period' of time. A call is considered 'resolved' when the same participant or a family member under the same subscriber ID has not contacted the administrator's customer service facility again regarding the same issue within 60 calendar days of the initial call.	95.00%	94.8%	Not Met
1.8	**Open Inquiry Closure:** addresses the time taken in hours and/or days by CSRs at the administrator's service facility to close open inquiries placed by participants of PEBP to the facility.	90.00% 48 Hours 98.00% 5 Business Days	94.9% 96.4%	Met Not Met
1.9	**CSR Audit, or Quality Scores:** determined by the process used to evaluate the effectiveness and accuracy of participant telephone call handling at the administrator's customer service facility.	97.00%	95.2%	Not Met
1.10	**CSR Callback Performance:** measured from the CSR commitment data in hours and/or days to the time the actual callback was placed to the participant.	90.00% Within 24 Hours	Unable to Report*	Unable to Report*
1.11	**Participant Email Response Performance:** measured from the time an email is received by the administrator's response team to the time in hours or days to the time the actual email response is sent to the participant.	90.00% Within 8 Hours 95.00% Within 24 Hours	100% 100%	Met Met
1.12	**Member Satisfaction:** At least 95%-member satisfaction with the services. Measured as the number of satisfied to highly satisfied survey ratings divided by the total number of survey responses. Survey tool and survey methodology to be mutually agreed upon by Offeror and PEBP.	95.0%	NA	Reported Annually
1.13	**Account Management – Plan will guarantee that the services provided by the TPA's team during the guarantee period will be satisfactory to PEBP. Areas of satisfaction will include:**			
	Knowledge/Capabilities – Account representative demonstrates competence in getting issues and problems resolved.	Agree	NA	Met
	Responsiveness – All calls returned within at most 24 hours; along with an alternate person identified who can assist with service issues when account representative is unavailable.			

	Metric	Service Objective	Actual	Met/ Not Met
	Ability to meet deadlines – Supplying all requested materials accurately and in a timely manner, along with all necessary documentation (i.e., enrollment kits, rate confirmations, plan performance work plans, group contracts, ZIP code file, etc.).			
	Professionalism – Demonstrates objectivity and empathy with customer problems.			
	Flexibility – Ability to meet client-specific needs.			
	Participation in periodic meetings – Attendance at all required client meetings or conference calls.			
	Guarantee measured with staff responses to internal questionnaire. A scale from 1 to 5 will be used to measure performance, where 1 means 'very dissatisfied' and 5 means 'very satisfied'; and 2 through 4 are defined, respectively.			
	Periodic program reports will be provided and presented with recommended actions. Standard program reports, within 30 days to quarter-end. Year-end activity report, within 45 days of program year end.			
	Open Enrollment Support: Accurate materials will be provided at least 60 days prior to the open enrollment period starting on April 1 each year. Representative will be available, if requested, for up to 5 employee benefit fairs.			
	Service Objective (out of a score of 5 on internal questionnaire):	350		
1.14	**Eligibility Processing:** Confirm daily and weekly eligibility and enrollment within specified business days of the receipt of the eligibility information, given that information is complete and accurate.	98.00% 2 Business Days	100.00%	Met
1.15	**Data Reporting:** Offeror will provide PEBP with 100% of the applicable reports (within 10 business days for standard reports and within 10 business days of Plan year-end for Annual Reports and Regulatory documents).	100% 10 Business Days	NA	PEBP Waived 10-day requirement
1.17	**ID Card Production and Distribution**	100% 10 Business Days	100%	Met
1.18	**Disclosure of Subcontractors:** Offeror will provide the identity of the subcontractors who have access to PEBP member PHI. Provide identity of subcontractors who have access to PHI within 30 calendar days of the subcontractors' gaining access.	100% 30 Calendar Days	100%	Met
1.19	**PHI:** Offeror will store PEBP member PHI data on designated servers. Must remove PEBP member PHI within 3 business days after offeror knows or should have known using commercially reasonable efforts that such PHI is not store on a designated server.	100% 30 Business Days	100%	Met
NETWORK ADMINISTRATION – SERVICES AND PERFORMANCE GUARANTEES				
2.1	**EDI Claims Re-Pricing Turnaround Time:** At least 97% of medical claims covered under the PEBP Medical PPO Network must be electronically re-priced within business 3 days and 99% within business 5 days.	97.00% 3 Business Days 99.00% 5 Business Days	90% 98%	Not Met Not Met
2.2	**EDI Claims Re-Pricing Accuracy:** At least 97% of claims re-priced by the PPO Network must be accurate and must not cause a claim adjustment by PEBP's TPA.	97.00%	98.9%	Met
2.3	**Data Reporting – Standard Reports (Quarterly reporting to include Service Performance Standards, Guarantee, Method of Measurement, Actual Performance Results, and Pass/Fail indicator.)** Standard reports must be delivered within business 10 days of end of reporting period or event as determined by PEBP.	100% 10 Business Days	NA	PEBP Waived 10-day requirement
2.4	**Subcontractor Disclosure:** 100% of all subcontractors used by vendor are disclosed prior to any work done on behalf of PEBP. Business Associate Agreements completed by all subcontractors.	100%	NA	Reported Annually
2.5	**Provider Directory:** Best efforts to resolve 100% of complaints within 10 business days. Provider Directory issue resolution log maintained by Vendor and periodically reviewed with PEBP.	100% 10 Business Days	100%	Met

	Metric	Service Objective	Actual	Met/ Not Met
2.6	**Website:** A website hosting a reasonably accurate and updated Provider directory must be available and accessible on all major browsers 99% of time.	99.00%	100%	Met
UTILIZATION MANAGEMENT/CASE MANAGEMENT – SERVICES AND PERFORMANCE GUARANTEES				
3.1	**Data Reporting – Standard Reports (Quarterly reporting to include Service Performance Standards, Guarantee, Method of Measurement, Actual Performance Results, and Pass/Fail indicator.)** Standard reports must be delivered within calendar 10 days of end of reporting period or event as determined by PEBP.	100% 10 Calendar Days	100%	Met
3.2	**Notification of potential high expense cases. High expense case is defined as a single claim or treatment plan expected to exceed $100,000.00.** Designated PEBP staff will be notified within 5 business days of the UM/CM vendors initial notification of the requested Service.	100% 5 Business Days	87%	Not Met
3.3	**Pre-Certification Requests:** Precertification requests from healthcare providers shall be completed in accordance with URAC/NCQA standards and turn-around timeframes; completed Pre-certifications shall be communicated to PEBP's Third Party Administrator using an approved method e.g., electronically, within 5 business days of UM completing Precertification determination.	98.00% 5 Business Days	NA	Reported Annually
3.4	**Concurrent Hospital Reviews:** Concurrent hospital reviews shall be completed in accordance with URAC/NCQA standards; completed reviews shall be communicated to the provider using an approved method e.g., electronically within 2 business days of determination decision.	98.00% 2 Business Days	NA	Reported Annually
3.5	**Retrospective Hospital Reviews:** Retrospective reviews must be completed in accordance with URAC/NCQA standards; completed reviews shall be communicated using an approved method e.g., electronically within 5 business days of determination decision.	98.00% 5 Business Days	NA	Reported Annually
3.8	**Hospital Discharge Planning:** CM will contact or attempt to contact 95% of patients discharged from any facility within 3 business days of notification of discharge with clinical coaching and discharge planning assistance.	95.00% 3 Business Days	NA	Reported Annually
3.9	**Large Case Management:** CM will identify and initiate case management for chronic disease, high dollar claims, and ER usage.	95.00%	NA	Reported Annually
3.10	**Utilization Management for Medical Necessity and Center of Excellence Usage:** UM review to determine medical necessity in accordance with the MPDs. Services to be performed at a Center of Excellence to be managed through the Case Management process.	98.00%	NA	Reported Annually
3.11	**Return On Investment (ROI) Guarantee – Utilization Management/Case Management:** 2:1 Savings to Fees for Utilization Management/Case Management.	100%	NA	Reported Annually
3.12	**Disclosure of Subcontractors:** All subcontractors who have access to PHI or PII data and physical locations where PEBP PHI or PII data is maintained and/or stored must be identified in this contract. Any changes to those subcontractors or physical locations where PEBP data is stored must be communicated to PEBP at least 60 days prior to implementation of services by the subcontractor. Implementation will not be in effect until PEBP has provided written authorization.	100% 60 Calendar Days	NA	Reported Annually

	Metric	Service Objective	Actual	Met/ Not Met
3.13	**Unauthorized Transfer of PEBP Data:** All PEBP PHI or PII data will be stored, processed, and maintained solely on currently designated servers and storage devices identified in this contract. Any changes to those designated systems during the life of this agreement shall be reported to PEBP at least 60 calendar days prior to the changes being implemented. Implementation will not be in effect until PEBP has provided written authorization.	100% 60 Calendar Days	NA	Reported Annually

**Note for 1.10 from UMR Leadership: "The CSR Callback performance guarantee is not something UMR has tracked or reported on previously. We found through the development and verification of the callback report that how we are entering and tracking the results will not work for properly reporting on the performance guarantee. UMR is in the process of implementing a new policy in recording callback data so that it can be properly reported as a performance guarantee going forward. We will be able to supply callback performance guarantee results starting with 1/1/2023 calls going forward."*

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 UMR 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 UMR during the audit period for both medical and dental claims. The accuracy and completeness of UMR's data directly impacted the screening categories we completed and the integrity of the 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
- Patient cost share
- Fraud, waste, and abuse
- Timely filing
- Coordination of benefits
- Large claim review
- Case and disease management
- Specific reinsurance reimbursement

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 UMR, we readjudicated each line on every claim the plan paid or denied during the audit period against the plan's benefits. CTI's Technical Lead Auditor tested a targeted sample of claims to provide insight into UMR's claim administration as well as operational policies and procedures. We followed these procedures to complete CTI's ESAS process:

- ***Electronic Screening Parameters Set*** – We used PEBP's plan document provisions to set the parameters in ESAS.
- ***Data Conversion*** – We converted and validated PEBP's 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, CTI's auditors analyzed the findings to confirm results were valid. Note: using ESAS could lead to false positives if there was incomplete claim data. CTI auditors made every effort to identify and remove false positives.
- ***Targeted Sample Analysis*** – From the categories identified with material amounts at risk, we selected the best examples of potential under- or overpayments to test. As cases were not randomly selected, we cannot extrapolate results. This quarter's targeted sample was expanded to 150 from the normal 50 samples at the request of PEBP. We selected 150 cases and sent UMR a questionnaire for each.

Targeted samples verified if the claim data supported CTI's finding and if CTI's understanding of plan provisions matched UMR'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 CTI's ESAS results. It should be noted that dollar amounts associated with the results represent potential payment errors and process improvement opportunities. To substantiate the findings, CTI would have to perform additional testing to provide the basis for remedial action planning or reimbursement.

Categories for Process Improvement

The following summary shows, by category, the number of line items or claimants with process improvement opportunities remaining after CTI's analysis and removal of verified false positives. A CTI auditor reviewed UMR's responses and supporting documentation. The administrator responses shown in the ESAS Detail Findings Report on the following page were copied directly from UMR's reply to audit findings. **It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so PEPB can discuss how to reduce errors and re-work in the future with UMR.**

Categories for Potential Amount at Risk				
Client: PEBP **Screening Period:** Q2 FY2023				
Category	**Number of Line Items**	**Number of Claimants**	**Billed Charge**	**Allowed Amount***
Duplicate Payments				
Providers and/or Employees	254	75	$142,802	$55,209
Exclusions				
Marriage Counseling	2,939	747	$539,120	$294,290
Limitations				
Hearing Aids - $1,500 Per Aid Per Aid 36 Months	27	13	$55,638	$43,928
Fraud, Waste, and Abuse				
Specialty Medications – Non-Hospital	322	134	$689,944	$427,439
Large Payments to Subscribers	74,034	23,536	$12,534,507	$8,816,302
Durable Medical Equipment (DME) Over Medicare Allowance	46	32	$7,639	$3,783
Copay Application				
Diagnostic Mammography	52	13	$39,316	$11,846
Preventive Services				
Preventive Services Denied	1,909	921	$264,308	$0
PPO Provider Without Discount	16,672	6,626	$3,650,459	$3,650,459
End Stage Renal Disease	578	10	$1,727,035	$257,035

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

Electronic screening of every service line 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 UMR for written response. After review of the response and any additional information provided, CTI confirmed the potential for process improvement.

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

The detailed report is longer than normal due to the expanded sample.

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Duplicate Payments				
25	$36.00	Agree.	Procedural deficiency and overpayments identified for duplicate claim payments. Note that any $0.00 Under/Over Paid amounts indicates an incorrect deductible accumulation occurred.	☒ M ☐ S
26	$58.45			☒ M ☐ S
27	$11.72			☒ M ☐ S
28	$193.70			☒ M ☐ S
30	$104.48			☒ M ☐ S
70	$37.50			☒ M ☐ S
71	$85.00			☐ M ☒ S
72	$214.20			☐ M ☒ S
73	$163.50			☐ M ☒ S
75	$0.00			☒ M ☐ S
76	$0.00			☒ M ☐ S
77	$0.00			☒ M ☐ S
78	$315.20			☐ M ☒ S
79	$111.20			☐ M ☒ S
80	$33.60			☐ M ☒ S
81	$21.00			☐ M ☒ S
83	$180.80			☐ M ☒ S
84	$39.00			☐ M ☒ S
85	$77.00			☐ M ☒ S
86	$682.00			☐ M ☒ S
89	$66.00			☒ M ☐ S
90	$72.00			☐ M ☒ S
93	$38.24			☒ M ☐ S
94	$1,237.46			☒ M ☐ S
95	$31.20			☐ M ☒ S
97	$90.00			☐ M ☒ S
98	$22.32			☒ M ☐ S
102	$908.80			☐ M ☒ S
104	$74.00			☐ M ☒ S
105	$61.00			☒ M ☐ S
106	$88.00			☒ M ☐ S

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
107	$19.10			☒ M ☐ S
108	$37.96			☒ M ☐ S
109	$506.40			☐ M ☒ S
110	$200.80			☐ M ☒ S
111	$24.87			☒ M ☐ S
112	$200.80			☒ M ☐ S
113	$107.20			☐ M ☒ S
114	$22.40			☐ M ☒ S
116	$0.00			☒ M ☐ S
117	$1,275.43			☐ M ☒ S
118	$77.00			☐ M ☒ S
119	$132.80			☐ M ☒ S
121	$0.00			☒ M ☐ S
122	$28.00			☒ M ☐ S
123	$0.00			☐ M ☒ S
124	$50.00			☐ M ☒ S
125	$90.00			☐ M ☒ S
126	$90.00			☐ M ☒ S
127	$16.00			☐ M ☒ S
128	$0.00			☐ M ☒ S
129	$43.00			☐ M ☒ S
130	$13.00			☐ M ☒ S
131	$74.00			☐ M ☒ S
132	$46.00			☐ M ☒ S
74	$5.99	Disagree. Claims xxxxxx4507 and xxxxxx4521 are not duplicate claims. The claims were submitted by different referring physicians and with different diagnosis codes.	Procedural deficiency and overpayment of $5.99 identified. There was one preventive visit from Dr. Gxxxx for 10/13/22. There were no visits billed by Dr. Kxxxxx in the first or second quarter data. Verification was not provided documenting these two providers ordered the same comprehensive metabolic panel for this member on the same day.	☒ M ☐ S
96	$4.40	Disagree. The claims are not duplicate, different diagnosis codes, and different referring physicians were billed.	Procedural deficiency and overpayment of $4.40 identified. There was a visit from Dr. Kxxx for 10/7/22. There were no visits billed by Mxx Bxxxx in the first or second quarter data. Verification was not provided documenting these two providers ordered the same glycated hemoglobin test for this member on the same day.	☒ M ☐ S
115	$208.60	Disagree. The member was seen in the ER for services on 11-3-2022. Sample claim xxxxxx67456 is the physicians claim and claim	Procedural deficiency and overpayment of $208.60 identified. Duplicate claims are from Dr. Sxxxx Wxxxx (claim numbers	☐ M ☒ S

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
		xxxxxx12977 from Renown Regional is the ER claim.	xxxxxx4265 and xxxxxx7456) the same laceration repair, procedure code 12015; place of service emerg room and outpt hosp. The member history documents an emergency room charge for this procedure only; there was no additional outpatient hospital visit for a laceration repair on this date of service.	
Plan Exclusions				
Marriage Counseling				
50	$40.00	Agree. The claim is Pended and reviewed based on Procedure and Diagnosis selections are coded in the UMR system to identify these claims. Marriage Counseling is excluded on this plan. Coding in the UMR system has been updated to deny all future claims billed with this type of diagnosis. This claim will be adjusted to deny, and an overpayment request will be sent to the provider. This results in a $40.00 overpayment. UMR will run impact report to adjust/review any claims related to Marriage Counseling.	Procedural deficiency and overpayment of $40.00 identified. Per page 94 of the plan document, marriage counseling was not covered by the plan.	☒ M ☐ S
Limitations				
Hearing Aids $1,500 Per Aid Per Ear Every 36 Months				
150	$3,000.00	Agree. Claim xxxxxx02248 is a duplicate to xxxxxx31247. xxxxxx02248 has been adjusted and an overpayment of $3,000.00 has been requested.	Procedural deficiency and overpayment of $3,000.00 identified. Duplicate payments were made, and the hearing aid limitation was exceeded.	☒ M ☐ S
Potential Fraud, Waste, and Abuse				
Specialty Medications				
35	$20,635.99	Agree. An incorrect allowance was provided on this claim from the Network team. Additional coaching has taken place and an additional quality review has been initiated. The allowable for code J0878 is $374.00. This results in a $20,635.99 overpayment. Claim xxxxxx37760 was adjusted on 3/29/2023.	Procedural deficiency and overpayment cited. The incorrect allowance for J0878 resulted in a $20,635.99 overpayment.	☒ M ☐ S
Large Payments to Subscribers				
36	$1,207.60	Agree. The CFR released payment to the member in error. Claim xxxxxx30978 was processed on 1/29/2023 and on 1/30/2023 was adjusted to issue payment to the provider. The overpayment was received on 3/30/2023.	Procedural deficiency and overpayment of $1,207.60 identified. Payment was issued to the member in error. Refund of overpayment received 3/30/23.	☒ M ☐ S
Durable Medical Equipment Over Medicare Allowance				
33	$329.20	Agree. Benefits are determined based on the billed services and the provider's contract for DME. Claims are reviewed based on services billed. Procedure and Diagnosis selections are	Procedural deficiency and overpayment of $329.20 identified. The incorrected allowed amount was paid for DME.	☒ M ☐ S

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
		coded in the UMR system to identify these claims. The CFR did not enter the correct allowed amount, based on provider contract. This claim was adjusted on 2/7/2023 and results in a $329.20 overpayment.		
Incorrect Copayment				
Diagnostic Mammogram				
16	($88.40)	Agree. The CFR did not apply the $40.00 outpatient diagnostic mammogram copay, then 100%. Additional coaching has taken place with the CFR. This results in a $88.40 underpayment. Claim was adjusted on 4/19/2023.	Procedural deficiency and underpayment of $88.40 identified. Per page 40 of the EPO plan document, diagnostic mammograms should have had a $40.00 copay applied then paid at 100%. The deductible was over accumulated by $100.00 and coinsurance by $28.40.	☒ M ☐ S
54	($97.19)	Agree. 77066 did not take a copay originally. The claim was adjusted on 2/9/2023 to add the copay per plan language. Claim was adjusted to apply a $40.00 copay on 2/9/2023.	Procedural deficiency and underpayment of $97.19 identified. The diagnostic mammogram should have had a $40.00 copay applied then 100%. The claim was corrected on 2/9/23.	☒ M ☐ S
Preventive Services				
Preventive Services Denied				
9	($440.00)	Disagree. This claim is for genetic testing. Only certain codes are preventive and S0265 is not. Authorization from the UM Vendor does not exist for code S0265. This claim denied correctly.	Procedural deficiency and underpayment of $440.00 identified. Services are for BRCA genetic counseling for member with family history of breast cancer and are payable under preventive benefits per page 58 of the plan document; and are under the recommended preventive benefits of USPSTF.	☒ M ☐ S
PPO Provider Without Discount				
69	$2,642.08	Agree. This provider participates with SHO. The claim was not routed to manual repricing. The claim was adjusted on 2/15/2023 to apply the repricing for this claim.	Procedural deficiency and overpayment of $2,642.08 identified. The provider discount was not applied to the claim. The claim was corrected on 2/15/23.	☒ M ☐ S
End Stage Renal Disease				
21	$113.16	Agree. Documentation from HSB. Dialysis started 05/18/18. Patient has Medicaid. UMR would be primary over Medicaid. Per employee dependent had other insurance Anthem as primary and that termed on 08/01/2022. UMR is third 07/01-31/22. Effective 08/01/2022 UMR is primary. Term date was confirmed with Anthem. This was paid in error. Overpaid $113.16- refund received 3/30/2023.	Procedural deficiency and overpayment of $113.16 identified. UMR was not primary until 8/1/22.	☒ M ☐ S

Additional Observations

During the Targeted Sample Analysis, CTI's auditor observed the following procedures or situations that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

Observation	Sample Number
Charges for psychotherapy to treat attention deficit hyperactivity disorder (ADHD) were paid by UMR. UMR and PEBP should work together to ensure benefits were applied appropriately and in accordance with the plan document.	48, 138, 139, and 140

RANDOM SAMPLE AUDIT

Objectives

The objectives of CTI's 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. UMR's performance was measured using the following key performance indicators:

- Financial Accuracy
- Claims Payment Accuracy
- Claims Processing Accuracy

We also measured claim turnaround time, a commonly relied upon performance measure.

Methodology

CTI's 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. CTI's auditors reviewed each sample claim selected to ensure it conformed to plan specifications, agreements, and negotiated discounts. We recorded the audit findings in CTI's 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 UMR 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 PEBB can discuss how to reduce errors and re-work in the future with UMR.**

CTI communicated with UMR in writing about any errors or observations using system-generated response forms. We sent UMR a preliminary report for its review and written response. We considered UMR's written response, as found in the Appendix, when producing the final reports. Note that the administrator responses have been copied directly from UMR'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 total paid in the 200-claim audit sample was $485,409.00. The claims sampled and reviewed revealed $1,152.61 in underpayments and $7,204.22 in overpayments, for an absolute value variance of $8,356.83. This reflects a weighted Financial Accuracy rate of 97.95% over the stratified sample. This is a decline in performance from the prior period. Detail is provided in the following Random Sample Findings Detail Report.

UMR did not meet the Performance Guarantee for PEBP in Q2 FY2023 of 99.4% for this measure. The penalty owed is 1.5% of the administrative fees of $1,292,524.65 or $19,387.87.

Claims Payment Accuracy

CTI defines Claims Payment Accuracy as the number of claims paid correctly compared to the total number of claims paid for the audit sample.

The audit sample revealed 6 incorrectly paid claims and 194 correctly paid claims. This is an improvement from the prior period. Detail is provided in the table below, Random Sample Findings Detail Report.

Total Claims	Incorrectly Paid Claims		Accuracy
	Underpaid Claims	Overpaid Claims	
200	3	3	97.0%

Overall Accuracy

CTI defines Overall Accuracy as the number of claims processed without errors compared to the total number of claims processed in the audit sample.

Although performance improved from the prior period, UMR did not meet the Performance Guarantee for PEBP in Q2 FY2023 of 98% for this measure. The penalty owed is 1.0% of the administrative fees of $1,292,524.65 or $12,925.25. Detail is provided in the table below, Random Sample Findings Detail Report.

Correctly Processed Claims	Incorrectly Processed Claims		Accuracy
	System	Manual	
194	0	6	97.0%

Random Sample Findings Detail Report				
Audit No.	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Denied Eligible Expense				
1060	($65.00)	Agree. There is a benefit on this claim for speech therapy. This claim will be adjusted and results in a $65.00 underpayment.	Adjudication error and underpayment of $65.00 identified for denial of eligible speech therapy charge.	☒ M ☐ S
1129	($673.61)	Agree. This claim denied based on the primary diagnosis billed which is not a valid diagnosis for the treatment. UMRs processing system flagged this claim to deny appropriately. There is other diagnosis on the claim in the 2nd, 3rd and 4th positions that would have allowed the service to be paid per the plan benefits. This claim will be adjusted to allow based on the other diagnosis on the claim. Claim xxxxxx60355 was adjusted 4/10/2023.	Adjudication error and underpayment of $673.61 identified. Eligible expenses for continued hospital care services were denied on this claim. There is an approved precertification on file for this inpatient stay and it should have been covered by the plan based on plan document page 35. Claim was corrected on 4/10/23.	☒ M ☐ S
PPO Discount				
1039	$5,783.09	Agree. The SHO allowed amount should be $1080. This results in a $5783.09 overpayment. Refund received 4/6/2023.	Adjudication error and overpayment of $5,783.09 identified. The discount amount was processed on the claim as $45,435.12 and it should have been $52,664.00.	☐ M ☐ S
1103	$1,366.99	Agree. This is a SHO contracted provider. UMR processed the claim with SHO pricing	Adjudication error and overpayment of $1,366.99 identified. The discount	☒ M ☐ S

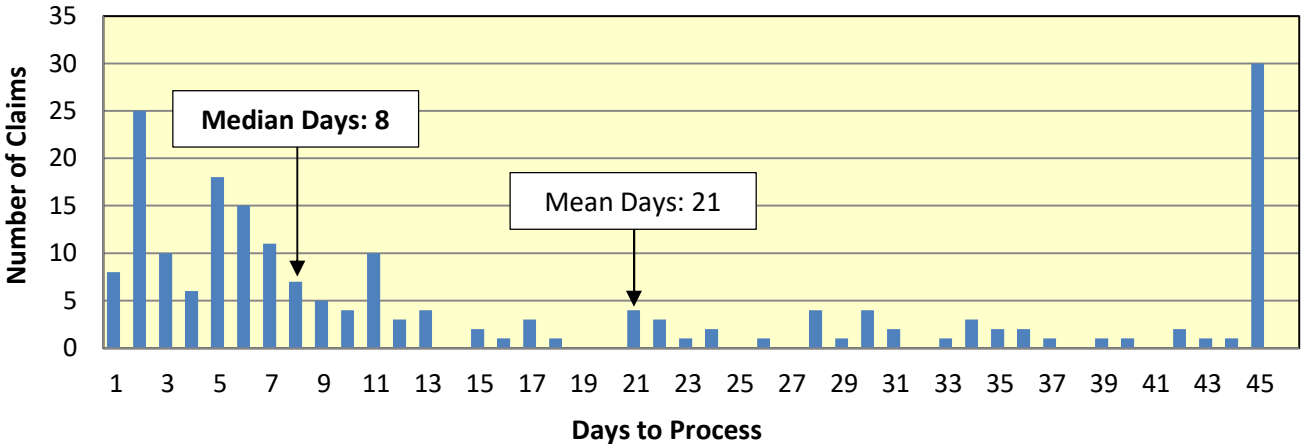
Random Sample Findings Detail Report				
Audit No.	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
		however code 70450 rev 350 was allowed at a percentage and should be at the per visit rate of $698.00. This results in a $1366.99 overpayment. Refund received 4/6/2023.	applied for revenue code 350 should have been $5,735.00.	
Copayment Calculation				
1134	($414.00)	Agree. A $30.00 copay should apply to each service. This results in a $414.00 underpayment. UMR will adjust this claim accordingly.	An adjudication error and underpayment of $414.00 identified. The copay should have been $30.00 per visit, and it was $0.00, with coinsurance applied. The plan states on page 40, a $30.00 copay per visit for applied behavioral therapy for the treatment of autism disorders from an in-network provider.	☒ M ☐ S
Duplicate Payment				
1114	$54.14	Agree. This is duplicate payment. The provider added a modifier to procedure code 90460 and rebilled. This change would not affect the payment. This results in a $54.14 overpayment on claim xxxxx1565. Refund received 4/3/2023.	Adjudication error and overpayment of $54.14 identified. A duplicate expense was paid.	☒ 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 a few claims with extended turnaround time from distorting the true performance picture.

Median and Mean Claim Turnaround



UMR met the Performance Guarantee for PEBP in Q2 FY2023 of 92% processed within 14 days. This is an improvement from the prior period. UMR did not meet the Performance Guarantee of 99% processed

within 30 days for this measure. The penalty owed for this Performance Guarantee is 1.0% of the administrative fees of $1,292,524.65 or $12,925.25.

Additional Observations

During the Random Sample Audit, CTI's auditor observed the following procedures or situations that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

Observation	Audit Number
Out-of-sample duplicate claim payments were identified for the sampled claims resulting in overpayments of $100.00 and $690.30, respectively.	1015 and 1059

DATA ANALYTICS

Medical Findings

This component of the audit used PEBP's 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 that calculating discounts in a consistent manner across CTI's book of business will allow for more meaningful comparisons to be made.

Scope

CTI compared submitted charges to allowable charges for 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

We were unable to calculate provider discounts for PEBP because UMR did not provide the data in their electronic claim data file.

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 other federal health care programs.

Scope

CTI received and converted an electronic data file containing every PEBP claim processed by UMR during the audit period. The claims screened included medical (not including prescription drug) and dental claims paid or denied during the audit period. Through electronic screening, we identified every claims in the audit universe that were non-facility claims, i.e., claims submitted by providers of service other than hospitals, nursing, or skilled care facilities, or durable medical equipment suppliers. These claims predominantly include physician and other medical professional claims.

Report

We screened 100% of non-facility claims against OIG's LEIE and identified the following provider as sanctioned. CTI's screening indicated the following provider received payment from the administrator during the audit period.

NPI	Exclusion Date	Reinstatement Date	Exclusion Type	Provider Name	Claim Count	Total Charged	Total Allowed	Total Paid
1104912278	20191219	N/A	1128a4	SHELBY,JAMES,S,DDS	1	$157	$157	$157
				Totals	**1**	**$157**	**$157**	**$157**

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 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. CTI's review analyzed in-network preventive care services to determine if UMR paid services in compliance with PPACA guidelines.

Scope

CTI's review included each in-network service 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%. CTI's 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.

CTI's 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.

Report

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 99.67% of the procedure codes identified as preventive services were paid by UMR at 100% when provided in-network. The following report provides an outline for discussion between PEBP and UMR.

Preventive Care Services Compliance Review												
		Claim Lines Submitted	Denied	Applied Deductible		Applied Copay		Applied Coinsurance		Paid @100%		
Edit Guideline	Preventive Service Benefit	#	#	#	Amount	#	Amount	#	Amount	#	Amount	%
HHS	Breastfeeding support and counseling - women	73	20	5	$1,102	3	$150	0	$0	43	$3,707	81.13%
USPSTF-A,B	Cholesterol abnormalities screening - women >19	701	54	26	$429	0	$0	27	$85	594	$8,112	91.81%
USPSTF-A	Cholesterol abnormalities screening - men 35-75	631	75	12	$179	0	$0	10	$27	533	$6,939	95.86%
USPSTF-B	Breast cancer mammography screening - >39	3,735	35	0	$0	0	$0	0	$0	3,699	$348,924	99.97%

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).

CTI's claim system code editing analysis identified services submitted to the plan and paid by UMR that Medicare and Medicaid would have denied. **Since UMR 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 UMR 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 every payer.

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. CTI's reports are grouped by outpatient hospital services and non-facility claims using CMS' quarterly updated data. If UMR is not currently using these CMS edits, CTI's reports will help PEBP evaluate the savings it 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	Amount
Code	Mod	Code	Mod	Mod Use			Count	CMS Would
74177	TC	96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	11	$6,690
					Standards of medical / surgical practice			
99213		99212		YES	Office/outpatient visit for E&M of estab patient, 2	Office/outpatient visit for E&M of estab pat	89	$5,788
					Misuse of column two code with column one code			
71275	TC	96374		YES	CT ANGIOGRAPHY CHEST	THER/PROPH/DIAG INJ IV PUSH	6	$4,568
					Standards of medical / surgical practice			
92526	GN	97530	GP	YES	ORAL FUNCTION THERAPY	THERAPEUTIC ACTIVITIES	6	$4,500
					Misuse of column two code with column one code			
70496		70450		YES	CT ANGIOGRAPHY HEAD	CT HEAD/BRAIN W/O DYE	1	$2,847
					Misuse of column two code with column one code			
92526	GN	97110	GP	YES	ORAL FUNCTION THERAPY	THERAPEUTIC EXERCISES	5	$2,256
					Misuse of column two code with column one code			
88173	TC	88333	TC	YES	CYTOPATH EVAL FNA REPORT	INTRAOP CYTO PATH CONSULT 1	2	$1,824
					CPT Manual or CMS manual coding instructions			
96374		96372		YES	THER/PROPH/DIAG INJ IV PUSH	THER/PROPH/DIAG INJ SC/IM	5	$1,738
					CPT Manual or CMS manual coding instructions			
70551	TC	70544	TC	YES	Mri brain stem w/o dye	MR ANGIOGRAPHY HEAD W/O DYE	1	$1,586
					Misuse of column two code with column one code			
90471		99283		YES	IMMUNIZATION ADMIN	EMERGENCY DEPT VISIT	1	$1,458
					CPT Manual or CMS manual coding instructions			
						Top 10 TOTAL	**127**	**$33,256**
						GRAND TOTAL	**369**	**$71,057**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)								
Primary		Secondary			Primary Description	Secondary Description	Line	Amount
Code	Mod	Code	Mod	Mod Use			Count	CMS Would
58552	79	44180	51,79,59	NO	LAPARO-VAG HYST INCL T/O	LAP ENTEROLYSIS	1	$698
					CPT "separate procedure" definition			
60650	LT	44180	51	NO	LAPAROSCOPY ADRENALECTOMY	LAP ENTEROLYSIS	1	$698
					CPT "separate procedure" definition			
93975		76700		YES	VASCULAR STUDY	US EXAM ABDOM COMPLETE	2	$658
					Misuse of column two code with column one code			
44626	58	44005	51	NO	REPAIR BOWEL OPENING	FREEING OF BOWEL ADHESION	1	$421
					CPT "separate procedure" definition			
70546		70551		YES	MR ANGIOGRAPH HEAD W/O&W/DYE	Mri brain stem w/o dye	1	$350
					Misuse of column two code with column one code			
99214	25	99354		NO	Office/outpatient visit for E&M of estab patient, 3	Prolonged service(s) in outpt setting requiri	2	$276
					CPT Manual or CMS manual coding instructions			
84481		84480		NO	FREE ASSAY (FT-3)	ASSAY TRIIODOTHYRONINE (T3)	14	$273
					More extensive procedure			
90461		99392	5	YES	IM ADMIN EACH ADDL COMPONENT	PREV VISIT EST AGE 1-4	1	$193
					CPT Manual or CMS manual coding instructions			
84439		84436		NO	ASSAY OF FREE THYROXINE	ASSAY OF TOTAL THYROXINE	19	$179
					More extensive procedure			
90460		99391	5	YES	IM ADMIN 1ST/ONLY COMPONENT	Per pm reeval est pat infant	1	$173
					CPT Manual or CMS manual coding instructions			
						Top 10 TOTAL	**43**	**$3,918**
						GRAND TOTAL	**127**	**$7,199**

Medically Unlikely Edits (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, and ancillary.

Note: UMR's Outpatient Hospital screening had no results.

Non-Facility (non-facility claims with CPT codes:00100 - 99999)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line count Exceeding Limit**	**Amount CMS Would Deny**
95165	30	ANTIGEN THERAPY SERVICES	15	$9,831
		Rationale: Clinical: Data		
J0475	8	BACLOFEN 10 MG INJECTION	2	$5,772
		Rationale: Prescribing Information		
88185	35	FLOWCYTOMETRY/TC ADD-ON	5	$5,605
		Rationale: Clinical: Data		
31295	1	Nasal/sinus endoscopy, surgical, w dilation (balloon dila	2	$3,427
		Rationale: CMS Policy		
97151	8	BEHAVIOR ID ASSESSMENT BY PHYS/QHP EA 15 MIN	2	$1,504
		Rationale: Clinical: CMS Workgroup		
97155	24	ADAPT BHV TX PRTCL MODIFICAJ PHYS/QHP EA 15 MIN	2	$1,470
		Rationale: Clinical: Society Comment		
30140	1	RESECT INFERIOR TURBINATE	6	$1,367
		Rationale: CMS Policy		
54512	1	EXCISE LESION TESTIS	1	$1,063
		Rationale: CMS Policy		
31267	1	ENDOSCOPY MAXILLARY SINUS	2	$831
		Rationale: CMS Policy		
97153	32	ADAPTIVE BEHAVIOR TX BY PROTOCOL TECH EA 15 MIN	1	$533
		Rationale: Clinical: Society Comment		
		Top 10 TOTAL	**38**	**$31,403**
		GRAND TOTAL	**83**	**$33,362**

Ancillary (All other claims not flagged Inpatient, Outpatient Hospital, or non-facility)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line count Exceeding Limit**	**Amount CMS Would Deny**
K0553	1	THER CGM SUPPLY ALLOWANCE	3	$2,925
		Rationale: Code Descriptor / CPT Instruction		
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	8	$842
		Rationale: Nature of Equipment		
E0443	1	PORTABLE 02 CONTENTS, GAS	3	$530
		Rationale: Code Descriptor / CPT Instruction		
V2510	2	CNTCT GAS PERMEABLE SPHERICL	4	$330
		Rationale: Anatomic Consideration		
V2520	2	CONTACT LENS HYDROPHILIC	3	$330
		Rationale: Anatomic Consideration		
A7032	6	REPLACEMENT NASAL CUSHION	2	$259
		Rationale: Published Contractor Policy		
A7520	1	TRACH/LARYN TUBE NON-CUFFED	1	$232
		Rationale: Published Contractor Policy		
A7046	1	REPL WATER CHAMBER, PAP DEV	5	$203
		Rationale: Published Contractor Policy		
A7038	6	POS AIRWAY PRESSURE FILTER	2	$146
		Rationale: Published Contractor Policy		
V2521	2	CNTCT LENS HYDROPHILIC TORIC	1	$110
		Rationale: Anatomic Consideration		
		Top 10 TOTAL	**32**	**$5,907**
		GRAND TOTAL	**39**	**$5,914**

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. CTI's analysis encompasses the three types of procedures with global surgical packages: simple, minor, and major. Each type has specific global periods including simple – one day, minor – ten days, and 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 the findings, we will help PEBP identify strategies to monitor and eliminate unbundling within PEBP's plan.

Audit Period 10/1/2022 - 12/31/2022									
	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	
Provider Id	Count	Allowed Charge	Count	% Surgeries with E/M Charges during Prohibited Global Fee Periods	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge
363261413	0	$0	1	100.0%	$2,613	1	$115	6	$2,142
770465765	8	$21,004	2	20.0%	$2,867	2	$747	1	$427
270028866	180	$129,938	61	25.3%	$10,622	49	$6,688	3	$413
455557052	2	$480	3	60.0%	$1,415	1	$172	2	$403
860800150	14	$31,585	3	17.6%	$3,208	1	$113	2	$287
956005449	2	$24	2	50.0%	$57	1	$88	1	$192
203395567	156	$36,182	11	6.6%	$2,827	8	$1,125	1	$190
20566741	32	$20,580	10	23.8%	$1,017	9	$1,414	1	$186
463758279	0	$0	1	100.0%	$263	0	$0	3	$150
880365656	22	$11,006	6	21.4%	$1,831	5	$687	1	$141
Top 10	**416**	**$250,798**	**100**	**19.4%**	**$26,719**	**77**	**$11,148**	**21**	**$4,532**
Overall Total	**5,038**	**$1,648,198**	**1,096**	**17.9%**	**$175,466**	**998**	**$108,195**	**25**	**$4,785**

CONCLUSION

UMR showed improvement in Overall Accuracy, Payment Accuracy, and Claim Turnaround Time from the Quarter 1 FY2023 audit; however, performance in Financial Accuracy declined from the prior period.

We consider it a privilege to have worked for, and with, the PEBP staff and its administrator. Thank you again for choosing CTI.

APPENDIX – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Additional information submitted to CTI from the administrator in response to the draft report is reviewed and observations may be removed prior to the final report being published. While a removed observation will not be included in the final report, it may be referenced in the administrator's response to the draft report.

UMR's response to the draft report follows:

Claim Technologies Incorporated
100 Court Avenue Suite 306
Des Moines, IA 50309

April 19, 2023

Joni,

Thank you for the opportunity to respond to the recent review of the State of Nevada Public Employees' Benefit Program Q2Y23 audit draft report.

Medical - ESAS Targeted Sample Analysis:

Duplicate Payments

QID 98 - UMR agrees with this error. This claim received a system edit for duplicate and the CFR bypassed the edit. Additional coaching has taken place with the CFR. This results in a $22.32 overpayment for on procedure CPT A7038. Claim [redacted] was adjusted on 2-3-2023.

QID 107-108 - UMR agrees with this error. This claim received a system edit for duplicate and the CFR bypassed the edit. Additional coaching has taken place with the CFR. This results in a $57.06 overpayment. Claim [redacted] was adjusted on 3-15-2023. QID 107 is the same claim number as QID 108.

QID 111-112 – UMR agrees with this finding. This claim received a system edit for duplicate and the CFR bypassed the edit. Additional coaching has taken place with the CFR. This results in a $24.87 overpayment on procedure CPT 87491. Claim [redacted] requires an adjustment. QID 111 is the same claim number as QID 112.

QID 25 – UMR disagrees with this finding. The provider of service did not mark this claim as a corrected claim and billed with two different TIN numbers. UMRs duplicate logic would not flag this claim as a duplicate.

QID 26 – UMR agrees with this finding. This claim received a system edit for duplicate and the Customer First Representative (CFR) bypassed the edit. Additional coaching has taken place with the CFR. This results in a $58.45 overpayment. Claim [redacted] was adjusted on 2-6-2023 and the overpayment was received on 3-23-2023.

QID 27 – UMR agrees with this finding. This claim received a system edit for duplicate and the CFR bypassed the edit. Additional coaching has taken place with the CFR. This results in a $11.42 overpayment. Claim [redacted] was adjusted on 2-6-2023 and the overpayment was received on 3-13-2023.

QID 28 – UMR agrees with this finding. Both claims were received on the same day which allowed them to pass through the UMR system with no duplicate edit. The claims were manually processed by a CFR and could have been identified as a duplicate. Additional training has been provided to the CFR. This results in a $193.70 overpayment. Claim [redacted] was adjusted on 2-6-2023.

715-841-7262 Julie.Frahm@UMR.com

QID 30 - UMR agrees with this finding. This claim was manually entered by the CFR. The CFR should have followed processing procedures to verify duplicate. Additional coaching has taken place with the CFR. This results in a $104.48 overpayment. Claim [redacted] was adjusted on 2-6-2023.

QID 74 and 96 – UMR disagrees with these findings. The claims in question were submitted by Lab Corp of American and each claim has different referring physicians and different diagnosis codes.

QID 75- 77 - UMR agrees with this finding. This claim received a system edit for duplicate and the CFR bypassed the edit. Additional coaching has taken place with the CFR. This results in a $314.64 overpayment. Claim [redacted] requires an adjustment. QID75 is the same claim number as QID 76 and QID 77.

QID 86 – UMR agrees with this finding. UMR received corrected claim with Medicare payments. CFR should have checked claim history and adjusted previously processed claim [redacted] as a duplicate. This results in a $682.00 overpayment. Claim [redacted] was adjusted on 3-7-2023.

QID 89 – UMR agrees with this finding. This claim received a system edit for duplicate and the CFR bypassed the edit. Additional coaching has taken place with the CFR. This results in a $66.00 overpayment. Claim [redacted] requires an adjustment.

QID 93-94 – UMR agrees with this finding. This claim received a system edit for duplicate and the CFR bypassed the edit. Additional coaching has taken place with the CFR. This results in a $11.42 overpayment. Claim [redacted] was adjusted on 2-6-2023 and the overpayment was received on 3-13-2023. QID 93 is the same claim number as QID 94.

QID 115 – UMR disagrees with this finding. The member was seen in the ER for services on 11-3-2022. Sample claim [redacted] is the physicians claim and claim [redacted] from Renown Regional is the ER claim.

Exclusions

Marriage Counseling QID 50 – UMR agrees with this finding. Marriage Counseling is excluded on this plan. Coding in the UMR system has been updated to deny all future claims billed with this type of diagnosis. Claim [redacted] was adjusted on 3-31-23. This results in a $40.00 overpayment.

Attention Deficit Hyperactivity Disorder

QID 48,138, 139, and 140 – UMR disagrees with this finding. Per the plan intent, attention deficit disorder is a covered diagnosis when treatment is related to the management of ADD/ADHD diagnosis and medication maintenance only. In addition, 90833 is psychotherapy that includes biofeedback and is allowed per the plan benefit.

Dental, Occlusal Guard

QID 44 – UMR disagrees with this finding. This claim is for the treatment of TMJ. This device was approved through the UM Vendor with auth [redacted].

Limitations

Hearing Aids -QID 150 – UMR agrees with this finding. There is a hearing aid limitation on this plan, and it was exceeded with the processing of this claim. UMR will provide additional coaching to the processing staff and review the procedures for tracking dollar maximums on the plan. This results in a $3000.00 overpayment. Claim [redacted] was adjusted on 2-21-2023.

715-841-7262 Julie.Frahm@UMR.com

Fraud, Waste, Abuse

Specialty Medications QID 35 – UMR agrees with this finding. An incorrect allowance was provided on this claim from the Network team. Additional coaching has taken place and an additional quality review has been initiated. The allowable for code J0878 is $374.00. This results in a $20,635.99 overpayment. Claim [redacted] was adjusted on 3-29-2023.

Large Payments to Subscribers – QID 36 – UMR disagrees with this finding. The CFR released payment to the member in error. Claim [redacted] was processed on 1-29-2023 and on 1-30-2023 was adjusted to issue payment to the provider. The overpayment was received on 3-30-2023.

Durable Medical Equipment Over Medicare Allowance

QID 33 - UMR agrees with this finding. An incorrect allowance was provided on this claim from the Network team. Additional coaching has taken place and an additional quality review has been initiated. This results in a $329.20 overpayment. Claim [redacted] was adjusted on 2-7-2023.

Incorrect Copayment

Diagnostic Mammogram

QID 16 – UMR agrees with this finding. The CFR did not apply the $40.00 outpatient diagnostic mammogram copay, then 100%. Additional coaching has taken place with the CFR. This results in a $88.40 underpayment. Claim [redacted] was adjusted on 4-19-2023.

QID 54 – UMR agrees with this finding. The CFR did not apply the $40.00 diagnostic mammogram copay, then 100%. Additional coaching has taken place with the CFR. This results in a $97.19 underpayment. Claim [redacted] was adjusted on 2-9-2023.

Speech Therapy

QID 17 – UMR disagrees with this finding. Per the plan benefits, a $40.00 copay for therapy applies one copay per day, not per service. This member had two therapy services on the same day. The copay applied to claim [redacted].

Preventive Services

Preventive Services Denied

QID 9 – UMR disagrees with this finding. This claim is for genetic testing. Only certain codes are preventive and S0265 is not. Authorization from the UM Vendor does not exist for code S0265. This claim denied correctly.

PPO Provider without Discount

QID 69 – UMR agrees with this finding. The CFR processed this claim without routing to the pricing team for a discount. Additional coaching has taken place. This results in a $2642.08 overpayment. Claim [redacted] was adjusted on 2-15-2023 and the overpayment was received on 3-23-2023.

End Stage Renal Disease

QID 21 – UMR agrees with this finding. The CFR processed this claim as primary and should have denied the claim for a primary carrier explanation of benefits. This results in a $113.16 overpayment. Claim [redacted] was adjusted on 2-1-2023 and the overpayment was received on 3-30-2023.

715-841-7262 Julie.Frahm@UMR.com

Dental - ESAS Targeted Sample Analysis:

Duplicate Payments

QID 70- UMR disagrees with this finding. The provider of service billed two claims with different billed amounts and was not noted as a corrected claim. The claims did not flag for duplicate for this reason. There is a $37.50 overpayment on claim [redacted].

QID 71-73 – UMR disagree with this finding. This is not a duplicate payment as the provider billed two separate claims with different tax ID numbers. The claim did not flag for duplicate as the provider TINs do not match. The provider will need to submit a corrected claim. QID 71 is the same claim number as QID 73.

QID 72 – UMR agrees with this finding. Code D2150 should not have allowed twice. This results in a $163.20 overpayment. The claim was adjusted on 3-23-2023.

QID 78 UMR disagrees with this finding. The provider of service billed two claims with different billed amounts and was not flagged as a corrected claim. The claims did not flag for duplicate for this reason. There is a $315.20 overpayment on claim [redacted]. The claim was adjusted on 2-6-2023 and the overpayment was received on 3-6-2023.

QID 79 UMR disagrees with this finding. The provider of service billed two claims with different billed amounts and was not flagged as a corrected claim. The claims did not flag for duplicate for this reason. There is a $111.20 overpayment on claim [redacted]. The claim was adjusted on 2-13-2023 and the overpayment was received on 3-16-2023.

QID 80-81, 83, 102 - UMR disagrees with this finding. The provider of service billed two claims with different billed amounts and was not flagged as a corrected claim. The provider will need to submit a corrected claim to determine duplicate and payment amounts. QID 80 is the same claim number as QID 81.

QID 84-85- UMR disagrees with this finding. The provider of service billed two claims with different billed amounts and was not flagged as a corrected claim. The claims did not flag for duplicate for this reason. There is a $116.00 overpayment on claim [redacted]. The claim was adjusted on 2-16-2023 and the overpayment was received on 3-20-2023. QID 84 is the same claim number as QID 85.

QID 90 - UMR disagrees with this finding. The provider of service billed two claims with different billed amounts and was not flagged as a corrected claim. The claims did not flag for duplicate for this reason. There is a $72.00 overpayment on claim [redacted]. The claim was adjusted on 2-9-2023 and the overpayment was received on 3-14-2023.

QID 95 – UMR disagrees with this finding. The provider of service billed two claims with different billed amounts and was not flagged as a corrected claim. The claims did not flag for duplicate for this reason. There is a $31.20 overpayment on claim [redacted]. The claim was adjusted on 3-20-2023.

QID 97 – UMR disagrees with this finding. The provider of service billed two claims with different billed amounts and was not flagged as a corrected claim. The claims did not flag for duplicate for this reason. There is a $90.00 overpayment on claim [redacted]. The claim was adjusted on 2-10-2023.

QID 104-106 – UMR disagrees with this finding. The provider of service billed two claims with different billed amounts and was not flagged as a corrected claim. The claims did not flag for duplicate for this reason. There is a $223.00 overpayment on claim [redacted]. The claim was adjusted on 2-16-2023 and the overpayment was received on 3-20-2023. QID 104 is the same claim number as QID 105 and QID 106.

715-841-7262 Julie.Frahm@UMR.com

QID 109-110 – UMR agrees with this finding. This was a manual processing error. Additional coaching has taken place with the CFR. This results in a $707.20 overpayment. Claim [redacted] was adjusted on 2-9-2023 and the overpayment was received on 3-14-2023. QID 109 is the same claim number as QID 110.

QID 127-129 – UMR disagrees with this finding. The provider of service billed two claims with different billed amounts and was not flagged as a corrected claim. The claims did not flag for duplicate for this reason. There is a $59.00 overpayment on claim [redacted]. The claim was adjusted on 2-13-2023 and the overpayment was received on 3-23-2023. QID 127 is the same claim number as QID 128 and QID 129.

Medical Random -Denied Eligible Expense

Sample 1060 – UMR agrees with this finding. This claim denied for speech therapy and should have allowed. This results in a $65.00 underpayment. The claim was adjusted on 2-13-2023. An impact report was reviewed and identified 264 additional claims requiring adjustment. The adjustments are in progress.

Sample 1129 – UMR disagrees with this finding. This claim denied based on the primary diagnosis billed which is not a valid diagnosis for the treatment. UMRs processing system flagged this claim to deny appropriately. There is other diagnosis on the claim in the 2nd, 3rd and 4th positions that would have allowed the service to be paid per the plan benefits. This claim will be adjusted to allow based on the other diagnosis on the claim. Claim [redacted] was adjusted 4-10-2023.

Medical Random - PPO discount

Sample 1039 - UMR agrees with this finding. This is the result of the CFR keying an incorrect discount amount of $45,435.12 at the time of processing. The correct pricing discount is $52,664.00. Additional coaching has taken place with the CFR. This results in a $5,783.09 overpayment. Claim [redacted] was adjusted on 3-6-2023 and the overpayment was received on 4-6-2023.

Sample 1103 – UMR agrees with this finding. This was the result of incorrect manual pricing by the MRU manual repricing analyst. Code 70450 should have been allowed at a per visit rate and not the percentage rate. The allowable should have been $698 versus the $2064.99. Additional coaching has taken place with the analyst. This results in a $1366.99 overpayment. Claim [redacted] was adjusted on 3-3-2023 and the overpayment was received on 4-6-2023.

Medical Random - Copayment Calculation

Sample 1134 – UMR agrees with this finding. A $30.00 copay and coinsurance should have applied per visit and UMR applied $0.00. Additional training and coding updates have been made for medical PC office visits. This results in $414.00 underpayment. Claim [redacted] was adjusted on 3-23-2023.

Medical Random - Duplicate Payment

Sample 1114 – UMR agrees with this finding. This is the result of the CFR overriding the duplicate logic in the system and not following system edits. Services 90460 and 90461 should have been denied a duplicate to a previously processed claim. Additional training has taken place with the CFR. This results in a $54.14 overpayment. Claim [redacted] was adjusted on 3-1-2023 and the overpayment was received on 4-3-2023.

715-841-7262 Julie.Frahm@UMR.com

Dental Random - Dollar Limit Maximum Exceeded

Sample 2007 – UMR disagrees with this finding. Dental code D0270 is a preventative and diagnostic service that can be done on the same day as other non-preventative services and does not apply to the $1500.00 annual maximum.

UMR is dedicated to improving the overall experience for the State of Nevada PEBP members and will work diligently on addressing any items during this review. If you have any questions or concerns regarding our responses, please feel free to contact me at 715-841-7262.

Sincerely,

Julie Frahm
SR. External/Regulatory Audit Coordinator
UMR External Audit Department

CLAIM TECHNOLOGIES
INCORPORATED

100 Court Avenue – Suite 306 • Des Moines, IA 50309
(515) 244-7322 • claimtechnologies.com