**DRAFT 03/15/2023**

**Comprehensive Claim Administration Audit**

# QUARTERLY FINDINGS REPORT

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

**Administered by UMR Insurance Company**

**Audit Period: July 1, 2022 – September 30, 2022**
**Audit Number 1.FY23.Q1**

**Presented to**

**State of Nevada Public Employees Benefits Program**

**Revised as of March 15, 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 July 1, 2022 through September 30, 2022 (quarter 1 (Q1) 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** | $19,802,190 |
| **Total Number of Claims Paid/Denied/Adjusted** | 121,231 |

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 our opinion:

1. UMR's Financial Accuracy, Overall Accuracy and Claim Turnaround Time did not meet the service objective and a penalty is owed (breakdown in summary below).
2. 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. Specific focus should be directed towards the identification of duplicate payments.
   - Review the 100% Electronic Screening with Targeted Sample results and focus on the most material findings.
   - Where appropriate, verify claim processor coaching, feedback, and retraining has occurred because most errors were manually processed.

## Summary of UMR's Guarantee Measurements

Based on CTI's Random Sample Audit results, UMR did not meet the claims processing measurements for PEBP in Q1 FY2023 and a penalty is owed. Reported administrative fees for the quarter totaled $1,303,565.40.

| Quarterly Metric | Guarantee | Met/Not Met | Penalty | Calculated Penalty |
|---|---|---|---|---|
| **Financial Accuracy (p.15)** | 99.4% | Not Met – 98.23% | 1.5% | $19,553.48 |
| **Overall Accuracy (p.16)** | 98% | Not Met – 91.0% | 1% | $13,035.65 |
| **Turnaround Time** | 92% in 14 Days | Not Met – 89.2% | 1% | $13,035.65 |
| | 99% in 30 Days | Not Met – 92.9% | 1% | $13,035.65 |
| **Total Penalty** | | | 4.5% | $55,660.44 |

## 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.

# 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 Q1 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 | 84.0% | 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 | 63.3% | 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% | 7.4% | Not Met |
| 1.7 | **First Call Resolution Rate:** the percentage of telephone inquiries completely resolved within a 'window period' of time. A call is considered 'resolved' when the same participant or a family member under the same subscriber ID has not contacted the administrator's customer service facility again regarding the same issue within 60 calendar days of the initial call. | 95.00% | 95.1% | 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 | 99.3%<br>99.5% | 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% | 94.0% | 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 | Unable to Report* | Unable to Report* |
| 1.11 | **Participant Email Response Performance:** measured from the time an email is received by the administrator's response team to the time in hours or days to the time the actual email response is sent to the participant. | 90.00%<br>Within 8 Hours<br>95.00%<br>Within 24 Hours | 0.0%<br>55% | Not Met<br>Not Met |
| 1.12 | **Member Satisfaction:** At least 95%-member satisfaction with the services. Measured as the number of satisfied to highly satisfied survey ratings divided by the total number of survey responses. Survey tool and survey methodology to be mutually agreed upon by Offeror and PEBP. | 95.0% | NA | Reported Annually |
| 1.13 | **Account Management – Plan will guarantee that the services provided by the TPA's team during the guarantee period will be satisfactory to PEBP. Areas of satisfaction will include:** | | | |
| | Knowledge/Capabilities – Account representative demonstrates competence in getting issues and problems resolved. | Agree | NA | Met |
| | Responsiveness – All calls returned within at most 24 hours; along with an alternate person identified who can assist with service issues when account representative is unavailable. | | | |

| | Metric | Service Objective | Actual | Met/ Not Met |
|---|---|---|---|---|
| | Ability to meet deadlines – Supplying all requested materials accurately and in a timely manner, along with all necessary documentation (i.e., enrollment kits, rate confirmations, plan performance work plans, group contracts, ZIP code file, etc.). | | | |
| | Professionalism – Demonstrates objectivity and empathy with customer problems. | | | |
| | Flexibility – Ability to meet client-specific needs. | | | |
| | Participation in periodic meetings – Attendance at all required client meetings or conference calls. | | | |
| | Guarantee measured with staff responses to internal questionnaire. A scale from 1 to 5 will be used to measure performance, where 1 means 'very dissatisfied' and 5 means 'very satisfied'; and 2 through 4 are defined, respectively. | | | |
| | Periodic program reports will be provided and presented with recommended actions. Standard program reports, within 30 days to quarter-end. Year-end activity report, within 45 days of program year end. | | | |
| | Open Enrollment Support: Accurate materials will be provided at least 60 days prior to the open enrollment period starting on April 1 each year. Representative will be available, if requested, for up to 5 employee benefit fairs. | | | |
| | Service Objective (out of a score of 5 on internal questionnaire): | 350 | | |
| 1.14 | **Eligibility Processing:** Confirm daily and weekly eligibility and enrollment within specified business days of the receipt of the eligibility information, given that information is complete and accurate. | 98.00%<br>2 Business Days | 100.00% | Met |
| 1.15 | **Data Reporting:** Offeror will provide PEBP with 100% of the applicable reports (within 10 business days for standard reports and within 10 business days of Plan year-end for Annual Reports and Regulatory documents). | 100%<br>10 Business Days | NA | PEBP Waived 10-day requirement |
| 1.16 | **Implementation Satisfaction:** Offeror shall effectively manage program implementation and resolve any issues identified with implementation in a timeframe mutually agreed by PEBP and the Account Executive. PEBP program manager will determine if expectations are met. | Agree | NA | PEBP Waived |
| | Pre-Implementation Audit: Offeror will fully fund (up to $35,000) and pass a pre-implementation audit focusing on its phone and claims system and will have any issues identified during the audit resolved prior to the July 1, 2022 effective date. At least 90% of audit claims processed correctly, and all audit issues corrected prior to effective date. | 90% | NA | PEBP Waived |
| 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 | 96%<br>99% | 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% | 99.9% | Met |
| 2.3 | **Data Reporting – Standard Reports (Quarterly reporting to include Service Performance Standards, Guarantee, Method of Measurement, Actual Performance Results, and Pass/Fail indicator.)** | 100%<br>10 Business Days | NA | PEBP Waived 10-day requirement |

| | Metric | Service Objective | Actual | Met/ Not Met |
|---|---|---|---|---|
| | Standard reports must be delivered within business 10 days of end of reporting period or event as determined by PEBP. | | | |
| 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 |
| **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 | 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 | 0% | Not Met |
| 3.3 | **Pre-Certification Requests:** Precertification requests from healthcare providers shall be completed in accordance with URAC/NCQA standards and turn-around timeframes; completed Pre-certifications shall be communicated to PEBP's Third Party Administrator using an approved method e.g., electronically, within 5 business days of UM completing Precertification determination. | 98.00%<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 |
| 3.6 | **Implementation (Tasks) – Initial transition from current UM/CM vendor and future transition to incoming UM/CM vendor during and after the termination of this contract.** Percent of tasks complete on time pursuant to the implementation or transition plan in the RFP response or as mutually agreed to by vendor and PEBP. | 98.00% | 100% | Met |
| 3.7 | **Implementation (Problem Resolution) – Initial transition from current UM/CM vendor and future transition to incoming UM/CM vendor during and after the termination of this contract.** Percent of problems documented within 2 business days and resolved within 10 business days or later if agreed to by PEBP. | 98.00%<br>2 Business Days<br>98.00%<br>10 Business Days | 100%<br>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 | NA | Reported Annually |

| | Metric | Service Objective | Actual | Met/ Not Met |
|---|---|---|---|---|
| 3.9 | **Large Case Management:** CM will identify and initiate case management for chronic disease, high dollar claims, and ER usage. | 95.00% | NA | Reported Annually |
| 3.10 | **Utilization Management for Medical Necessity and Center of Excellence Usage:** UM review to determine medical necessity in accordance with the MPDs. Services to be performed at a Center of Excellence to be managed through the Case Management process. | 98.00% | NA | Reported Annually |
| 3.11 | **Return On Investment (ROI) Guarantee – Utilization Management/Case Management:** 2:1 Savings to Fees for Utilization Management/Case Management. | 100% | NA | Reported Annually |
| 3.12 | **Disclosure of Subcontractors:** All subcontractors who have access to PHI or PII data and physical locations where PEBP PHI or PII data is maintained and/or stored must be identified in this contract. Any changes to those subcontractors or physical locations where PEBP data is stored must be communicated to PEBP at least 60 days prior to implementation of services by the subcontractor. Implementation will not be in effect until PEBP has provided written authorization. | 100% 60 Calendar Days | NA | Reported Annually |
| 3.13 | **Unauthorized Transfer of PEBP Data:** All PEBP PHI or PII data will be stored, processed, and maintained solely on currently designated servers and storage devices identified in this contract. Any changes to those designated systems during the life of this agreement shall be reported to PEBP at least 60 calendar days prior to the changes being implemented. Implementation will not be in effect until PEBP has provided written authorization. | 100% 60 Calendar Days | NA | Reported Annually |

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

# 100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

## Objective

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

## Scope

CTI electronically screened 100% of the service lines processed by UMR during the audit period for both medical and dental claims. The accuracy and completeness of UMR's data directly impacted the screening categories we completed and the integrity of 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
- Specific reinsurance reimbursement

## Methodology

We used ESAS to analyze claim payment accuracy as well as any opportunities for system and process improvement. Using the data file provided by UMR, we readjudicated each line on every claim the plan paid or denied during the audit period against the plan's benefits. 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 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 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.

## 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 following detail report shows, by category, the number of line items or claimants with process improvement opportunities remaining after our analysis and removal of verified false positives. A CTI auditor reviewed UMR's responses and supporting documentation. The administrator responses are 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 you can discuss how to reduce errors and re-work in the future with your administrator.**

| Categories for Potential Amount at Risk | | | | |
|---|---|---|---|---|
| **Client:** PEBP<br>**Screening Period:** Q1 FY2023 | | | | |
| **Category** | **Number of Line Items** | **Number of Claimants** | **Billed Charge** | **Allowed Amount*** |
| **Duplicate Payments** | | | | |
| Providers and/or Employees | 88 | 26 | $17,215 | $14,215 |
| **Exclusions** | | | | |
| Marriage Counseling | 2,808 | 858 | $299,741 | $207,444 |
| Massage Therapy | 3 | 2 | $60 | $30 |
| **Fraud, Waste, and Abuse** | | | | |
| Specialty Medications – Non-hospital | 176 | 86 | $426,454 | $222,672 |

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

Electronic screening of all service lines processed revealed the potential for incorrectly paid claims. Analysis confirmed the opportunity for process improvement and further testing is recommended. For each potential error, we sent an ESAS Questionnaire (QID) to 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** | | | | |
| 71 | $43.99 | Agree. | Procedural deficiency and overpayment remain for duplicate claim payments. | ☒ M ☐ S |
| 73 | $31.36 | | | ☒ M ☐ S |
| 79 | $18.58 | | | ☒ M ☐ S |
| 80 | $451.05 | | | ☒ M ☐ S |
| 83 | $22.58 | | | ☒ M ☐ S |
| 89 | $6,138.88 | | | ☒ M ☐ S |
| 91 | $30.00 | | | ☒ M ☐ S |
| 95 | $18.58 | | | ☒ M ☐ S |
| 96 | $18.37 | | | ☒ M ☐ S |
| 97 | $13.32 | | | ☒ M ☐ S |
| 98 | $25.49 | | | ☒ M ☐ S |
| 99 | $9.42 | | | ☒ M ☐ S |
| 100 | $8.87 | | | ☒ M ☐ S |
| 102 | $36.71 | | | ☒ M ☐ S |
| 103 | $85.00 | | | ☒ M ☐ S |
| 104 | $65.00 | | | ☐ M ☒ S |
| 106 | $38.66 | | | ☒ M ☐ S |
| 77 | $0.00 | Agree. This was a manual processing error. Additional coaching and training have taken place with the CFR. This resulted in a $0.00 payment as there was no payment made. The claim was adjusted and denied on 10-24-2022. | Procedural deficiency and overpayment remain. Duplicate claims processed and applied to the deductible. | ☒ M ☐ S |
| 78 | $252.00 | Disagree. These are not duplicate claims. Each claim has different diagnosis. Claim xxxxxxx433 auto adjudicated, Claim xxxxxxx664 was manually processed. | Procedural deficiency and overpayment remain. Duplicate charges for an opthalmological exam (92014) on same day for services rendered by the same physician should have been investigated as a potential duplicate claim. Claims were not billed with a modifier indicating repeat procedure. | ☒ M ☒ S |
| 82 | $0.00 | Disagree. The provider submitted claims for the same date of service with different billed amounts. The duplicate logic considers these as 2 separate claims. The provider identified the billing error on their end and notified UMR. The overpayment was credited back on 11-1-2022 in the amount of $231.00. | Procedural deficiency and deductible overapplication of $17 identified. Duplicate claims paid. UMR corrected the claim on 11/1/22, prior to the audit beginning 11/14/22. | ☐ M ☒ S |
| **Plan Exclusions** | | | | |
| **Marriage Counseling** | | | | |
| 143 | $52.80 | Agree. Marriage Counseling is excluded on this plan. Coding in the UMR system has been updated to deny all future claims billed with this type of diagnosis. This claim will be adjusted to deny, and an overpayment | Procedural deficiency and overpayment identified. Per page 94 of the plan document, marriage/ couples therapy is not a covered expense. The diagnosis code billed Z63.0 is for problems in relationship with spouse or partner. | ☒ M ☐ S |

| ESAS Findings Detail Report | | | | |
|---|---|---|---|---|
| **QID** | **Under/ Over Paid** | **UMR Response** | **CTI Conclusion** | **Manual or System** |
| | | request will be sent to the provider. This results in a $52.80 overpayment. UMR has requested an impact report and can provide results to PEBP upon completion of the review. | | |
| **Massage Therapy** | | | | |
| 147 | $10.00 | Agree. Claims are identified by diagnosis and procedure code selections. Code 97124 was allowed in error. This results in a $10.00 overpayment. | Procedural deficiency and overpayment identified. Massage therapy is excluded on page 115 of the plan document. | ☒ M ☐ S |
| **Potential Fraud, Waste, and Abuse** | | | | |
| **Specialty Medications** | | | | |
| 110 | $3,753.79 sampled claim and $20,339.29 on entire claim. | Agree. This error is the result of a manual repricing error. Additional coaching and training have taken place. This results in a $20,339.29 overpayment. The claim has been adjusted and an overpayment request send to the provider. | Procedural deficiency and overpayment identified. The allowance for J0878 should have been $44.94 paid at 80%. | ☒ M ☐ S |

# 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
- Claims Processing 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 you can discuss how to reduce errors and re-work in the future with your administrator.**

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 $203,086.07. The claims sampled and reviewed revealed $2,458.86 in underpayments and $161.00 in overpayments, for an absolute value variance of $2,619.86. This reflects a weighted Financial Accuracy rate of 98.23% over the stratified sample. Detail provided in the table below, Random Sample Findings Detail Report.

UMR did not meet the Performance Guarantee for PEBP in Q1 FY2023 of 99.4% for this measure. The penalty owed is 1.5% of the administrative fees of $1,303,565.40 or $19,553.48.

**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 16 incorrectly paid claims and 184 correctly paid claims. Detail provided in the table below, Random Sample Findings Detail Report.

| Total Claims | Incorrectly Paid Claims | | Accuracy |
|---|---|---|---|
| | Underpaid Claims | Overpaid Claims | |
| 200 | 3 | 13 | 92.0% |

**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. Detail provided in the table below, Random Sample Findings Detail Report.

UMR did not meet the Performance Guarantee for PEBP in Q1 FY2023 of 98% for this measure. The penalty owed is 1.0% of the administrative fees of $1,303,565.40 or $13,035.65.

| Correctly Processed Claims | Incorrectly Processed Claims | | Accuracy |
|---|---|---|---|
| | System | Manual | |
| 182 | 7 | 11 | 91.0% |

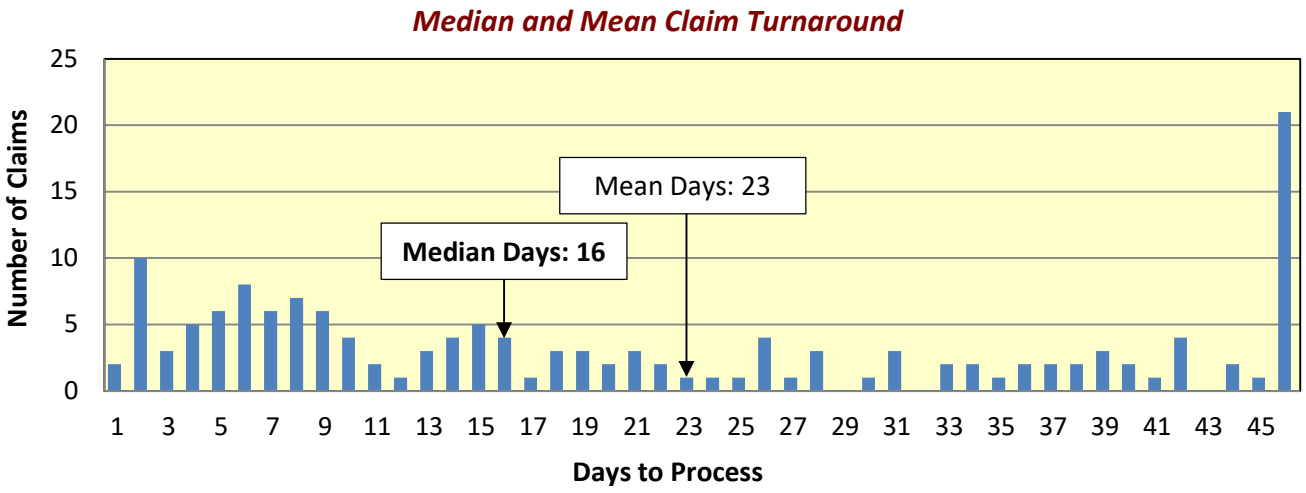
| Random Sample Findings Detail Report | | | | |
|---|---|---|---|---|
| **Audit No.** | **Under/ Over Paid** | **UMR Response** | **CTI Conclusion** | **Manual or System** |
| **Coinsurance Calculation** | | | | |
| 2002 | $4.60 | Agree. Code 0220 is on procedure selection to pay at deductible then 80%. Th(ese) claim(s) paid at 100% in error. UMR has requested an impact review and can provide results to PEBP upon complete of their review. | Adjudication error and overpayment identified. The coinsurance applied for the periapical film should have been 80% and it was $0.00. The plan states on page 13, film fees, including examination and diagnosis are covered under Basic Services. | ☐ M ☒ S |
| 2007 | $4.20 | | | ☐ M ☒ S |
| 2008 | $4.60 | | | ☐ M ☒ S |
| 2009 | $5.20 | | | ☐ M ☒ S |
| 2011 | $3.20 | | | ☐ M ☒ S |
| 2018 | $4.60 | | | ☒ M ☐ S |
| 2024 | $4.60 | | | ☐ M ☒ S |
| 2031 | $5.80 | | | ☒ M ☐ S |
| 2048 | $4.20 | | | ☒ M ☐ S |
| **Deductible Calculation** | | | | |
| 2005 | $21.00 | Agree. Code 0220 is on procedure selection to pay at deductible then 80%. Th(ese) claim(s) paid at 100% in error. UMR has requested an impact review and can provide results to PEBP upon complete of their review. | Adjudication error and overpayment identified. The deductible should have been applied for the periapical film and it was not. The plan states on page 13, film fees, including examination and diagnosis are covered under Basic Services. | ☐ M ☒ S |
| 2019 | $21.00 | | | ☒ M ☐ S |
| 2023 | $28.00 | | | ☒ M ☐ S |
| **Denied Eligible Expense** | | | | |
| 1085 | $0 | Agree. The claim should have been priced per the contract and allow $1987.00 with a discount of $1317.00 for rev code 450 CPT | Adjudication error and deductible under accumulation of $1,317.00 identified for | ☒ M ☐ S |

| Random Sample Findings Detail Report | | | | |
|---|---|---|---|---|
| **Audit No.** | **Under/ Over Paid** | **UMR Response** | **CTI Conclusion** | **Manual or System** |
| | | 99283. The full $1987.00 would apply to the members deductible. This results in a $0.00 payment error. | denial of eligible emergency room charge. | |
| 1127 | ($271.66) | Agree. This claim was denied for COB in error. This results in a $271.66 underpayment. | Adjudication error and underpayment identified. The sample claim was submitted with no indication of other insurance and the other insurance review reflects no other coverage. However, the claim was denied for primary coverage EOB. | ☒ M ☐ S |
| **Copayment Calculation** | | | | |
| 1008 | ($20.00) | Agree. A $20.00 PCP copay should have applied to this claim. This results in a $20.00 underpayment. | Adjudication error underpayment identified. The copay should have been $20.00, and it was $40.00. | ☒ M ☐ S |
| 1143 | $50.00 | Agree. A specialist copay should have been applied to this claim. This results in a $50.00 overpayment. | Adjudication error overpayment identified. The copay should have been $50.00, and it was $0.00. | ☒ M ☐ S |
| **PPO Discount** | | | | |
| 1102 | ($2,167.20) | Agree. This claim should have been priced utilizing the Mountain View Hospital contract. Revenue code 450 CPT 99284 $4,180.00 allowable amount is $2,709.00. $4,180 - $1,471 (discount) = $2,709 x 80% = $2,167.20 payment. This results in a $2,167.20 underpayment. | An adjudication error and underpayment identified. The entire claim amount of $19,485.00 was denied as a discount in error. This claim should have been priced utilizing the Mountain View Hospital contract. | ☐ M ☒ S |
| **Incorrect COB With Medicare** | | | | |
| 1053 | NA | Agree. UMR did not coordinate this claim correctly with Medicare. $688.55 is the correct amount to apply to this member's deductible and $1190.31 is the amount that was overapplied to the member's OOP for the plan year. UMR will adjust this claim accordingly and review the member's file. This results in a $0.00 payment error as there was no payment made. | Adjudication error, deductible and coinsurance over accumulation identified. Benefits were not correctly coordinated with Medicare. The Medicare EOMB states the patient responsibility is $78.66. | ☒ 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.




UMR did not meet the Performance Guarantees for PEBP in Q1 FY2023 of 92% processed within 14 days and 99% processed within 30 days for this measure. The penalty owed for each of the Performance Guarantee is 1.0% of the administrative fees of $1,303,565.40 or $26,071.31.

The increased claim turnaround time observed during this audit period may have impacted the total paid amount and volume of claims processed because these are notably lower than in prior audits.

# DATA ANALYTICS

## Medical Findings

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

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

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

**Network Provider Utilization and Discount Savings**

The Network Provider Utilization and Discount Savings report provides an evaluation of provider network discounts obtained during the audit period. Since discounts can be calculated differently by administrators, carriers, and benefit consultants, we believe calculating discounts in the same manner for all our clients will allow for more meaningful comparisons to be made.

***Scope***

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

***Report***
We screened 100% of non-facility claims against OIG's LEIE and there were no claims paid to providers on the OIG's LEIE. This is an improvement from prior audits.

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

***Scope***
Our review included all in-network services we believe should be categorized as preventive and paid at 100%. The guidance provided by HHS for the definition of preventive services is somewhat vague, leaving it up to individual health plans to define their own system edits. In addition to the U.S. Preventive Services Task Force recommendations, CTI researched best practices of major health plan administrators to develop a compliance review we believe reflects the industry's most comprehensive overview of procedures to be paid at 100%. Our review did not include services:

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

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

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

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

The preventive services compliance review shows the frequency of claims paid at less than required benefit levels (i.e., claims reduced payment due to the application of deductibles, coinsurance, and/or

copayments). We electronically screened 78 categories of preventive services that match the preventive care services specified by HHS including immunizations, women's health, tobacco use counseling, cholesterol and cancer screenings, and wellness examinations. This review either confirms compliance with PPACA or highlights areas for improvement.

CTI's analysis also found that 99.74% of the procedure codes identified as preventive services were paid by UMR at 100% when provided in-network. The following reports provide an outline for discussion between PEBP and UMR. This is an improvement from prior audits

| Preventive Care Services Compliance Review | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Claim Lines Submitted | Denied | Applied Deductible | | Applied Copay | | Applied Coinsurance | | Paid @100% | | |
| Edit Guideline | Preventive Service Benefit | # | # | # | Amount | # | Amount | # | Amount | # | Amount | % |
| HHS | Breastfeeding support and counseling - women | 34 | 6 | 7 | $1,517 | 3 | $150 | 2 | $67 | 16 | $1,755 | 57.14% |
| USPSTF-A,B | Cholesterol abnormalities screening - women >19 | 578 | 37 | 0 | $0 | 0 | $0 | 0 | $0 | 521 | $9,500 | 96.30% |
| USPSTF-A | Cholesterol abnormalities screening - men 35-75 | 428 | 36 | 0 | $0 | 0 | $0 | 0 | $0 | 381 | $5,611 | 97.19% |
| HHS | Gestational Diabetes Mellitus screening - women | 91 | 11 | 0 | $0 | 0 | $0 | 1 | $1 | 79 | $1,050 | 98.75% |

**NCCI Editing Compliance**

While there are no universally accepted correct coding guidelines among private insurers and administrators, the Centers for Medicare & Medicaid Services (CMS), the nation's largest payer for health care, took the initiative to provide valuable guidance for medical benefit plans. Implementation of NCCI mandated several initiatives to prevent improperly billed claims from being paid under Medicare and Medicaid.

***Scope***

The two NCCI initiatives that can offer the greatest return benefit to self-funded employee benefit plans are the Procedure-to-Procedure (PTP) Edits and Medically Unlikely Edits (MUEs).

Our claim system code editing analysis identified services submitted to the plan and paid by 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 your administrator to determine the extent to which they incorporate CMS edits. Using these edits typically reduces claim expense and furthers efforts toward achieving standardized code-editing systems for all payers.

***PTP Edits Reports***

PTP Edits compare procedure codes from multiple claim lines on the same day to identify when procedures submitted on the same claim cannot be billed together. Our reports are grouped by outpatient hospital services and non-facility claims using CMS' quarterly updated data. If your administrator is not currently using these CMS edits, CTI's reports will help you evaluate the savings you would have realized had the PTP Edits been in place.

| Procedure to Procedure Edits | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| PEBP - UMR | | | | | | | | |
| Based on Paid Dates 7/1/2022 through 9/30/2022 | | | | | | | | |
| Outpatient Hospital Services (facility claims with codes not designated inpatient) | | | | | | | | |
| Primary | | Secondary | | | Primary Description | Secondary Description | Line | Amount CMS |
| Code | Mod | Code | Mod | Mod Use | | | Count | Would Deny |
| 94760 | | 99284 | 2 | YES | MEASURE BLOOD OXYGEN LEVEL | EMERGENCY DEPT VISIT | 7 | $14,755 |
| | | | | | CPT Manual or CMS manual coding instructions | | | |
| 94760 | | 99285 | 2 | YES | MEASURE BLOOD OXYGEN LEVEL | EMERGENCY DEPT VISIT | 3 | $7,469 |
| | | | | | CPT Manual or CMS manual coding instructions | | | |
| 90471 | | 99285 | 2 | YES | IMMUNIZATION ADMIN | EMERGENCY DEPT VISIT | 3 | $7,321 |
| | | | | | CPT Manual or CMS manual coding instructions | | | |
| 94640 | | 99285 | 2 | YES | AIRWAY INHALATION TREATMENT | EMERGENCY DEPT VISIT | 4 | $5,087 |
| | | | | | CPT Manual or CMS manual coding instructions | | | |
| 99152 | | 99285 | 2 | YES | MOD SED SAME PHYS/QHP INITIAL 15 MINS 5/> YR | EMERGENCY DEPT VISIT | 2 | $4,721 |
| | | | | | Standards of medical / surgical practice | | | |
| 45385 | 3 | 45380 | 05,03 | YES | LESION REMOVAL COLONOSCOPY | COLONOSCOPY AND BIOPSY | 7 | $4,595 |
| | | | | | More extensive procedure | | | |
| 90471 | | 99282 | | YES | IMMUNIZATION ADMIN | EMERGENCY DEPT VISIT | 5 | $4,530 |
| | | | | | CPT Manual or CMS manual coding instructions | | | |
| 90471 | | 99284 | 2 | YES | IMMUNIZATION ADMIN | EMERGENCY DEPT VISIT | 3 | $4,302 |
| | | | | | CPT Manual or CMS manual coding instructions | | | |
| 90471 | | 99283 | 2 | YES | IMMUNIZATION ADMIN | EMERGENCY DEPT VISIT | 4 | $4,247 |
| | | | | | CPT Manual or CMS manual coding instructions | | | |
| 22853 | | 22845 | 5 | YES | INSJ BIOMCHN DEV INTERVERTEBRAL DSC SPC W/A | INSERT SPINE FIXATION DEVICE | 1 | $3,067 |
| | | | | | HCPCS/CPT procedure code definition | | | |
| | | | | | | **Top 10 TOTAL** | **39** | **$60,093** |
| | | | | | | **GRAND TOTAL** | **291** | **$130,060** |

| Non-Facility (non-facility claims with CPT codes:00100 - 99999) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Primary | | Secondary | | | Primary Description | Secondary Description | Line | Amount CMS |
| Code | Mod | Code | Mod | Mod Use | | | Count | Would Deny |
| 90460 | | 99394 | 2 | YES | IM ADMIN 1ST/ONLY COMPONENT | PREV VISIT EST AGE 12-17 | 205 | $26,946 |
| | | | | | CPT Manual or CMS manual coding instructions | | | |
| 90460 | | 99392 | 2 | YES | IM ADMIN 1ST/ONLY COMPONENT | PREV VISIT EST AGE 1-4 | 210 | $25,126 |
| | | | | | CPT Manual or CMS manual coding instructions | | | |
| 90471 | | 99396 | 2 | YES | IMMUNIZATION ADMIN | PREV VISIT EST AGE 40-64 | 86 | $18,307 |
| | | | | | CPT Manual or CMS manual coding instructions | | | |
| 90460 | | 99391 | 2 | YES | IM ADMIN 1ST/ONLY COMPONENT | Per pm reeval est pat infant | 136 | $14,619 |
| | | | | | CPT Manual or CMS manual coding instructions | | | |
| 90471 | | 99214 | 2 | YES | IMMUNIZATION ADMIN | Office/outpatient visit for E&M of estab | 82 | $14,144 |
| | | | | | CPT Manual or CMS manual coding instructions | | | |
| 90460 | | 99393 | 2 | YES | IM ADMIN 1ST/ONLY COMPONENT | PREV VISIT EST AGE 5-11 | 100 | $12,241 |
| | | | | | CPT Manual or CMS manual coding instructions | | | |
| 17000 | | 99213 | 2 | YES | DESTRUCT PREMALG LESION | Office/outpatient visit for E&M of estab | 123 | $12,176 |
| | | | | | CPT Manual or CMS manual coding instructions | | | |
| 11102 | | 99213 | 2 | YES | TANGENTIAL BIOPSY SKIN SINGLE LESION | Office/outpatient visit for E&M of estab | 105 | $9,990 |
| | | | | | CPT Manual or CMS manual coding instructions | | | |
| 17110 | | 99213 | 2 | YES | DESTRUCT B9 LESION 1-14 | Office/outpatient visit for E&M of estab | 101 | $9,022 |
| | | | | | CPT Manual or CMS manual coding instructions | | | |
| 96372 | | 99214 | 2 | YES | THER/PROPH/DIAG INJ SC/IM | Office/outpatient visit for E&M of estab | 40 | $5,659 |
| | | | | | Standards of medical / surgical practice | | | |
| | | | | | | **Top 10 TOTAL** | **1,188** | **$148,232** |
| | | | | | | **GRAND TOTAL** | **3,666** | **$386,395** |

### *Medically Unlikely Edits (MUE) Reports*

An MUE is an edit that tests claim lines for the same beneficiary, procedure code, date of service, and billing provider against a maximum allowable number of service units. The MUE rule for a given code is the maximum number of service units a provider should report for a single day of service. MUE errors could be caused by incorrect coding, inappropriate services performed, or fraud. MUEs do not require Medicare contractors to perform a manual review or suspend claims; rather, claim lines are denied and must be correctly resubmitted by providers, typically with a lesser payment amount.

CTI's MUE analyses are grouped into three separate reports, outpatient hospital, non-facility, and ancillary. Note: UMR's Outpatient Hospital screening had no results.

| NCCI MUE Edits | | | | |
|---|---|---|---|---|
| PEBP - UMR | | | | |
| Based on Paid Dates 7/1/2022 through 9/30/2022 | | | | |
| **Non-Facility (non-facility claims with CPT codes:00100 - 99999)** | | | | |
| **Procedure Code** | **Service Unit Limit** | **Procedure Description** | **Line count Exceeding Limit** | **Amount CMS Would Deny** |
| 95165 | 30 | ANTIGEN THERAPY SERVICES | 10 | $6,719 |
| | | Rationale: Clinical: Data | | |
| 31295 | 1 | Nasal/sinus endoscopy, surgical, w dilation (balloon dila | 5 | $4,824 |
| | | Rationale: CMS Policy | | |
| 97155 | 24 | ADAPT BHV TX PRTCL MODIFICAJ PHYS/QHP EA 15 MIN | 2 | $1,800 |
| | | Rationale: Clinical: Society Comment | | |
| 86255 | 5 | FLUORESCENT ANTIBODY SCREEN | 1 | $1,632 |
| | | Rationale: Clinical: Data | | |
| 96133 | 7 | NEUROPSYCHOLOGICAL TST EVAL PHYS/QHP EA ADDL HR | 1 | $1,215 |
| | | Rationale: Nature of Service/Procedure | | |
| 31255 | 1 | REMOVAL OF ETHMOID SINUS | 2 | $995 |
| | | Rationale: CMS Policy | | |
| 30140 | 1 | RESECT INFERIOR TURBINATE | 4 | $684 |
| | | Rationale: CMS Policy | | |
| J3480 | 40 | INJ POTASSIUM CHLORIDE | 3 | $450 |
| | | Rationale: Clinical: Data | | |
| 31256 | 1 | EXPLORATION MAXILLARY SINUS | 1 | $266 |
| | | Rationale: CMS Policy | | |
| 84182 | 6 | PROTEIN WESTERN BLOT TEST | 2 | $240 |
| | | Rationale: Clinical: Data | | |
| | | **Top 10 TOTAL** | **31** | **$18,825** |
| | | **GRAND TOTAL** | **48** | **$20,376** |

| 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+336:5 | 1 | THER CGM SUPPLY ALLOWANCE | 4 | $3,885 |
| | | Rationale: Code Descriptor / CPT Instruction | | |
| V2520 | 2 | CONTACT LENS HYDROPHILIC | 6 | $565 |
| | | Rationale: Anatomic Consideration | | |
| A7520 | 1 | TRACH/LARYN TUBE NON-CUFFED | 1 | $232 |
| | | Rationale: Published Contractor Policy | | |
| K0001 | 1 | STANDARD WHEELCHAIR | 2 | $224 |
| | | Rationale: Code Descriptor / CPT Instruction | | |
| E0443 | 1 | PORTABLE 02 CONTENTS, GAS | 1 | $214 |
| | | Rationale: Code Descriptor / CPT Instruction | | |
| V2523 | 2 | CNTCT LENS HYDROPHIL EXTEND | 2 | $110 |
| | | Rationale: Anatomic Consideration | | |
| V2500 | 2 | CONTACT LENS PMMA SPHERICAL | 1 | $110 |
| | | Rationale: Anatomic Consideration | | |
| A7035 | 1 | POS AIRWAY PRESS HEADGEAR | 2 | $84 |
| | | Rationale: Published Contractor Policy | | |
| A4253 | 1 | BLOOD GLUCOSE/REAGENT STRIPS | 4 | $62 |
| | | Rationale: Nature of Equipment | | |
| K0003 | 1 | LIGHTWEIGHT WHEELCHAIR | 1 | $51 |
| | | Rationale: Code Descriptor / CPT Instruction | | |
| | | **Top 10 TOTAL** | **24** | **$5,537** |
| | | **GRAND TOTAL** | **29** | **$5,607** |

## Global Surgery Prohibited Fee Period Analysis

CMS created the definition of global surgical package to make payments for services provided by a surgeon before, during, and after procedures. The objective of CTI's Global Surgery Prohibited Fee Period Analysis is to compare paid surgical claims to Medicare's payment guidelines and identify instances of unbundling and improper use of evaluation and management (E/M) coding.

### *Scope*

The scope of the Global Surgery Prohibited Fee Period Analysis is surgery charges provided in any setting, including inpatient hospital, outpatient hospital, ambulatory surgical center (ASC), and physician's office. Claims for surgeon visits in intensive care or critical care units are also included in the global surgical package. Our analysis encompasses the three types of procedures with global surgical packages: simple, minor, and major. Each type has specific global periods 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 our findings, we will help you identify strategies to monitor and eliminate unbundling within your plan.

| PEBP - UMR | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Audit Period 7/1/2022 - 9/30/2022 | | | | | | | | | |
| 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 |
| 813253496 | 862 | $169,927 | 134 | 13.5% | $20,044 | 0 | $0 | 117 | $13,968 |
| 880103557 | 312 | $178,545 | 106 | 25.4% | $13,310 | 0 | $0 | 95 | $8,320 |
| 880175775 | 406 | $73,162 | 75 | 15.6% | $10,674 | 0 | $0 | 69 | $5,850 |
| 880133501 | 290 | $86,930 | 41 | 12.4% | $7,460 | 0 | $0 | 43 | $5,640 |
| 203395567 | 196 | $36,264 | 22 | 10.1% | $18,059 | 0 | $0 | 21 | $3,670 |
| 270028866 | 92 | $79,803 | 23 | 20.0% | $11,808 | 0 | $0 | 21 | $2,808 |
| 20566741 | 40 | $27,815 | 22 | 35.5% | $1,951 | 0 | $0 | 19 | $2,790 |
| 880498458 | 23 | $10,537 | 15 | 39.5% | $2,661 | 0 | $0 | 16 | $2,782 |
| 208628418 | 80 | $36,521 | 18 | 18.4% | $7,224 | 0 | $0 | 16 | $2,674 |
| 680405220 | 66 | $96,298 | 13 | 16.5% | $2,963 | 0 | $0 | 13 | $2,341 |
| **Top 10** | **2,367** | **$795,803** | **469** | **16.5%** | **$96,155** | **0** | **$0** | **430** | **$50,843** |
| **Overall Total** | **5,359** | **$1,823,740** | **1,257** | **19.0%** | **$268,342** | **0** | **$0** | **1,145** | **$129,213** |

## CONCLUSION

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

# APPENDIX – ADMINISTRATOR RESPONSE TO DRAFT REPORT

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.

Your administrator's response to the draft report follows.

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

Revised-March 9, 2023

Joni,

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

Performance Guarantees: UMR Account Management Team has provided CTI with the requested reports noted in the report.

**Targeted Sample Analysis:**

**Duplicate Payment**

**QID 71, 73, 79, 80, 83, 89, 95, 96, 97, 98, 99, 100, 102, 103, and 106 –** UMR agrees with these errors. These were manual processing errors. Additional coaching and training have taken place with the Customer First Representative (CFR). These claims will be adjusted to deny, and an overpayment request sent to the provider of service. This results in a $6813.59 overpayment. UMR has requested an impact report and can provide results to PEBP upon completion of the review.

**QID 77 –** UMR agrees with this error. This was a manual processing error. Additional coaching and training have taken place with the CFR. This resulted in a $0.00 payment as there was no payment made. The claim was adjusted and denied on 10-24-2022.

**QID 78 –** UMR disagrees with this error. UMR has enhanced duplicate logic programming in place. The logic is reviewed regularly as we continue to find ways of improving and finding specific criteria to alleviate duplicate claim submission payments. The sample claim has a different referring physician and diagnosis from the identified related claim. These differences are considered a new claim and will not be flagged for duplicate. These claims are allowed appropriately.

**QID 82 –** UMR disagrees with this error. The provider submitted claims for the same date of service with different billed amounts. The duplicate logic considers these as 2 separate claims. The provider identified the billing error on their end and notified UMR. The overpayment was credited back on 11-1-2022 in the amount of $231.00.

**QID 91 –** UMR agrees with this error. This was a manual processing error. Additional coaching and training have taken place with the CFR. This resulted in a $20.00 overpayment. The claim was adjusted and denied on 12-5-2022.

**QID 104 –** UMR agrees with this error. This was a system limitation error due to the code not having a maximum frequency. This results in a $0.00 payment error as there was no payment made. This claim was adjusted on 11-23-2022.

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

**Plan Exclusions**

**QID 143 –** UMR agrees with this error. Marriage Counseling is excluded on this plan. Coding in the UMR system has been updated to deny all future claims billed with this type of diagnosis. This claim will be adjusted to deny, and an overpayment request will be sent to the provider. This results in a $52.80 overpayment. UMR has requested an impact report and can provide results to PEBP upon completion of the review.

**QID 147 –** UMR agrees with this error. Massage Therapy is excluded on this plan. Coding in the UMR system has been updated to deny all future claims billed with this type of procedure. This results in a $10.00 overpayment. This claim has been adjusted and an overpayment request send to the provider. UMR has requested an impact report and can provide results to PEBP upon completion of the review.

**Potential Fraud, Waste, and Abuse**

**QID 110 –** After further review UMR agrees with is error. This error is the result of a manual repricing error. Additional coaching and training have taken place. This results in a $20,339.29 overpayment. The claim has been adjusted and an overpayment request send to the provider.

**Random Sample Audit**

**Coinsurance Calculation**

**Samples 2002, 2007, 2008, 2009 2011, 2018, 2024, 2031, and 2048 –** UMR agrees with these errors. Coding update was completed on 10/18/22 to pay this code at 80% per plan intent. Claims are in the process of being adjusted with correct coinsurance. This results in a $41 overpayment. UMR has requested an impact review and can provide results to PEBP upon completion of the review

**Deductible Calculation**

**Samples 2005, 2019 and 2023 –** UMR agrees with these errors. Coding update was completed on 10/18/22 to apply the deductible per plan intent. Claims are in the process of being adjusted with correct deductible and coinsurance. This results in a $70 overpayment. UMR has requested an impact review and can provide results to PEBP upon completion of the review.

**Denied Eligible Expense**

**Sample 1085 –** UMR agrees with this error. This claim was manually repriced incorrectly by the repricing analyst. An incorrect allowable amount was applied. Additional coaching and training have taken place. The claim has been adjusted and additional payment of $1589.60 was issued to the provider.

**Sample 1127 –** UMR agrees with this error. Coordination of Benefits logic has been updated in the system per the plan intent. Controls have been put into place to remediate the error. This claim was adjusted and additional payment of $271.66 has been issued to the provider. UMR has requested an impact review and can provide results to PEBP upon completion of the review.

**Sample 2036 –** UMR disagrees with this error. Per the plan intent, these services require Xray's, and UMR denied the claims for additional review. The review was completed on 10/10/22. The claim was adjusted on 10/11/22 issuing payment of $924.50 per plan benefits.

**Sample 2048 –** After further review, UMR agrees with this error. No frequency applies to inlays per plan intent. The claim has been adjusted and payment issued to the provider. This results in a $214.80 underpayment.

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**Sample 1008 –** UMR agrees with this error. The CFR did not follow the procedures that are in place to apply the correct copay for this type of claim. Additional coaching and training have taken place. This claim has been adjusted with additional payment of $20.00 issued to the provider.
**Sample 1143** – UMR agrees with this error. This was a system error. The claim has been adjusted and overpayment request sent to the provider. This results in a $50 overpayment. UMR has requested an impact review and can provide results to PEBP upon completion of the review.

**PPO Discount**

**Sample 1102 –** UMR agrees with this error. This claim was manually repriced in correctly by the repricing team. An incorrect allowable amount was applied. Additional training and coaching have taken place. The claim was adjusted on 11-22-2022 with additional payment of $2167.20 issued to the provider.

**Incorrect COB with Medicare**
**Sample 1053 –** UMR agrees with this error. This was a manual processing error by the CFR. COB with Medicare was not correctly entered. Additional coaching and training have taken place. This claim has been adjusted to deny per receipt of corrected claim 22285301314. This results in a $0.00 payment as no payment was made.

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

Sincerely,

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


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