Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT and Annual Operational Review

State of Nevada Public Employees' Benefits Program Plans

Administered by UMR Insurance Company

Audit Period: April 1, 2024 – June 30, 2024
Audit Number 1.FY24.Q4

Presented to

State of Nevada Public Employees' Benefits Program

November 21, 2024

CLAIM TECHNOLOGIES INCORPORATED

PART OF THE BROWN & BROWN TEAM

TABLE OF CONTENTS

EXECUTIVE SUMMARY

This ***Quarterly Findings Report*** is a compilation of the detailed information, findings, and conclusions drawn from Claim Technologies Incorporated's (CTI's) audit of UMR Insurance Company's (UMR's) administration of the State of Nevada Public Employees' Benefits Program (PEBP) medical and dental plans.

Scope

CTI performed an audit for the period of April 1, 2024 through June 30, 2024 (quarter 4 (Q4) for Fiscal Year (FY) 2024). The population of claims and amount paid during the audit period reported by UMR Benefits:

Medical and Dental	
Total Paid Amount	$70,620,439
Total Number of Claims Paid/Denied/Adjusted	228,502

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

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

Auditor's Opinion

Based on these findings, and in our opinion:

1. UMR's Financial Accuracy and Overall Accuracy performance decreased in Q4 FY2024, both performance guarantees were not met, and a 2.5% penalty is owed. Claim turnaround time performance increased in Q4 and no penalty is owed.
2. CTI Recommends UMR should:
    - Review the financial errors identified in our random sample audit and determine if system changes or claim processor training could help reduce or eliminate errors of a similar nature in the future.
    - Review the 100% Electronic Screening with Targeted Sample results and focus on the most material findings.
    - Where appropriate, verify claim processor coaching, feedback, and retraining has occurred because most errors were manually processed.

Summary of UMR's Guarantee Measurements

Based on CTI's Random Sample Audit results, UMR did not meet the Financial Accuracy and Overall Accuracy measurements and penalties are owed. It did, however, meet the Claim Turnaround Time measurements for PEBP in Q4 FY2024. Reported administrative fees for the quarter totaled $1,372,307.36.

Quarterly Metric	Guarantee	Met/Not Met	Penalty	Calculated Penalty
Financial Accuracy (p. 15)	99.4%	Not Met – 96.41%	1.5%	$20,584.61
Overall Accuracy (p. 16)	98.0%	Not Met – 97.5%	1.0%	$13,723.07
Claim Turnaround Time (p. 17)	92% in 14 Days 99% in 30 Days	Met – 93.3% Met – 99.5%	NA NA	$0 $0
		Total Penalty	2.5%	$34,307.68

AUDIT OBJECTIVES

This report contains CTI's findings from our audit of UMR Insurance Company's (UMR) administration of the State of Nevada Public Employees' Benefits Program (PEBP) plans. We provide this report to PEBP, the plan sponsor, and UMR, the claim administrator. A copy of UMR's response to these findings can be found in the Appendix of this report.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and information provided by PEBP and UMR. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to obtain reasonable assurance claims were adjudicated according to the terms of the contract between UMR and PEBP.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of policies, procedures, and systems UMR used to pay PEBP's claims during the audit period. While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

The objectives of CTI's audit of UMR's claim administration were to determine whether:

- UMR followed the terms of its contract with PEBP;
- UMR paid claims according to the provisions of the plan documents and if those provisions were clear and consistent; and
- members were eligible and covered by PEBP's plans at the time a service paid by UMR was incurred.

ANNUAL OPERATIONAL REVIEW

Objective

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

Scope

The scope of the Operational Review included:

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

Methodology

CTI used an Operational Review Questionnaire to gather information from UMR. We modeled our questionnaire after the audit tool used by certified public accounting firms when conducting a Systems and Organization Controls (SOC) audit of a service administrator. We modified that tool to elicit information specific to the administration of your plans.

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

Findings

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

- UMR indicated it maintained levels and types of insurance reasonable and customary for a health services organization with comparable size and market presence.
- UMR was audited by Baker Tilly for compliance with the standards of the American Institute of Certified Public Accountants through the issuance of a Service Organization Controls (SOC) 1 Report. Under SOC 1, the administrator was required to provide a description of its system and controls, which the service auditor validated. CTI received a copy of the report for the period of January 1, 2023 to December 31, 2023. A bridge letter dated July 8, 2024 was also provided noting no material changes were made to internal controls.
- UMR stated it had incorporated all CMS National Correct Coding Initiative edits into its unbundling software.
- High dollar claims billed over $25,000 did not auto adjudicate and were processed by the large dollar claim team. Checks exceeding $100,000 were handled by the internal review team and those exceeding $250,000 were reviewed by an operations senior vice president.
- UMR batched provider payments and issued payments to providers twice weekly for PEBP claim payments.
- UMR reported it honored assignment of benefits for non-network providers which allowed non-network providers to receive payment directly from UMR versus having to pay the member who would then have to pay the non-network provider. This is a best practice.
- UMR had adequately documented training, workflow, procedures, and systems.
- UMR received daily eligibility files; all changes, additions, and terminations were processed daily by UMR.
- Verification of initial or continued coordination of benefits (COB) by UMR was not required by PEBP. When UMR was the secondary payor, it would never pay more than its total allowable amount. UMR reported COB savings of $5,031,092 for the PEBP plans for FY2024.
- UMR reported 94.4% of claims were received electronically during the audit period and 75.05% of claims received were auto adjudicated. These were increases from the prior year.
- UMR reported it had a $100.00 minimum dollar threshold to recoup an overpayment and could automatically recoup a refund from the next payment made to the same provider. No minimum dollar threshold was imposed when recovered via auto recoupment. UMR reported it used vendors to perform overpayment recovery. No fee was charged back to PEBP for recoveries from Optum Payment Recovery Services. A 20% fee was charged back to PEBP for credit balance recoveries through Optum. An overpayment recovery report was not provided to CTI for FY2024.
- UMR used the OnBase appeal tracking system. UMR leadership monitored tracking daily to ensure timely responses to member appeals. UMR provided a member appeal tracking report to CTI for FY2024. It showed 203 appeals received; 149 appeals upheld the original determination and 54 were overturned. Sixteen appeals took more than 20 days to resolve.

- UMR created system edits, developed review procedures, and provided special training to its claim professionals to help identify potential fraudulent situations. UMR reported 2,642 new potential fraud, waste, and abuse cases opened in FY2024 with 241 closed.
- UMR stated it used state websites and the Office of Inspector General's List of Excluded Individuals/Entities to identify sanctioned providers. CTI identified two providers on the LEIE that were paid by UMR during FY2024.
- UMR reported it received 99.1% of PEBP's eligible charges from in-network providers. To help drive additional provider savings, UMR participated in programs such as Cancer Resource Programs and Centers of Excellence.
- UMR put policies and procedures in place to comply with the Transparency in Coverage Act (No Surprises Billing) effective January 1, 2022. UMR reported 16 appeals and 34 inquiries received for allowances made for out-of-network services. Seven appeals and ten inquiries were overturned.
- UMR's parent company, UnitedHealthcare's privacy office, developed and implemented HIPAA compliance training. All new employees were required to complete HIPAA training and all employees were required to complete the training annually. UMR reported no breeches during the audit period.

QUARTERLY PERFORMANCE GUARANTEE VALIDATION

As part of CTI's quarterly audit of PEBP, we reviewed the Performance Guarantees included in its contract with UMR. The results for Q4 FY2024 follow.

	Metric	Service Objective	Actual	Met/ Not Met
CLAIMS ADMINISTRATION – SERVICES AND PERFORMANCE GUARANTEES				
1.4	**Claim Adjustment Processing Time:** measured from the time a prior claim submission requiring an adjustment is identified through the date the claim adjustment is processed by service facility personnel.	95.00% 7 Calendar/ 5 Business Days	97.8%	Met
1.5	**Telephone Service Factor:** Defined as the percentage of Client telephone inquiries answered by facility Customer Service Representatives (CSRs) within 30 seconds. Measured from the time caller completes the prompts of the automated telephone system to the time the caller reaches a CSR.	85.00% Calls answered within 30 seconds	92.8%	Met
1.6	**Call Abandonment Rate:** total number of participant and provider calls abandoned, divided by the total number of calls received by the facility's customer service telephone system.	3.00%	0.6%	Met
1.7	**First Call Resolution Rate:** 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%	96.3%	Met
1.8	**Open Inquiry Closure:** addresses the time taken in hours and/or days by CSRs at the administrator's service facility to close open inquiries placed by participants of PEBP to the facility.	90.00% 48 Hours 98.00% 5 Business Days	98.4% 99.6%	Met 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%	97.5%	Met
1.10	**CSR Callback Performance:** measured from the CSR commitment data in hours and/or days to the time the actual callback was placed to the participant.	90.00% Within 24 Hours	100%	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% Within 8 Hours 95.00% Within 24 Hours	100% 100%	Met Met
1.12	**Member Satisfaction:** At least 95%-member satisfaction with the services. Measured as the number of satisfied to highly satisfied survey ratings divided by the total number of survey responses. Survey tool and survey methodology to be mutually agreed upon by Offeror and PEBP.	95.0%	95.63%	Met
1.13	**Account Management – Plan will guarantee that the services provided by the TPA's team during the guarantee period will be satisfactory to PEBP. Areas of satisfaction will include:**			
	Knowledge/Capabilities – Account representative demonstrates competence in getting issues and problems resolved.	Agree	5	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.).			
	Professionalism – Demonstrates objectivity and empathy with customer problems.			
	Flexibility – Ability to meet client-specific needs.			

	Metric	Service Objective	Actual	Met/ Not Met
	Participation in periodic meetings – Attendance at all required client meetings or conference calls.			
	Guarantee measured with staff responses to internal questionnaire. A scale from 1 to 5 will be used to measure performance, where 1 means 'very dissatisfied' and 5 means 'very satisfied'; and 2 through 4 are defined, respectively.			
	Periodic program reports will be provided and presented with recommended actions. Standard program reports, within 30 days to quarter-end. Year-end activity report, within 45 days of program year end.			
	Open Enrollment Support: Accurate materials will be provided at least 60 days prior to the open enrollment period starting on April 1 each year. Representative will be available, if requested, for up to 5 employee benefit fairs.			
	Service Objective (out of a score of 5 on internal questionnaire):	350		
1.14	**Eligibility Processing:** Confirm daily and weekly eligibility and enrollment within specified business days of the receipt of the eligibility information, given that information is complete and accurate.	98.00% 2 Business Days	94.19% 81 days met/ 86 total days	Not Met
1.15	**Data Reporting:** Offeror will provide PEBP with 100% of the applicable reports (within 10 business days for standard reports and within 10 business days of Plan year-end for Annual Reports and Regulatory documents).	100% 10 Business Days	100%	Met
1.17	**ID Card Production and Distribution**	100% 10 Business Days	100%	Met
1.18	**Disclosure of Subcontractors:** Offeror will provide the identity of the subcontractors who have access to PEBP member PHI. Provide identity of subcontractors who have access to PHI within 30 calendar days of the subcontractors' gaining access.	100% 30 Calendar Days	No New Subcontractors	Met
1.19	**PHI:** Offeror will store PEBP member PHI data on designated servers. Must remove PEBP member PHI within 3 business days after offeror knows or should have known using commercially reasonable efforts that such PHI is not store on a designated server.	100% 30 Business Days	No Issues	Met
NETWORK ADMINISTRATION – SERVICES AND PERFORMANCE GUARANTEES				
2.1	**EDI Claims Re-Pricing Turnaround Time:** At least 97% of medical claims covered under the PEBP Medical PPO Network must be electronically re-priced within business 3 days and 99% within business 5 days.	97.00% 3 Business Days 99.00% 5 Business Days	99.5% 99.5%	Met 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%	99.5%	Met
2.3	**Data Reporting – Standard Reports (Quarterly reporting to include Service Performance Standards, Guarantee, Method of Measurement, Actual Performance Results, and Pass/Fail indicator.)** Standard reports must be delivered within business 10 days of end of reporting period or event as determined by PEBP.	100% 10 Business Days	100%	Met
2.4	**Subcontractor Disclosure:** 100% of all subcontractors used by vendor are disclosed prior to any work done on behalf of PEBP. Business Associate Agreements completed by all subcontractors.	100%	No New Subcontractors	Met
2.5	**Provider Directory:** Best efforts to resolve 100% of complaints within 10 business days. Provider Directory issue resolution log maintained by Vendor and periodically reviewed with PEBP.	100% 10 Business Days	No Issues	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%	99.99%	Met

	Metric	Service Objective	Actual	Met/ Not Met
UTILIZATION MANAGEMENT/CASE MANAGEMENT – SERVICES AND PERFORMANCE GUARANTEES				
3.1	**Data Reporting – Standard Reports (Quarterly reporting to include Service Performance Standards, Guarantee, Method of Measurement, Actual Performance Results, and Pass/Fail indicator.)** Standard reports must be delivered within calendar 10 days of end of reporting period or event as determined by PEBP.	100% 10 Calendar Days	100%	Met
3.2	**Notification of potential high expense cases. High expense case is defined as a single claim or treatment plan expected to exceed $100,000.00.** Designated PEBP staff will be notified within 5 business days of the UM/CM vendors initial notification of the requested Service.	100% 5 Business Days	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% 5 Business Days	99.99%	Met
3.4	**Concurrent Hospital Reviews:** Concurrent hospital reviews shall be completed in accordance with URAC/NCQA standards; completed reviews shall be communicated to the provider using an approved method e.g., electronically within 2 business days of determination decision.	98.00% 2 Business Days	100%	Met
3.5	**Retrospective Hospital Reviews:** Retrospective reviews must be completed in accordance with URAC/NCQA standards; completed reviews shall be communicated using an approved method e.g., electronically within 5 business days of determination decision.	98.00% 5 Business Days	100%	Met
3.8	**Hospital Discharge Planning:** CM will contact or attempt to contact 95% of patients discharged from any facility within 3 business days of notification of discharge with clinical coaching and discharge planning assistance.	95.00% 3 Business Days	98.11%	Met
3.9	**Large Case Management:** CM will identify and initiate case management for chronic disease, high dollar claims, and ER usage.	95.00%	95.00%	Met
3.10	**Utilization Management for Medical Necessity and Center of Excellence Usage:** UM review to determine medical necessity in accordance with the MPDs. Services to be performed at a Center of Excellence to be managed through the Case Management process.	98.00%	100%	Met
3.11	**Return On Investment (ROI) Guarantee – Utilization Management/ Case Management:** 2:1 Savings to Fees for Utilization Management/Case Management.	100%	100%	Met
3.12	**Disclosure of Subcontractors:** All subcontractors who have access to PHI or PII data and physical locations where PEBP PHI or PII data is maintained and/or stored must be identified in this contract. Any changes to those subcontractors or physical locations where PEBP data is stored must be communicated to PEBP at least 60 days prior to implementation of services by the subcontractor. Implementation will not be in effect until PEBP has provided written authorization.	100% 60 Calendar Days	No New Subcontractors	Met
3.13	**Unauthorized Transfer of PEBP Data:** All PEBP PHI or PII data will be stored, processed, and maintained solely on currently designated servers and storage devices identified in this contract. Any changes to those designated systems during the life of this agreement shall be reported to PEBP at least 60 calendar days prior to the changes being implemented. Implementation will not be in effect until PEBP has provided written authorization.	100% 60 Calendar Days	No Issues	Met

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

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

Scope

CTI electronically screened 100% of the service lines processed by UMR during the audit period for both medical and dental claims. The accuracy and completeness of UMR's data directly impacted the screening categories we completed and the integrity of our findings. We screened the following high-level ESAS categories to identify potential amounts at risk:

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

Methodology

We used ESAS to analyze claim payment and eligibility maintenance accuracy as well as any opportunities for system and process improvement. Using the data file provided by UMR, we readjudicated each line on every claim the plan paid or denied during the audit period against plan benefits. Our Technical Lead Auditor tested a targeted sample of claims to provide insight into UMR's claim administration as well as operational policies and procedures. We followed these procedures to complete our ESAS process:

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

- ***Audit of Administrator Response and Documentation*** – We reviewed and redacted the responses to eliminate personal health information. Based on the responses and further analysis of the findings, we removed false positives identified from the potential amounts at risk.
- ***Eligibility Verification of Every Claim by Date of Service*** – We used ESAS to compare service dates against the eligibility periods provided to us by the eligibility vendor TELUS Health to look for claims paid for ineligible members.

Findings

We are confident in the accuracy of our ESAS results. It should be noted that dollar amounts associated with the results represent potential payment errors and process improvement opportunities. To substantiate the findings, CTI would have to perform additional testing to provide the basis for remedial action planning or reimbursement.

Categories for Process Improvement

The ESAS Findings Detail Report shows by category the line items where exceptions were noted. PEBP should work with its TPA, UMR, to examine areas of concern. A CTI auditor reviewed UMR's responses and supporting documentation. The administrator responses shown in the ESAS Detail Findings Report on the following pages were copied directly from UMR's reply to audit findings. **It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so PEBP can discuss how to reduce errors and re-work in the future with UMR.**

For each potential error, we sent an ESAS Questionnaire (QID) to UMR for written response. After review of the response and any additional information provided, CTI confirmed the potential for process improvement.

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

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Duplicate Payments				
44	$114.40	Agree.	Procedural deficiency and overpayments remain. UMR paid duplicate charges.	☐ M ☒ S
46	$44.00			☐ M ☒ S
47	$13.06			☒ M ☐ S
50	$79.00			☐ M ☒ S
Plan Exclusions				
Dental, Prosthodontics				
37	$2,484.50	Agree. Non-accident-related dental crown procedures are excluded on the medical plan. This claim should have been denied under the medical plan.	Procedural deficiency and overpayment remain. Per page 93 of the master plan document (MPD), the plan excluded non-accident-related dental expenses.	☒ M ☐ S
Potential Fraud, Waste, and Abuse				
Durable Medical Equipment Over Medicare Allowance				
26	$867.64	Agree. Services billed are medically necessary and appropriate for treatment billed. However, claim was manually entered and paid at billed charges without discount applied.	Procedural deficiency and overpayment remain. The provider discount was not applied to the claim in error.	☒ M ☐ S

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Specialty Medication (Non-Hospital)				
28	$5,113.92	Agree. Specialty medication claims are pended to the CFR processor for review. Authorization is on file. CPT J0585 was priced incorrectly. The allowed amount is $2,739.60.	Procedural deficiency and overpayment remain. The correct provider discount amount was not applied.	☒ M ☐ S
Cardiovascular Genetic Testing				
36	$3,750.00	Agree. This claim should have been denied due to the UM Vendor denial. This claim will be adjusted accordingly requesting $3,750.00 reimbursement.	Procedural deficiency and overpayment remain. Claim should have denied as the required prior authorization was not obtained.	☒ M ☐ S
Copay Application				
Diagnostic Mammography				
12	$3.45	Agree. Per the plan Diagnostic Mammography does have a copay. This results in a $40.00 overpayment. This claim will be adjusted at the completion of the audit.	Procedural deficiency and overpayment remain. Page 32 of the MPD specifically states diagnostic mammography has a $40 copayment. No copay was taken for this date of service (office visit, facility or professional).	☒ M ☐ S
PPO Provider Without Discount				
25	$8,293.00	Agree. This is a SHO provider. The correct allowable is $2,879.84 This is a processor error for not applying appropriate discount. This claim was adjusted on 8/8/24 and is overpaid $8,293.00.	Procedural deficiency and overpayment remain. The provider discount was not applied to the claim in error.	☒ M ☐ S
Preventive Services				
With Copay Applied				
3	($40.00)	Agree. This claim should be allowed at 100%. The claim was adjusted on 7/22/24. This results in a $40.00 underpayment.	Procedural deficiency and underpayment remain. Charge should have paid at 100% of allowed amount under preventive.	☒ 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.

QID Number	Observation
14	To align the plan language with intent, CTI recommends adding language to the EPO MPD to waive the Diagnostic Mammography $40.00 copay when performed for a non-diagnostic reason; for example, when performed after a biopsy to document marker placement.
34	The sampled claim, with a date of service of April 26, 2024, was for procedure code 81479 (Tier 2 - Unlisted Molecular Pathology) genetic testing code. CTI notes a public records release by the U.S. Attorney's Office, District of South Carolina, in July 2019 found the provider of service entered into a Civil settlement regarding false claims act allegations of genetic cancer screening tests. According to the National Health Care Anti-Fraud Association, cardiovascular genetic testing codes have a high-risk of provider abuse, specifically when genetic testing codes are billed by laboratories without a corresponding office visit claim by a physician or other medical provider on the same day as genetic testing procedures, as found on the sampled claim.

QID Number	Observation
	CTI recommends UMR review all genetic testing claims and payments to this provider for medical necessity, including requests for medical records. In addition, CTI recommends UMR have a formal written policy regarding authorization for cardiovascular genetic testing codes. Finally, CTI recommends this provider be referred to UMR's SIU for potential fraud, waste, and abuse review.

Annual Eligibility Verification

CTI electronically compared dates of service for FY2024 Q1 through Q4 and PEBP's electronic eligibility file from TELUS Health. The screening revealed that some services were paid during the audit period for potentially ineligible claimants. The output was provided to TELUS Health for its review and comment. At this time, potentially overpaid amounts have been flagged into one of the following categories:

Employee Eligibility Screening Subcategory	Amount Paid
No Identification Match to Any Eligible Employee	$27,937
Payments Prior to Effective Date	$4,882
Payments During Gaps in Coverage	$86
After Termination Date of Employee's Coverage	$2,031
Subtotal	$34,936
Dependent Eligibility Screening Subcategory	**Amount Paid**
No Identification Match to Any Eligible Employee	$2,485
Payments Prior to Effective Date	$680
Payments During Gaps in Coverage	$2,747
After Termination Date of Employee's Coverage	$37,486
Subtotal	$43,399
COMBINED TOTAL*	**$78,334**

**CTI notes that 0.11% of the PEBP's total medical expense processed by UMR was identified as paid for members who may not have been eligible for coverage. These results are normal compared to the less than 0.5% CTI generally reports.*

RANDOM SAMPLE AUDIT

Objectives

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

Scope

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

- Financial Accuracy
- Claims Payment Accuracy
- Overall Accuracy

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

Methodology

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

When applicable, we cited claim payment and processing errors identified by comparing the way a selected claim was paid and the information UMR had available at the time the transaction was processed**. It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so PEBP can discuss how to reduce errors and re-work in the future with UMR.**

CTI communicated with UMR in writing about any errors or observations using system-generated response forms. We sent UMR a preliminary report for its review and written response. We considered UMR's written response, as found in the Appendix, when producing our final reports. Note that the administrator responses have been copied directly from UMR's reply.

Financial Accuracy

CTI defines Financial Accuracy as the total correct claim payments made compared to the total dollars of correct claim payments that should have been made for the audit sample.

The total paid in the 200-claim audit sample was $1,988,229.15. The claims sampled and reviewed revealed $708.30 in underpayments and $7,983.25 in overpayments. This reflects a weighted Financial Accuracy rate of 96.41% over the stratified sample. This is a decrease in performance from the prior periods. Detail is provided in the following table, Random Sample Findings Detail Report.

UMR did not meet the Performance Guarantee for PEBP in Q4 FY2024 of 99.40% for this measure. The penalty owed is 1.5% of the administrative fees of $1,372,307.36 or $20,584.61.

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 a decrease in performance from the prior period. Detail is provided in the table below.

Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid Claims	Overpaid Claims	
200	1	4	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 decreased from the prior period. UMR did not meet the Performance Guarantee for PEBP in Q4 FY2024 of 98.0% for this measure. The penalty owed is 1% of the administrative fees of $1,372,307.36 or $13,723.07. Detail is provided in the table below.

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
195	0	5	97.50%

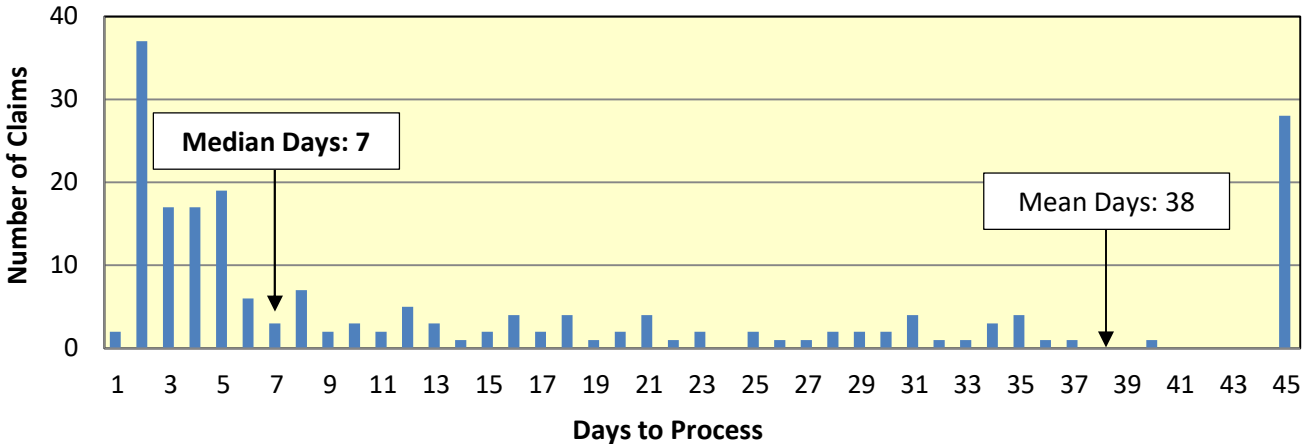
Random Sample Findings Detail Report				
Audit No.	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
PPO Discount				
1045	($708.30)	Agree. This claim was considered with incorrect pricing and was reconsidered with correct pricing on 7/30/24.	Procedural error and underpayment remain. An incorrect PPO discount was applied to the sampled claim.	☒ M ☐ S
1071	$3,868.25	Agree. This claim was allowed in full with no discount applied. The claim has been adjusted.	Procedural errors and overpayments remain. An incorrect PPO discount was applied to the sampled claim.	☒ M ☐ S
1113	$19.00	Agree. Claim was overpaid by $19.00 for code S9379.		☒ M ☐ S
Non-Compliance with Pre-certification Requirements				
1042	$3,596.00	Agree. This is a manual processing error for not obtaining discount and authorization. The rate for E0676 is $2697.00. UMR will pursue a retro authorization with DME UM Vendor as this is over $1000.00.	Procedural error and overpayment remain. No documentation of precertification was required for DME exceeding $1,000.	☒ M ☐ S
Copay Calculation Error				
1125	$500.00	Agree. A $500 copay should have applied to this claim. The original allowable was $2520 x 80% = $2016.00. The new allowable is $2020.00 x 100% (OOP met) = $2020.00. The claim was adjusted on 9-30-2024 and results in a $4.00 underpayment.	Procedural error and overpayment remain. There was an incorrect copay on this claim. Per page 42 of the MPD, "TMJ Surgical Services (including surgical services)" had a $500 copay, and the sample claim did not apply a copay. The MPD specifically excludes surgical services from the office visit copay section; "Office Based Services (excluding surgical services)".	☒ M ☐ S

Claim Turnaround

CTI defines Claim Turnaround as the number of calendar days required to process a claim – from the date the claim was received by the administrator to the date a payment, denial, or additional information request was processed – expressed as both the Median and Mean for the audit sample.

Claim administrators commonly measure claim turnaround time in mean days. Median days, however, is a more meaningful measure for administrators to focus on when analyzing claim turnaround because it prevents just a few claims with extended turnaround time from distorting the true performance picture.

Median and Mean Claim Turnaround



UMR met the Performance Guarantees for PEBP in Q4 FY2024 of 92% processed within 14 days and 99% processed within 30 days. This performance increased from the prior periods.

Additional Observations

During the random sample audit, our auditor observed the following procedures or situations that may not have caused an error but may impact future claims or overall quality of service.

Audit Number	Observation
1008 and 1012	An incorrect copay of $40 was originally applied to these claims. UMR identified the errors prior to provision of claim data to CTI; the sampled claims were adjusted to apply correct copay of $20.
2007	CTI notes the denial reason on the explanation of benefits was not specific stating the service was denied because the member had met their annual dental maximum. Instead, it stated "Maximum has been met for this type of service - see Schedule of Benefits".
2011	Procedure Code D0393, treatment simulation using 3D image volume, was allowed at 100% as a preventive service and paid $304.00. UMR had historically coded it as preventive instead of a basic service, PEBP should verify this is the plan's intent.

DATA ANALYTICS

Medical Findings

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

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

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

Network Provider Utilization and Discount Savings

The Network Provider Utilization and Discount Savings report provides an evaluation of provider network discounts obtained during the audit period. Since discounts can be calculated differently by administrators, carriers, and benefit consultants, we believe calculating discounts in a consistent manner across CTI's book of business will allow for more meaningful comparisons to be made.

Scope

CTI compared submitted charges to allowable charges for claims paid during the audit period.

The review was divided into three subsets:

- In-network
- Out-of-network
- Secondary networks

Each of these subsets was further delineated into four subgroups:

- Ancillary services – such as durable medical equipment
- Non-facility services – such as an office visit
- Facility inpatient – such as services received at a hospital
- Facility outpatient – such as services received at a surgical center

Report

PEBP's members under age 65 had utilization of network or secondary network medical providers at 96.3% of all allowed charges and 96.1% of all claims.

Total of All Claims		
Claim Type	**Provider Discount**	
Ancillary	$3,683,547.72	46.8%
Non-Facility	$39,044,038.29	54.3%
Facility Inpatient	$45,008,175.36	69.7%
Facility Outpatient	$51,937,672.10	67.2%
Total	**$139,673,433.47**	**63.0%**

Sanctioned Provider Identification

The Sanctioned Provider Identification report identifies services rendered by providers on the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE). OIG's LEIE provides information to the healthcare industry, patients, and the public about individuals and entities currently excluded from participation in Medicare, Medicaid, and all other federal health care programs.

Scope

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

Report

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

NPI	Exclusion Date	Reinstatement Date	Exclusion Type	Provider Name	Claim Count	Total Charged	Total Allowed	Total Paid
1104912278	20191219	N/A	1128a4	SHELBY,JAMES,S,DDS	1	$291	$253	$245
1699741041	20200120	N/A	1128a4	LI,SHOUPING,MD	5	$931	$499	$235
				Totals	**6**	**$1,222**	**$752**	**$480**

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 its own system edits. In addition to the U.S. Preventive Services Task Force recommendations, CTI researched best practices of major health plan administrators to develop a compliance review we believe reflects the industry's most comprehensive overview of procedures to be paid at 100%. CTI's review did not include services:

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

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

Reports

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

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

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

CTI's analysis also found that 93.99% of the procedure codes identified as preventive services were paid by UMR at 100% when provided in-network. This total is net of claims denied as a duplicate of a preventive claim paid in a prior period.

NCCI Editing Compliance

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

Scope

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

CTI's claim system code editing analysis identified services submitted to the plan and paid by UMR that Medicare and Medicaid would have denied. **Since UMR paid the billed charges, the payments represent a potential savings opportunity to PEBP.**

It is difficult to establish the extent to which administrators and carriers use NCCI edits; however, CTI recommends these reports be discussed with UMR to determine the extent to which they incorporate CMS edits. Using these edits typically reduces claim expense and furthers efforts toward achieving standardized code-editing systems for every payer.

PTP Edits Reports

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

Outpatient Hospital Services (facility claims with codes not designated inpatient)								
Primary		Secondary			Primary Description	Secondary Description	Line Count	Amount CMS Would Deny
Code	Mod	Code	Mod	Mod Use				
74177	TC	96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	12	$8,168
					Standards of medical/surgical practice			
80053		80048		NO	COMPREHEN METABOLIC PANEL	METABOLIC PANEL TOTAL CA	8	$2,505
					CPT Manual or CMS manual coding instruction			
93005		15772		YES	ELECTROCARDIOGRAM TRACING	Grafting autologous fat harvstd by liposctn	1	$2,196
					Misuse of Column Two code with Column One code			
70491	TC	96374		YES	CT SOFT TISSUE NECK W/DYE	THER/PROPH/DIAG INJ IV PUSH	2	$1,957
					Standards of medical/surgical practice			
70553	TC	70544	TC	YES	Mri brain stem w/o & w/dye	MR ANGIOGRAPHY HEAD W/O DYE	1	$1,874
					Misuse of Column Two code with Column One code			
92950		93005		YES	HEART/LUNG RESUSCITATION CPR	ELECTROCARDIOGRAM TRACING	2	$1,698
					Standards of medical/surgical practice			
92526	GN	97530	GP	YES	ORAL FUNCTION THERAPY	THERAPEUTIC ACTIVITIES	7	$1,603
					Misuse of Column Two code with Column One code			
46922		64430	50	YES	EXCISION OF ANAL LESION(S)	Injection(s), anesthetic agent(s) and/or ster	1	$1,560
					Standards of medical/surgical practice			
22856		95939	TC	YES	CERV ARTIFIC DISKECTOMY	C MOTOR EVOKED UPR&LWR LIMBS	1	$1,543
					Misuse of Column Two code with Column One code			
70496	TC	96374		YES	CT ANGIOGRAPHY HEAD	THER/PROPH/DIAG INJ IV PUSH	2	$1,535
					Standards of medical/surgical practice			
						Top 10 TOTAL	**37**	**$24,640**
						GRAND TOTAL	**368**	**$96,011**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)								
Primary		Secondary			Primary Description	Secondary Description	Line Count	Amount CMS Would Deny
Code	Mod	Code	Mod	Mod Use				
90837		97803		NO	Psytx pt&/family 60 minutes	MED NUTRITION INDIV SUBSEQ	4	$640
					Misuse of Column Two code with Column One code			
92609	GN	92507	GN	YES	USE OF SPEECH DEVICE SERVICE	SPEECH/HEARING THERAPY	10	$608
					Misuse of Column Two code with Column One code			
31500		99291		YES	INSERT EMERGENCY AIRWAY	CRITICAL CARE FIRST HOUR	1	$470
					CPT Manual or CMS manual coding instruction			
93975		76700		YES	VASCULAR STUDY	US EXAM ABDOM COMPLETE	1	$405
					Misuse of Column Two code with Column One code			
52000		51703	51	NO	CYSTOSCOPY	INSERT BLADDER CATH COMPLEX	1	$338
					CPT Manual or CMS manual coding instruction			
88344	26	88342	26	YES	Immunohistochemistry or immunocytochemistry,	IMMUNOHISTOCHEMISTRY	2	$274
					CPT Manual or CMS manual coding instruction			
84481		84480		NO	FREE ASSAY (FT-3)	ASSAY TRIIODOTHYRONINE (T3)	13	$253
					More extensive procedure			
90471		99214	5	YES	IMMUNIZATION ADMIN	OFFICE/OUTPATIENT VISIT FOR E&M ESTAB P	1	$193
					CPT Manual or CMS manual coding instruction			
84439		84436		NO	ASSAY OF FREE THYROXINE	ASSAY OF TOTAL THYROXINE	19	$179
					More extensive procedure			
93015		99223		YES	CARDIOVASCULAR STRESS TEST	Initial hospital inpatient or observation ca	1	$178
					Misuse of Column Two code with Column One code			
						Top 10 TOTAL	**53**	**$3,538**
						GRAND TOTAL	**105**	**$5,120**

MUE Reports

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

CTI's MUE analyses are grouped into three separate reports, outpatient hospital, non-facility, and ancillary. Of note: the outpatient hospital screening had no results.

Non-Facility (non-facility claims with CPT codes:00100 - 99999)				
Procedure Code	Service Unit Limit	Procedure Description	Line Count Exceeding Limit	Amount CMS Would Deny
97154	18	GROUP ADAPTIVE BHV TX BY PROTOCOL TECH EA 15 MIN	43	$21,017
		Rationale: Clinical: CMS Workgroup		
J9332	600	Inj efgartigimod 2mg	6	$11,545
		Rationale: Prescribing Information		
31295	1	Nasal/sinus endoscopy, surgical, w dilation (balloon dila	5	$10,362
		Rationale: CMS Policy		
95999	1	NEUROLOGICAL PROCEDURE	6	$6,253
		Rationale: Clinical: CMS Workgroup		
96133	7	NEUROPSYCHOLOGICAL TST EVAL PHYS/QHP EA ADDL HR	2	$3,136
		Rationale: Nature of Service/Procedure		
97151	8	BEHAVIOR ID ASSESSMENT BY PHYS/QHP EA 15 MIN	3	$2,081
		Rationale: Clinical: CMS Workgroup		
88341	13	Immunohistochemistry or immunocytochemistry, per spe	2	$1,252
		Rationale: Clinical: Data		
30140	1	RESECT INFERIOR TURBINATE	6	$1,220
		Rationale: CMS Policy		
68720	1	CREATE TEAR SAC DRAIN	1	$1,120
		Rationale: CMS Policy		
86317	6	IMMUNOASSAY INFECTIOUS AGENT	3	$732
		Rationale: Clinical: CMS Workgroup		
		Top 10 TOTAL	**77**	**$58,718**
		GRAND TOTAL	**119**	**$63,686**

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
A4239	1	Non-adju cgm supply allow	6	$2,720
		Rationale: Nature of Equipment		
A4238	1	Adju cgm supply allowance	1	$1,081
		Rationale: CMS Policy		
V2522	2	CNTCT LENS HYDROPHIL BIFOCL	4	$564
		Rationale: Anatomic Consideration		
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	4	$383
		Rationale: Nature of Equipment		
V2520	2	CONTACT LENS HYDROPHILIC	4	$330
		Rationale: Anatomic Consideration		
B4035	1	ENTERAL FEED SUPP PUMP PER D	2	$206
		Rationale: Code Descriptor / CPT Instruction		
V2510	2	CNTCT GAS PERMEABLE SPHERICL	1	$110
		Rationale: Anatomic Consideration		
V2521	2	CNTCT LENS HYDROPHILIC TORIC	1	$110
		Rationale: Anatomic Consideration		
A7046	1	REPL WATER CHAMBER, PAP DEV	2	$109
		Rationale: Published Contractor Policy		
V2104	2	SPHEROCYLINDR 4.00D/2.12-4D	2	$60
		Rationale: Anatomic Consideration		
		Top 10 TOTAL	**27**	**$5,673**
		GRAND TOTAL	**30**	**$5,718**

Global Surgery Prohibited Fee Period Analysis

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

Scope

The scope of the Global Surgery Prohibited Fee Period Analysis is surgery charges provided in any setting, including inpatient hospital, outpatient hospital, ambulatory surgical center (ASC), and physician's office. Claims for surgeon visits in intensive care or critical care units are also included in the global surgical package. CTI's analysis encompasses the three types of procedures with global surgical packages: simple, minor, and major. Each type has specific global periods including simple – one day, minor – ten days, and major – ninety days.

CMS allows providers to bill for an E/M service after surgery if the patient's condition required a significant, separately identifiable E/M service beyond the usual pre-operative and post-operative care. When this occurs, the provider can add a modifier 24, 25, or 57 to the E/M service procedure code that alerts the administrator special payment circumstances may exist. The administrator must also submit supporting documentation with the claim.

Report

The following report provides a summary of:

- top 10 providers with and without E/M charges during prohibited periods and associated charges;
- analysis of same providers' surgeries with modifier 24, 25, or 57 when Medicare would have required supporting documentation before payment; and
- analysis of the same providers' surgeries without modifier 24, 25, or 57 when Medicare would have denied payment.

Payment of unbundled, post-surgical E/M services during the global fee period increases the cost of a claim. While there are no universally accepted guidelines for global surgery fee periods with 24, 25, or 57 modifiers, some states and groups mandate providers accept assignment of benefits on those claims. This mitigates the financial impact of unbundling and improper coding. When we discuss the findings, we will help PEBP identify strategies to monitor and eliminate unbundling within PEBP's plan.

Audit Period 4/1/2024 - 6/30/2024									
	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		Surgery with E/M Charge during Prohibited Global Fee Periods			E/M Procedure Codes with Modifier 24, 25, or 57		E/M Procedure Codes without Modifier 24, 25, or 57	
Provider ID	Count	Allowed Charge	Count	% Surgeries with E/M Charges during Prohibited Global Fee Periods	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge
880115812	0	$0	1	100.0%	$149	1	$92	1	$92
880383202	2	$1,319	3	60.0%	$1,562	2	$185	1	$92
853977236	0	$0	1	100.0%	$138	1	$124	0	$0
843370496	0	$0	1	100.0%	$93	1	$83	0	$0
464920174	0	$0	1	100.0%	$90	1	$73	0	$0
460577493	0	$0	1	100.0%	$434	1	$134	0	$0
452698394	2	$505	1	33.3%	$660	1	$268	0	$0
270028866	0	$0	1	100.0%	$276	1	$190	0	$0
264836128	2	$181	1	33.3%	$151	1	$89	0	$0
260076062	0	$0	2	100.0%	$457	2	$279	0	$0
Top 10	**6**	**$2,005**	**13**	**68.4%**	**$4,008**	**12**	**$1,517**	**2**	**$184**
Overall Total	**40**	**$11,849**	**29**	**42.0%**	**$6,461**	**28**	**$3,395**	**2**	**$184**

FY2024 REVIEW AND RECOMMENDATIONS

The table below presents a summary of UMR's performance against the FY2024 quarterly metrics based on CTI's random sample audit results. Results shown in red represent where UMR missed the metric.

Measure	Guarantee	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Financial Accuracy	**99.4%**	97.5%	99.89%	98.47%	96.41%
Overall Accuracy	**98.0%**	96.0%	97.5%	98.5%	97.5%
Claim Turnaround Time	**92% in 14 Days**	92.8%	93.9%	94.0%	93.3%
	99% in 30 Days	95.9%	96.9%	98.5%	99.5%

CTI has the following recommendations that represent recurring issues identified in the FY2024 quarterly audits:

1. UMR should review each of the financial errors identified in our FY2024 random sample audits and determine if system changes or additional claim processor training could help reduce or eliminate errors of a similar nature in the future. It should focus specifically on steps necessary to improve Financial Accuracy.
2. UMR should conduct a focused analysis of the errors identified through ESAS to determine if overpayment recovery and/or system improvements are possible and to reduce or eliminate similar errors going forward. For the issues identified by ESAS, CTI can prepare claim detail for UMR to use in its analysis.
3. PEBP should review the results of the eligibility screening and perform causal analysis to identify workflow and/or system improvements to reduce or eliminate paying claims on ineligible claimants.
4. UMR should review its procedures for excluding claim payments from sanctioned providers that appear on the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE).

CONCLUSION

UMR met the performance metrics for claim turnaround 92% within 14 days for all four quarters of FY2024 and 99% within 30 days in quarter 4. UMR did not meet the performance metrics for financial accuracy and overall accuracy in three out of four quarters in FY2024.

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

APPENDIX – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Your administrator's response to the draft report follows.

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

115 West Wausau Ave
Wausau, WI 54401

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

October 3, 2024

Joni,

Thank you for the opportunity to respond to the recent review of the State of Nevada Public Employees' Benefit Program Q4Y24 audit draft report. The following is our response to the draft report completed by CTI.

ESAS Targeted Sample Analysis

Duplicate Payments

QID 44 – Claim [redacted] is a duplicate to previously processed claim [redacted]. This results in a $114.40 overpayment.

QID 46 – Dental claim [redacted] is a duplicate to previously processed claim [redacted]. This results in a $44.00 overpayment.

QID 47 – Claim [redacted] is a duplicate to previously processed claim [redacted]. The claim was adjusted on 8-27-2024 and results in a $13.06 overpayment.

QID 50 – Claim [redacted] is a duplicate to previously processed claim [redacted]. This results in a $79.00 overpayment.

Plan Exclusions – Dental, Prosthodontics

QID 37 – UMR agrees with this finding. Non-accident-related dental crown procedures are excluded on the medical plan. This claim was allowed in error. This results in $2484.50 overpayment. An adjustment will be considered at the completion of the audit.

Potential Fraud, Waste and Abuse – DME

QID 26 – UMR agrees with this finding. This claim was considered at billed charges, with no discount applied. The claim was adjusted on 9-12-2024 and results in a $867.64 overpayment.

Fraud, Waste and Abuse – Specialty Medications (Non-Hospital)

QID 28 – UMR agrees with this finding. CPT J0585 was priced incorrectly allowing $9132.00. The correct allowable is $2739.60. This results in a $5113.92 overpayment. An adjustment will be considered at the completion of the audit.

Fraud, Waste and Abuse – Cardiovascular Genetic Testing

QID 36 – UMR agrees with this finding. There is a UM Vendor denial for this claim and therefore should have been denied. The claim was adjusted on 10-1-2024 and results in a $3750.00 overpayment.

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

Copay Application - DX Mammography

QID 12 – After further review, UMR agrees with this finding. Per the plan Diagnostic Mammography does have a copay. This results in a $40.00 overpayment. This claim will be adjusted at the completion of the audit.

QID 14 – UMR disagrees with this finding. Per the plan benefit, a copay does not apply to this outpatient hospital claim due to the ology benefit.

Timely Filing

QID 6 – UMR disagrees with this finding. UMR managed the reprocessing of this claim appropriately. HSB initially processed as out of network. UMR was notified this is a participating provider and followed policy and procedures to correct the claim per the plan benefits. An exception from PEBP is not required as the claim was initially processed timely.

PPO Provider Without Discount

QID 25 – UMR agrees with this finding. The SHO discount was not applied to this claim at the time of processing. This is a manual processing error. The claim was adjusted on 8-8-2024 and results in a $8293.00 overpayment.

Preventive Services – with Copay Applied

QID 3 – UMR agrees with this finding. This claim should have allowed at 100% per the preventive benefits with no copay. The claim was adjusted on 7-22-2024 and results in a $40.00 underpayment.

Additional Observation:

QID 34 – Provider for this claim has been referred to UMR's SIU team for review.

Random Sample Findings

PPO Discount

Sample 1045 – UMR agrees with this finding. This claim was considered with incorrect pricing. The claim was adjusted on 7-30-2024 and results in a $708.30 underpayment.

Sample 1071 – UMR agrees with this error. This claim was considered at billed charges, with no discount applied. The claim was adjusted on 8-13-2024 and results in a $3868.25 overpayment.

Sample 1113 – UMR agrees with this finding. CPT S9379 was considered at billed charges, with no discount applied. The allowable is $66.00. The claim was adjusted on 9-6-2024 and results in a $19.00 overpayment.

Sample 1129 – UMR disagrees with this error. The provider of service submitted a corrected claim. Total billed charges changed to $3795.46. Corrected claim and pricing are attached.

Non-Compliance with Pre-Certification Requirements

Sample 1042 – UMR agrees with this finding. Authorization was not on file at the time this claim was processed. This is a manual processing error. This results in a $3596.00 overpayment. UMR will pursue a retro authorization with the DME UM Vendor.

Copay Calculation Error

Sample 1125 – After further review, UMR agrees with this finding. A $500 copay should have applied to this claim. The original allowable was $2520 x 80% = $2016.00. The new allowable is $2020.00 x 100% (OOP met) = $2020.00. The claim was adjusted on 9-30-2024 and results in a $4.00 underpayment.

Denied Eligible Expense

Sample 2027 – UMR disagrees with this finding. At the time of services, 2-26-2024, this member had dental coverage primary through United Healthcare. This claim was processed as secondary by UMR utilizing the EOB from UHC. CPT 00270 for bitewings, billed charge $52.00 - $30.00 provider negotiated discount. UHC allowed and paid $22.00. There was no balance for UMR to make a payment. The member notified UMR on 4-8-2024 there is no other insurance. UMR updated this member file accordingly. This is why at the time of audit, the members file notes there is No Other Insurance. Claim Image and OI EOB are attached.

Additional Observations:

Sample 1008 and 1012 - A copay application error was identified by the UMR Claims Team. An adjustment project was completed on 6-26-2024.

Sample 2007 – The denial reason code on the explanation of benefits is UMRs standard when the maximum has been met.

Sample 2011 – D0393 is considered a diagnostic service on the UMR platform, we pay it at 100% for in-network and 80% for out of network.

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. 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 715-841-7262.

Sincerely,

Julie Frahm
Sr. UMR External Audit Coordinator

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

CLAIM TECHNOLOGIES INCORPORATED

PART OF THE BROWN & BROWN TEAM

100 Court Avenue – Suite 306 • Des Moines, IA 50309

(515) 244-7322 • claimtechnologies.com