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CELESTENA GLOVER
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JACK ROBB
*Board Chair*

**Date:** July 27, 2023

**Item Number:** IX

**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 third 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 $1,237,363.10:

| Performance Guarantee | Result | Fees at Risk | Calculated Penalty |
|---|---|---|---|
| 1.4 Claim Adjustment Processing Time | NOT MET | 1.0% | $12,373.63 |
| 1.5 Telephone Service Factor | NOT MET | 1.0% | $12,373.63 |
| 1.8 Open Inquiry Closure | NOT MET | 1.0% | $12,373.63 |
| 1.9 CSR Audit | NOT MET | 1.0% | $12,373.63 |
| **Total** | | **4.0%** | **$49,494.52** |

*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 $660,756.00:

| Performance Guarantee | Result | Fees at Risk | Calculated Penalty |
|---|---|---|---|
| 2.1 EDI Claims Repricing Turnaround Time | NOT MET | 2.0% | $13,215.12 |
| **Total** | | | **$13,215.12** |

*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 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 | $49,494.52 |
| 2. Network Administration | $13,215.12 |
| 3. Utilization Management and Case Management | $0.00 |
| **Total** | **$62,709.64** |

The penalties, totaling $62,709.64, are administratively and automatically assessed by PEBP to the vendor. In conjunction with the audited penalties totaling $55,681.34, the calculated penalties for the period ending 03/31/2023 total **$118,390.98.**

Comprehensive Claim Administration Audit

# QUARTERLY FINDINGS REPORT

State of Nevada Public Employees' Benefits Program

Administered by UMR Insurance Company

Audit Period: January 1, 2023 – March 31, 2023
Audit Number 1.FY23.Q3

Presented to

State of Nevada Public Employees' Benefits Program

July 27, 2023

CLAIM TECHNOLOGIES INCORPORATED

*Proprietary and Confidential*

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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 January 1, 2023 through March 31, 2023 (quarter 3 (Q3) 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** | $60,944,250 |
| **Total Number of Claims Paid/Denied/Adjusted** | 203,718 |

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 penalties are owed (breakdown in summary below).
2. CTI recommends UMR should:
    - Review the financial errors identified in the random sample audit and determine if system enhancements or claim processor training could help reduce or eliminate errors of a similar nature in the future. Specific focus should be on 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 Q3 FY2023 and penalties are owed. Reported administrative fees for the quarter totaled $1,237,363.10.

| Quarterly Metric | Guarantee | Met/Not Met | Penalty | Calculated Penalty |
|---|---|---|---|---|
| **Financial Accuracy (p.14)** | 99.4% | Not Met – 98.12% | 1.5% | $18,560.45 |
| **Overall Accuracy (p.15)** | 98% | Not Met – 97.5% | 1% | $12,373.63 |
| **Claim Turnaround Time** | 92% in 14 Days<br>99% in 30 Days | Not Met – 90.8%<br>Not Met – 93.7% | 1%<br>1% | $12,373.63<br>$12,373.63 |
| | | **Total Penalty** | 4.5% | $55,681.34 |

## 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' 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 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 Q3 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%<br>7 Calendar/ 5 Business Days | 92.7% | 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 | 83.8% | 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% | 2.5% | 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% | 95.4% | 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 | 91.9%<br>92.6% | Met<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% | 96.4% | 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 | 90.32% | 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>100% | Met<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. | 95.00% | 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 | 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): | 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%<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 | NA | PEBP Waived 10-day requirement |
| 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 | 95%<br>100% | Not 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% | 99.1% | 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 | 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%<br>10 Business Days | 100% | 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 10 calendar days of end of reporting period or event as determined by PEBP. | 100%<br>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%<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 | 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%<br>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%<br>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%<br>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%<br>60 Calendar Days | NA | Reported Annually |
| 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 | NA | Reported Annually |

# 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

## 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 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 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 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.

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** | | | | |
| 42 | $32.00 | Agree. | Procedural deficiencies and overpayments identified for duplicate claim payments.<br>Note: Any $0.00 Under/Over Paid amounts indicates an incorrect deductible accumulation occurred. | ☐ M ☒ S |
| 43 | $0.00 | | | ☐ M ☒ S |
| 44 | $0.00 | | | ☐ M ☒ S |
| 45 | $40.00 | | | ☐ M ☒ S |
| 46 | $71.00 | | | ☐ M ☒ S |
| 47 | $47.00 | | | ☐ M ☒ S |
| 48 | $39.00 | | | ☐ M ☒ S |
| 49 | $62.00 | | | ☐ M ☒ S |
| 50 | $37.00 | | | ☐ M ☒ S |
| 51 | $47.00 | | | ☐ M ☒ S |
| 52 | $62.00 | | | ☐ M ☒ S |
| 53 | $61.60 | | | ☒ M ☐ S |
| 56 | $45.00 | | | ☐ M ☒ S |
| 57 | $26.70 | | | ☐ M ☒ S |
| 58 | $71.20 | | | ☐ M ☒ S |
| 59 | $28.00 | | | ☐ M ☒ S |

| ESAS Findings Detail Report | | | | |
|---|---|---|---|---|
| QID | Under/ Over Paid | UMR Response | CTI Conclusion | Manual or System |
| 60 | $70.00 | | | ☐ M ☒ S |
| 61 | $215.00 | | | ☐ M ☒ S |
| 62 | $0.00 | | | ☐ M ☒ S |
| 63 | $0.00 | | | ☐ M ☒ S |
| 64 | $48.00 | | | ☐ M ☒ S |
| 65 | $77.00 | | | ☐ M ☒ S |
| 66 | $46.00 | | | ☐ M ☒ S |
| 67 | $16.80 | | | ☐ M ☒ S |
| 68 | $14.40 | | | ☐ M ☒ S |
| 69 | $50.00 | | | ☐ M ☒ S |
| 70 | $79.20 | | | ☐ M ☒ S |
| 71 | $50.00 | | | ☐ M ☒ S |
| 72 | $61.00 | | | ☐ M ☒ S |
| 73 | $65.00 | | | ☒ M ☐ S |
| 74 | $50.00 | | | ☐ M ☒ S |
| 75 | $50.00 | | | ☐ M ☒ S |
| 76 | $136.00 | | | ☒ M ☐ S |
| 77 | $136.30 | | | ☒ M ☐ S |
| 80 | $270.00 | | | ☒ M ☐ S |
| 81 | $47.00 | | | ☐ M ☒ S |
| 82 | $39.00 | | | ☐ M ☒ S |
| 83 | $62.00 | | | ☐ M ☒ S |
| 84 | $47.00 | | | ☐ M ☒ S |
| 85 | $4.80 | | | ☐ M ☒ S |
| 86 | $0.00 | | | ☐ M ☒ S |
| 87 | $39.00 | | | ☐ M ☒ S |
| 88 | $62.00 | | | ☐ M ☒ S |
| 89 | $47.00 | | | ☐ M ☒ S |
| 90 | $39.00 | | | ☐ M ☒ S |
| 91 | $62.00 | | | ☐ M ☒ S |
| 92 | $56.20 | | | ☒ M ☐ S |
| 93 | $109.60 | | | ☐ M ☒ S |
| 94 | $162.52 | | | ☒ M ☐ S |
| 95 | $36.80 | | | ☐ M ☒ S |
| 96 | $12.80 | | | ☐ M ☒ S |
| 97 | $540.80 | | | ☐ M ☒ S |
| 98 | $47.00 | | | ☐ M ☒ S |
| 99 | $62.00 | | | ☐ M ☒ S |
| 100 | $377.60 | | | ☐ M ☒ S |
| **Plan Exclusions** | | | | |
| **Massage Therapy** | | | | |

| ESAS Findings Detail Report | | | | |
|---|---|---|---|---|
| **QID** | **Under/ Over Paid** | **UMR Response** | **CTI Conclusion** | **Manual or System** |
| 133 | $50.00 | Agree. The claim is pended and reviewed based on Procedure and Diagnosis selections are coded in the UMR system to identify these claims. Massage Therapy is excluded on this plan. This should have been denied. | Procedural deficiency and overpayment remain. Massage therapy was excluded by the plan. | ☒ M ☐ S |
| **Limitations** | | | | |
| **Pre-Certification for DME in Excess of $1,000** | | | | |
| 143 | $3,854.40 | Agree. No authorization is on file for this DME. The claim was processed in error by analyst. Claim has been sent for adjustment. | Procedural deficiency and overpayment remain. Precertification for DME over $1,000.00 was not performed as required by the plan document. | ☒ M ☐ S |
| **Potential Fraud, Waste, and Abuse** | | | | |
| **Specialty Medications** | | | | |
| 106 | $147.50 | Agree. Pricing was not properly obtained resulting in a $147.50 overpayment. The claim was reprocessed on 5/5/23 to reflect corrected pricing. | Procedural deficiency and overpayment remain. UMR corrected pricing for incorrect specialty medication allowance on 5/5/23. | ☒ M ☐ S |
| 109 | $1,045.90 | Agree. Claim would be repriced. All therapies and supplies that are not itemized shall be reimbursed at 50% of provider's billed charges for per diems, and at AWP - 10% for pharmaceuticals. Allowable would be 0.76 * 6 units on bill = 4.56 * 90% = 4.10 allowable. Sent for reprocessing. | Procedural deficiency and overpayment remain for incorrect specialty medication allowance. | ☒ M ☐ S |
| **UCR Provider Specialty-Pain Specialist** | | | | |
| 118 | $1,906.48 | Agree. Claim was paid without pricing at billed charges. This claim has been reprocessed with pricing obtained on 5/8/23. Overpayment amount is $1,906.48. | Procedural deficiency and overpayment remain; payment was issued with incorrect allowable. | ☒ M ☐ S |
| **Durable Medical Equipment Over Medicare Allowance** | | | | |
| 103 | $131.26 | Agree. The Choice Plus fee schedule rate for the rental of E0601 is $43.96. The claim was adjusted on 7/11/23. | Procedural deficiency and overpayment remain. UMR allowed $208.04 for the rental instead of $43.96. | ☒ M ☐ S |
| 104 | $618.61 | Agree. This specific CPT is 90% of the Medicare allowable according to the contract. No manual repricing was done initially so the total amount billed was allowed ($918). Based on my review today the repricing should be as follows: E2622 ALLOWABLE= $299. Sent for reprocessing. | Procedural deficiency and overpayment remain. UMR allowed $918.00 for the rental instead of $299.39. | ☒ M ☐ S |
| **Incorrect Copayment** | | | | |
| **Office Visit - PCP** | | | | |
| 28 | $30.00 | Agree. Claim should have applied $30 copay for PCP Visit. | Procedural deficiency and overpayment remain. The provider was a family practitioner, and the | ☐ M ☒ S |

| ESAS Findings Detail Report | | | | |
|---|---|---|---|---|
| **QID** | **Under/ Over Paid** | **UMR Response** | **CTI Conclusion** | **Manual or System** |
| | | | PCP $30.00 copay should have been applied ($0.00 was applied). | |
| **Diagnostic Mammogram** | | | | |
| 19 | ($1.14) | Agree. Claim should have applied $40 copay for diagnostic mammogram. | Procedural deficiency and underpayment remain. Coinsurance instead of a copay was applied to the diagnostic mammogram. | ☒ M ☐ S |
| **Speech Therapy** | | | | |
| 24 | $50.00 | Agree. Claim should have applied $50 copay for Speech Therapy. The claim was adjusted on 7/11/23. | Procedural deficiency and overpayment remain. A $50.00 copay should have been applied for speech therapy, code 92507-GN. | ☒ M ☐ S |
| **Occupational Therapy** | | | | |
| 27 | $50.00 | Agree. Claim should have applied $50 copay for Occupational Therapy. | Procedural deficiency and overpayment remain. A $50.00 copay should have been applied for occupational therapy. | ☐ M ☒ S |

| Preventive Services | | | | |
|---|---|---|---|---|
| **Preventive Services Denied** | | | | |
| 16 | Unable to calculate. | Disagree. The claim denied correctly. The member had an annual wellness exam on file at the time of processing. The original preventive visit was denied for a billing error. The provider resubmitted the claim as a medical diagnosis. | Procedural deficiency and underpayment remain. This preventive visit, procedure code 99396, was denied in error. The claim data does not include another annual wellness exam claim paid during the FY2023 period. The original claim was denied on 12/5/22, both claims had the same wellness diagnosis. | ☒ M ☐ S |
| **PPO Provider Without Discount** | | | | |
| 37 | $2,890.80 | Agree. Retiree Medicare entitled due to age, not entitled to free Part A. Part B effective 12/01/19, but retiree termed Part B effective 10/31/21. We should estimate Part B and coordinate. COB is updated now correctly. Per call to COBA 855-798-2627. Part A – Not entitled; Part B – Termed 10/31/21 Allowed greater than billed, confirmed that claims are auto-pricing with SHO. This claim was adjusted on 7/11/2023. | Procedural deficiency and overpayment remain. The member was eligible for Medicare Part B but terminated their coverage. Medicare payment of 80% should have been estimated instead of allowing billed charges per page 132 of the plan document. | ☒ M ☐ S |

**Additional Observations**

During the ESAS review, our 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 | QID Number |
|---|---|
| A $40.00 copay should have been applied for the diagnostic mammogram, code 77066. UMR states the copay is only applied to the technical component claim, however, neither the technical nor professional component claim had the $40.00 diagnostic mammogram copayment applied. | 23 |

# 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
- Overall 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 $388,157.28. The claims sampled and reviewed revealed $10,758.90 in underpayments and $0.00 in overpayments, for an absolute value variance of $10,758.90. This reflects a weighted Financial Accuracy rate of 98.12% over the stratified sample. This is an improvement 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 Q3 FY2023 of 99.4% for this measure. The penalty owed is 1.5% of the administrative fees of $1,237,363.10 or $18,560.45.

**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 5 incorrectly paid claims and 195 correctly paid claims. This is also 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 | | Accuracy |
|---|---|---|---|
| | Underpaid Claims | Overpaid Claims | |
| 200 | 5 | 0 | 97.50% |

**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 period. UMR did not meet the Performance Guarantee for PEBP in Q3 FY2023 of 98% for this measure. The penalty owed is 1.0% of the administrative fees of $1,237,363.10 or $12,373.63. Detail is provided in the Random Sample Findings Detail Report below.

| Correctly Processed Claims | Incorrectly Processed Claims | | Accuracy |
|---|---|---|---|
| | System | Manual | |
| 195 | 0 | 5 | 97.50% |

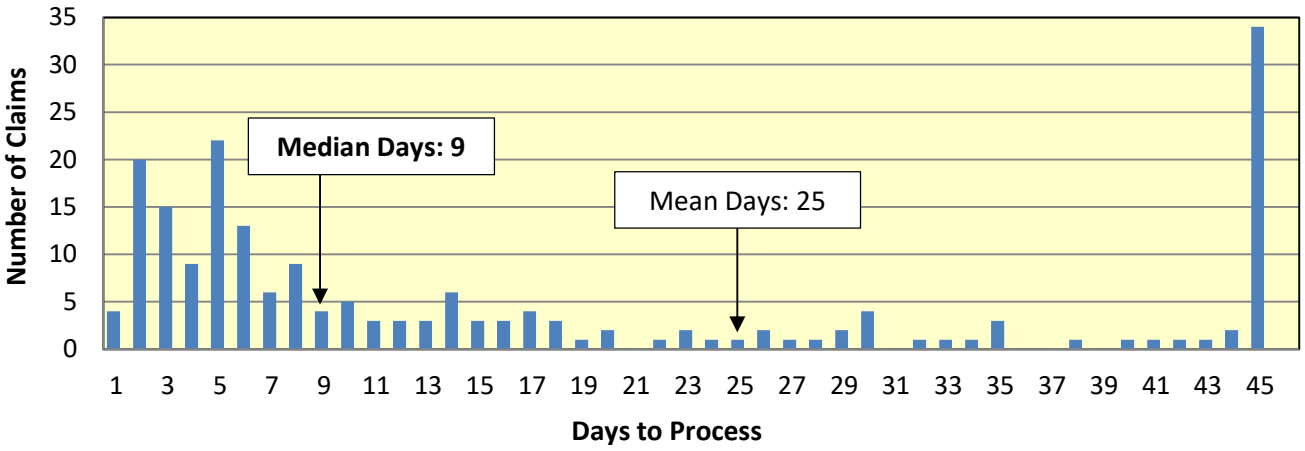
| Random Sample Findings Detail Report | | | | |
|---|---|---|---|---|
| **Audit No.** | **Under/ Over Paid** | **UMR Response** | **CTI Conclusion** | **Manual or System** |
| **Denied Eligible Expense** | | | | |
| 1037 | ($7,058.90) | Agree. CCN-xxxxxx01529 is a corrected claim to CCN-xxxxxx77099. The corrected claim was denied as a duplicate in error. Underpayment of $7058.90. | Adjudication error and underpayment remain for denial of eligible corrected claim submission. | ☒ M ☐ S |
| 2022 | ($102.00) | Agree with underpayment of $102.00. | Adjudication error and underpayment remain. Eligible expenses under Basic Services for 2-D oral images, procedure code D0350, were denied. | ☒ M ☐ S |
| **PPO Discount** | | | | |
| 1072 | ($2,744.00) | Agree. This claim was processed without using the SHO pricing: REV 450 CPT 99284 ALLOW $2744. Family maximum OOP was met. | Adjudication error and underpayment remain due to application of incorrect provider discount. | ☒ M ☐ S |
| 1099 | ($804.00) | Agree. This claim was processed with the incorrect provider contract amount. The claim will be adjusted. | Adjudication error and underpayment remain for application of incorrect provider discount. | ☒ M ☐ S |
| 1150 | ($50.00) | Agree. Contract pricing was not utilized. Discount of $198.99 should have been applied to the claim. UMR agrees to an underpayment of $50.00. | An adjudication error and underpayment remain. The correct provider discount was not applied to the claim. | ☒ 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 did not meet the Performance Guarantees for PEBP in Q3 FY2023 of 92% processed within 14 days and 99% processed within 30 days. This performance is worse than the prior period. The penalty owed for these two Performance Guarantees is 1.0% of the administrative fees of $1,292,524.65 for each metric or $25,850.50.

# 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 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 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 | 2 | $1,504 | $1,504 | $741 |
| | | | | **Totals** | **2** | **$1,504** | **$1,504** | **$741** |

**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 99.25% 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.

| | | Claim Lines Submitted | Denied* | Applied Deductible | | Applied Copay | | Applied Coinsurance | | Paid @100% | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Edit Guideline | Preventive Service Benefit | # | # | # | Amount | # | Amount | # | Amount | # | Amount | % |
| USPSTF-A | Hepatitis B screening - women | 173 | 12 | 0 | $0 | 1 | $85 | 0 | $0 | 113 | $1,385 | 70.19% |
| USPSTF-A,B | Cholesterol abnormalities screening - women >19 | 790 | 33 | 0 | $0 | 0 | $0 | 0 | $0 | 709 | $10,800 | 93.66% |
| USPSTF-A | Cholesterol abnormalities screening - men 35-75 | 612 | 31 | 0 | $0 | 0 | $0 | 0 | $0 | 548 | $9,186 | 94.32% |
| HHS | Breastfeeding support and counseling - women | 138 | 20 | 1 | $110 | 1 | $50 | 2 | $162 | 114 | $10,094 | 96.61% |
| HHS | Wellness Examinations - women | 2,811 | 133 | 6 | $4,507 | 0 | $0 | 0 | $0 | 2,634 | $438,364 | 98.36% |
| USPSTF-B | Vision screening - 3- 5 | 143 | 10 | 0 | $0 | 0 | $0 | 1 | $6 | 132 | $4,469 | 99.25% |
| USPSTF-B | Healthy diet counseling | 305 | 158 | 0 | $0 | 1 | $30 | 0 | $0 | 146 | $18,255 | 99.32% |
| USPSTF-A | Colorectal cancer screening - 45-75 | 770 | 31 | 0 | $0 | 0 | $0 | 0 | $0 | 738 | $341,185 | 99.86% |
| HHS | Contraceptive methods - women | 683 | 45 | 0 | $0 | 0 | $0 | 0 | $0 | 637 | $123,064 | 99.84% |
| USPSTF-B | BRCA screening counseling - women | 25 | 4 | 0 | $0 | 0 | $0 | 0 | $0 | 19 | $7,740 | 90.48% |

*Claim lines denied may include claim lines denied as a duplicate on a previously processed claim.

**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 | | Mod Use | Primary Description | Secondary Description | Line Count | Amount CMS Would Deny |
| Code | Mod | Code | Mod | | | | | |
| 74177 | TC | 96374 | | YES | CT ABD & PELV W/CONTRAST | THER/PROPH/DIAG INJ IV PUSH | 13 | $9,104 |
| | | | | | Standards of medical / surgical practice | | | |
| 70496 | TC | 96374 | | YES | CT ANGIOGRAPHY HEAD | THER/PROPH/DIAG INJ IV PUSH | 5 | $3,757 |
| | | | | | Standards of medical / surgical practice | | | |
| 77280 | TC | 77336 | | YES | SET RADIATION THERAPY FIELD | RADIATION PHYSICS CONSULT | 4 | $3,500 |
| | | | | | Misuse of column two code with column one code | | | |
| 71275 | TC | 96374 | | YES | CT ANGIOGRAPHY CHEST | THER/PROPH/DIAG INJ IV PUSH | 4 | $2,870 |
| | | | | | Standards of medical / surgical practice | | | |
| 76819 | TC | 59025 | | YES | FETAL BIOPHYS PROFIL W/O NST | FETAL NON-STRESS TEST | 3 | $2,451 |
| | | | | | Misuse of column two code with column one code | | | |
| 49560 | | 96361 | | YES | RPR VENTRAL HERN INIT REDUC | HYDRATE IV INFUSION ADD-ON | 1 | $1,922 |
| | | | | | Misuse of column two code with column one code | | | |
| 88331 | TC | 88333 | TC | YES | PATH CONSULT INTRAOP 1 BLOC | INTRAOP CYTO PATH CONSULT 1 | 1 | $1,623 |
| | | | | | CPT Manual or CMS manual coding instructions | | | |
| 90471 | | 99282 | | YES | IMMUNIZATION ADMIN | Emergency department visit for evaluation & | 2 | $1,601 |
| | | | | | CPT Manual or CMS manual coding instructions | | | |
| 70553 | | 70545 | | YES | Mri brain stem w/o & w/dye | MR ANGIOGRAPHY HEAD W/DYE | 1 | $1,601 |
| | | | | | Misuse of column two code with column one code | | | |
| 90471 | | 99283 | | YES | IMMUNIZATION ADMIN | Emergency department visit for E&M of pati | 1 | $1,576 |
| | | | | | CPT Manual or CMS manual coding instructions | | | |
| | | | | | | **Top 10 TOTAL** | **35** | **$30,005** |
| | | | | | | **GRAND TOTAL** | **307** | **$83,721** |

| Non-Facility (non-facility claims with CPT codes:00100 - 99999) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Primary | | Secondary | | Mod Use | Primary Description | Secondary Description | Line Count | Amount CMS Would Deny |
| Code | Mod | Code | Mod | | | | | |
| 45385 | 22 | 45380 | 51 | YES | LESION REMOVAL COLONOSCOPY | COLONOSCOPY AND BIOPSY | 1 | $1,301 |
| | | | | | More extensive procedure | | | |
| 95925 | | 95926 | | NO | SOMATOSENSORY TESTING | SOMATOSENSORY TESTING | 1 | $780 |
| | | | | | CPT Manual or CMS manual coding instructions | | | |
| 84481 | | 84480 | | NO | FREE ASSAY (FT-3) | ASSAY TRIIODOTHYRONINE (T3) | 14 | $272 |
| | | | | | More extensive procedure | | | |
| 99203 | | 99213 | 5 | YES | Office/outpatient visit for E&M of new patient. 30 | Office/outpatient visit for E&M of estab pat | 1 | $264 |
| | | | | | Misuse of column two code with column one code | | | |
| 90853 | | 90834 | | YES | GROUP PSYCHOTHERAPY | Psytx pt&/family 45 minutes | 2 | $250 |
| | | | | | CPT Manual or CMS manual coding instructions | | | |
| 92541 | | 92545 | | YES | SPONTANEOUS NYSTAGMUS TEST | OSCILLATING TRACKING TEST | 1 | $152 |
| | | | | | CPT Manual or CMS manual coding instructions | | | |
| 84439 | | 84436 | | NO | ASSAY OF FREE THYROXINE | ASSAY OF TOTAL THYROXINE | 16 | $151 |
| | | | | | More extensive procedure | | | |
| 22633 | AS | 63056 | AS | YES | Arthrodesis, combined posterior or posterolatera | Decompress spinal cord lmbr | 1 | $141 |
| | | | | | Standards of medical / surgical practice | | | |
| 90460 | | 99393 | 5 | YES | IM ADMIN 1ST/ONLY COMPONENT | PREV VISIT EST AGE 5-11 | 1 | $126 |
| | | | | | CPT Manual or CMS manual coding instructions | | | |
| 92609 | GN | 92507 | GN | YES | USE OF SPEECH DEVICE SERVICE | SPEECH/HEARING THERAPY | 1 | $108 |
| | | | | | Misuse of column two code with column one code | | | |
| | | | | | | **Top 10 TOTAL** | **39** | **$3,545** |
| | | | | | | **GRAND TOTAL** | **67** | **$4,229** |

### *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 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 |
| 97151 | 8 | BEHAVIOR ID ASSESSMENT BY PHYS/QHP EA 15 MIN | 4 | $3,870 |
| | | Rationale: Clinical: CMS Workgroup | | |
| A9581 | 20 | GADOXETATE DISODIUM INJ | 1 | $1,500 |
| | | Rationale: Clinical: Data | | |
| 97152 | 16 | BEHAVIOR ID SUPPORT ASSMT BY 1 TECH EA 15 MIN | 1 | $960 |
| | | Rationale: Clinical: CMS Workgroup | | |
| J9395 | 20 | INJECTION, FULVESTRANT | 1 | $582 |
| | | Rationale: Prescribing Information | | |
| V2520 | 2 | CONTACT LENS HYDROPHILIC | 4 | $440 |
| | | Rationale: Anatomic Consideration | | |
| Q4038 | 2 | CAST SUP SHRT LEG FIBERGLASS | 2 | $337 |
| | | Rationale: Anatomic Consideration | | |
| 83521 | 2 | Immunoglobulin light chains free each | 2 | $323 |
| | | Rationale: Nature of Analyte | | |
| Q4008 | 2 | CAST SUP LONG ARM PED FBRGLS | 2 | $191 |
| | | Rationale: Anatomic Consideration | | |
| 87428 | 1 | severe acute respiratory syndrome coronavirus and influ | 1 | $163 |
| | | Rationale: Nature of Analyte | | |
| 95999 | 1 | NEUROLOGICAL PROCEDURE | 1 | $153 |
| | | Rationale: Clinical: CMS Workgroup | | |
| | | **Top 10 TOTAL** | **19** | **$8,519** |
| | | **GRAND TOTAL** | **26** | **$7,544** |

| 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 | 2 | $1,935 |
| | | Rationale: Code Descriptor / CPT Instruction | | |
| V2520 | 2 | CONTACT LENS HYDROPHILIC | 7 | $759 |
| | | Rationale: Anatomic Consideration | | |
| J2930 | 25 | METHYLPREDNISOLONE INJECTION | 1 | $719 |
| | | Rationale: Clinical: Data | | |
| A4595 | 6 | TENS SUPPL 2 LEAD PER MONTH | 2 | $652 |
| | | Rationale: Code Descriptor / CPT Instruction | | |
| B4034 | 1 | ENTER FEED SUPKIT SYR BY DAY | 3 | $410 |
| | | Rationale: Code Descriptor / CPT Instruction | | |
| V2521 | 2 | CNTCT LENS HYDROPHILIC TORIC | 4 | $407 |
| | | Rationale: Anatomic Consideration | | |
| A4253 | 1 | BLOOD GLUCOSE/REAGENT STRIPS | 8 | $290 |
| | | Rationale: Nature of Equipment | | |
| V2020 | 1 | VISION SVCS FRAMES PURCHASES | 2 | $220 |
| | | Rationale: Clinical: Data | | |
| E0443 | 1 | PORTABLE 02 CONTENTS, GAS | 1 | $171 |
| | | Rationale: Code Descriptor / CPT Instruction | | |
| B4035 | 1 | ENTERAL FEED SUPP PUMP PER D | 1 | $169 |
| | | Rationale: Code Descriptor / CPT Instruction | | |
| | | **Top 10 TOTAL** | **31** | **$5,730** |
| | | **GRAND TOTAL** | **38** | **$6,086** |

### 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.

| Provider Id | Surgeries with 'CMS Defined' Prohibited Global Fee Periods | | | | | Evaluation and Management Services using Same ID as Surgeon and Within Prohibited Global Fee Period | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Surgeries without E/M Procedures during Prohibited Global Fee Periods | | Surgery with E/M Charge during Prohibited Global Fee Periods | | | E/M Procedure Codes with Modifier 24, 25, or 57 | | E/M Procedure Codes without Modifier 24, 25, or 57 | |
| | Count | Allowed Charge | Count | % Surgeries with E/M Charges during Prohibited Global Fee Periods | Allowed Charge | Total Count; 0,10 & 90 days | Allowed Charge | Total Count; 0,10 & 90 days | Allowed Charge |
| 853859410 | 0 | $0 | 1 | 100.0% | $30 | 1 | $55 | 1 | $32 |
| 880198997 | 0 | $0 | 1 | 100.0% | $210 | 1 | $104 | 0 | $0 |
| 880175775 | 1 | $171 | 1 | 50.0% | $171 | 1 | $66 | 0 | $0 |
| 880133501 | 7 | $2,385 | 1 | 12.5% | $296 | 1 | $144 | 0 | $0 |
| 880107997 | 0 | $0 | 1 | 100.0% | $707 | 1 | $90 | 0 | $0 |
| 870302621 | 0 | $0 | 1 | 100.0% | $268 | 1 | $150 | 0 | $0 |
| 860857176 | 1 | $166 | 1 | 50.0% | $146 | 1 | $116 | 0 | $0 |
| 582505541 | 0 | $0 | 1 | 100.0% | $233 | 1 | $129 | 0 | $0 |
| 263147146 | 6 | $936 | 2 | 25.0% | $311 | 2 | $276 | 0 | $0 |
| 260076062 | 3 | $999 | 1 | 25.0% | $444 | 1 | $101 | 0 | $0 |
| **Top 10** | **18** | **$4,656** | **11** | **37.9%** | **$2,815** | **11** | **$1,231** | **1** | **$32** |
| **Overall Total** | **33** | **$9,343** | **26** | **44.1%** | **$5,398** | **26** | **$2,892** | **1** | **$32** |

# CONCLUSION

UMR demonstrated improvement in Financial Accuracy, Overall Accuracy and Payment Accuracy from the quarter 2 FY2023 audit; and Claim Turnaround Time performance decreased.

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 INITIAL REPORT

Additional information submitted to CTI from the administrator in response to the initial 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 initial report.

UMR's response to the initial report follows:


Joni Amato
CTI
State of Nevada - PEBP
Updated Draft Responses
July 12, 2023

Hi Joni,

After our further review and per the discussion with the group on 7/11/2023, UMR has agreed to some of the previously disagreed with errors. We understand that these are selections from the Focused ESAS findings and are not used to report negatively on performance guarantees.

94 – UMR Agrees to a $162.52 overpayment.

103 – UMR Agrees to $131.26 overpayment. This claim was adjusted on 7/11/2023.

24 – UMR Agrees to a $50.00 overpayment. This claim was adjusted on 7/11/2023.

16 – UMR Agrees to this finding. The original preventive visit was denied for a billing error. The provider resubmitted the claim as a medical diagnosis.

23 – UMR Disagrees to this finding. A copay would never apply to the professional component of a mammogram; therefore, this claim is processed correctly.

61 – UMR Agrees with this finding. UMR is contacting provider for correct billing.

37 - UMR Agrees with this finding. This claim was adjusted on 7/11/2023.

Thank you for the opportunity to address these claims. Please let me know if you have any questions.

Sincerely,

Lori Fish
UMR External Audit Coordinator

115 West Wausau Ave
Wausau, WI 54401

CLAIM TECHNOLOGIES INCORPORATED
100 COURT AVENUE SUITE 306
DES MOINES, IA 50309

June 19, 2023
Revised June 22, 2023

Joni,

Thank you for the opportunity to respond to the recent review of the State of Nevada Public Employees' Benefit Program Q3Y23 audit draft report. The following is our response to the draft report completed by CTI.

**Findings**

UMR has reviewed samples for each of the **Categories for Potential Amount at Risk.**

- **Duplicate Payments** Providers and/or Employees
  - UMR is implementing process upgrades to reduce the number of claims paid as duplicates
- **Exclusions** Massage Therapy
  - Claims are considered based on provider contract. Review and feedback were conducted with the responsible processor(s).
- **Limitations** Pre-certification for DME in Excess of $1000.00
  - UMR has a robust editing system to identify claims requiring pre-certification. From the sample claims provided by CTI, 94% did not require pre-cert, 6% have auth on file.
- **Fraud, Waste, and Abuse**
  - **Specialty Medications**
    - The claims are pended and reviewed based on the State of Nevada guidelines.
  - **Pain Specialist**
    - Claims are considered based on provider's contract and State of Nevada Plan benefits.
  - **DME Over Medicare Allowance**
    - Claims are considered based on provider's contract and State of Nevada Plan benefits.
  - **Copay Application**
    - Claims are considered based on provider specialty.
  - **Preventive Services**
  - UMR's standard approach includes preventive care services which are mandated by HCR to be allowable at no cost sharing when delivered by a network provider.
  - **PPO Provider Without Discount**
    - Claims are considered based on provider's contract.

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

UMR respectfully requests that the 'Categories for Potential Amount at Risk' be removed from this report. Our extensive review shows that most claims are processed correctly. The financial accuracy from the random samples in the audit, of 200 claims 194 paid correctly. The audit firm noted 97% accuracy.

**ESAS Targeted Sample Analysis**

**Duplicate Payments**

**QID- 41, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 56, 57, 58, 59, 60, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 7576, 77, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 95, 96, 97, 98, 99, 100** UMR Agrees to duplicate payments for Dental. These claims were submitted by the provider as two claims for the same date of service with different billed amounts. UMR is committed to system upgrades to expand our duplicate claim logic. All claims have been adjusted.

**QID 61**- UMR Disagrees with this finding. Each claim identified has a different Tax IDs and billing address. Our efforts to upgrade UMR's system for duplicate logic is underway.

**QID 79**- UMR Disagrees with this finding. CPT 90833 CCN 23066246110 – provider billed claim to UMR EDI for UMR to pay as secondary. CCN 23027175912 – crossover claim from Medicare.

**QID 94**- UMR Disagrees with this finding. CPT 90792 CCN 22320373527 - Different TINS billing issue but same provider - education to the billing vendor has been provided.

**Plan Exclusions**

**QID 133**- UMR Agrees to $50.00 overpayment. The claim is pended and reviewed based on Procedure and Diagnosis selections are coded in the UMR system to identify these claims. Massage Therapy is excluded on this plan. This claim should have been denied. Review and feedback were completed with the responsible processor. The claim has been adjusted.

**Limitations**

**QID 143-** UMR Agrees to a $3854.40 overpayment. No authorization is on file for this DME. The claim was processed in error. Review and feedback were completed with the responsible processing team. The claim has been adjusted.

**Specialty Medications**

**QID 106-** UMR Agrees to a $147.50 overpayment. Pricing was not properly obtained resulting in a $147.50 overpayment. The claim was reprocessed on 5/5/23 to reflect corrected pricing.

**QID 109-** UMR Agrees to a $1045.90 overpayment. Claim should be repriced. All therapies and supplies that are not itemized shall be reimbursed at 50% of provider's billed charges for per diems, and at AWP - 10% for pharmaceuticals. Allowable would be 0.76 * 6 units on bill = 4.56 * 90% = 4.10 allowable. Review and feedback were completed with the responsible processor. The claim has been adjusted.

**UCR Provider Specialty-Pain Specialist**

**QID 118-** UMR Agrees to a $1906.48 overpayment. Claim was paid at billed charges. Pricing has been obtained and the claim is processed correctly. Review and feedback were completed with the responsible processor.

**Durable Medical Equipment**

**QID 103-** UMR Disagrees with this finding. The Choice Plus fee schedule rate for the rental of E0601 is $43.96.

**QID 104-** UMR Agrees to a $618.61 overpayment. This specific CPT paid at 90% of Medicare allowable according to the network contract. Review and feedback were completed with the responsible processor. The claim has been adjusted.

**Office Visit – Specialist**

**QID 25-** UMR Disagrees with this finding. The claim paid correctly per plan benefits.
**QID 26-** UMR Disagrees with this finding. The diagnosis on the claim is routine exam, (Z0000). Preventive services are covered at 100%, no cost share.
**QID 29-** UMR Disagrees with this finding. This is a prenatal visit with no cost share.

**Office Visit - PCP**

**QID 20-** UMR Disagrees with this finding. Claim are reviewed based on services billed. Procedure and diagnosis selections are coded in the UMR system.
**QID 21-** UMR Disagrees with this finding. Claims are reviewed based on services billed. Procedure and diagnosis selections are coded in the UMR system to identify these claims.
**QID 28-** UMR Agrees that a $30.00 copay for PCP visit should have been assessed. The claim has been adjusted.

**Diagnostic Mammogram**

**QID 19-** UMR Agrees with an underpayment of $1.14. The claim should have applied a $40.00 copay for diagnostic mammogram. The claim has been adjusted.
**QID 23**- UMR Disagrees with this finding. Claims are reviewed based on services billed. Procedure and Diagnosis selections are coded in the UMR system to identify these claims.

**Speech Therapy**

**QID 24-** UMR Disagrees with this finding. The claim priced and processed correctly.
**QID 27-** UMR Agrees with this $50.00 overpayment. Claim should have applied a copay. The claim has been corrected.

**Preventive Services**

**QID 16-** UMR Disagrees with this finding. The claim denied correctly. The member had an annual wellness exam on file at the time of processing.

**PPO Provider Without Discount**

**QID 37-** UMR Disagrees with this finding. Retiree Medicare entitled due to age, not entitled to free Part A. Part B effective 12/01/19, but retiree termed Part B effective 10/31/21. We should estimate Part B and coordinate. COB is now correctly updated. Per call to COBA 855-798-2627. Part A – Not entitled Part B – Termed 10/31/21 Allowed greater than billed, confirmed that claims are auto-pricing with SHO.

**Random Sample Findings**

**Denied Eligible Expenses**

**Sample 1037-** UMR Agrees to an underpayment of $7058.09. The corrected claim was denied as a duplicate in error.
**Sample 2022- Dental –** UMR Agrees with an underpayment of $102.00.

**PPO Discount**

**Sample 1072-** UMR Agrees to an underpayment of 2744.00. This claim was processed without using the SHO pricing: REV 450 CPT 99284 allow $2744. Family maximum OOP was met.
**Sample 1099-** UMR Agrees to an underpayment of $804.00. This claim was processed with the incorrect provider contract amount. The claim has been adjusted. Review and feedback were

completed with the responsible processor.
**Sample 1150-** UMR Agrees to an underpayment of $50.00. Contract pricing was not utilized. Discount of $198.99 should have been applied to the claim. The claim has been adjusted. Review and feedback were completed with the responsible processor.

**Deductible Error**

**Sample 2026- Dental -** UMR Disagrees with this finding. This claim paid correctly. Deductible was applied on this claim

**UMR Editing system**

UMR has a robust claim editing system. This is explained here.
**Provider Claims**:
■ Internal system edits: We include both CPS edits and benefit coding configuration/edits in this group. All claims received at UMR are subject to all internal system edits as defined:
■ CPS edits: These include edits for elements such as: duplicate claims, fraud control, potential third-party liability, medical necessity, and eligibility. Our claim payment system also edits for experimental and/or investigational care, and cosmetic coding.
■ Benefit coding configuration/edits: Our internal coding includes items such as: coordination of benefits (COB) option, deductibles, out-of-pocket maximums, participation, and plan maximums.
■ Reimbursement policy edits: Depending on the individual provider's relationship with UMR, each provider claim is routed through additional software, sometimes referred to as clinical editing software.
■ UnitedHealthcare providers: All UnitedHealthcare network provider claims are routed through the Ingenix Claims Edit System (iCES), an internal system, to review for bundling, unbundling, inappropriate diagnosis codes, age edits and other reimbursement policy edits specific to the provider contract.
■ Non-UnitedHealthcare and non-network providers: We purchase Claims Edit System (CES) software from Optum, and route provider claims through this system to review for bundling, unbundling, upcoding and other provider billing practices.
**Hospital/Facility Claims**: Hospital claims are subject to internal system edits, however, because these claims are billed with revenue codes that can include a range of services, rather than CPT/HCPCS codes, we do not review hospital claims for unbundling. Revenue coding limits the opportunity for unbundling. We also perform hospital bill reviews/large bill reviews on these claims

**Summary**

UMR is dedicated to improving the overall experience for the State of Nevada PEBP members and will continue to work diligently on addressing any issues highlighted by this review. Our efforts to upgrade UMR's system for duplicate logic is underway. Coaching and ongoing training is held with our dedicated processors. We continue to meet with the staff daily to go over quality reports, identifying trending errors, initiating refresher training for skill gaps, and using this data to improve the overall quality of the staff.

If you have any questions or concerns regarding our responses, please feel free to contact me at 715-841-3284

Sincerely,

Lori Fish
UMR External Audit Coordinator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