Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employees' Benefits Program Plans

Administered by UMR

Audit Period: July 1, 2024 – September 30, 2024
Audit Number 1.FY25.Q1

Presented to

State of Nevada Public Employees' Benefits Program

January 23, 2025

CLAIM TECHNOLOGIES INCORPORATED

Proprietary and Confidential

TABLE OF CONTENTS

EXECUTIVE SUMMARY

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

Scope

CTI performed an audit for the period of July 1, 2024 through September 30, 2024 (quarter 1 (Q1) for Fiscal Year (FY) 2025). The population of claims and amount paid during the audit period reported by UMR:

Medical and Dental	
Total Paid Amount	$66,244,693
Total Number of Claims Paid/Denied/Adjusted	236,049

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

- Quarterly Performance Guarantees Validation and Review of Self-Reported Results
- 100% Electronic Screening with 50 Targeted Samples
- Random Sample Audit of 200 Claims

Auditor's Opinion

Based on these findings, and in our opinion:

1. UMR met 26 of 27 self-reported performance guarantees in which CTI reviewed UMR's summary reports.
2. UMR's Financial Accuracy did not meet the service objective and a penalty is owed (breakdown in summary below).
3. CTI recommends UMR should:
   - Review 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.

Random Sample Audit Performance Guarantee Summary

Based on CTI's Random Sample Audit of 200 claims, UMR did not meet its target for Financial Accuracy in Q1 FY2025 and a penalty is assessed. The penalty is 1.5% of the quarter's total administrative fees of $1,393,483.98. The following outlines results and any assessed penalties for not meeting guarantees.

Quarterly Metric	Guarantee	Met/Not Met	Penalty	Calculated Penalty
Financial Accuracy	99.4%	Not Met – 98.68%	1.5%	$20,902.26
Overall Accuracy	98.0%	Met – 98.0%	NA	$0.00
Claim Turnaround Time	92% in 14 Days 99% in 30 Days	Met – 94.2% Met – 99.0%	NA NA	$0.00 $0.00
		Total Penalty	1.5%	$20,902.26

The following table presents a summary of UMR's historical performance against the quarterly metrics based on CTI's random sample audit results for the last four quarters. Results shown in red represent where UMR missed the agreed upon metric.

Measure	Guarantee	Quarter 2 FY24	Quarter 3 FY24	Quarter 4 FY24	Quarter 1 FY25
Financial Accuracy	**99.4%**	99.89%	98.47%	96.41%	98.68%
Overall Accuracy	**98.0%**	97.5%	98.5%	97.5%	98.0%
Claim Turnaround Time	**92% in 14 Days**	93.9%	94.0%	93.3%	94.2%
	99% in 30 Days	96.9%	98.5%	99.5%	99.0%

AUDIT OBJECTIVES

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

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

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

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

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

QUARTERLY PERFORMANCE GUARANTEE VALIDATION

As part of CTI's quarterly audit of PEBP, we reviewed the Performance Guarantees included in its contract with UMR. The results for Q1 FY2025 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	94.4%	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%	0.5%	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%	97.5%	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	98.5% 98.9%	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%	98.1%	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
1.13	**Account Management – Plan will guarantee that the services provided by the TPA's team during the guarantee period will be satisfactory to PEBP. Areas of satisfaction will include:**			
	Knowledge/Capabilities – Account representative demonstrates competence in getting issues and problems resolved.	Agree	5	Met
	Responsiveness – All calls returned within at most 24 hours; along with an alternate person identified who can assist with service issues when account representative is unavailable.			
	Ability to meet deadlines – Supplying all requested materials accurately and in a timely manner, along with all necessary documentation (i.e., enrollment kits, rate confirmations, plan performance work plans, group contracts, ZIP code file, etc.).			
	Professionalism – Demonstrates objectivity and empathy with customer problems.			

	Metric	Service Objective	Actual	Met/ Not Met
	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 changes	Met
NETWORK ADMINISTRATION – SERVICES AND PERFORMANCE GUARANTEES				
2.1	**EDI Claims Re-Pricing Turnaround Time:** At least 97% of medical claims covered under the PEBP Medical PPO Network must be electronically re-priced within business 3 days and 99% within business 5 days.	97.00% 3 Business Days 99.00% 5 Business Days	99.5% 99.5%	Met Met
2.2	**EDI Claims Re-Pricing Accuracy:** At least 97% of claims re-priced by the PPO Network must be accurate and must not cause a claim adjustment by PEBP's TPA.	97.00%	98.9%	Met
2.3	**Data Reporting – Standard Reports (Quarterly reporting to include Service Performance Standards, Guarantee, Method of Measurement, Actual Performance Results, and Pass/Fail indicator.)** Standard reports must be delivered within business 10 days of end of reporting period or event as determined by PEBP.	100% 10 Business Days	100%	Met
2.4	**Subcontractor Disclosure:** 100% of all subcontractors used by vendor are disclosed prior to any work done on behalf of PEBP. Business Associate Agreements completed by all subcontractors.	100%	No new subcontractors	Met
2.5	**Provider Directory:** Best efforts to resolve 100% of complaints within 10 business days. Provider Directory issue resolution log maintained by Vendor and periodically reviewed with PEBP.	100% 10 Business Days	No complaints filed	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
3.12	**Disclosure of Subcontractors:** All subcontractors who have access to PHI or PII data and physical locations where PEBP PHI or PII data is maintained and/or stored must be identified in this contract. Any changes to those subcontractors or physical locations where PEBP data is stored must be communicated to PEBP at least 60 days prior to implementation of services by the subcontractor. Implementation will not be in effect until PEBP has provided written authorization.	100% 60 Calendar Days	No new subcontractors	Met
3.13	**Unauthorized Transfer of PEBP Data:** All PEBP PHI or PII data will be stored, processed, and maintained solely on currently designated servers and storage devices identified in this contract. Any changes to those designated systems during the life of this agreement shall be reported to PEBP at least 60 calendar days prior to the changes being implemented. Implementation will not be in effect until PEBP has provided written authorization.	100% 60 Calendar Days	No changes	Met

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

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

Scope

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

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

Methodology

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

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

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

Findings

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

Categories for Process Improvement

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

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

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

ESAS Findings Detail Report				
QID	**(Under)/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Duplicate Payments				
25	$91.00	Agree. Adjustments completed on 11/5/24.	Procedural deficiencies and overpayments remain. UMR paid duplicate charges.	☐ M ☒ S
26	$79.00			☐ M ☒ S
27	$50.00			☐ M ☒ S
Plan Exclusions				
Dental Services				
40	$987.50	Agree. These services should not have been allowed under the medical plan. The claims will be adjusted at the completion of the audit.	Procedural deficiencies and overpayments remain. Excluded dental implant services were paid under the medical plan in error.	☒ M ☐ S
41	$108.50			☒ M ☐ S
42	$1,031.50		Procedural deficiency and overpayment remain. The service for an occlusal guard for overbite should not have paid under the medical plan.	☒ M ☐ S
Massage Therapy				
47	$55.00	Agree. Massage Therapy code 97124 is a non-covered benefit. This service should have denied. This claim will be adjusted at the completion of the audit.	Procedural deficiency and overpayment remain. Massage therapy, procedure 97124, is excluded per pages 102 and 105 of the LDPPO plan document.	☒ M ☐ S

Incorrect Preferred Provider Discount Applied				
Specialty Medications				
29	$16,080.75	Agree. The claim was adjusted in error and applied the incorrect contracted amount. This results in a $16,080.75 overpayment. Adjustment was completed on 12/19/24.	Procedural deficiency and overpayment remain. Claim originally priced at $8,606.74. Sampled claim paid billed charges, with no explanation for additional payment of billed charges over the previously paid contract rate.	☒ M ☐ S
30	$12,492.84	Agree. Pricing was not correctly applied on original processing. Claim was adjusted with corrected pricing on 10/23/24. The correct allowance for J9263 is $36.80. $12,492.84 overpayment for this service.	Procedural deficiency and overpayment remain. The network contract amount was not paid.	☒ M ☐ S
Copay Application				
Acupuncture				
11	$12.00	Agree. MPD indicates a $50.00 copay applies per visit for acupuncture. Copay not applied correctly. This claim will be adjusted at the completion of the audit.	Procedural deficiency and overpayment remain. A $50.00 copay was applicable for acupuncture and only $38.00 was applied.	☒ M ☐ S
Office Visit – Specialist				
19	$50.00	Agree. Specialty copay should have applied. This claim will be adjusted at the completion of the audit.	Procedural deficiency and overpayment remain. A $50.00 copay was applicable for a specialist office visit, and none was applied.	☐ M ☒ S
Preventive Services				
Denied				
7	($171.53)	Agree. The claim was manually denied in error for COB. Adjustment complete 12/12/24.	Procedural deficiency and underpayment remain. Claimant was employee; PEBP does not require annual COB questionnaires, and no indication was presented indicating the member had other insurance. This preventive claim should have been allowed.	☒ M ☐ S

Additional Observations

During the ESAS review, our auditor observed the following procedures or situations that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

QID Number	Observation
10, 13	Sampled claims paid without application of $40.00 diagnostic mammography copay. CTI notes claims were both corrected, applying $40.00 copay prior to provision of the data file to CTI.

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 $2,514,257.52. The claims sampled and reviewed revealed $183.06 in underpayments and $1,126.24 in overpayments. This reflects a weighted Financial Accuracy rate of 98.68% over the stratified sample. This is an increase 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 FY2025 of 99.40% for this measure. The penalty owed is 1.5% of the administrative fees of $1,393,483.98 or $20,902.26.

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 4 incorrectly paid claims and 196 correctly paid claims. This is an increase 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	1	3	98.00%

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 increased from the prior period. UMR met the Performance Guarantee for PEBP in Q1 FY2025 of 98.00% for this measure. Detail is provided in the table below, Random Sample Findings Detail Report.

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
196	1	3	98.00%

Random Sample Findings Detail Report

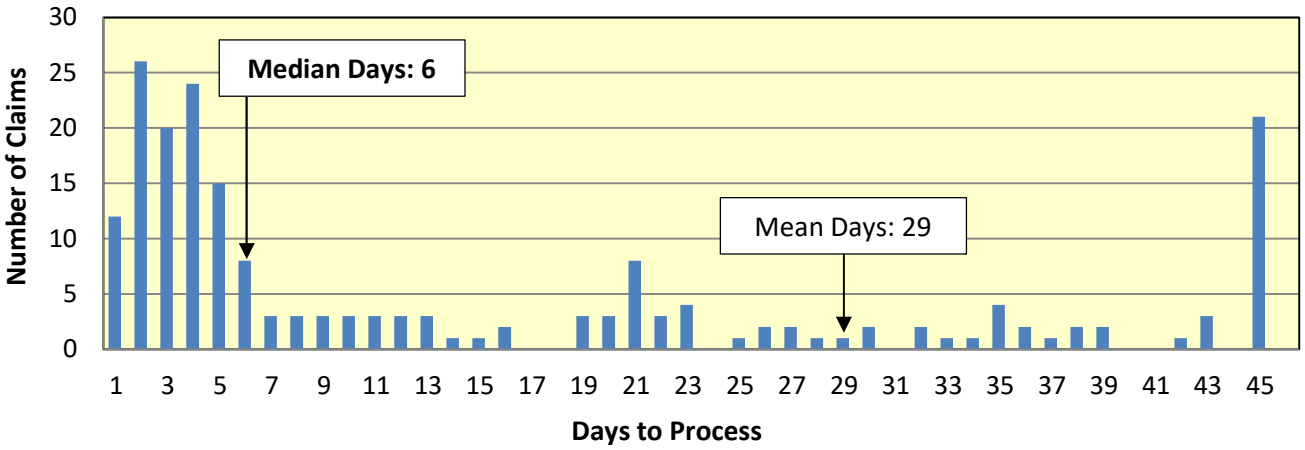
Audit No.	Under/ Over Paid	UMR Response	CTI Conclusion	Manual or System
PPO Discount				
1023	$126.24	Agree. Claim priced with incorrect allowed amount. Correct allowed amount is $48.85. This results in an overpayment of $126.24. Claim was adjusted on 11/12/24, and overpayment requested.	Procedural error and overpayment remain. An incorrect PPO discount was applied to the sampled claim.	☒ M ☐ S
Incorrect Copay				
1129	$20.00	Agree. Claim should have taken a $50 copay. Claim will be adjusted at the completion of the audit.	Procedural error and overpayment remain. Copay should have been $50.00, and it was $30.00. Provider was a urologist specialist.	☒ M ☐ S
1136	($183.06)	Agree. Claim should have applied a $50 copay and resulted in a $183.06 underpayment. Claim was adjusted on 10/31/2024.	Procedural error and underpayment remain. The copay should have been $50.00, and it was $0.00. Claim also over applied deductible by $250.99.	☒ M ☐ S
Paid Ineligible Procedure				
2030	$980.00	Agree. UMR's logic for code D3348-retreatment of a root canal, is allowed under the Basic benefit. Per the PEBP intent for the dental plan, there is no coverage for root canal therapy when the pulp chamber was opened before coverage under this dental plan. This member was effective 9/1/23 and there is no history on this member file of the initial root canal service. UMR would like to review this benefit with PEBP to confirm the intent.	Procedural error and overpayment remain. Coverage for root canal therapy (D3348) requires root canal to originally be opened while coverage was active as specified in the plan document on page 13 *No coverage for root canal therapy when the pulp chamber was opened before coverage under this dental plan began.* Member became effective on the plan on 9/1/23 and the original root canal date is unknown.	☐ M ☒ S

Claim Turnaround

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

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

Median and Mean Claim Turnaround



UMR met the Performance Guarantees for PEBP in Q1 FY2025 of 92% processed within 14 days and 99% processed within 30 days. The performance of both measures improved from the prior period and there is no penalty due.

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
1099, 1100	Sampled claims applied a copay to ABA therapy in error. The claims were adjusted and corrected prior to the data file being provided to CTI for audit, therefore we did not assess payment errors.
1108, 1109	Sampled claims were paid as out of network in error. The claims were adjusted and corrected prior to the data file being provided to CTI for audit, therefore we did not assess payment errors.

FOCUSED RANDOM SAMPLE AUDIT

At the request of PEBP, CTI selected a second random sample of 100 claims for one provider of service, Carson-Tahoe Hospital (CTH). All the above outlined procedures were followed for the second focused random sample audit.

CTI identified 12 incorrectly paid claims in the 100-claim CTH sample. Eleven of the 12 were due to a billing issue on CTH's end where the claims were billed on the incorrect form causing UMR to pay the claim at an incorrect rate. An error was not cited on those samples, and they are detailed in the Additional Observation section of the report.

Financial Accuracy

The total paid in the 100-claim audit sample was $895,796.56. The claims sampled and reviewed revealed no underpayments and $1,134.91 in overpayments. This reflects a weighted Financial Accuracy rate of 99.42% for the stratified sample. Detail is provided in the following table, Random Sample Findings Detail Report.

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 1 incorrectly paid claim and 99 correctly paid claims. Detail is provided in the table below, Random Sample Findings Detail Report.

Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid Claims	Overpaid Claims	
100	0	1	99.42%

Overall Accuracy

CTI defines Overall Accuracy as the number of claims processed without errors compared to the total number of claims processed in the audit sample. Detail is provided in the table below, Random Sample Findings Detail Report.

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
98	0	1	99.00%

Random Sample Findings Detail Report

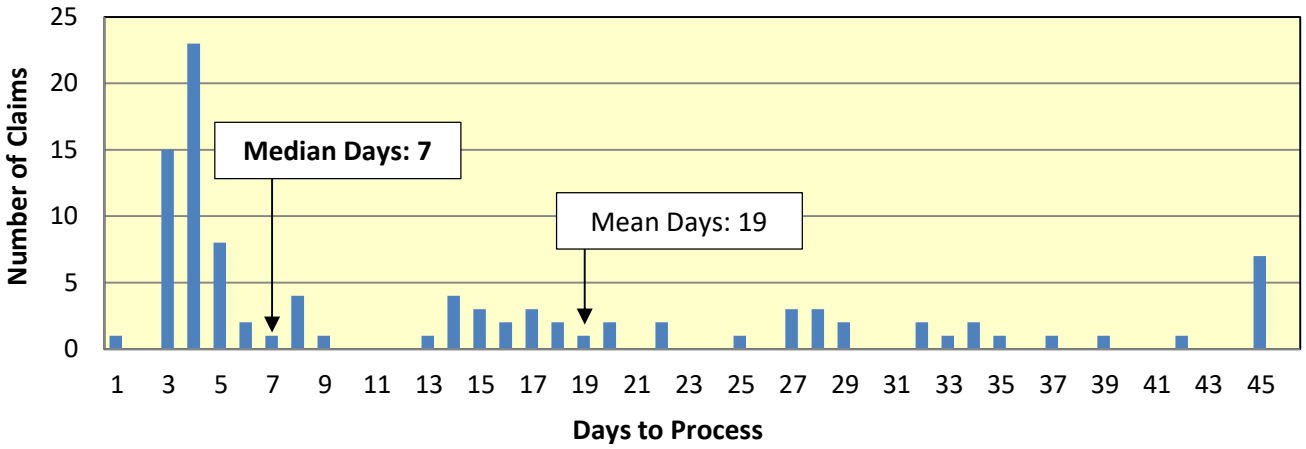
Audit No.	Under/ Over Paid	UMR Response	CTI Conclusion	Manual or System
PPO Discount				
1069	$1,134.91	Agree. An incorrect discount amount was manually keyed in error. This results in a $1,134.91 overpayment. Adjustment was complete 11/23/24.	Procedural error and overpayment remain. Discount amount processed as $2,193.04 and it should have been $3,611.68.	☒ M ☐ S

Claim Turnaround

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

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

Median and Mean Claim Turnaround



Additional Observations

During the Random Sample Audit of CTH, 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 Numbers	Observation
1006, 1017, 1022, 1023 1025, 1026, 1044, 1045, 1058, 1065, and 1074	The discount amount processed on these claims was incorrect. Three claims were overpaid and eight were underpaid. UMR provided a copy of an email from CTH confirming a billing issue on their end where CTH submitted the claims on HCFA forms instead of UB04 forms which resulted in the claims being processed at an incorrect rate.

CONCLUSION

UMR did not meet the performance metrics for financial accuracy in the first quarter of FY2025. A penalty of $20,902.26, or 1.5% of the administration fees for the quarter, is owed.

The focused random sample revealed 12 out of the 100-claim sample had an incorrect provider discount applied; 11 of the 12 were due to a billing issue on CTH's end where claims were billed on the incorrect form causing UMR to pay the claim at an incorrect rate.

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.

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December 20, 2024

Joni,

Thank you for the opportunity to respond to the recent review of the State of Nevada Public Employees' Benefit Program Q1Y25 audit draft report. The following is our response to the draft report completed by CTI.

ESAS Targeted Sample Analysis

Duplicate Payments

QID 25 – Dental claim [redacted] is a duplicate to previously processed claim [redacted]. This results in a $91.00 overpayment. Adjustment was completed on 11-5-2024.

QID 26 – Dental claim [redacted] is a duplicate to previously processed claim [redacted] This results in a $79.00 overpayment Adjustment was completed on 11-5-2024.

QID 27 – Dental Claim [redacted] is a duplicate to previously processed claim [redacted]. This results in a $50.00 overpayment. Adjustment was completed on 11-5-2024.

Plan Exclusions – Dental Services

QID 40-42 – UMR agrees with these findings. These dental services are not allowed under the medical plan per the plan exclusions. Total overpayment amount for the 3 claims is $2127.50. These claims will be adjusted at the completion of the audit.

Inappropriate Use of Modifier 26/TC

QID 43 – UMR disagrees with this finding. The lab charge is allowed appropriately per the MPD for Ancillary charges, related to the ER claim that is on file for this member on the same date of service.

Experimental/Investigational

QID 46 – UMR disagrees with this finding. After further review, the services rendered do not require an authorization. This claim was allowed correctly per the plan benefits.

Massage Therapy

QID 47 – UMR agrees with this finding. Massage Therapy 97124 is excluded on the plan and was allowed in error by the claim processor. This results in a $55.00 overpayment. Adjustment was completed on 11-14-2024.

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Incorrect Preferred Provider Discount Applied – Specialty Medication

QID 29 – After further review, UMR agrees with this finding. The claim was adjusted in error and applied the incorrect contracted amount. This results in a $16080.75 overpayment. Adjustment was completed on 12-19-2024.

QID 30 – UMR agrees with this finding. An incorrect contract allowance was applied to CPT J9263. The correct allowable is $36.80. This results in a $12,492.84 overpayment. Adjustment was completed on 10-23-2024.

Copay Application - Acupuncture

QID 11 – UMR agrees with this finding. A $50.00 copay should apply, per visit, for acupuncture. This results in a $12.00 overpayment. Adjustment was completed on 12-11-2024.

Copay Application – Office Visit - Specialist

QID 19 – UMR agrees with this finding. A $50.00 copay should apply for a specialist office visit. This results in a $50.00 overpayment. Adjustment was completed on 11-15-2024.

Preventive Services – Denied

QID 7 – UMR agrees with this finding. After further review, this claim was manually denied in error for COB. This results in a $171.53 underpayment. Adjustment was completed on 12-12-2024.

Random Sample Findings

PPO Discount

Sample 1023 – UMR agrees with this finding. This claim was considered with incorrect pricing. This results in a $126.24 overpayment. Adjustment was completed on 11-12-2024.

Incorrect Copay

Sample 1129 – UMR agrees with this finding. A $50.00 copay should apply for a specialist. This results in a $20.00 overpayment. This claim will be adjusted at the completion of the audit.

Sample 1136 - UMR agrees with this finding. A $50.00 copay should apply for this visit. This claim initially applied to the deductible. The claim was adjusted on 10-31-2024 paying $183.06.

Paid Ineligible Procedure

Sample 2030 – After further review, UMR agrees with this finding. UMRs logic for code D3348 - retreatment of a root canal, is allowed under the Basic benefit. Per the PEBP intent for the dental plan, there is no coverage for root canal therapy when the pulp chamber was opened before coverage under this dental plan. This member was effective 9-1-2023 and there is no history on this member file of the initial root canal service. UMR would like to review this benefit with PEPB to confirm the intent.

Carson Tahoe Random Sample Findings

Sample 1020 – UMR disagrees with this error. After further review, this service is an urgent care visit for an infection and was treated. This is covered per the plan.

Sample 1010 – UMR disagrees with this error. UHC priced this claim allowing $15,322.56. UMR processed the claim correctly. Carson Tahoe submitted a corrected claim with additional services, UHC allowing $22,835.53. The corrected claim was received on 10-10-2024. Adjustment was completed on 11-5-2024.

Sample 1023 – UMR and Carson Tahoe identified a billing issue on the claim that was submitted, and Carson Tahoe submitted a corrected claim on 11-12-2024.
Sample 1026 – UMR and Carson Tahoe identified a billing issue on the claim that was submitted, and Carson Tahoe submitted a corrected claim on 11-13-2024.
Sample 1069 – UMR agrees with this error. The discount of manually keyed incorrectly at the time of processing. This results in a $1134.91 overpayment. Adjustment was completed on 11-23-2024.

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

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