Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employee's Benefit Program Plans

Administered by UMR Insurance Company

Audit Period: July 1, 2023 – September 30, 2023
Audit Number 1.FY24.Q1

Presented to

State of Nevada Public Employee's Benefit Program

January 26, 2024

CLAIM TECHNOLOGIES INCORPORATED

Proprietary and Confidential

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EXECUTIVE SUMMARY

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

Scope

CTI performed an audit for the period of July 1, 2023 through September 30, 2023 (quarter 1 (Q1) 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	$54,932,316
Total Number of Claims Paid/Denied/Adjusted	217,995

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

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

Auditor's Opinion

Based on these findings, and in our opinion:

1. UMR's Financial Accuracy, Overall Accuracy and Claim Turnaround Time did not meet the service objective and a penalty is owed (breakdown in summary below).
2. 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 claims processing measurements for PEBP in Q1 FY2024 and a penalty is owed. Reported administrative fees for the quarter totaled $1,326,302.50.

Quarterly Metric	Guarantee	Met/Not Met	Penalty	Calculated Penalty
Financial Accuracy (p.12)	99.4%	Not Met – 97.5%	1.5%	$19,894.54
Overall Accuracy (p. 13)	98.0%	Not Met – 96.0%	1.0%	$13,263.03
Claim Turnaround Time (p. 14)	92% in 14 Days 99% in 30 Days	Met – 92.8% Not Met – 95.9%	NA 1.0%	$0.00 $13,263.03
		Total Penalty	3.5%	$46,420.60

AUDIT OBJECTIVES

This report contains CTI's findings from our audit of UMR Insurance Company's (UMR) administration of the State of Nevada Public Employee's Benefit 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 Q1 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	93.1%	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	90.3%	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%	1.1%	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%	93.8%	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	94.7% 95.3%	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%	95.5%	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	85%	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

	Metric	Service Objective	Actual	Met/ Not 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.			
	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	98% 100%	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%	98.3%	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

	Metric	Service Objective	Actual	Met/ Not 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%	99.96%	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	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.	100% 60 Calendar Days	No new subcontractors	Met

	Metric	Service Objective	Actual	Met/ Not Met
	Implementation will not be in effect until PEBP has provided written authorization.			
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				
33	$78.90	Agree.	Procedural deficiency and overpayments remain. UMR paid duplicate charges. CTI notes QID 33 was corrected on 10/27/23; and QID 37 was corrected on 12/20/23. Both overpayments adjusted.	☐ M ☒ S
34	$137.28			☒ M ☐ S
35	$508.68			☒ M ☐ S
36	$38.00			☐ M ☒ S
37	$205.54			☒ M ☐ S
Plan Exclusions				
Massage Therapy				
49	$119.07	Agree. Massage Therapy code 97124 is an excluded service on the plan.	Procedural deficiency and overpayment remain. Massage therapy, procedure 97124, is excluded per pages 100 and 102 of the CDHP plan document.	☒ M ☐ S
Potential Fraud, Waste, and Abuse				
Repeated Genetic Testing				
45	$1,662.42	Agree. At the time this claim was processed there was no authorization on file for code 81420.	Procedural deficiency and overpayment remain. The service authorized was for procedure 81420 which paid $1,062.67 for services rendered on 7/5/23. The procedure code for repeat genetic testing (81479) should have been denied.	☒ M ☐ S

ESAS Findings Detail Report				
QID	**(Under)/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Copay Application				
Specialist				
16	$18.23	Agree. There should be a $40.00 copay applied to this claim for services by a specialist.	Procedural deficiency and overpayment remain. The $40.00 specialist copay should have applied instead of the $20.00 PCP copay. Claim paid $18.23 after COB savings applied, should have paid $0.00.	☒ M ☐ S
18	($25.41)		Procedural deficiency and underpayment remain. A $40.00 copay should have applied instead of the deductible.	☒ M ☐ S
Diagnostic Mammography				
14	($122.73)	Agree. Diagnostic mammograms are subject to a $40.00 copay.	Procedural deficiency and overpayment remain. The EPO plan had a $40.00 copay for diagnostic mammography, deductible and coinsurance were applied in error.	☒ M ☐ S
15	($39.99)			☒ M ☐ S
17	($80.13)			☒ M ☐ S
PPO Provider Without Discount				
28	$13,467.20	Agree. This claim was allowed at billed charges in error. Pricing for the claim has been completed. This claim was adjusted on 11-3-2023 and results in a $13,467.20 overpayment.	Procedural deficiency and overpayment remain. This in-network PPO provider was paid without a discount.	☒ M ☐ S
Preventive Services				
Denied				
6	($375.00)	Agree. PEBP does not require annual COB investigations.	Procedural deficiency and underpayment remain. The claimant was the employee; PEBP does not require UMR to send annual COB questionnaires, and no indication was presented indicating the member had other insurance. This preventive claim should have been allowed.	☐ M ☒ S

RANDOM SAMPLE AUDIT

Objectives

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

Scope

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

- Financial Accuracy
- Claims Payment Accuracy
- 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 $439,011.21. The claims sampled and reviewed revealed $9,512.18 in underpayments and $7,968.32 in overpayments. This reflects a weighted Financial Accuracy rate of 97.50% over the stratified sample. This is a decrease in performance from the prior period. Detail is provided in the following table, Random Sample Findings Detail Report.

UMR did not meet the Performance Guarantee for PEBP in Q1 FY2024 of 99.40% for this measure. The penalty owed is 1.5% of the administrative fees of $1,326,302.50 or $19,894.54.

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 8 incorrectly paid claims and 192 correctly paid claims. This is a decrease 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	5	96.0%

Overall Accuracy

CTI defines Overall Accuracy as the number of claims processed without errors compared to the total number of claims processed in the audit sample.

Performance decreased from the prior period. UMR did not meet the Performance Guarantee for PEBP in Q1 FY2024 of 98.0% for this measure. The penalty owed is 1.0% of the administrative fees of $1,326,302.50 or $13,263.04. Detail is provided in the table below, Random Sample Findings Detail Report.

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
192	2	6	96.0%

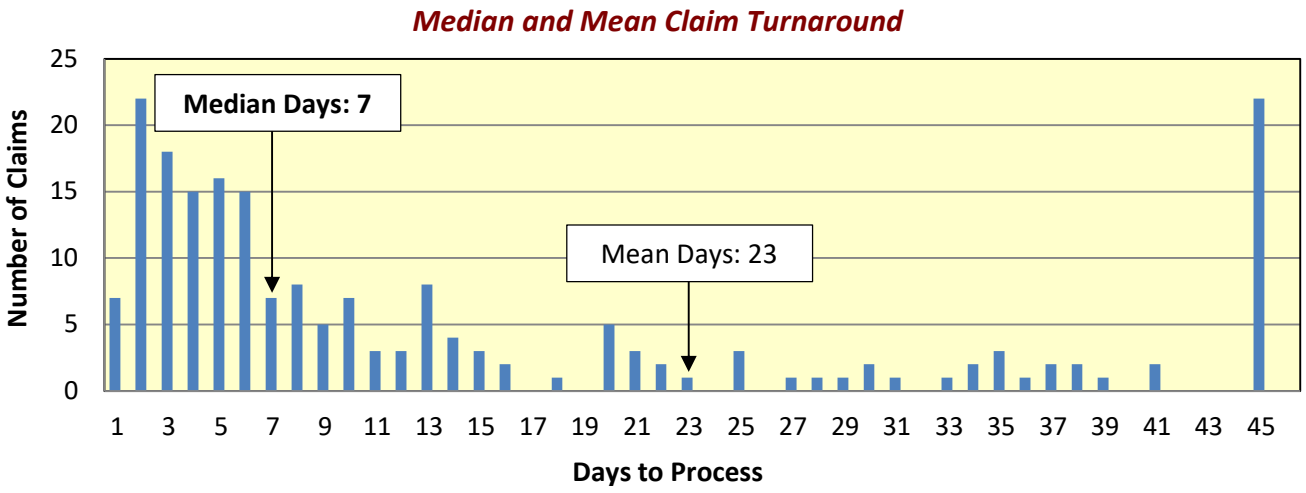
Random Sample Findings Detail Report				
Audit No.	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Denied Eligible Expense				
1076	($6,771.55)	Agree. The Customer First Representative (CFR) updated the COB status in the CPS processing system to reflect Medicare Primary in error. This caused the claim to deny for a MEOB. This claim has since been adjusted on 12-12-2023 with a payment of $6,771.55 to the provider	Procedural error and underpayment remain. Eligible expenses were denied on this claim for a Medicare EOB. The member was in an active group and the file stated this member had Medicare as secondary.	☒ M ☐ S
PPO Discount				
1061	($2,727.51)	Agree. The SHO allowed amount for this claim is $24,501.27. UMR allowed $21,773.76 in error. This claim was adjusted on 11-29-2023 to allow the SHO contract case rate $24,501.27 with an additional payment made of $2727.51.	Procedural error and underpayment remain. An incorrect PPO discount was applied to the sampled claim.	☒ M ☐ S
1112	$7,476.55	Agree. UMR agrees there is an error with the processing of this claim. An incorrect allowable amount was used to process this claim.	Procedural error and overpayment remain. An incorrect PPO discount was applied to the sampled claim.	☒ M ☐ S
1129	$239.76	Agree. An incorrect allowable was applied to this claim during processing.	Procedural error and overpayment remain. The pricing documentation provided by UMR states the correct	☒ M ☐ S

Random Sample Findings Detail Report				
Audit No.	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
			allowed amount for the sample claim was $17,779.90. The allowed amount processed on the claim was $18,019.66.	
Coinsurance Error				
1131	$144.61	Agree. Outpatient surgery copay $500 should apply to this claim. This results in a $144.61 overpayment. This claim will be adjusted at the completion of the audit.	Procedural error and overpayment remain. Per page 39 of the plan document, there should have been a $500.00 copay applied to these in-network hospital surgery services followed by no coinsurance.	☒ M ☐ S
2012	$23.40	Agree. Coinsurance should have been applied to the service. This resulted in an overpayment of $23.40. UMR will adjust the claim at the completion of the audit.	Procedural error and overpayment remain. The coinsurance applied should have been $23.40 and it was $0.00. Per page 12 of the plan document, periapical x-rays should be allowed under the Basic Services benefit.	☐ M ☒ S
2014	($13.12)	Agree. Incorrect coinsurance was applied to the claim. This resulted in an overpayment of $13.12. UMR will adjust the claim at the completion of the audit.	Procedural error and underpayment remain. There was incorrect coinsurance on this claim. The coinsurance applied should have been $3.28 and it was $16.40.	☒ M ☐ S
Deductible Error				
2023	$84.00	Agree. Deductible should have been taken on the service. This resulted in an overpayment of $84.00. UMR will adjust the claim at the completion of the audit.	Procedural error and overpayment remain. The deductible applied should have been $84.00 and it was $0.00. The sample claim full mouth series should have applied Basic Services according to page 13 of the plan document. The member had not met the plan year individual or family deductible.	☐ 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 Q1 FY2024 of 92% processed within 14 days but did meet 99% processed within 30 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 $1,326,302.50 or $13,263.04.

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 Number	Observation
1015	UMR stated a general health panel, code 80050, was not on the Health Care Reform preventive coverage list payable without patient cost share. However, page 60 of the CDHP plan document states a general health panel should be paid as preventive. CTI recommends PEBP update the plan documents to align with UMR's stated procedure.

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. CTI's screening indicated there were no sanctioned providers that received payment from UMR during the audit period.

PPACA Preventive Services Coverage Compliance

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

Scope

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

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

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

Reports

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

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

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

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

CTI's analysis also found that 95.80% 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 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			Primary Description	Secondary Description	Line	Amount CMS
Code	Mod	Code	Mod	Mod Use			Count	Would Deny
74177	TC	96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	21	$14,034
					Standards of medical/surgical practice			
70496		70450		YES	CT ANGIOGRAPHY HEAD	CT HEAD/BRAIN W/O DYE	3	$4,430
					Misuse of Column Two code with Column One code			
58662		58350		YES	LAPAROSCOPY EXCISE LESIONS	REOPEN FALLOPIAN TUBE	1	$2,406
					Standards of medical/surgical practice			
97162	GP	64448		YES	PHYSICAL THERAPY EVALUATION MOD COMPLEX 30	femoral nerve, continuous infusion by cath	1	$2,309
					Misuse of Column Two code with Column One code			
90853		90832		YES	GROUP PSYCHOTHERAPY	Psytx pt&/family 30 minutes	3	$1,936
					CPT Manual or CMS manual coding instruction			
74177		96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	7	$1,729
					Standards of medical/surgical practice			
93975		76700		YES	VASCULAR STUDY	US EXAM ABDOM COMPLETE	1	$1,692
					Misuse of Column Two code with Column One code			
70551	TC	70544	TC	YES	Mri brain stem w/o dye	MR ANGIOGRAPHY HEAD W/O DYE	1	$1,586
					Misuse of Column Two code with Column One code			
96374		G0463		YES	THER/PROPH/DIAG INJ IV PUSH	Hospital outpatient clinic visit for assessm	1	$1,237
					Standards of medical/surgical practice			
99213		99212		YES	Office/outpatient visit for E&M of estab patient, 2	Office/outpatient visit for E&M of estab pat	17	$1,201
					Misuse of Column Two code with Column One code			
						Top 10 TOTAL	**56**	**$32,561**
						GRAND TOTAL	**253**	**$70,034**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)								
Primary		Secondary			Primary Description	Secondary Description	Line	Amount CMS
Code	Mod	Code	Mod	Mod Use			Count	Would Deny
92609	GN	92507	GN	YES	USE OF SPEECH DEVICE SERVICE	SPEECH/HEARING THERAPY	26	$2,817
					Misuse of Column Two code with Column One code			
01480	AA	64447	51	YES	ANESTH LOWER LEG BONE SURG	femoral nerve, including imaging guidance	2	$1,545
					Standard preparation/monitoring services for anesthesia			
19342	50	19370	99	YES	Insertion or replacement of breast implant on sep	Revision of peri-implant capsule, breast,inc	1	$837
					Misuse of Column Two code with Column One code			
84481		84480		NO	FREE ASSAY (FT-3)	ASSAY TRIIODOTHYRONINE (T3)	22	$428
					More extensive procedure			
33477		93317	26	YES	Transcatheter pulmonary valve implantation, per	ECHO TRANSESOPHAGEAL	1	$272
					Misuse of Column Two code with Column One code			
93975	26	76700	26	YES	VASCULAR STUDY	US EXAM ABDOM COMPLETE	1	$226
					Misuse of Column Two code with Column One code			
11104		99215	5	YES	PUNCH BIOPSY SKIN SINGLE LESION	Office/outpatient visit for E&M of estab pat	1	$223
					CPT Manual or CMS manual coding instruction			
84439		84436		NO	ASSAY OF FREE THYROXINE	ASSAY OF TOTAL THYROXINE	23	$217
					More extensive procedure			
G6015		77321		NO	Intensity modulated treatment delivery, single or	SPECIAL TELETX PORT PLAN	1	$204
					Misuse of Column Two code with Column One code			
90460		99392	5	YES	IM ADMIN 1ST/ONLY COMPONENT	PREV VISIT EST AGE 1-4	1	$193
					CPT Manual or CMS manual coding instruction			
						Top 10 TOTAL	**79**	**$6,962**
						GRAND TOTAL	**136**	**$9,447**

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
99292	8	CRITICAL CARE ADDL 30 MIN	1	$5,610
		Rationale: Clinical: Data		
31295	1	Nasal/sinus endoscopy, surgical, w dilation (balloon dila	6	$5,331
		Rationale: CMS Policy		
96133	7	NEUROPSYCHOLOGICAL TST EVAL PHYS/QHP EA ADDL HR	3	$5,040
		Rationale: Nature of Service/Procedure		
19364	1	with free flap (eg, fTRAM, DIEP, SIEA, GAP flap)	1	$2,602
		Rationale: Nature of Service/Procedure		
97151	8	BEHAVIOR ID ASSESSMENT BY PHYS/QHP EA 15 MIN	3	$2,528
		Rationale: Clinical: CMS Workgroup		
19318	1	Breast reduction	1	$1,878
		Rationale: CMS Policy		
30140	1	RESECT INFERIOR TURBINATE	7	$1,711
		Rationale: CMS Policy		
64905	1	NERVE PEDICLE TRANSFER	1	$1,225
		Rationale: Clinical: Data		
97153	32	ADAPTIVE BEHAVIOR TX BY PROTOCOL TECH EA 15 MIN	2	$1,176
		Rationale: Clinical: Society Comment		
31276	1	SINUS ENDOSCOPY SURGICAL	1	$1,021
		Rationale: CMS Policy		
		Top 10 TOTAL	**26**	**$28,123**
		GRAND TOTAL	**56**	**$33,561**

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
E2402	1	NEG PRESS WOUND THERAPY PUMP	4	$11,842
		Rationale: Code Descriptor / CPT Instruction		
V2520	2	CONTACT LENS HYDROPHILIC	15	$990
		Rationale: Anatomic Consideration		
B4035	1	ENTERAL FEED SUPP PUMP PER D	5	$747
		Rationale: Code Descriptor / CPT Instruction		
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	12	$677
		Rationale: Nature of Equipment		
V2521	2	CNTCT LENS HYDROPHILIC TORIC	6	$440
		Rationale: Anatomic Consideration		
V2020	1	VISION SVCS FRAMES PURCHASES	4	$414
		Rationale: Clinical: Data		
V2522	2	CNTCT LENS HYDROPHIL BIFOCL	3	$220
		Rationale: Anatomic Consideration		
A7030	1	CPAP FULL FACE MASK	1	$208
		Rationale: Published Contractor Policy		
B4034	1	ENTER FEED SUPKIT SYR BY DAY	3	$194
		Rationale: Code Descriptor / CPT Instruction		
A7046	1	REPL WATER CHAMBER, PAP DEV	3	$155
		Rationale: Published Contractor Policy		
		Top 10 TOTAL	**56**	**$15,888**
		GRAND TOTAL	**63**	**$16,100**

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 7/1/2023 - 9/30/2023							
Provider Id	Surgeries with 'CMS Defined' Prohibited Global Fee Periods					Evaluation and Management Services using Same ID as Surgeon and Within Prohibited Global Fee Period	
	Surgeries without E/M Procedures during Prohibited Global Fee		Surgery with E/M Charge during Prohibited Global Fee Periods			E/M Procedure Codes without Modifier 24, 25, or 57	
	Count	Allowed Charge	Count	% Surgeries with E/M Charges during Prohibited Global Fee Periods	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge
880459017	0	$0	1	100.0%	$129	2	$138
854064968	0	$0	1	100.0%	$30	0	$0
852202580	0	$0	1	100.0%	$141	0	$0
844822939	0	$0	1	100.0%	$30	0	$0
840404253	0	$0	1	100.0%	$127	0	$0
510566371	0	$0	1	100.0%	$115	0	$0
462843588	0	$0	1	100.0%	$160	0	$0
462812080	0	$0	1	100.0%	$103	0	$0
452698394	2	$1,319	1	33.3%	$660	0	$0
275302424	0	$0	1	100.0%	$201	0	$0
Top 10	**2**	**$1,319**	**10**	**83.3%**	**$1,695**	**2**	**$138**
Overall Total	**22**	**$5,913**	**28**	**56.0%**	**$5,008**	**2**	**$138**

CONCLUSION

UMR did not meet the performance metrics for financial accuracy, overall accuracy or claim turnaround in the first quarter of FY2024. A penalty of $46,420.60, or 3% 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

December 22, 2023

Joni,

Thank you for the opportunity to respond to the recent review of the State of Nevada Public Employees' Benefit Program Q1Y24 audit draft report. The following is our response to the draft report completed by CTI.

ESAS Targeted Sample Analysis

Duplicate Payments

QID- 33 – Claim [redacted]6660 was adjusted and denied on 10-27-2023 as a duplicate to previously processed claim [redacted]5132. The payment error is $0.00 as there was no payment made.

Line 1 - Payment Information					Adjust Service
001	Deductible	.00	Total Amount Paid		.00
	Full Pay	.00	Withhold		.00
	Partial Pay	.00	CDH		.00
	% Paid	00	Tax Amount		
	Prov Go Out Rate	.00			

Claim Control #	[redacted]	Billed Amount	333.00		Release Date	08/31/23
Begin Date	08/22/23	Ineligible 1	.00	000	Draft Sub	0002
End Date	08/22/23	Ineligible 2	284.89	908	Provider	[redacted]
CPT Code	99214	Ineligible 3	48.11	858	Refer Prov	0000000

QID 34 – Claim [redacted]3047 was adjusted and denied on 12-20-2023 as a duplicate to previously processed claim [redacted]5372. This results in a $137.28 payment error.
QID 35 – Claim [redacted]2828 was adjusted and denied on 12-20-2023 as a duplicate to previously processed claim [redacted]7215. This results in a $508.68 payment error.
QID 37 – Claim [redacted]3569 was adjusted and denied on 12-202-023 as a duplicate to previously processed claim [redacted]4708. This results in a $0.00 payment error as there was no payment made.

Line 1 - Payment Information					Adjust Service
002	Deductible	205.54	Total Amount Paid		.00
	Full Pay	.00	Withhold		.00
	Partial Pay	.00	CDH		.00
	% Paid	00	Tax Amount		
	Prov Go Out Rate	.00			

Claim Control #	[redacted]	Billed Amount	635.67		Release Date	09/07/23
Begin Date	08/07/23	Ineligible 1	430.13	908	Draft Sub	0002
End Date	08/07/23	Ineligible 2	.00	000	Provider	[redacted]
CPT Code	99215	Ineligible 3	.00	000	Refer Prov	0000000

QID 36 – Claim [redacted]9264 was adjusted and denied on 12/19/2023 as a duplicate to previously processed claim [redacted]5758. This results in a $96.00 payment error.

Plan Exclusions – Massage Therapy
QID 49 - After further review, UMR agrees with this finding. Massage Therapy code 97124 is an excluded service on the plan. This claim will be adjusted and results in a $119.07 overpayment.

Potential Fraud, Waste, and Abuse – Repeated Genetic Testing
QID 45 – After further review, UMR agrees with this finding. At the time this claim was processed there was no authorization on file for code 81420. This claim was adjusted on 12-20-2023 and results in a $1662.42 overpayment.

Copay Application
PCP
QID 11- UMR disagrees with this finding. The provider specialty for this claim is OB GYN. This is a specialist and correctly applied a $50.00 copay.
Specialist
QID 16 – UMR agrees with this finding. A $40.00 copay was not applied this claim. This claim was adjusted on 12-20-2023 and results in a $0.00 payment error as the balance after Medicare remains the same.
QID 18 – UMR agrees with this finding. A $40.00 copay was not applied to this claim. This claim was adjusted on 11-3-2023 and results in a $25.41 underpayment.
Diagnostic Mammography
UMR agrees with these findings. The claims should have applied a $40.00 copay for diagnostic mammogram.
QID 14 – This claim was adjusted on 12-20-2023 and results in $36.54 underpayment.
QID 15 - This claim was adjusted on 11-14-2023 and results in a $39.99 underpayment.
QID 17 - This claim was adjusted on 11-14-2023 and results in a $80.13 underpayment.

PPO Provider without Discount
QID 28 – UMR agrees with this finding. This claim was allowed without pricing. The claim was adjusted on 11-3-2023 and results in a $13, 467.20 overpayment.

Preventive Services – Denied
QID 6 - After further review, UMR agrees with this finding. PEBP does not require annual COB investigations. This claim was adjusted on 12-20-2023 and results in a $375.00 underpayment.

Random Sample Findings

Denied Eligible Expenses
Sample 1076 – UMR agrees to a procedure error on this claim. The Customer First Representative (CFR) updated the COB status in the CPS processing system to reflect Medicare Primary in error. This caused the claim to deny for a MEOB. This claim has since been adjusted on 12-12-2023 with a payment of $6771.55 to the provider.

PPO Discount
Sample 1061 – [redacted]**8046 -** UMR agrees with this finding. An incorrect allowable was applied to this claim during processing. This claim was adjusted on 11-29-2023 to apply the correct SHO contract case rate. This results in a $2727.51 underpayment.

Sample 1112 – [redacted]**4982** - UMR agrees with this finding. An incorrect allowable was applied to this claim during processing. This claim was adjusted on 12-19-2023 to apply the correct SHO contract case rate. This results in a $7476.55 overpayment.
Sample 1129 – [redacted]**6220 –** UMR agrees with this finding. An incorrect allowable was applied to this claim during processing. This claim will be adjusted. This results in a $239.76 overpayment.

Coinsurance Error
Sample 1131 – UMR agrees with this finding. This outpatient surgery claim was processed with an incorrect POS. For this reason, the copay did not apply per the plan benefits and was allowed at 80%. This claim was adjusted on 12-20-2023 and results in a $144.61 overpayment.
Sample 2012 - UMR agrees with this finding. An incorrect coinsurance applied to this claim. This claim will be adjusted and results in a $23.40 overpayment. UMR is investigating the root cause.
Sample 2014 - UMR agrees with this finding. An incorrect coinsurance applied to this claim. This claim will be adjusted and results in a $13.12 underpayment. UMR is investigating the root cause.

Deductible Error
Sample 2023 – UMR agrees with this finding. This claim should have applied to the deductible. This claim will be adjusted and results in a $84.00 overpayment. UMR is investigating the root cause.

MUE – Page 19 and 20 - As a commercial payer, we do not only adhere to CMS or NCCI guidelines, but rather we also consider AMA interpretation and the interpretation of the Nationally recognized sources such as the various specialty societies and associations. If the AMA or one of these other sources have a different guideline or interpretation, that will be applied within our editing as a commercial payer instead of NCCI.

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.

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