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**CELESTENA GLOVER**
*Executive Officer*

**JACK ROBB**
*Board Chair*

**Date:** December 7, 2023

**Item Number:** 8

**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 are separate from the Random Sample Audit results. The tables below illustrate additional penalties being assessed by PEBP for unmet performance guarantees not under in the fourth quarter (Q4) 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 the exceptions noted in the audited performance guarantees, there were four (4) guarantees reported to be "Not Met" with penalties calculated against total fees of $1,294,358.40:

| Performance Guarantee | Result | Fees at Risk | Calculated Penalty |
|---|---|---|---|
| 1.4 Claim Adjustment Processing Time | NOT MET | 1.0% | $12,943.58 |
| 1.7 First Call Resolution Rate | NOT MET | 2.0% | $25,887.17 |
| 1.8 Open Inquiry Closure | NOT MET | 1.0% | $12,943.58 |
| 1.9 CSR Audit | NOT MET | 1.0% | $12,943.58 |
| **Total** | | **5.0%** | **$64,717.92** |

*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 $666,118.80:

UMR Performance Guarantees Summary
December 7, 2023

| Performance Guarantee | Result | Fees at Risk | Calculated Penalty |
|---|---|---|---|
| 2.5 Provider Directory | NOT MET | 0.5% | $3,330.59 |
| **Total** | | | **$3,330.59** |

*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 were no missed performance guarantees for this period.

*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 | $64,717.92 |
| 2. Network Administration | $3,330.59 |
| 3. Utilization Management and Case Management | $0.00 |
| **Total** | **$68,048.51** |

The penalties, totaling $68,048.51, are administratively and automatically assessed by PEBP to the vendor. In conjunction with the audited penalties totaling $25,887.16, the calculated penalties for the period ending 06/30/2023 total **$93,935.67.**

Comprehensive Claim Administration Audit

# QUARTERLY FINDINGS REPORT and Annual Operational Review

## State of Nevada Public Employees' Benefits Program Plans

## Administered by UMR Insurance Company

**Audit Period: April 1, 2023 – June 30, 2023**
**Audit Number 1.FY23.Q4**

**Presented to**

**State of Nevada Public Employees' Benefits Program**

**December 7, 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' Benefits Program (PEBP) medical and dental plans.

## Scope

CTI performed an audit for the period of April 1, 2023 through June 30, 2023 (quarter 4 (Q4) for Fiscal Year (FY) 2023). The population of claims and amount paid during the audit period reported by UMR Benefits:

| **Medical and Dental** | |
|---|---|
| **Total Paid Amount** | $56,874,977 |
| **Total Number of Claims Paid/Denied/Adjusted** | 187,729 |

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

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

## Auditor's Opinion

Based on these findings, and in our opinion:

1. UMR's Financial Accuracy and Overall Accuracy improved in Q4 FY2023, both performance guarantees were met, and no penalty is owed. Claim turnaround time performance decreased in Q4 and a penalty of 2% of administrative fees is owed.
2. CTI Recommends UMR should:
    - Review the financial errors identified in our 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.
    - 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 met the Financial Accuracy and Overall Accuracy measurements, but did not meet the Claim Turnaround Time measurements for PEBP in Q4 FY2023 and penalties are owed. Reported administrative fees for the quarter totaled $2,447,881.20.

| Quarterly Metric | Guarantee | Met/Not Met | Penalty | Calculated Penalty |
|---|---|---|---|---|
| **Financial Accuracy (p.15)** | 99.4% | Met - 99.45% | NA | $0 |
| **Overall Accuracy (p. 16)** | 98.0% | Met – 98.5% | NA | $0 |
| **Claim Turnaround Time (p. 17)** | 92% in 14 Days<br>99% in 30 Days | Not Met – 90.5%<br>Not Met – 95.9% | 1%<br>1% | $24,478.81<br>$24,478.81 |
| | | **Total Penalty** | 2% | $48,957.62 |

## AUDIT OBJECTIVES

This report contains CTI's findings from our audit of UMR Insurance Company's (UMR) administration of the State of Nevada Public Employees' Benefits Program (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 our audit findings on the data and information provided by PEBP and UMR. The validity of our 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 all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

The objectives of CTI's audit of 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.

# ANNUAL OPERATIONAL REVIEW

## Objective

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

## Scope

The scope of the Operational Review included:

- Claim administrator information
  - Insurance and bonding
  - Conflicts of interest
  - Financial reporting
  - Business continuity planning
  - Claim payment system and coding protocols
  - Data and system security
- Claim funding:
  - Claim funding mechanism
  - Check processing and security
  - Large claim payment process
- Claim adjudication, customer service, and eligibility maintenance procedures:
  - Exception claim processing
  - Eligibility maintenance and investigation
  - Other insurance coverage and adjudication
  - Overpayment recovery
  - Network utilization
  - Utilization review, case management, and disease management
  - Subrogation and other third-party liability
  - Appeals processing
- HIPAA compliance

## Methodology

CTI used an Operational Review Questionnaire to gather information from UMR. We modeled our questionnaire after the audit tool used by certified public accounting firms when conducting a Statement on Standards for Attestation Engagements (SSAE) 18 audit of a service administrator. This attestation was developed to assesses controls at service organizations and includes the framework for SOC 2 reports, which evaluate the security, availability, processing integrity, confidentiality, and privacy of data and systems at a service organization. We modified that tool to elicit information specific to the administration of your plans.

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

## Findings

We observed the following from UMR's response to the operational review questionnaire:

- UMR provided the following insurance coverage information:

| Coverage | Amount |
|---|---|
| **Errors and Omissions** | $10,000,000 |
| **Crime** | $5,000,000 |
| **General Liability** | $10,000,000 |

- UMR was audited by Baker Tilly, for compliance with the standards of the American Institute of Certified Public Accountants through the issuance of a Service Organization Controls (SOC) 1 Report. Under the SOC 1, the administrator was required to provide a description of its system and controls, which the service auditor validated. CTI received a copy of the report for the period of January 1, 2022 to December 31, 2022. A bridge letter dated July 17, 2023 was also provided noting no material changes were made to internal controls. UMR indicated a copy of the SOC 1 report and bridge letter was also provided to PEBP.
- UMR stated it had incorporated all CMS National Correct Coding Initiative edits into their unbundling software.
- High dollar claims billed over $25,000 were processed by the large dollar claim team. Bill audit review was conducted if the allowed amount exceeded $80,000. PEBP received a large dollar notification when allowed amount was in excess of $100,000.
- UMR batched provider payments and issued payments to providers twice weekly for PEBP claim payments.
- UMR reported it honored assignment of benefits for non-network providers which allowed non-network providers to receive payment directly from UMR versus having to pay the member who would then have to pay the non-network provider. This is a best practice.
- UMR had adequately documented training, workflow, procedures, and systems.
- UMR received daily eligibility files; all changes, additions and terminations were processed daily by UMR.
- Verification of initial or continued coordination of benefits (COB) by UMR was not required by PEBP. When UMR was the secondary payor, it would never pay more than its total allowable amount. UMR did not provide a copy of a report showing COB savings for the PEBP plans for FY2023.
- UMR reported 92.72% of claims were received electronically during the audit period and 61.55% of claims received were auto adjudicated.
- UMR reported it had a $100.00 minimum dollar threshold to recoup an overpayment and could automatically recoup a refund from the next payment made to the same provider. UMR reported

it used vendors to perform overpayment recovery. An overpayment recovery report was not provided to CTI for FY2023.

- UMR used the OnBase appeal tracking system. UMR leadership monitored tracking daily to ensure timely responses to member appeals. UMR did not provide a member appeal tracking report to CTI for FY2023.
- UMR created system edits, developed review procedures, and provided special training to its claim professionals to help identify potential fraudulent situations.
- UMR used state websites to identify sanctioned or indicted providers; and indicated it did not make use of the Office of Inspector General's List of Excluded Individuals/Entities to identify sanctioned providers.
- UMR reported it received 92.31% of PEBP's claims and 95.46% of eligible charges from in-network providers. To help drive additional provider savings, UMR participated in programs such as Doctors on Demand, and Centers of Excellence for transplant care.
- UMR put policies and procedures in place to comply with the Transparency in Coverage Act (No Surprises Billing) that became effective January 1, 2022. UMR reported eight appeals and six inquiries received for the allowances made for out-of-network services. Five appeals and four inquiries were overturned.
- The UnitedHealthcare privacy office developed and implemented HIPAA compliance training. All new employees were required to complete HIPAA training and all employees were required to complete the training annually. UMR reported no breeches during the audit period.

# QUARTERLY PERFORMANCE GUARANTEE VALIDATION

As part of CTI's quarterly audit of PEBP, we reviewed the Performance Guarantees included in its contract with UMR. The results for Q4 FY2023 follow.

| | 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%<br>7 Calendar/ 5 Business Days | 92.50% | 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%<br>Calls answered within 30 seconds | 94.30% | 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% | 0.60% | 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% | 91.20% | 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%<br>48 Hours<br>98.00%<br>5 Business Days | 93.80%<br><br>94.30% | Met<br><br>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% | 95.40% | 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%<br>Within 24 Hours | 92.59% | Met |
| 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%<br>Within 8 Hours<br>95.00%<br>Within 24 Hours | 100%<br><br>100% | Met<br><br>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% | 97.35% | Met |
| 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 | Agree | 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. | | | |
| | 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.). | | | |

| | Metric | Service Objective | Actual | Met/ Not Met |
|---|---|---|---|---|
| | 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): | | 5 | |
| 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%<br>2 Business Days | 100% | 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%<br>10 Business Days | No custom reports requested | Met |
| 1.17 | **ID Card Production and Distribution** | 100%<br>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%<br>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%<br>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%<br>3 Business Days<br>99.00%<br>5 Business Days | 99.50%<br>99.50% | Met<br>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% | 98.30% | 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%<br>10 Business Days | No custom reports requested | Met |
| 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% | 100% | Met |
| 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%<br>10 Business Days | 0%<br>0/1 complaints | 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 |

| | Metric | Service Objective | Actual | Met/ Not 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%<br>10 Calendar Days | No custom reports requested | 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%<br>5 Business Days | 100% | 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%<br>5 Business Days | 99.99% | Met |
| 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%<br>2 Business Days | 100% | Met |
| 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%<br>5 Business Days | 100% | Met |
| 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%<br>3 Business Days | 97.7% | Met |
| 3.9 | **Large Case Management:** CM will identify and initiate case management for chronic disease, high dollar claims, and ER usage. | 95.00% | 100% | Met |
| 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% | 100% | Met |
| 3.11 | **Return On Investment (ROI) Guarantee – Utilization Management/Case Management:** 2:1 Savings to Fees for Utilization Management/Case Management. | 100% | 100% | Met |
| 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%<br>60 Calendar Days | 100% | 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%<br>60 Calendar Days | 100% | Met |

# 100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

## Objective

CTI's Electronic Screening and Analysis System (ESAS®) software identified and quantified potential claim administration payment errors. PEBP and 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 our findings. We screened the following high-level ESAS categories to identify potential amounts at risk:

- Duplicate payments to providers and/or employees
- Plan exclusions and limitations
- Patient cost share
- Fraud, waste, and abuse
- Timely filing
- Coordination of benefits
- Large claim review
- Case and disease management

## Methodology

We used ESAS to analyze claim payment and eligibility maintenance 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. Our 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 our ESAS process:

- ***Electronic Screening Parameters Set*** – We used your plan document provisions to set the parameters in ESAS.
- ***Data Conversion*** – We converted and validated your claim data, reconciled it against control totals, and checked it for reasonableness.
- ***Electronic Screening*** – We systematically screened 100% of the service lines processed and flagged claims not administered according to plan parameters.
- ***Auditor Analysis*** – If claims within an ESAS screening category represented a material amount, our auditors analyzed the findings to confirm results were valid. Note using ESAS could lead to false positives if there was incomplete claim data. CTI auditors made every effort to identify and remove false positives.
- ***Targeted Sample Analysis*** – From the categories identified with material amounts at risk, we selected the best examples of potential under- or overpayments to test. As cases were not randomly selected, we did not extrapolate results. We selected 50 cases and sent your administrator a questionnaire for each. Targeted samples verified if the claim data supported our finding and if our understanding of plan provisions matched 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.
- ***Eligibility Verification of Every Claim by Date of Service*** – We used ESAS to compare service dates against the eligibility periods provided to us by the eligibility vendor Lifeworks (now TELUS Health) to look for claims paid for ineligible members.

## Findings

We are confident in the accuracy of our 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 ESAS Findings Detail Report shows by category the line items where exceptions were noted. PEBP should work with its TPA, UMR, to examine areas of concern. A CTI auditor reviewed UMR's responses and supporting documentation. The administrator responses shown in the ESAS Detail Findings Report on the following pages 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 PEBP can discuss how to reduce errors and re-work in the future with UMR.**

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.

| ESAS Findings Detail Report | | | | |
|---|---|---|---|---|
| **QID** | **Under/ Over Paid** | **UMR Response** | **CTI Conclusion** | **Manual or System** |
| **Duplicate Payments** | | | | |
| 29 | $89.59 | Agree. UMR agrees to 13 duplicate payment errors. We continue to work on upgrades to our duplicate logic system. | Procedural deficiency and overpayment remain. UMR paid duplicate charges. | ☒ M ☐ S |
| 30 | $72.50 | | | ☒ M ☐ S |
| 31 | $140.00 | | | ☒ M ☐ S |
| 33 | $359.36 | | | ☒ M ☐ S |
| 34 | $93.00 | | | ☐ M ☒ S |
| 36 | $188.52 | | | ☐ M ☒ S |
| 37 | $119.95 | | | ☐ M ☒ S |
| 38 | $79.33 | | | ☒ M ☐ S |
| 39 | $89.59 | | | ☐ M ☒ S |
| 40 | $21.91 | | | ☒ M ☐ S |
| 41 | $25.00 | | | ☐ M ☒ S |
| 42 | $212.40 | | | ☒ M ☐ S |
| 43 | $2,521.00 | | | ☐ M ☒ S |

| ESAS Findings Detail Report | | | | |
|---|---|---|---|---|
| **QID** | **Under/ Over Paid** | **UMR Response** | **CTI Conclusion** | **Manual or System** |
| **Plan Exclusions** | | | | |
| **Attention Deficit Disorder (Hyperkinetic)** | | | | |
| 26 | $63.75 | Agree. The claim is reviewed to see if additional diagnosis billed in addition to ADHD. If not, as such, we request a treatment plan. A treatment plan was requested, but not received prior to claim payment. | Procedural deficiency and overpayments remain. A treatment plan was not approved prior to payment of psychotherapy for treatment of ADHD. | ☒ M ☐ S |
| **Plan Limitations** | | | | |
| **Chiropractic Care 20 Visits per Plan Year** | | | | |
| 47 | $48.00 | Agree. System was manually overridden to allow additional services. These were manual overrides and the claim processors have been identified and coached. | Procedural deficiency and overpayments remain. The chiropractic plan limitation of 20 visits per plan year was exceeded. | ☒ M ☐ S |
| 48 | $20.00 | | | ☒ M ☐ S |
| **Bitewing X-Rays 2 per Year** | | | | |
| 49 | $19.00 | Agree. The plan limitation of bitewing x-rays twice per plan year was exceeded. | Procedural deficiency and overpayments remain. The bitewing x-ray plan limitation of twice per plan year was exceeded. | ☒ M ☐ S |
| 50 | $40.00 | | | ☐ M ☒ S |
| **Potential Fraud, Waste, and Abuse** | | | | |
| **Medical Equipment Over Medicare Allowance** | | | | |
| 21 | $3,185.07 | Agree to error. Correct pricing was not used. | Procedural deficiency and overpayments remain. Billed charges were allowed instead of the correct allowable of $86.94. | ☒ M ☐ S |
| **Specialty Medication (Non Hospital)** | | | | |
| 22 | $4,968.50 | Agree. Specialty medication claims pend to the CFR. AWP -12% for this contract. Pricing now has a Call Track for this claim. | Procedural deficiency and overpayments remain. Claim line paid billed charges instead of the contract rate of $73.92. | ☒ M ☐ S |
| **Copay Application** | | | | |
| **Acupuncture** | | | | |
| 5 | $20.00 | Agree. Acupuncture takes a $50.00 copay not the family medicine copay of $30.00. | Procedural deficiency and overpayment remain. Services were for acupuncture; the plan document states copay for acupuncture is $50.00, only $30.00 was applied. | ☒ M ☐ S |
| **Diagnostic Mammography** | | | | |
| 11 | $40.00 | Agree. Diagnostic mammograms are subject to a $40.00 copay. | Procedural deficiency and overpayment remain. The EPO plan has a $40.00 copay for diagnostic mammography, and $0.00 was applied. | ☒ M ☐ S |
| **Case Management** | | | | |
| 16 | NA | Agree. Services were performed outpatient. There was no hospital admission to prompt that Case Management was needed. SHO will open an OPCM case for this member now and attempt outreach. | Procedural deficiency remains. Case management should have been initiated as well as reported to PEBP for high expense case. Claims for MS exceeded $126,000 for this member. | ☒ M ☐ S |

| ESAS Findings Detail Report | | | | |
|---|---|---|---|---|
| **QID** | **Under/ Over Paid** | **UMR Response** | **CTI Conclusion** | **Manual or System** |
| **PPO Provider Without Discount** | | | | |
| 18 | $214.30 | Agree. ER claim checked UHC Choice pricing. Pricing group states claim was not repriced by UHC Choice Plus when it was received. It was not routed out and it wasn't sent manually for repricing. The hospital is in-network with Choice Plus and the claim could have been repriced at 95% of the amount billed which would have been $17,111.12. | Procedural deficiency and overpayment remain. The provider discount of 5% was not applied; the entire claim was overpaid by $900.59. | ☒ M ☐ S |
| 20 | $1,125.25 | Agree. Claims were not routed for pricing. | Procedural deficiency and overpayment remain. Claim paid without provider discount. | ☒ M ☐ S |
| **Preventive Services** | | | | |
| **With Coinsurance Applied** | | | | |
| 3 | ($7.49) | Agree. CPT 99392 should have paid 100% of the allowed amount. | Procedural deficiency and underpayment remain. The charge should have been paid at 100% of the allowed amount under the preventive benefit. | ☒ M ☐ S |

**Annual Eligibility Verification**

CTI electronically compared dates of service for FY2023 Q1 through Q4 and PEBP's electronic eligibility file received from TELUS Health. The screening revealed that some services were paid during the audit period for potentially ineligible claimants. The output was provided to TELUS Health for their review and comment. At this time, potentially overpaid amounts have been flagged into one of the following categories:

| Employee Eligibility Screening Subcategory | Amount Paid |
|---|---|
| No Identification Match to Any Eligible Employee | $10,289 |
| Payments Prior to Effective Date | $87,134 |
| Payments During Gaps in Coverage | $17,285 |
| After Termination Date of Employee's Coverage | $46,434 |
| Subtotal | $161,142 |
| **Dependent Eligibility Screening Subcategory** | **Amount Paid** |
| No Identification Match to Any Eligible Employee | $331,004 |
| Payments Prior to Effective Date | $20,530 |
| Payments During Gaps in Coverage | 1,795 |
| After Termination Date of Employee's Coverage | $49,292 |
| Subtotal | $402,621 |
| **COMBINED TOTAL*** | **$563,763** |

**CTI notes that 0.30% of the PEBP's total medical expense processed by UMR was identified as paid for members who may not have been eligible for coverage. These results are normal compared to the less than 1% CTI generally reports.*

# RANDOM SAMPLE AUDIT

## Objectives

The objectives of our Random Sample Audit were to determine if medical and dental claims were paid according to plan specifications and the administrative agreement, to measure and benchmark process quality, and to prioritize areas of administrative deficiency for further review and remediation.

## Scope

CTI's statistically valid Random Sample Audit included a stratified random sample of 200 paid or denied claims. UMR's performance was measured using the following key performance indicators:

- Financial Accuracy
- Claims Payment Accuracy
- Overall Accuracy

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

## Methodology

Our Random Sample Audit ensures a high degree of consistency in methodology and is based upon the principles of statistical process control with a management philosophy of continuous quality improvement. Our auditors reviewed each sample claim selected to ensure it conformed to plan specifications, agreements, and negotiated discounts. We recorded our findings in our proprietary audit system.

When applicable, we cited claim payment and processing errors identified by comparing the way a selected claim was paid and the information 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 PEBP 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 our 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 $778,628.37. The claims sampled and reviewed revealed $2,002.96 in underpayments and no overpayments. This reflects a weighted Financial Accuracy rate of 99.45% over the stratified sample. This is an improvement in performance from the prior periods. Detail is provided in the following table, Random Sample Findings Detail Report.

UMR met the Performance Guarantee for PEBP in Q4 FY2023 of 99.4% for this measure. No penalty is owed.

**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 4 incorrectly paid claims and 196 correctly paid claims. This is an improvement in performance from the prior period. Detail is provided in the table below, Random Sample Findings Detail Report.

| Total Claims | Incorrectly Paid Claims | | Frequency |
|---|---|---|---|
| | Underpaid Claims | Overpaid Claims | |
| 200 | 4 | 0 | 98.0% |

**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.

Performance improved from the prior periods. UMR met the Performance Guarantee for PEBP in Q4 FY2023 of 98% for this measure. No penalty is owed. Detail is provided in the table below, Random Sample Findings Detail Report.

| Correctly Processed Claims | Incorrectly Processed Claims | | Frequency |
|---|---|---|---|
| | System | Manual | |
| 196 | 4 | 0 | 98.0% |

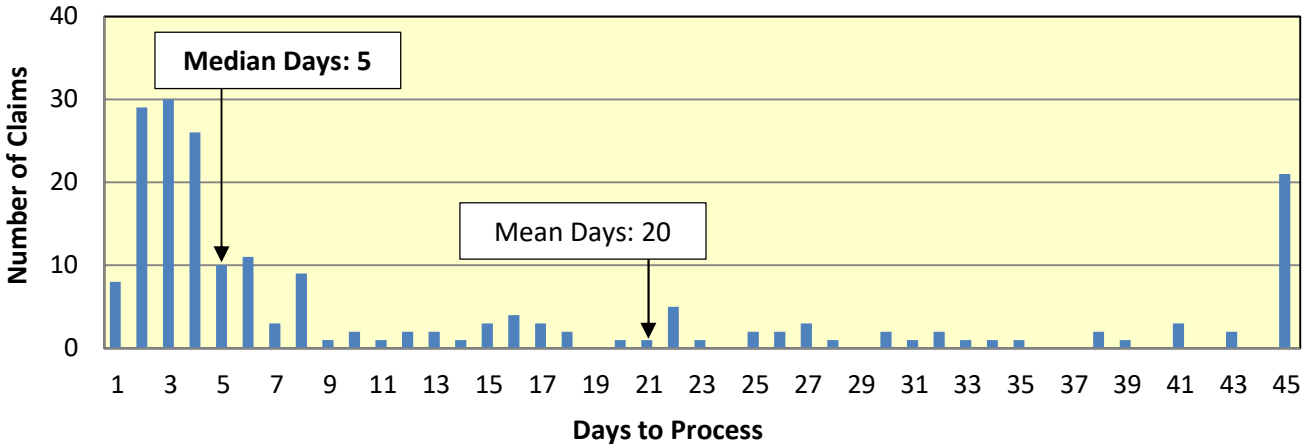
| Random Sample Findings Detail Report | | | | |
|---|---|---|---|---|
| **Audit No.** | **Under/ Over Paid** | **UMR Response** | **CTI Conclusion** | **Manual or System** |
| **Denied Eligible Expense** | | | | |
| 2023 | ($160.00) | Agree with error, claim sent to the adjustment team. | Procedural error and underpayment remain. Eligible expenses for denture repair were denied. | ☒ M ☐ S |
| **PPO Discount** | | | | |
| 1096 | ($77.82) | Agree. CCN-xxxxxx4363 allowable amount should be $107.82 according to SHO pricing. | Procedural error and underpayment remain. An incorrect PPO discount was applied to the sampled claim. | ☒ M ☐ S |
| 1129 | ($1,261.71) | Agree. The provider network is SHO and doesn't appear on web claims. The initial claim was priced based on system contracting pricing but has been reprocessed based on updated pricing received. | | ☒ M ☐ S |
| 1135 | ($503.43) | Agree. Per the contracted agreement I have supplied the pricing for each code on the claim. Total allowable is $2,367.43 | | ☒ 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 just a few claims with extended turnaround time from distorting the true performance picture.

***Median and Mean Claim Turnaround***




UMR did not meet the Performance Guarantees for PEBP in Q4 FY2023 of 92% processed within 14 days and 99% processed within 30 days. This performance decreased from the prior period. The penalty owed for these two Performance Guarantees is 1.0% of the administrative fees of $2,447,881.20 for each metric, or $48,957.62.

# DATA ANALYTICS

## Medical Findings

This component of our audit used your electronic claim data to identify improvement opportunities and potential recoveries. The informational categories we analyzed include:

- Network Provider Utilization and Discount Savings;
- Sanctioned Provider Identification;
- Patient Protection and Affordable Care Act (PPACA) Preventive Services Payment Compliance;
- National Correct Coding Initiative (NCCI) Editing Compliance; and
- Global Surgery Prohibited Fee Period Analysis.

The following pages provide the scope and report for each data analytic to enable more-informed decisions about ways PEBP can maximize benefit plan administration and performance.

**Network Provider Utilization and Discount Savings**

The Network Provider Utilization and Discount Savings report provides an evaluation of provider network discounts obtained during the audit period. Since discounts can be calculated differently by administrators, carriers, and benefit consultants, we believe calculating discounts in 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 all 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 claims in the data 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 provider received payment from UMR 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 | $1,484 | $1,274 | $479 |
| | | | | **Totals** | **1** | **$1,484** | **$1,274** | **$479** |

According to the OIG, James Shelby was excluded on December 19, 2019 with for a felony-controlled substance conviction.

**PPACA Preventive Services Coverage Compliance**

The Preventive Services Coverage Compliance report confirms that the administrator processed preventive services as required by PPACA and as regulated by the Department of Health and Human Services (HHS). The federal PPACA mandate for 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.

***Reports***

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

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

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

CTI's analysis also found that 94.04% of the procedure codes identified as preventive services were paid by UMR at 100% when provided in-network. This total is net of claims denied as a duplicate of a preventive claim paid in a prior period.

**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 Count | Amount CMS Would Deny |
| Code | Mod | Code | Mod | Mod Use | | | | |
| 74177 | TC | 96374 | | YES | CT ABD & PELV W/CONTRAST | THER/PROPH/DIAG INJ IV PUSH | 25 | $17,098 |
| | | | | | Standards of medical / surgical practice | | | |
| 70496 | | 70450 | | YES | CT ANGIOGRAPHY HEAD | CT HEAD/BRAIN W/O DYE | 4 | $7,901 |
| | | | | | Misuse of column two code with column one code | | | |
| 99213 | | 99212 | | YES | Office/outpatient visit for E&M of estab patient, 20-29 m | Office/outpatient visit for E&M of estab pat | 73 | $5,229 |
| | | | | | Misuse of column two code with column one code | | | |
| 22612 | | 95938 | TC | YES | lumbar (with lateral transverse technique, when perform | SOMATOSENSORY TESTING | 1 | $3,365 |
| | | | | | Misuse of column two code with column one code | | | |
| 22612 | | 95940 | | YES | lumbar (with lateral transverse technique, when perform | Ionm in operatng room 15 min | 1 | $2,938 |
| | | | | | Standards of medical / surgical practice | | | |
| 94626 | | 94625 | | YES | Physician services for outpatient pulmonary rehabilitati | Physician services for outpatient pulmonar | 9 | $2,732 |
| | | | | | Mutually exclusive procedures | | | |
| 71275 | TC | 96374 | | YES | CT ANGIOGRAPHY CHEST | THER/PROPH/DIAG INJ IV PUSH | 3 | $2,458 |
| | | | | | Standards of medical / surgical practice | | | |
| 96402 | | 96523 | | NO | CHEMO HORMON ANTINEOPL SQ/IM | IRRIG DRUG DELIVERY DEVICE | 3 | $2,167 |
| | | | | | CPT Manual or CMS manual coding instructions | | | |
| 76819 | TC | 59025 | | YES | FETAL BIOPHYS PROFIL W/O NST | FETAL NON-STRESS TEST | 2 | $1,986 |
| | | | | | Misuse of column two code with column one code | | | |
| 99284 | | 99283 | | YES | Emergency department visit for E&M of patient requiring | Emergency department visit for E&M of pati | 3 | $1,877 |
| | | | | | Misuse of column two code with column one code | | | |
| | | | | | | **Top 10 TOTAL** | **124** | **$47,750** |
| | | | | | | **GRAND TOTAL** | **391** | **$92,684** |

| Non-Facility (non-facility claims with CPT codes:00100 - 99999) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Primary | | Secondary | | | Primary Description | Secondary Description | Line Count | Amount CMS Would Deny |
| Code | Mod | Code | Mod | Mod Use | | | | |
| 93503 | | 99292 | | YES | INSERT/PLACE HEART CATHETER | CRITICAL CARE ADDL 30 MIN | 1 | $1,530 |
| | | | | | CPT Manual or CMS manual coding instructions | | | |
| 76856 | 26 | 93976 | 26 | YES | US EXAM PELVIC COMPLETE | VASCULAR STUDY | 5 | $355 |
| | | | | | Misuse of column two code with column one code | | | |
| 84481 | | 84480 | | NO | FREE ASSAY (FT-3) | ASSAY TRIIODOTHYRONINE (T3) | 17 | $331 |
| | | | | | More extensive procedure | | | |
| 97012 | GP | 97140 | GP | YES | MECHANICAL TRACTION THERAPY | Manual therapy 1/> regions | 3 | $235 |
| | | | | | Mutually exclusive procedures | | | |
| 92609 | GN | 92507 | GN | YES | USE OF SPEECH DEVICE SERVICE | SPEECH/HEARING THERAPY | 2 | $217 |
| | | | | | Misuse of column two code with column one code | | | |
| 19301 | 51 | 19285 | 51 | YES | PARTICAL MASTECTOMY | Placement of breast location device(s) first | 1 | $198 |
| | | | | | CPT Manual or CMS manual coding instructions | | | |
| 84439 | | 84436 | | NO | ASSAY OF FREE THYROXINE | ASSAY OF TOTAL THYROXINE | 16 | $151 |
| | | | | | More extensive procedure | | | |
| 97810 | | 99204 | | YES | ACUPUNCT W/O STIMUL 15 MIN | Office/outpatient visit for E&M of new patie | 1 | $150 |
| | | | | | CPT Manual or CMS manual coding instructions | | | |
| 36566 | | 36556 | | YES | INSERT TUNNELED CV CATH | INSERT NON-TUNNEL CV CATH | 1 | $138 |
| | | | | | Mutually exclusive procedures | | | |
| 76857 | 26 | 93975 | 26 | YES | US EXAM PELVIC LIMITED | VASCULAR STUDY | 1 | $127 |
| | | | | | Misuse of column two code with column one code | | | |
| | | | | | | **Top 10 TOTAL** | **48** | **$3,432** |
| | | | | | | **GRAND TOTAL** | **113** | **$4,912** |

### *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. Of note: the 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 |
| 31295 | 1 | Nasal/sinus endoscopy, surgical, w dilation (balloon dilation) max | 3 | $3,046 |
| | | Rationale: CMS Policy | | |
| 88377 | 5 | Morphometric analysis, in situ hybridization (quantitative or semi- | 2 | $1,761 |
| | | Rationale: Clinical: Data | | |
| 97811 | 2 | ACUPUNCT W/O STIMUL ADDL 15M | 16 | $1,253 |
| | | Rationale: Nature of Service/Procedure | | |
| 95165 | 30 | ANTIGEN THERAPY SERVICES | 1 | $1,068 |
| | | Rationale: Clinical: Data | | |
| 28470 | 2 | TREAT METATARSAL FRACTURE | 1 | $947 |
| | | Rationale: CMS Policy | | |
| 97151 | 8 | BEHAVIOR ID ASSESSMENT BY PHYS/QHP EA 15 MIN | 1 | $800 |
| | | Rationale: Clinical: CMS Workgroup | | |
| J9395 | 20 | INJECTION, FULVESTRANT | 1 | $417 |
| | | Rationale: Prescribing Information | | |
| 30140 | 1 | RESECT INFERIOR TURBINATE | 2 | $364 |
| | | Rationale: CMS Policy | | |
| 84182 | 6 | PROTEIN WESTERN BLOT TEST | 1 | $272 |
| | | Rationale: Clinical: Data | | |
| 51798 | 1 | US URINE CAPACITY MEASURE | 1 | $231 |
| | | Rationale: Nature of Service/Procedure | | |
| | | **Top 10 TOTAL** | **29** | **$10,159** |
| | | **GRAND TOTAL** | **40** | **$11,220** |

| 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 |
| A4595 | 6 | TENS SUPPL 2 LEAD PER MONTH | 2 | $1,036 |
| | | Rationale: Code Descriptor / CPT Instruction | | |
| V2520 | 2 | CONTACT LENS HYDROPHILIC | 6 | $550 |
| | | Rationale: Anatomic Consideration | | |
| A4253 | 1 | BLOOD GLUCOSE/REAGENT STRIPS | 6 | $458 |
| | | Rationale: Nature of Equipment | | |
| V2521 | 2 | CNTCT LENS HYDROPHILIC TORIC | 4 | $330 |
| | | Rationale: Anatomic Consideration | | |
| V2020 | 1 | VISION SVCS FRAMES PURCHASES | 2 | $220 |
| | | Rationale: Clinical: Data | | |
| V2510 | 2 | CNTCT GAS PERMEABLE SPHERICL | 3 | $220 |
| | | Rationale: Anatomic Consideration | | |
| V2522 | 2 | CNTCT LENS HYDROPHIL BIFOCL | 1 | $110 |
| | | Rationale: Anatomic Consideration | | |
| V2523 | 2 | CNTCT LENS HYDROPHIL EXTEND | 1 | $110 |
| | | Rationale: Anatomic Consideration | | |
| A7038 | 6 | POS AIRWAY PRESSURE FILTER | 3 | $100 |
| | | Rationale: Published Contractor Policy | | |
| B4034 | 1 | ENTER FEED SUPKIT SYR BY DAY | 1 | $25 |
| | | Rationale: Code Descriptor / CPT Instruction | | |
| | | **Top 10 TOTAL** | **29** | **$3,158** |
| | | **GRAND TOTAL** | **29** | **$3,158** |

## 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 that alerts the administrator special payment circumstances may exist. The administrator must also 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.

| | 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 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 |
| 880133501 | 32 | $11,108 | 3 | 8.6% | $871 | 1 | $144 |
| 880236758 | 3 | $740 | 1 | 25.0% | $217 | 1 | $133 |
| 954748861 | 0 | $0 | 1 | 100.0% | $30 | 1 | $32 |
| 880103557 | 3 | $728 | 2 | 40.0% | $485 | 0 | $0 |
| 860857176 | 2 | $299 | 1 | 33.3% | $166 | 0 | $0 |
| 844822939 | 0 | $0 | 1 | 100.0% | $109 | 0 | $0 |
| 834372348 | 0 | $0 | 3 | 100.0% | $329 | 0 | $0 |
| 821756034 | 2 | $317 | 1 | 33.3% | $159 | 0 | $0 |
| 813253496 | 3 | $556 | 1 | 25.0% | $186 | 0 | $0 |
| 472242077 | 0 | $0 | 1 | 100.0% | $511 | 0 | $0 |
| **Top 10** | **45** | **$13,748** | **15** | **25.0%** | **$3,062** | **3** | **$310** |
| **Overall Total** | **50** | **$15,183** | **30** | **37.5%** | **$4,997** | **3** | **$310** |

## FY2023 REVIEW AND RECOMMENDATIONS

The table below presents a summary of UMR's performance against the FY2023 quarterly metrics based on CTI's random sample audit results. Results shown in red represent where UMR missed the metric.

| Measure | Guarantee | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
|---|---|---|---|---|---|
| **Financial Accuracy** | **99.4%** | 98.23% | 97.5% | 98.12% | 99.45% |
| **Overall Accuracy** | **98.0%** | 91.0% | 97.0% | 97.5% | 98.5% |
| **Claim Turnaround Time** | **92% in 14 Days** | 89.2% | 92.9% | 90.8% | 90.5% |
| | **99% in 30 Days** | 92.9% | 97.5% | 93.7% | 95.9% |

CTI has the following recommendations that represent recurring issues identified in the FY2023 quarterly audits:

1. UMR should review each of the financial errors identified in our FY2023 random sample audits and determine if system changes or additional claim processor training could help reduce or eliminate errors of a similar nature in the future. It should focus specifically on steps necessary to improve Financial Accuracy.
2. UMR should conduct a focused analysis of the errors identified through ESAS to determine if overpayment recovery and/or system improvements are possible and to reduce or eliminate similar errors going forward. For the issues identified by ESAS, CTI can prepare claim detail for UMR to use in its analysis.
3. PEBP should review the results of the eligibility screening and perform causal analysis to identify workflow and/or system improvements to reduce or eliminate paying claims on ineligible claimants.
4. UMR is using state sanctioned provider listings and should consider using the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE) to exclude claim payments from sanctioned providers.

## CONCLUSION

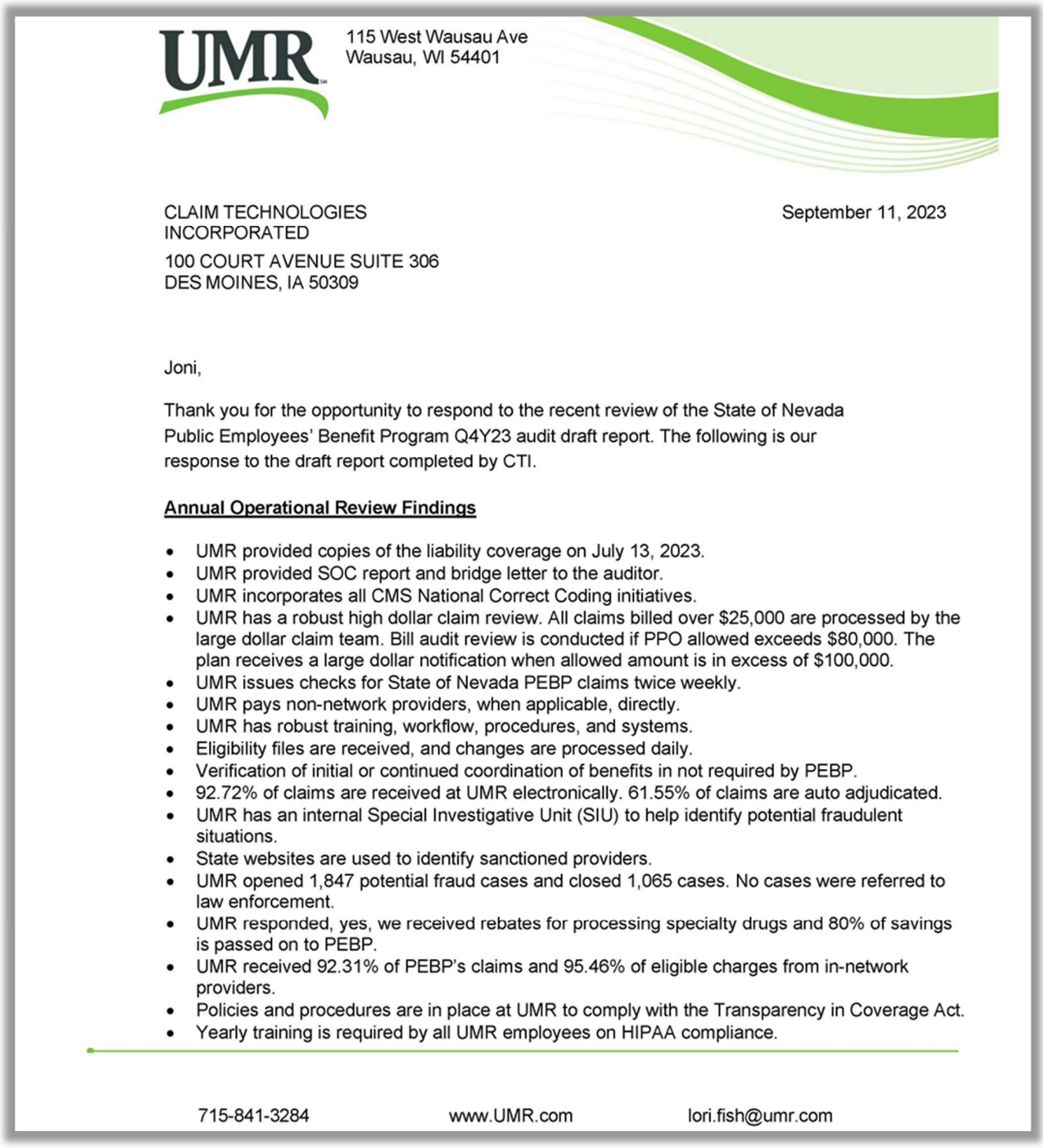
UMR did not meet the performance metrics for financial accuracy, overall accuracy or claim turnaround in the first three quarters in FY2023; in quarter 4, UMR met the performance metrics for financial accuracy and overall accuracy but continued to miss the metric for claim turnaround.

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

Your administrator's response to the draft report follows.

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

115 West Wausau Ave
Wausau, WI 54401

CLAIM TECHNOLOGIES
INCORPORATED

100 COURT AVENUE SUITE 306
DES MOINES, IA 50309

September 11, 2023

Joni,

Thank you for the opportunity to respond to the recent review of the State of Nevada Public Employees' Benefit Program Q4Y23 audit draft report. The following is our response to the draft report completed by CTI.

**Annual Operational Review Findings**

- UMR provided copies of the liability coverage on July 13, 2023.
- UMR provided SOC report and bridge letter to the auditor.
- UMR incorporates all CMS National Correct Coding initiatives.
- UMR has a robust high dollar claim review. All claims billed over $25,000 are processed by the large dollar claim team. Bill audit review is conducted if PPO allowed exceeds $80,000. The plan receives a large dollar notification when allowed amount is in excess of $100,000.
- UMR issues checks for State of Nevada PEBP claims twice weekly.
- UMR pays non-network providers, when applicable, directly.
- UMR has robust training, workflow, procedures, and systems.
- Eligibility files are received, and changes are processed daily.
- Verification of initial or continued coordination of benefits in not required by PEBP.
- 92.72% of claims are received at UMR electronically. 61.55% of claims are auto adjudicated.
- UMR has an internal Special Investigative Unit (SIU) to help identify potential fraudulent situations.
- State websites are used to identify sanctioned providers.
- UMR opened 1,847 potential fraud cases and closed 1,065 cases. No cases were referred to law enforcement.
- UMR responded, yes, we received rebates for processing specialty drugs and 80% of savings is passed on to PEBP.
- UMR received 92.31% of PEBP's claims and 95.46% of eligible charges from in-network providers.
- Policies and procedures are in place at UMR to comply with the Transparency in Coverage Act.
- Yearly training is required by all UMR employees on HIPAA compliance.

715-841-3284 www.UMR.com lori.fish@umr.com

## ESAS Targeted Sample Analysis

**Duplicate Payments**
**QID 29, 30, 31, 33, 34, 36, 37, 38, 39, 40, 41, 42, and 43** - UMR agrees to 13 duplicate payment errors. We continue to work on upgrades to our duplicate logic system.

**Attention Deficit Disorder**
**QID 26** – UMR agrees with this error. Treatment plan was not on file prior to processing.

**Chiropractic Care 20 Visits per Plan Year**
**QID 47, 48** – UMR agrees with these errors. System was manually overridden to allow additional services. These were manual overrides and the claim processors have been identified and coached.

**Bitewing X-Rays 2 per Plan Year**
**QID 49, 50 –** UMR agrees to these errors. Per the Master Plan Document Bitewing X-Rays all allowed 2 per plan year.

**DME**
**QID 21** – UMR agrees with this error. Corrected pricing was not used.

**Specialty Medication**
**QID 22 –** UMR agrees to this error. Corrected pricing was not used.

**Acupuncture**
**QID 5 –** UMR agrees to this error. Acupuncture takes a $50.00 copay not the family medicine copay of $30.00.

**Office Visits**
**QID 6 –** UMR disagree with this finding. The member's out of pocket maximum was met prior to processing this claim. Once member meets their out of pocket, claims no longer take a copay.

**QID 8 –** UMR disagrees with this finding. Per HCR, contraceptive management regardless of diagnosis billed, is covered at 100%, no cost share.

**Diagnostic Mammogram**
**QID 11 –** UMR agrees with this error. Diagnostic mammograms are subject to a $40.00 copay.

**Case Management**
**QID 16 –** UMR agrees with this error. Case management should have been initiated.

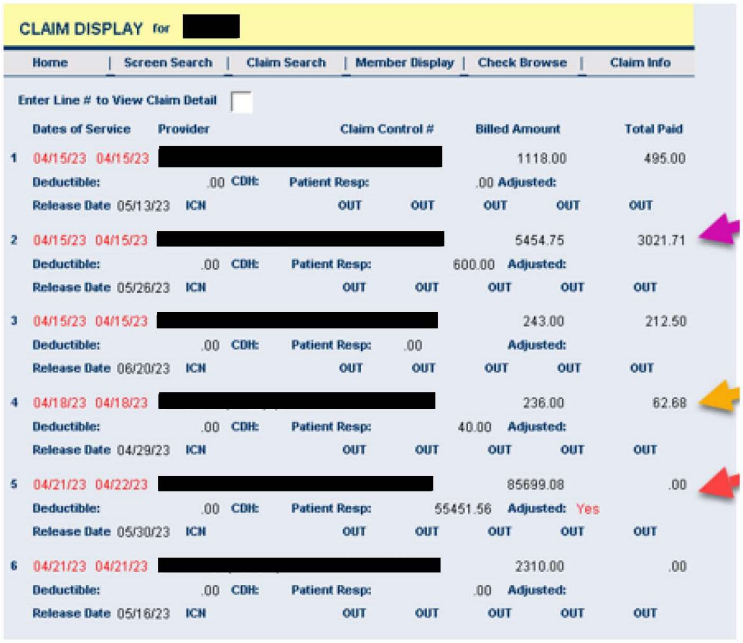
**PPO Provider without Discount**
**QID 18, 20 –** UMR agrees with these errors. Claims were not routed for pricing.

**Preventive Services**
**QID 3 –** UMR agrees with this error. CPT 99392 should have paid at 100%.

## Random Audit

**Denied Eligible Expenses**

**QID 1008 –** UMR disagrees with this finding. The EPO Plan has no out of area benefit outside the 14 counties, per plan documents. This was an elective surgery. Member was seen at Carson Valley Medical on 4/15/23, treated, given a brace, and released. On 4/18/23, member had office visit with Dr. Swanson. Scheduled surgery was conducted on 4/21/23 at an out of area facility. This requires an approval from the UM vendor per PEBP guidelines. This claim processed correctly.



CLAIM DISPLAY for [redacted]

Home | Screen Search | Claim Search | Member Display | Check Browse | Claim Info

Enter Line # to View Claim Detail

| | Dates of Service | Provider | Claim Control # | Billed Amount | Total Paid |
|---|---|---|---|---|---|
| 1 | 04/15/23 04/15/23 | [redacted] | | 1118.00 | 495.00 |
| | Deductible: .00 | CDH: | Patient Resp: | .00 Adjusted: | |
| | Release Date 05/13/23 | ICN | OUT OUT | OUT OUT | OUT |
| 2 | 04/15/23 04/15/23 | [redacted] | | 5454.75 | 3021.71 |
| | Deductible: .00 | CDH: | Patient Resp: | 600.00 Adjusted: | |
| | Release Date 05/26/23 | ICN | OUT OUT | OUT OUT | OUT |
| 3 | 04/15/23 04/15/23 | [redacted] | | 243.00 | 212.50 |
| | Deductible: .00 | CDH: | Patient Resp: .00 | Adjusted: | |
| | Release Date 06/20/23 | ICN | OUT OUT | OUT OUT | OUT |
| 4 | 04/18/23 04/18/23 | [redacted] | | 236.00 | 62.68 |
| | Deductible: .00 | CDH: | Patient Resp: | 40.00 Adjusted: | |
| | Release Date 04/29/23 | ICN | OUT OUT | OUT OUT | OUT |
| 5 | 04/21/23 04/22/23 | [redacted] | | 85699.08 | .00 |
| | Deductible: .00 | CDH: | Patient Resp: 55451.56 | Adjusted: Yes | |
| | Release Date 05/30/23 | ICN | OUT OUT | OUT OUT | OUT |
| 6 | 04/21/23 04/21/23 | [redacted] | | 2310.00 | .00 |
| | Deductible: .00 | CDH: | Patient Resp: | .00 Adjusted: | |
| | Release Date 05/16/23 | ICN | OUT OUT | OUT OUT | OUT |

ER claim on 4/15/23 treated, given brace and sent home.

Office visit with Dr. Swanson 4/18/23

Scheduled surgery- non-emergent, on 4/21/23, at Out of Area facility. No prior authorization on file. This claim was billed with admission type, 3- see below. This claim was denied as per plan language. No error

This was a scheduled procedure, not ER related and as such would require an approval by UM vendor. PEBP Out of Area gap exceptions must be approved by UM vendor.

### Type of Admission or Visit Codes

View Visit Code and Type of Admission/Visit.

1 = Emergency
2 = Urgent
3 = Elective
4 = Newborn
5 = Trauma Center
9 = Information Not Available

**QID 2023 –** UMR agrees to this $160.00 underpayment.

**PPO Discount**

**QID 1096 –** UMR agrees to this $77.82 underpayment.

**QID 1129 –** UMR agrees to this $1,261.71 underpayment.

**QID 1135 -** UMR agrees to this $503.43 underpayment.

**QID 2028 –** UMR disagrees with this procedural error. Children under the age of 19 have an unlimited maximum. In this case, the plan's annual maximum is not tracked as it is open ended due to the age of the patient. Patient is Robert, age 17 years.

**Random Sample Summary**

Six Claims are indicated on the Random Sample as errors.

- UMR disagrees with the findings on QID 1008 and has provided adequate data to have this error removed.
- UMR disagrees with the findings on QID 2028. The EOB does not show an annual maximum amount because the patient is under age 19. The plan has no annual maximum amount imposed on dependent children; therefore, no dollars are accumulated. UMR asks respectfully to have this error removed.
- UMR agrees to $2,002.96 in underpayments. These claims have been reprocessed.

If you have any questions regarding this response, please contact me at 715-841-3284.

Sincerely,

Lori Fish
UMR External Audit Coordinator

*Claim Technologies Incorporated representatives may from time to time provide observations regarding certain tax and legal requirements including the requirements of federal and state health care reform legislation. These observations are based on our good-faith interpretation of laws and regulations currently in effect and are not intended to be a substitute for legal or tax advice. Please contact your legal counsel and tax accountant for advice regarding legal and tax requirements.*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