Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employees' Benefits Program Plans
Administered by UMR Insurance Company

Audit Period: January 1, 2024 – March 31, 2024
Audit Number 1.FY24.Q3

Presented to

State of Nevada Public Employees' Benefits Program

July 25, 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 Employees' Benefits Program (PEBP) medical and dental plans.

Scope

CTI performed an audit for the period of January 1, 2024 through March 31, 2024 (quarter 3 (Q3) for Fiscal Year (FY) 2024). The population of claims and amount paid during the audit period reported by UMR Benefits:

Medical and Dental	
Total Paid Amount	$70,303,130
Total Number of Claims Paid/Denied/Adjusted	222,754

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 30 days did not meet the service objective and a penalty is owed (breakdown in summary below). Overall Accuracy and Claim Turnaround Time within 14 days met the service objective.
2. CTI recommends UMR should:
   - Review the financial errors identified in our random sample audit and determine if system changes or claim processor training could help reduce or eliminate errors of a similar nature in the future.
   - Review the 100% Electronic Screening with Targeted Sample results and focus on the most material findings.
   - Where appropriate, verify claim processor coaching, feedback, and retraining has occurred because most errors were manually processed.

Summary of UMR's Guarantee Measurements

Based on CTI's Random Sample Audit results, UMR did not meet the financial accuracy and claim turnaround within 30 days measurements for PEBP in Q3 FY2024 and a penalty is owed. Reported administrative fees for the quarter totaled $1,351,734.20.

Quarterly Metric	Guarantee	Met/Not Met	Penalty	Calculated Penalty
Financial Accuracy (p. 12)	99.4%	Not Met – 98.47%	1.5%	$20,276.01
Overall Accuracy (p. 13)	98.0%	Met – 98.5%	NA	$0.00
Claim Turnaround Time (p. 14)	92% in 14 Days	Met – 94.0%	NA	$0.00
	99% in 30 Days	Not Met – 98.5%	1.0%	$13,517.34
		Total Penalty	2.5%	$33,586.70

AUDIT OBJECTIVES

This report contains CTI's findings from our audit of UMR Insurance Company' (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 Q3 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	94.30%	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	92.20%	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%	0.50%	Met
1.7	**First Call Resolution Rate:** the percentage of telephone inquiries completely resolved within a 'window period' of time. A call is considered 'resolved' when the same participant or a family member under the same subscriber ID has not contacted the administrator's customer service facility again regarding the same issue within 60 calendar days of the initial call.	95.00%	95.80%	Met
1.8	**Open Inquiry Closure:** addresses the time taken in hours and/or days by CSRs at the administrator's service facility to close open inquiries placed by participants of PEBP to the facility.	90.00% 48 Hours 98.00% 5 Business Days	98.00% 99.20%	Met Met
1.9	**CSR Audit, or Quality Scores:** determined by the process used to evaluate the effectiveness and accuracy of participant telephone call handling at the administrator's customer service facility.	97.00%	97.00%	Met
1.10	**CSR Callback Performance:** measured from the CSR commitment data in hours and/or days to the time the actual callback was placed to the participant.	90.00% Within 24 Hours	100%	Met
1.11	**Participant Email Response Performance:** measured from the time an email is received by the administrator's response team to the time in hours or days to the time the actual email response is sent to the participant.	90.00% Within 8 Hours 95.00% Within 24 Hours	100% 100%	Met Met
1.12	**Member Satisfaction:** At least 95%-member satisfaction with the services. Measured as the number of satisfied to highly satisfied survey ratings divided by the total number of survey responses. Survey tool and survey methodology to be mutually agreed upon by Offeror and PEBP.	95.0%	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	99.00% 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%	97.80%	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%	100%	Met

	Metric	Service Objective	Actual	Met/ Not Met
UTILIZATION MANAGEMENT/CASE MANAGEMENT – SERVICES AND PERFORMANCE GUARANTEES				
3.1	**Data Reporting – Standard Reports (Quarterly reporting to include Service Performance Standards, Guarantee, Method of Measurement, Actual Performance Results, and Pass/Fail indicator.)** Standard reports must be delivered within 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. 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 or 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				
39	$20.70	Agree.	Procedural deficiencies and overpayments remain. UMR paid duplicate charges.	☒ M ☐ S
40	$72.86			☒ M ☐ S
42	$52.00			☐ M ☒ S
43	$400.00			☐ M ☒ S
44	$79.00			☐ M ☒ S
45	$52.00			☐ M ☒ S
46	$188.92			☒ M ☐ S
47	$52.00			☐ M ☒ S
48	$534.40			☐ M ☒ S
Plan Exclusions				
Potential Cosmetic Procedure				
36	$1,955.00	Agree. Claims are reviewed based on services billed. Procedure and Diagnosis selections are coded in the UMR system to identify these claims. These types of claims require prior authorization from the UM Vendor. This claim is paid in error.	Procedural deficiency and overpayment remain. Payment for potential cosmetic service (procedure 19318) was not authorized.	☒ M ☐ S

ESAS Findings Detail Report				
QID	**(Under)/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Inappropriate Use of Modifier 26/TC				
33	$11.84	Disagree. Services billed by laboratory for professional component of a service or procedure and has also prepared a written interpretation and report based on the modifier billed on this claim.	Procedural deficiency and overpayment remain. There was not a separate reimbursable professional component for this automated lab test. The full reimbursement for 80053 was made to Memorial University Medical Center on 11/30/23.	☐ M ☒ S
Copay Application				
Diagnostic Mammogram				
10	($3.31)	Agree. A $40 copay should have applied between codes 77066 and G0279, with coinsurance being applied on procedure 76642. The claim will be adjusted.	Procedural deficiency and underpayment remain. The diagnostic mammogram should have paid at 100% of allowable after application of $40.00 copay, $43.31 coinsurance was applied in error.	☒ M ☐ S
Fraud, Waste and Abuse				
Durable Medical Equipment (DME) Allowance				
21	$445.31	Agree. UMR reviewed this claim post payment. UM approved the enteral feeding/supplies under case id xxxx80064. UM approved the enteral feeding/supplies under case id xxxx80064. This claim was allowed without the out of network pricing. The correct allowable is $ 349.37. The plan should pay $ 174.69, we paid $620.00, which resulted in overpayment of $445.31.	Procedural deficiency and overpayment remain. The incorrect allowable was processed for this DME claim.	☒ M ☐ S
Specialty Medications (Non Hospital)				
23	$1,114.30	Agree. Prior authorization was approved for these services. The correct allowable for code J0585 is $7.00 per unit. The provider billed 1 unit. $7.00 x 80% = $5.60. This claim will be adjusted and is overpaid $1114.30.	Procedural deficiency and overpayment remain. The incorrect allowable was calculated for specialty drug J0585.	☒ M ☐ S
24	$2,519.05	Agree. Prior authorization was approved for these services. The correct allowable for code J1602 is $40.78 per unit. The provider billed 150 units. $6,117.45 at 100%. This claim will be adjusted and is overpaid $2,519.05.	Procedural deficiency and overpayment remain. The incorrect allowable was calculated for specialty drug J1602.	☒ M ☐ S
High Dollar Payments to Employees				
26	$7,333.58	Agree. This claim was paid in error to the member. Stop payment was completed. UMR will reissue payment to the provider. Member has Medicare Part B. Medicare denied as not covered.	Procedural deficiency and overpayment remain. Payment should have been made to the provider but was issued to the member in error.	☒ M ☐ S
UCR Assistant Surgeon				
27	$5,322.06	Agree. Allowance should have been 140% of Medicare = $237.08. Claim adjusted 05/07/24 – overpaid $5,322.06. Customer First Representative did not route the claim for out of network pricing.	Procedural deficiency and overpayment remain The incorrect out of network pricing was calculated for this procedure.	☒ M ☐ S

ESAS Findings Detail Report				
QID	**(Under)/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Cardiovascular Genetic Testing				
30	$4,524.60	Agree. The claim was allowed in error. No prior authorization was done. Claim was paid in error and overpaid. An adjustment will be made, and overpayment requested.	Procedural deficiencies and overpayments remain. Services were paid without the required prior authorization.	☐ M ☒ S
31	$4,659.22			☒ 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
2, 3, 4	UMR did not use the Procedure to Procedure CMS NCCI edits that disallow payments for procedures that cannot be billed together. UMR stated it is working on system enhancements to allow for historical UHC claim editing, which is targeted for 2025.

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 $2,385,161.61. The claims sampled and reviewed revealed $100.00 in underpayments and $54,099.89 in overpayments. This reflects a weighted Financial Accuracy rate of 98.47% over the stratified sample. This is a decrease in performance from the prior period. Detail is provided on the following page in the Random Sample Findings Detail Report table.

UMR did not meet the Performance Guarantee for PEBP in Q3 FY2024 of 99.40% for this measure. The penalty owed is 1.5% of the administrative fees of $1,351,734.20 or $20,276.01.

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 3 incorrectly paid claims and 197 correctly paid claims. This is an increase in performance from the prior period. Detail is provided below, Random Sample Findings Detail Report.

Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid Claims	Overpaid Claims	
200	1	2	98.50%

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 met the Performance Guarantee for PEBP in Q3 FY2024 of 98.0% for this measure, performance increased from the prior period. Detail is provided in the table below, Random Sample Findings Detail Report.

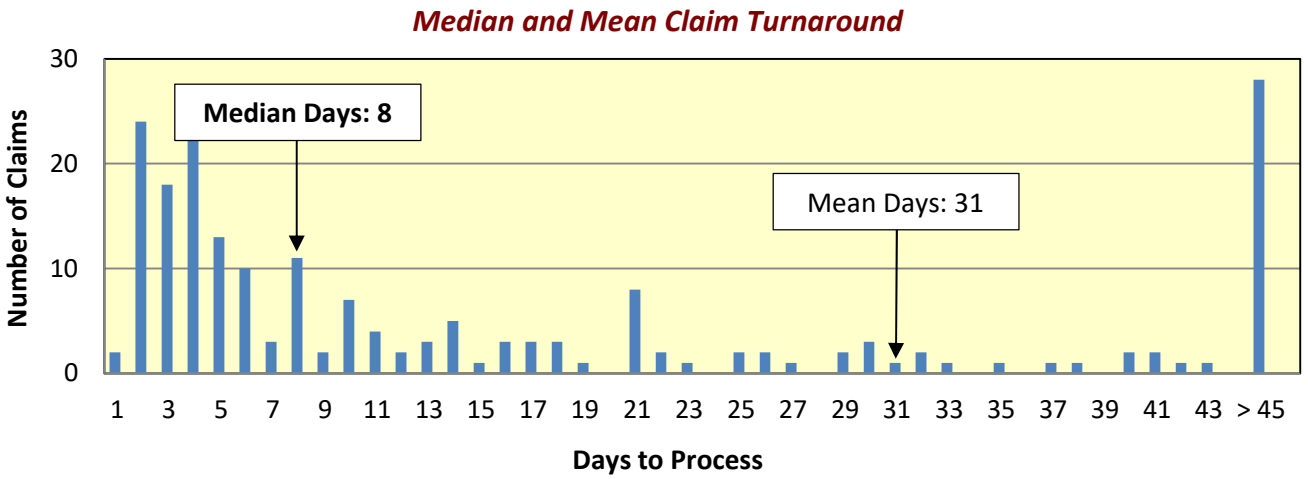
Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
197	1	2	98.50%

Random Sample Findings Detail Report				
Audit No.	(Under)/ Over Paid	UMR Response	CTI Conclusion	Manual or System
PPO Discount Error				
1048	$49.89	Agree. The pricing analyst transposed the allowable amount on the contract. H0015 allowable is $170.00. This claim was adjusted on 5/15/24 and results in a $49.89 overpayment.	Procedural error and overpayment remain. An incorrect PPO discount was applied. The allowable amount was $186.63, and it should have been $170.00 for each of three dates of service.	☒ M ☐ S
1114	$54,050.00	Agree. Claim was allowed at billed charge in error. The correct allowable is $4,299.00. This results in a $54,050 overpayment. The claim adjusted on 5/22/24 requesting provider refund.	Procedural error and overpayment remain. An incorrect PPO discount was applied. The allowable amount was $68,949, and it should have been $4,299.00.	☒ M ☐ S
Denied Eligible Expense				
1126	($100.00)	Agree. vision hardware was denied in error and should have been covered. This results in a $100 underpayment. Claim was adjusted on 5/10/24 issuing an additional payment of $100.	Procedural error and underpayment remain. The vision hardware was denied in error and should have been covered.	☐ 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 Q3 FY2024 of 99% processed within 30 days but did meet 92% processed within 14 days. This performance did improve from the prior period, but a penalty is still due. The penalty owed for this Performance Guarantee is 1.0% of the administrative fees of $1,351,734.20 or $13,517.20.

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
1032	The sample claim was an adjustment with a corrected provider allowed amount. The original claim paid on 8/10/23 with an incorrect allowed amount of $76.00. UMR provider contract effective 7/1/23 was loaded on 1/24/24. The update was completed in UMR's system on 2/9/24. The sample claim was adjusted to allow the updated rate of $110.00. UMR should explain why it took over seven months to load the correct contract rates and provide confirmation all other claims paid for PEBP members using the incorrect contract have been adjusted.
2031	The plan document did not reflect coverage for crowns on a primary tooth. The sample claim allowed coverage on four primary tooth crowns and paid $610.00 in benefits under UMR's standard logic. PEBP should review to ensure payment for a crown on primary teeth is an intended benefit.

DATA ANALYTICS

Medical Findings

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

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

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

Network Provider Utilization and Discount Savings

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

Scope

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

The review was divided into three subsets:

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

Each of these subsets was further delineated into four subgroups:

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

Report

PEBP's members under age 65 had utilization of network or secondary network medical providers at 97.1% of all allowed charges and 95.9% of all claims.

Total of All Claims				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$3,571,886.98	$2,975,696.86	45.4%	$3,085,378.97
Non-Facility	$32,083,057.34	$37,952,089.76	54.2%	$23,958,786.81
Facility Inpatient	$19,188,512.10	$46,763,240.17	70.9%	$18,115,090.87
Facility Outpatient	$28,388,787.96	$52,354,669.95	64.8%	$23,306,139.54
Total	**$83,232,244.38**	**$140,045,696.74**	**62.7%**	**$68,465,396.19**

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 found no providers on the sanctioned list 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.

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.

Report

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 98.96% 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.

Procedure to Procedure Edits								
PEBP - UMR								
Based on Paid Dates 1/1/2024 through 3/31/2024								
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	18	$11,590
					Standards of medical/surgical practice			
19318	50	15200	50	YES	Breast reduction	SKIN FULL GRAFT TRUNK	1	$5,826
					Standards of medical/surgical practice			
19342	50	19380	50	YES	Insertion or replacement of breast implant on sep	Revision of reconstructed breast(eg,signific	1	$5,560
					More extensive procedure			
70496	TC	96374		YES	CT ANGIOGRAPHY HEAD	THER/PROPH/DIAG INJ IV PUSH	5	$4,437
					Standards of medical/surgical practice			
94626		94625		YES	Physician services for outpatient pulmonary reha	Physician services for outpatient pulmonar	10	$3,125
					Mutually exclusive procedures			
76819	TC	59025		YES	FETAL BIOPHYS PROFIL W/O NST	FETAL NON-STRESS TEST	3	$2,777
					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	$2,721
					Misuse of Column Two code with Column One code			
99285		99284		YES	Emergency department visit for E&M of patient re	Emergency department visit for E&M of pati	1	$2,697
					Misuse of Column Two code with Column One code			
90853		90832		YES	GROUP PSYCHOTHERAPY	Psytx pt&/family 30 minutes	4	$2,397
					CPT Manual or CMS manual coding instruction			
94640		99285		YES	AIRWAY INHALATION TREATMENT	Emergency department visit for E&M of pati	1	$2,195
					CPT Manual or CMS manual coding instruction			
						Top 10 TOTAL	**45**	**$43,327**
						GRAND TOTAL	**327**	**$100,183**

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
54640	99	54512	50	YES	Orchiopexy, inguinal or scrotal approach	EXCISE LESION TESTIS	1	$2,108
					Standards of medical/surgical practice			
92609	GN	92507	GN	YES	USE OF SPEECH DEVICE SERVICE	SPEECH/HEARING THERAPY	12	$1,261
					Misuse of Column Two code with Column One code			
19370	50	11970	50	YES	Revision of peri-implant capsule, breast,includin	Replacement of tissue expander with perma	1	$441
					More extensive procedure			
00580	AA	93312	26	YES	ANESTH HEART/LUNG TRANSPLNT	ECHO TRANSESOPHAGEAL	1	$413
					Standard preparation/monitoring services for anesthesia			
88360	26	88341	26	YES	TUMOR IMMUNOHISTOCHEM/MANUAL	Immunohistochemistry or immunocytochen	3	$409
					CPT Manual or CMS manual coding instruction			
90460		99392	5	YES	IM ADMIN 1ST/ONLY COMPONENT	PREV VISIT EST AGE 1-4	2	$386
					CPT Manual or CMS manual coding instruction			
98941		97140	GP	YES	Chiropract manj 3-4 regions	Manual therapy 1/> regions	16	$335
					Standards of medical/surgical practice			
29880	51	29876	51	YES	KNEE ARTHROSCOPY/SURGERY	KNEE ARTHROSCOPY/SURGERY	1	$305
					Standards of medical/surgical practice			
00562	AA	93312	26	YES	ANESTH HRT SURG W/PMP AGE 1+	ECHO TRANSESOPHAGEAL	1	$281
					Standard preparation/monitoring services for anesthesia			
84481		84480		NO	FREE ASSAY (FT-3)	ASSAY TRIIODOTHYRONINE (T3)	14	$272
					More extensive procedure			
						Top 10 TOTAL	**52**	**$6,212**
						GRAND TOTAL	**125**	**$8,546**

MUE Reports

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

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

Non-Facility (non-facility claims with CPT codes:00100 - 99999)				
Procedure Code	Service Unit Limit	Procedure Description	Line Count Exceeding Limit	Amount CMS Would Deny
97154	18	GROUP ADAPTIVE BHV TX BY PROTOCOL TECH EA 15 MIN	20	$9,257
		Rationale: Clinical: CMS Workgroup		
31295	1	Nasal/sinus endoscopy, surgical, w dilation (balloon dila	3	$8,360
		Rationale: CMS Policy		
88332	13	PATH CONSULT INTRAOP ADDL	1	$3,764
		Rationale: Clinical: Data		
32667	3	THORACOSCOPY W/W RESECT ADDL	2	$3,546
		Rationale: Clinical: Data		
96133	7	NEUROPSYCHOLOGICAL TST EVAL PHYS/QHP EA ADDL HR	1	$1,568
		Rationale: Nature of Service/Procedure		
90837	2	Psytx pt&/family 60 minutes	2	$1,450
		Rationale: Clinical: CMS Workgroup		
97151	8	BEHAVIOR ID ASSESSMENT BY PHYS/QHP EA 15 MIN	3	$1,343
		Rationale: Clinical: CMS Workgroup		
54640	1	Orchiopexy, inguinal or scrotal approach	1	$945
		Rationale: CMS Policy		
86255	5	FLUORESCENT ANTIBODY SCREEN	1	$807
		Rationale: Clinical: Data		
30140	1	RESECT INFERIOR TURBINATE	3	$573
		Rationale: CMS Policy		
		Top 10 TOTAL	**37**	**$31,613**
		GRAND TOTAL	**63**	**$35,097**

Ancillary (All other claims not flagged Inpatient, Outpatient Hospital, or non-facility)				
Procedure	Service Unit	Procedure Description	Line count	Amount CMS
A4238	1	Adju cgm supply allowance	15	$16,219
		Rationale: CMS Policy		
A4239	1	Non-adju cgm supply allow	7	$4,776
		Rationale: Nature of Equipment		
B4035	1	ENTERAL FEED SUPP PUMP PER D	4	$1,810
		Rationale: Code Descriptor / CPT Instruction		
V2521	2	CNTCT LENS HYDROPHILIC TORIC	7	$550
		Rationale: Anatomic Consideration		
V2520	2	CONTACT LENS HYDROPHILIC	8	$500
		Rationale: Anatomic Consideration		
L2830	2	SOFT INTERFACE ABOVE KNEE SE	2	$270
		Rationale: Anatomic Consideration		
V2020	1	VISION SVCS FRAMES PURCHASES	2	$220
		Rationale: Clinical: Data		
V2100	2	LENS SPHER SINGLE PLANO 4.00	4	$220
		Rationale: Clinical: Data		
V2510	2	CNTCT GAS PERMEABLE SPHERICL	2	$220
		Rationale: Anatomic Consideration		
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	5	$127
		Rationale: Nature of Equipment		
		Top 10 TOTAL	**56**	**$24,912**
		GRAND TOTAL	**65**	**$25,230**

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.

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 with Modifier 24, 25, or 57		E/M Procedure Codes without Modifier 24, 25, or 57	
	Count	Allowed Charge	Count	% Surgeries with E/M Charges during Prohibited Global Fee Periods	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge
880133501	20	$6,985	6	23.1%	$1,444	5	$741	2	$289
880459167	0	$0	1	100.0%	$125	1	$77	0	$0
880335489	0	$0	1	100.0%	$125	1	$179	0	$0
880236758	3	$650	3	50.0%	$534	3	$289	0	$0
863930553	0	$0	1	100.0%	$30	1	$32	0	$0
813253496	1	$191	2	66.7%	$382	2	$287	0	$0
452698394	2	$1,319	2	50.0%	$1,319	2	$306	0	$0
270773333	2	$255	1	33.3%	$127	1	$166	0	$0
263303591	2	$753	1	33.3%	$172	1	$123	0	$0
223951517	0	$0	1	100.0%	$30	1	$20	0	$0
Top 10	**30**	**$10,152**	**19**	**38.8%**	**$4,289**	**18**	**$2,222**	**2**	**$289**
Overall Total	**34**	**$10,642**	**22**	**39.3%**	**$4,689**	**21**	**$2,489**	**2**	**$289**

CONCLUSION

UMR did not meet the performance metrics for financial accuracy and claim turnaround within 30 days; however, they did meet the performance metrics for overall accuracy and claim turnaround within 14 days in the third quarter of FY2024. A penalty of $33,586.70 or 2.5% of the administration fees for the quarter, is owed.

We consider it a privilege to have worked for, and with, 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.

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Wausau, WI 54401

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

June 19, 2024

Joni,

Thank you for the opportunity to respond to the recent review of the State of Nevada Public Employees' Benefit Program Q3Y24 audit draft report. The following is our response to the draft report completed by CTI.

ESAS Targeted Sample Analysis

Duplicate Payments

QID 39 and 40 – Claim 23350436609 is a duplicate to previously processed claim 23341347680. This results in a $20.70 overpayment. UMR has requested an overpayment for this claim. Sample selection 39 and 40 are for the same claim.

QID 42 – Claim 24061361134 was adjusted and denied on 5/7/2024 as a duplicate to previously processed claim 24075434038. This results in a $31.20 overpayment.

QID 43 – Claim 24016002922 was adjusted and denied on 5/7/2024 as a duplicate to previously processed claim 23206159133. This results in a $400.00 overpayment.

QID 44 – Claim 24016012796 was adjusted and denied on 5/7/2024 as a duplicate to previously processed claim 23227000700. This results in a $79.00 overpayment.

QID 45 – Claim 24095258614 was adjusted and denied on 5/7/2024 as a duplicate to previously processed claim 24066347772. This results in a $52.00 overpayment.

QID 46 – Claim 23165421857was adjusted and denied on 5/7/2024 as a duplicate to previously processed claim 23132152998. This results in a $188.92 overpayment. UMR has requested an overpayment for this claim.

QID 47 – Claim 24075258313 was adjusted and denied on 5/7/2024 as a duplicate to previously processed claim 24066347757. This results in a $52.00 overpayment.

QID 48 – Claim 24079003472 was adjusted and denied on 5/7/2024 as a duplicate to previously processed claim 24058700591. This results in a $534.40 overpayment.

Plan Exclusions – Potential Cosmetic Procedure

QID 36 – UMR agrees with this finding. This service was not authorized prior to payment and should have been denied. This results in a $3107.50 overpayment. This claim was adjusted on 6-18-2024.

Plan Exclusions - Inappropriate Use of Modifier 26/TC

QID 33 – UMR disagrees with this finding. Services billed by laboratory for professional component of a service or procedure and has also prepared a written interpretation and report based on the modifier billed on this claim.

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

Copay Application - DX Mammography/Chiro
QID 10 – UMR agrees with this finding. The benefit is to apply a $40.00 copayment for diagnostic mammograms. This claim was adjusted on 6/5/2024 and results in a $43.31 overpayment.

Fraud, Waste and Abuse – DME
QID 21 – UMR agrees with this finding. UM approved the enteral feeing/supplies under cases management. This claim was allowed without the out of network pricing that should apply to this claim. This results in a $445.31 overpayment. This claim was adjusted on 6-18-2024.

Fraud, Waste and Abuse – Specialty Medications (Non-Hospital)
QID 23 – UMR agrees with this finding. An incorrect allowable for code J0585 was applied to this claim. This results in a $1114.30 overpayment. This claim was adjusted on 6-18-2024.
QID 24 - UMR agrees with this finding. An incorrect allowable for code J1602 was applied to this claim. This results in a $2519.05 overpayment. This claim will be adjusted at the completion of this audit.

Fraud, Waste and Abuse – High Dollar Payments to Employees
QID 26 – UMR agrees with this finding. This claim was paid to the member in error. A stop payment was completed, and UMR reissued payment to the provider on 5/5/2024.

Fraud, Waste and Abuse – UCR Assistant Surgeon
QID 27 – UMR agrees with this finding. This claim should have been allowed at 140% of Medicare. This claim was adjusted on 5/7/2024 and results in a $5322.06 overpayment.

Fraud, Waste and Abuse – Cardiovascular Genetic Testing
QID 30 – UMR agrees with this finding. This service was not authorized prior to payment and should have been denied. This results in a $4524.60 overpayment. This claim was adjusted on 6-18-2024.
QID 31 – UMR agrees with this finding. This service was not authorized prior to payment and should have been denied. This results in a $5716.78 overpayment. This claim was adjusted on 6-18-2024.

Additional Observations:
QID 2, 3, 4 - UMR currently does not subscribe to historical iCES editing, therefore the claim repriced correctly based on the current editing software in place. UMR is in the process of a system enhancement to allow for historical UHC claim editing, and this is targeted for 2025.
QID 17 – For certain high -cost specialty drugs administered under the medical plan (i.e., certain gene therapy drugs), United Healthcare may negotiate with the provider. When the claim was originally processed, network pricing was applied based on the billed revenue code for drug charges rather than the negotiated rate for the specific gene therapy drug. UHC Network team verified an agreement was on file and the claim was adjudicated per the single case agreement.

Random Sample Findings

PPO Discount Error
Sample 1039 – 24039138722 UMR disagrees with this finding. This claim is processed correctly with the most current Medicare Allowable Rate that was in our system at the time this claim was processed. This claim will be adjusted at the completion of the audit.
Sample 1048 – UMR agrees with this finding. The allowable amount on the contract was transposed. This is a manual error and results in a $49.89 overpayment. This claim was adjusted on 5-15-2024.

Sample 1114 – UMR agrees with is finding. This claim was allowed at billed charges with an incorrect discount amount. This was a manual processor error and results in a $54,050 overpayment. The claim was adjusted on 5-22-2024.

Deductible Error

Sample 1084 – UMR disagrees with this finding. Per the plan benefits, Ology claims are to be paid INN when referred by a participating physician. The referring provider on the claim is a PPO provider. This claim is processed correctly at 80%.

Denied Eligible Expense

Sample 1076 – UMR disagrees with this error. The claim was reviewed by Advanced Claim Review, to deny for global billing of modifiers TC and 26. Claim adjustment is the result of a provider dispute, original determination over-turned, and claim adjusted 3/1/2024 with network pricing provided.

Sample 1126 – UMR agrees with this finding. Vision hardware is a covered expense on the plan. This results in a $100 underpayment. This claim was adjusted on 5-10-2024.

Additional Observations:

Sample 1032 – UMR received a retro contract effective 1/7/2023. This was received on 1-24-2024 and updated in our system on 2-9-2024. The claim was adjusted on 3-18-2024 with the updated rates.

Sample 1122 – UMR disagrees with this finding. Enrollment and monthly documentation is required from the provider for the Obesity Care Management program. There is a process in place to identify the lab claims related to the enrollment in this program for retrospective review and reconsideration of affected claims. The claim was adjusted on 1-31-024.

Sample 2031 – UMR's standard logic for code D2929 is covered under basic services.

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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