Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employees' Benefits Program Plans
Administered by United Medical Resources

Audit Period: October 1, 2023 – December 31, 2023
Audit Number 1.FY24.Q2

Presented to

State of Nevada Public Employees' Benefits Program

May 23, 2024

CLAIM TECHNOLOGIES INCORPORATED

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 United Medical Resources' (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 October 1, 2023 through December 31, 2023 (quarter 2 (Q2) 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	$53,920,419
Total Number of Claims Paid/Denied/Adjusted	210,866

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 and Claim Turnaround Time within 14 days met the service objective. Overall Accuracy and Claim Turnaround Time within 30 days did not meet the service objective and a penalty is owed (breakdown in summary below).
2. CTI recommends UMR should:
   - Review the financial errors identified in 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 overall accuracy and claim turnaround within 30 days measurements for PEBP in Q2 FY2024 and a penalty is owed. Reported administrative fees for the quarter totaled $1,292,524.65.

Quarterly Metric	Guarantee	Met/Not Met	Penalty	Calculated Penalty
Financial Accuracy (p. 11)	99.4%	Met – 99.89%	NA	$0.00
Overall Accuracy (p. 12)	98.0%	Not Met – 97.5%	1.0%	$12,925.25
Claim Turnaround Time (p. 14)	92% in 14 Days 99% in 30 Days	Met – 93.9% Not Met – 96.6%	NA 1.0%	$0.00 $12,925.25
		Total Penalty	2.0%	$25,850.50

AUDIT OBJECTIVES

This report contains CTI's findings from our audit of United Medical Resources' (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 with UMR. The results for Q2 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	94.50%	Not Met
1.5	**Telephone Service Factor:** Defined as the percentage of the Client telephone inquiries answered by facility Customer Service Representatives (CSRs) within 30 seconds. Measured from the time the caller completes the prompts of the automated telephone system to the time the caller reaches a CSR.	85.00% Calls answered within 30 seconds	97.80%	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%	0.10%	Met
1.7	**First Call Resolution Rate:** the percentage of telephone inquiries completely resolved within a 'window period' of time. A call is considered 'resolved' when the same participant or a family member under the same subscriber ID has not contacted the administrator's customer service facility again regarding the same issue within 60 calendar days of the initial call.	95.00%	91.00%	Not Met
1.8	**Open Inquiry Closure:** addresses the time taken in hours and/or days by CSRs at the administrator's service facility to close open inquiries placed by participants of PEBP to the facility.	90.00% 48 Hours 98.00% 5 Business Days	95.20% 95.50%	Met Not Met
1.9	**CSR Audit, or Quality Scores:** determined by the process used to evaluate the effectiveness and accuracy of participant telephone call handling at the administrator's customer service facility.	97.00%	96.80%	Not Met
1.10	**CSR Callback Performance:** measured from the CSR commitment data in hours and/or days to the time the actual callback was placed to the participant.	90.00% Within 24 Hours	76.92%	Not 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%	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	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.).			

	Metric	Service Objective	Actual	Met/ Not Met
	Professionalism – Demonstrates objectivity and empathy with customer problems.			
	Flexibility – Ability to meet client-specific needs.			
	Participation in periodic meetings – Attendance at all required client meetings or conference calls.			
	Guarantee measured with staff responses to internal questionnaire. A scale from 1 to 5 will be used to measure performance, where 1 means 'very dissatisfied' and 5 means 'very satisfied'; and 2 through 4 are defined, respectively.			
	Periodic program reports will be provided and presented with recommended actions. Standard program reports, within 30 days to quarter-end. Year-end activity report, within 45 days of program year end.			
	Open Enrollment Support: Accurate materials will be provided at least 60 days prior to the open enrollment period starting on April 1 each year. Representative will be available, if requested, for up to 5 employee benefit fairs.			
	Service Objective (out of a score of 5 on internal questionnaire):	350		
1.14	**Eligibility Processing:** Confirm daily and weekly eligibility and enrollment within specified business days of the receipt of the eligibility information, given that information is complete and accurate.	98.00% 2 Business Days	100%	Met
1.15	**Data Reporting:** Offeror will provide PEBP with 100% of the applicable reports (within 10 business days for standard reports and within 10 business days of Plan year-end for Annual Reports and Regulatory documents).	100% 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	99.50% 99.50%	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%	97.90%	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	0 complaints	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%	99.97%	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	92.30%	Not Met
3.3	**Pre-Certification Requests:** Precertification requests from healthcare providers shall be completed in accordance with URAC/NCQA standards and turn-around timeframes; completed Pre-certifications shall be communicated to PEBP's Third Party Administrator using an approved method e.g., electronically, within 5 business days of UM completing Precertification determination.	98.00% 5 Business Days	NA	Reported Annually
3.4	**Concurrent Hospital Reviews:** Concurrent hospital reviews shall be completed in accordance with URAC/NCQA standards; completed reviews shall be communicated to the provider using an approved method e.g., electronically within 2 business days of determination decision.	98.00% 2 Business Days	NA	Reported Annually
3.5	**Retrospective Hospital Reviews:** Retrospective reviews must be completed in accordance with URAC/NCQA standards; completed reviews shall be communicated using an approved method e.g., electronically within 5 business days of determination decision.	98.00% 5 Business Days	NA	Reported Annually
3.8	**Hospital Discharge Planning:** CM will contact or attempt to contact 95% of patients discharged from any facility within 3 business days of notification of discharge with clinical coaching and discharge planning assistance.	95.00% 3 Business Days	NA	Reported Annually
3.9	**Large Case Management:** CM will identify and initiate case management for chronic disease, high dollar claims, and ER usage.	95.00%	NA	Reported Annually
3.10	**Utilization Management for Medical Necessity and Center of Excellence Usage:** UM review to determine medical necessity in accordance with the MPDs. Services to be performed at a Center of Excellence to be managed through the Case Management process.	98.00%	NA	Reported Annually
3.11	**Return On Investment (ROI) Guarantee – Utilization Management/Case Management:** 2:1 Savings to Fees for Utilization Management/Case Management.	100%	NA	Reported Annually
3.12	**Disclosure of Subcontractors:** All subcontractors who have access to PHI or PII data and physical locations where PEBP PHI or PII data is maintained and/or stored must be identified in this contract. Any changes to those subcontractors or physical locations where PEBP data is stored must be communicated to PEBP at least 60 days prior to implementation of services by the subcontractor. Implementation will not be in effect until PEBP has provided written authorization.	100% 60 Calendar Days	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 changes	Met

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

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

Scope

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

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

Methodology

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

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

- ***Audit of Administrator Response and Documentation*** – We reviewed the responses and redacted the responses to eliminate personal health information. Based on the responses and further analysis of the findings, we removed false positives identified from the potential amounts at risk.

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 with an identification number (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				
40	$12.80	Agree.	Procedural deficiency and overpayments remain. UMR paid duplicate charges.	☐ M ☒ S
41	$1,089.00			☒ M ☐ S
42	$167.07			☒ M ☐ S
43	$35.00			☒ M ☐ S
44	$491.00			☐ M ☒ S
45	$16.78			☒ M ☐ S
46	$18.68			☒ M ☐ S
47	$2,160.00			☒ M ☐ S
Plan Exclusions				
Service Not Authorized				
27	$1,256.53	Agree. Review of these types of claims are based on procedure and diagnosis selections coded in the UMR system to pend for review. No authorization on file for services rendered.	Procedural deficiency and overpayment remain. Services were not authorized and should have been denied.	☒ M ☐ S
38	$617.51	Agree. CPT code 15839 was approved by UM vendor for medical necessity. This claim was not allowed appropriately based on the review and allowed amount. CPT	Procedural deficiency and overpayment remain. Payment for cosmetic services (procedure 15830) was not authorized.	☒ M ☐ S

ESAS Findings Detail Report				
QID	**(Under)/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
		15830 should be denied, and CPT 15839 allowed amount is $1059.77. This results in a $617.51 overpayment.		
Copay Application				
Outpatient Surgery				
14	$174.70	Agree. This claim did not apply the $350.00 copay for outpatient surgery. This results in a $174.70 overpayment.	Procedural deficiency and overpayment remain. The claim included outpatient surgery and a $350.00 copay was not applied.	☒ M ☐ S
PPO Provider Without Discount				
24	$2,419.20	Agree. The provider was participating at the time services were rendered. Claim was a reconsideration, and the service was paid with no discount in error.	Procedural deficiency and overpayment remain. Provider discount not applied.	☒ M ☐ S
Preventive Services				
Denied				
3	($177.73)	Agree. Preventive service was denied in error. This claim was adjusted on 2/9/24. This results in a $177.73 underpayment.	Procedural deficiency and underpayment remain. The preventive service was denied in error.	☒ M ☒ S

Additional Observations

During the Targeted Audit, 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
13	The EPO plan has a $40.00 copay for diagnostic mammography; however, deductible and coinsurance were applied on this claim in error. The claim was processed on 10/27/23 and applied $46.03 to the deductible and $43.39 in coinsurance. The claim was corrected on 11/17/23 and applied the $40.00 copay. Because the error was identified through UMR's internal QA process and corrected prior to the audit data being pulled and submitted to CTI, no error has been assessed.

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 $1,613,655.34. The claims sampled and reviewed revealed $158.50 in underpayments and $358.40 in overpayments. This reflects a weighted Financial Accuracy rate of 99.89% over the stratified sample. This is an increase in performance from the prior period. Detail is provided on the following page in the Random Sample Findings Detail Report table.

UMR met the Performance Guarantee for PEBP in Q2 FY2024 of 99.40% for this measure.

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 an improvement in performance from the prior period. Detail is provided in the table below, Random Sample Findings Detail Report.

Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid Claims	Overpaid Claims	
200	3	2	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.

UMR did not meet the Performance Guarantee for PEBP in Q2 FY2024 of 98.0% for this measure; however, performance did increase from the prior period. The penalty owed is 1.0% of the administrative fees of $1,292,524.65 or $12,925.25. Detail is provided in the table below, Random Sample Findings Detail Report.

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

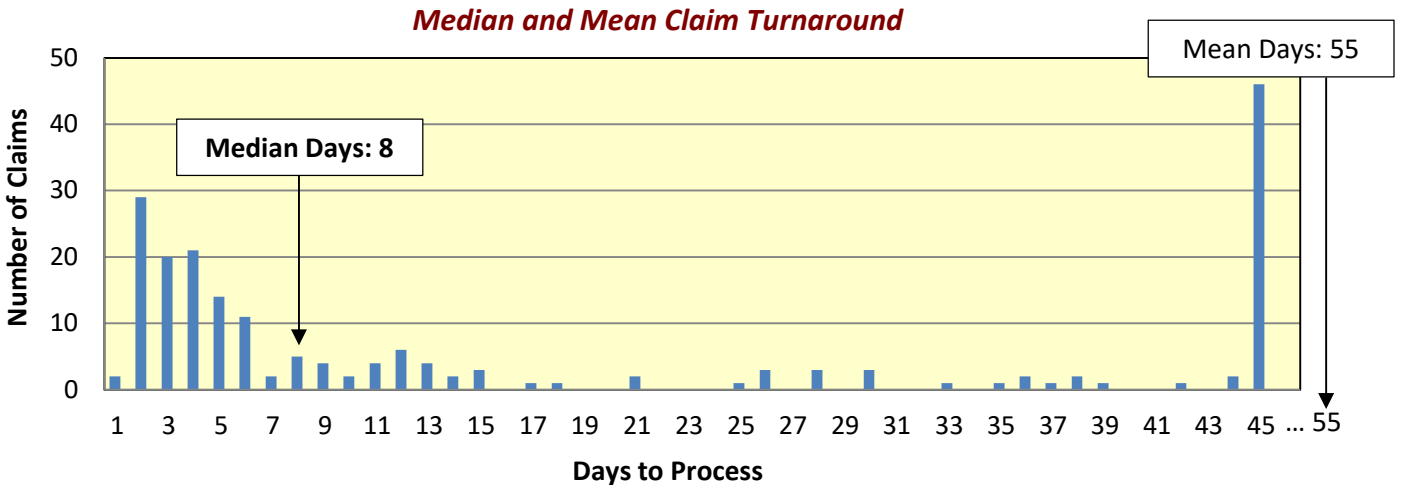
Random Sample Findings Detail Report				
Audit No.	**(Under) / Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
PPO Discount Error				
1001	$4.00	Agree. Billed charges are to be used if the maximum allowed is greater than billed. This claim was adjusted on 3/11/24 and results in a $4.00 underpayment.	Procedural error and overpayment identified. An incorrect PPO discount was applied to the claim. The discount amount was processed on the third line of the claim as -$20.00 resulting in an incorrect coinsurance calculation. The allowed amount was $20.00 more than charged amount.	☒ M ☐ S
1092	($75.48)	Agree. An incorrect discount amount was entered for rev code 305. The billed amount is $150.96 - $75.48 (discount) = $75.48. This results in a $75.48 underpayment.	Procedural error and underpayment remain. The discount amount was $18,524.58, and it should have been $18,600.06.	☒ M ☐ S
1093	$354.40	Agree. UHC network pricing for this claim allows $308.00. The claim was initially processed allowing billed charges. The claim was adjusted on 2/6/24 allowing the $308.00 at 80%. This results in $354.40 overpayment.	Procedural error and overpayment remain. An incorrect PPO discount was applied. The discount amount was $0.00, and it should have been $443.00.	☒ M ☐ S

Deductible Error				
1033	($5.30)	Agree. Procedure 81025 should be allowed as preventive with no cost share when performed in conjunction with contraceptive management. Claim adjusted on 3/11/24 and results in a $5.30 underpayment.	Procedural error and underpayment identified. This contraceptive management pregnancy test should have paid at 100%. The visit was for removal and reinsertion of IUD, the pregnancy test was performed in conjunction with the preventive contraceptive service. The deductible applied should have been $0.00 and it was $5.30.	☒ M ☐ S
Copay Calculation Error				
1025	($77.72)	Agree. Pre-admission testing on 7/6/23 should not have a separate copayment applied. These services should be allowed at deductible then coinsurance. This claim has been adjusted and results in a $77.72 underpayment.	Procedural error and underpayment remain. There was an incorrect copay on this claim. The copay should have been $350.00, and it was $700.00. Deductible and coinsurance should have applied to pre-admission testing.	☒ 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.



UMR did not meet the Performance Guarantee for PEBP in Q2 FY2024 of 99% processed within 30 days but did meet 92% processed within 14 days. This performance did not improve from the prior period. The penalty owed for this Performance Guarantee is 1.0% of the administrative fees of $1,292,524.65 or $12,925.25.

Additional Observations

During the Random Sample Audit, 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.

Audit No.	Observation
2004, 2024, 2027, 2035, 2044	CTI notes page 14 of the dental MPD states "Crown, including crown build up" is covered under Major Services payable at 50%. PEBP and UMR previously agreed to use the UMR standard when determining coverage level; and D2950 (crown build up) falls under the Basic Services under the UMR standard, payable at 80% under the plan. This conflicts with the MPD language. CTI recommends PEBP consider updating the dental MPD for crown build ups to align with the plan 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

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

Sanctioned Provider Identification

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

Scope

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

Report

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

NPI	Exclusion Date	Reinstatement Date	Exclusion Type	Provider Name	Claim Count	Total Charged	Total Allowed	Total Paid
1104912278	20191219	N/A	1128a4	SHELBY,JAMES,S,DDS	3	$1,661	$1,661	$898
				Totals	**3**	**$1,661**	**$1,661**	**$898**

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

PPACA Preventive Services Coverage Compliance

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

Scope

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

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

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

Reports

We analyzed the payments to determine if they were compliant. To demonstrate full compliance with PPACA's requirements, the analysis 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 99.43% 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. This is an improvement from the 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 payor 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 payor.

PTP Edits Reports

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

Outpatient Hospital Services (facility claims with codes not designated inpatient)								
Primary		Secondary		Mod	Primary Description	Secondary Description	Line	Amount CMS
Code	Mod	Code	Mod	Use			Count	Would Deny
74177	TC	96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	20	$12,514
					Standards of medical/surgical practice			
93351		93306		YES	STRESS TTE COMPLETE	TTE W/DOPPLER COMPLETE	1	$4,842
					HCPCS/CPT procedure code definition			
93453		75710		YES	R&L HRT CATH W/VENTRICLGRPHY	ARTERY X-RAYS ARM/LEG	1	$3,737
					Misuse of Column Two code with Column One code			
70496	TC	96374		YES	CT ANGIOGRAPHY HEAD	THER/PROPH/DIAG INJ IV PUSH	3	$2,893
					Standards of medical/surgical practice			
12002		64450		YES	Rpr s/n/ax/gen/trnk2.6-7.5cm	Injection(s), anesthetic agent(s) and/or ster	1	$2,471
					Anesthesia service included in surgical procedure			
71275	TC	96374		YES	CT ANGIOGRAPHY CHEST	THER/PROPH/DIAG INJ IV PUSH	3	$1,961
					Standards of medical/surgical practice			
90471		99282		YES	IMMUNIZATION ADMIN	Emergency department visit for evaluation &	2	$1,812
					CPT Manual or CMS manual coding instruction			
99285		99284		YES	Emergency department visit for E&M of patient re	Emergency department visit for E&M of pati	1	$1,796
					Misuse of Column Two code with Column One code			
96374		96372		YES	THER/PROPH/DIAG INJ IV PUSH	THER/PROPH/DIAG INJ SC/IM	5	$1,770
					CPT Manual or CMS manual coding instruction			
99284		99283		YES	Emergency department visit for E&M of patient re	Emergency department visit for E&M of pati	2	$1,591
					Misuse of Column Two code with Column One code			
						Top 10 TOTAL	**39**	**$35,386**
						GRAND TOTAL	**251**	**$71,783**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)								
Primary		Secondary		Mod	Primary Description	Secondary Description	Line	Amount CMS
Code	Mod	Code	Mod	Use			Count	Would Deny
92609	GN	92507	GN	YES	USE OF SPEECH DEVICE SERVICE	SPEECH/HEARING THERAPY	17	$1,842
					Misuse of Column Two code with Column One code			
34710		37236	99	YES	Delayed placement of distal or proximal extensio	Transcatheter placement of an intravascula	2	$900
					Misuse of Column Two code with Column One code			
93975		76700		YES	VASCULAR STUDY	US EXAM ABDOM COMPLETE	1	$553
					Misuse of Column Two code with Column One code			
99233		99232		NO	Subsequent hospital inpatient or observation car	Subsequent hospital inpatient or observatio	5	$428
					HCPCS/CPT procedure code definition			
84481		84480		NO	FREE ASSAY (FT-3)	ASSAY TRIIODOTHYRONINE (T3)	20	$389
					More extensive procedure			
63047	AS	63042	AS	YES	Remove spine lamina 1 lmbr	LAMINOTOMY SINGLE LUMBAR	1	$364
					HCPCS/CPT procedure code definition			
99238		99232		NO	Hospital inpatient or observation, discharge day	Subsequent hospital inpatient or observatio	4	$300
					CPT Manual or CMS manual coding instruction			
92133		92134		NO	CMPTR OPHTH IMG OPTIC NERVE	CPTR OPHTH DX IMG POST SEGMT	2	$252
					CPT Manual or CMS manual coding instruction			
97012	GP	97140	GP	YES	MECHANICAL TRACTION THERAPY	Manual therapy 1/> regions	11	$234
					Mutually exclusive procedures			
99222		99232		NO	Initial hospital inpatient or observation care, per	Subsequent hospital inpatient or observatio	1	$207
					HCPCS/CPT procedure code definition			
						Top 10 TOTAL	**64**	**$5,468**
						GRAND TOTAL	**154**	**$8,173**

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-Fa+A9:E57cility (non-facility claims with CPT codes:00100 - 99999)				
Procedure Code	Service Unit Limit	Procedure Description	Line Count Exceeding Limit	Amount CMS Would Deny
31295	1	Nasal/sinus endoscopy, surgical, w dilation (balloon dila	7	$12,076
		Rationale: CMS Policy		
86255	5	FLUORESCENT ANTIBODY SCREEN	2	$5,053
		Rationale: Clinical: Data		
97151	8	BEHAVIOR ID ASSESSMENT BY PHYS/QHP EA 15 MIN	4	$2,991
		Rationale: Clinical: CMS Workgroup		
19357	1	Tissue expander placement in breast reconstruction, incl	1	$1,837
		Rationale: CMS Policy		
88307	8	TISSUE EXAM BY PATHOLOGIST	1	$1,714
		Rationale: Clinical: Data		
30140	1	RESECT INFERIOR TURBINATE	7	$1,343
		Rationale: CMS Policy		
97153	32	ADAPTIVE BEHAVIOR TX BY PROTOCOL TECH EA 15 MIN	5	$1,243
		Rationale: Clinical: Society Comment		
31254	1	REVISION OF ETHMOID SINUS	3	$1,079
		Rationale: CMS Policy		
37236	1	Transcatheter placement of an intravascular stent	2	$900
		Rationale: Code Descriptor / CPT Instruction		
J2248	150	MICAFUNGIN SODIUM INJECTION	1	$736
		Rationale: Prescribing Information		
		Top 10 TOTAL	**33**	**$28,971**
		GRAND TOTAL	**65**	**$32,215**

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
A4238	1	Adju cgm supply allowance	2	$2,221
		Rationale: CMS Policy		
E2402	1	NEG PRESS WOUND THERAPY PUMP	1	$1,940
		Rationale: Code Descriptor / CPT Instruction		
V2521	2	CNTCT LENS HYDROPHILIC TORIC	12	$980
		Rationale: Anatomic Consideration		
K0553	1	THER CGM SUPPLY ALLOWANCE	1	$975
		Rationale: Code Descriptor / CPT Instruction		
V2520	2	CONTACT LENS HYDROPHILIC	8	$768
		Rationale: Anatomic Consideration		
B4035	1	ENTERAL FEED SUPP PUMP PER D	2	$368
		Rationale: Code Descriptor / CPT Instruction		
V2523	2	CNTCT LENS HYDROPHIL EXTEND	4	$330
		Rationale: Anatomic Consideration		
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	8	$290
		Rationale: Nature of Equipment		
B4224	1	PARENTERAL ADMINISTRATION KI	1	$210
		Rationale: Code Descriptor / CPT Instruction		
B4034	1	ENTER FEED SUPKIT SYR BY DAY	3	$179
		Rationale: Code Descriptor / CPT Instruction		
		Top 10 TOTAL	**42**	**$8,261**
		GRAND TOTAL	**49**	**$8,621**

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 10/1/2023 - 12/31/2023							
	Surgeries with 'CMS Defined' Prohibited Global Fee Periods					Evaluation and Management Services using Same ID as Surgeon and Within Prohibited Global Fee Period	
	Surgeries without E/M Procedures during Prohibited Global Fee Periods		Surgery with E/M Charge during Prohibited Global Fee Periods			E/M Procedure Codes without Modifier 24, 25, or 57	
Provider ID	Count	Allowed Charge	Count	% Surgeries with E/M Charges during Prohibited Global Fee Periods	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge
860800150	0	$0	1	100.0%	$7,067	1	$218
880341656	3	$2,458	1	25.0%	$1,317	1	$107
840404253	2	$287	1	33.3%	$161	0	$0
832310783	0	$0	1	100.0%	$388	0	$0
823819185	0	$0	1	100.0%	$106	0	$0
510566371	0	$0	1	100.0%	$115	0	$0
472242077	0	$0	2	100.0%	$1,022	0	$0
460227855	0	$0	1	100.0%	$341	0	$0
263303591	0	$0	1	100.0%	$191	0	$0
263147146	8	$1,291	1	11.1%	$155	0	$0
Top 10	**13**	**$4,037**	**11**	**45.8%**	**$10,862**	**2**	**$325**
Overall Total	**53**	**$17,495**	**26**	**32.9%**	**$14,027**	**2**	**$325**

CONCLUSION

UMR met the performance metrics for financial accuracy and claim turnaround within 14 days; however, they did not meet the performance metrics for overall accuracy and claim turnaround within 30 days in the second quarter of FY2024. A penalty of $25,925.25 or 2.0% of the administration fees for the quarter, is owed.

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

March 12, 2024

Joni,

Thank you for the opportunity to respond to the recent review of the State of Nevada Public Employees' Benefit Program Q2Y24 audit draft report. The following is our response to the draft report completed by CTI.

ESAS Targeted Sample Analysis

Duplicate Payments

QID 40 – Claim 23312448209 was adjusted prior to the audit and denied on 2/1/2024 as a duplicate to previously processed claim 23295183056. This results in a $24.00 overpayment.
QID 41 – Claim 23300253043 was adjusted and denied on 3/8/2024 as duplicate to previously processed claim 23311148319. This results in a $1089.00 overpayment.
QID 42 – Claim 23312703283 was adjusted and denied on3/8/2024 as a duplicate to previously processed claim 23285394058. This results in a $167.07 overpayment.
QID 43 – Claim 23317237027 was adjusted and denied on 3/8//2024 as a duplicate to previously processed claim 23317237023. This results in a $35.00 payment error.
QID 44 – Claim 23344700314 was adjusted prior to the and denied on 1/31/2024 as a duplicate to previously processed claim 23334000010. This results in a $494.00 payment error.
QID 45 – Claim 23283517764 was adjusted and denied on 3/8/2024 as a duplicate to previously processed claim 23279139859. This results in a $16.78 payment error.
QID 46 – Claim 23325129892 was adjusted prior to the audit and denied on 12-14-2023 as a duplicate to previously processed claim 23319222708. This results in a $18.68 payment error.
QID 47 – Claim 23310163243 was adjusted and denied on 3/8/2024 as a duplicate to previously processed claim 23273192815. This results in a $2160.00 payment error.

Plan Exclusions

QID 27 – UMR agrees with this finding. This service was not authorized prior to payment and should have been denied. This claim was adjusted on 3/7/2024 and results in a $1256.53 overpayment.
QID 38 – UMR agrees with this finding. Based on the review of Medical Necessity for Procedure Code 15839 this claim was not allowed appropriately. This claim was adjusted on 3/8/2024 and results in a $442.26 underpayment.

Copay Application - DX Mammography/Chiro

QID 13 – UMR disagrees with this finding. The benefit is to apply a $40.00 copayment for diagnostic mammograms. This was identified prior to this audit and corrected. UMR adjusted this claim on 11-17-2023.

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

QID 14 - UMR agrees with this finding. The benefit is to apply a $350.00 copayment for outpatient surgery. A copayment was not applied in error. This claim was adjusted on 3/8/2024 and results in a $174.70 overpayment.
QID 15 – UMR disagrees with this finding. Procedure 97112, DOS 8-2-2024 a copayment was applied to a previously processed claim. A second copayment would not apply to the sample claim for the same procedure and DOS.

PPO Provider without Discount
QID 24 – UMR agrees with this finding. The provider was participating at the time of services. Network pricing for CPT code 73700 was not applied in error. This claim has been adjusted and results in a $2419.20 overpayment.

Preventive Services – Denied
QID 3 – UMR agrees with this finding. Preventive service was denied in error. This claim was adjusted on 2/9/2024 and results in a $177.73 underpayment.

Random Sample Findings

PPO Discount
Sample 1001 – After further review, UMR agrees with this finding. Billed charges are to be used if the maximum allowed is greater than billed. This claim was adjusted on 3/11/2024 and results in a $4.00 underpayment.
Sample 1055 – UMR disagrees with this finding. This claim was initially processed correctly based on the provider status of out-of-network. The provider submitted an appeal and UHC Choice Plus updated this provider to participating and provided UMR with updated pricing for this claim. This claim was identified and adjusted on 11/18/2023 prior to the audit.
Sample 1092 – UMR agrees with this finding. An incorrect discount amount was entered on Rev code 305 at the time of processing. This claim was adjusted on 3/11/2024 and results in a $75.48 underpayment.
Sample 1093 – UMR agrees with this finding. This claim was allowed at billed charges in error. This claim was adjusted on 2/6/2024 to apply the network discount. This results in a $354.40 overpayment.

Coinsurance Error
Sample 2004, 2024, 2027, 2035, 2044 - UMR disagrees with these findings. UMR considers ADA code D2950 as a basic service as this service is a type of filling material and used to restore a tooth. This procedure is done prior to a crown placement.

Deductible Error
Sample 1033 – After further review, UMR agrees with this finding. Procedure 81025 should be allowed as preventive with no cost share when performed in conjunction with contraceptive management. This claim was adjusted on 3/11/2024 and results in a $5.30 underpayment.

Copay Calculation Error
Sample 1025 – UMR agrees with this finding. A separate $350.00 copay should not have applied to the pre-admission testing. This claim was adjusted on 2-14-2024 and results in a $77.72 underpayment.

Non-Compliance with Pre-Certification Requirements

Sample 1040 – UMR disagrees with this error. Per MPD (pages 29-30) Partial Hospitalization and Intensive Outpatient Therapy require prior authorization from UM vendor. This claim is not for intensive outpatient treatment or partial hospitalization.

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

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

(515) 244-7322 • claimtechnologies.com