Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employees' Benefits Program Plans

Administered by UMR

Audit Period: October 1, 2024 – December 31, 2024
Audit Number 1.FY25.Q2

Presented to

State of Nevada Public Employees' Benefits Program

May 22, 2025

CLAIM TECHNOLOGIES INCORPORATED

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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'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 October 1, 2024 through December 31, 2024 (quarter 2 (Q2) 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	$68,305,570
Total Number of Claims Paid/Denied/Adjusted	237,292

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 all 27 self-reported performance guarantees in which CTI reviewed UMR's summary reports.
2. UMR met the service objective for Financial Accuracy, Overall Accuracy and Claim Turnaround Time and no penalty is owed.
3. CTI recommends UMR should:
   - Review errors identified in our Random Sample audit as well as the additional observations and determine if procedures, 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 met its target for Financial Accuracy, Overall Accuracy and Claim Turnaround Time in Q2 FY2025 and no penalty is assessed.

Quarterly Metric	Guarantee	Met/Not Met	Penalty	Calculated Penalty
Financial Accuracy	99.4%	Met – 99.99%	NA	$0.00
Overall Accuracy	98.0%	Met – 99.0%	NA	$0.00
Claim Turnaround Time	92% in 14 Days 99% in 30 Days	Met – 95.6% Met – 99.3%	NA NA	$0.00 $0.00
		Total Penalty	NA	$0.00

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	FY 2024		FY 2025	
		Quarter 3	Quarter 4	Quarter 1	Quarter 2
Financial Accuracy	**99.4%**	98.47%	96.41%	98.68%	99.99%
Overall Accuracy	**98.0%**	98.5%	97.5%	98.0%	99.0%
Claim Turnaround Time	**92% in 14 Days**	94.0%	93.3%	94.2%	95.6%
	99% in 30 Days	98.5%	99.5%	99.0%	99.3%

AUDIT OBJECTIVES

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

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

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

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

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

QUARTERLY PERFORMANCE GUARANTEE VALIDATION

As part of CTI's quarterly audit of PEBP, we reviewed the Performance Guarantees included in its contract with UMR. The results for Q2 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	96.0%	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	96.8%	Met
1.6	**Call Abandonment Rate:** total number of participant and provider calls abandoned, divided by the total number of calls received by the facility's customer service telephone system.	3.00%	0.3%	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%	97.3%	Met
1.8	**Open Inquiry Closure:** addresses the time taken in hours and/or days by CSRs at the administrator's service facility to close open inquiries placed by participants of PEBP to the facility.	90.00% 48 Hours 98.00% 5 Business Days	98.5% 99.3%	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%	98.6%	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.			
	Flexibility – Ability to meet client-specific needs.			

	Metric	Service Objective	Actual	Met/ Not Met
	Participation in periodic meetings – Attendance at all required client meetings or conference calls.			
	Guarantee measured with staff responses to internal questionnaire. A scale from 1 to 5 will be used to measure performance, where 1 means 'very dissatisfied' and 5 means 'very satisfied'; and 2 through 4 are defined, respectively.			
	Periodic program reports will be provided and presented with recommended actions. Standard program reports, within 30 days to quarter-end. Year-end activity report, within 45 days of program year end.			
	Open Enrollment Support: Accurate materials will be provided at least 60 days prior to the open enrollment period starting on April 1 each year. Representative will be available, if requested, for up to 5 employee benefit fairs.			
	Service Objective (out of a score of 5 on internal questionnaire):	350		
1.14	**Eligibility Processing:** Confirm daily and weekly eligibility and enrollment within specified business days of the receipt of the eligibility information, given that information is complete and accurate.	98.00% 2 Business Days	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% 99.77%	Met Met
2.2	**EDI Claims Re-Pricing Accuracy:** At least 97% of claims re-priced by the PPO Network must be accurate and must not cause a claim adjustment by PEBP's TPA.	97.00%	99.5%	Met
2.3	**Data Reporting – Standard Reports (Quarterly reporting to include Service Performance Standards, Guarantee, Method of Measurement, Actual Performance Results, and Pass/Fail indicator.)** Standard reports must be delivered within business 10 days of end of reporting period or event as determined by PEBP.	100% 10 Business Days	100%	Met
2.4	**Subcontractor Disclosure:** 100% of all subcontractors used by vendor are disclosed prior to any work done on behalf of PEBP. Business Associate Agreements completed by all subcontractors.	100%	No new subcontractors	Met
2.5	**Provider Directory:** Best efforts to resolve 100% of complaints within 10 business days. Provider Directory issue resolution log maintained by Vendor and periodically reviewed with PEBP.	100% 10 Business Days	No 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				
45	$91.00	Agree.	Procedural deficiencies and overpayments remain. UMR paid duplicate charges.	☐ M ☒ S
49	$207.20			☐ M ☒ S
50	$491.48			☒ M ☐ S
Service Not Authorized				
37	$800.00	Agree. Prior authorization was not on file for CPT code 97151.	Procedural deficiency and overpayment remain. The applied behavioral analysis (ABA) services required prior authorization, which was not done. The ABA services should have been denied as not authorized.	☒ M ☐ S
Plan Exclusions				
Liposuction (Cosmetic Surgery)				
42	$3,710.25	Agree. The charges for 15877 and 15878 should have been reviewed for medical necessity before payment. UMR will request medical records for post payment review prior to pursing overpayment recovery.	Procedural deficiency and overpayment remain. Per page 92 of the EPO MPD, cosmetic procedures were excluded by the plan. The charges for lipectomy (procedure codes 15877 and 15878) were not prior authorized or reviewed for medical necessity prior to payment. The charges should have been denied.	☒ M ☐ S
Incorrect Preferred Provider Discount Applied				
21	$578.15	Agree. The claim should have taken a discount.	Procedural deficiency and overpayment remain. The provider discount was not applied to the claim.	☒ M ☐ S

Copay Application				
Office Visit - PCP				
15	$30.00	Agree. The copayment applies per visit not per day. $30.00 copay should apply to this claim per the plan benefits.	Procedural deficiency and overpayment remain. The MPD states copays are per visit and not per day.	☒ M ☐ S
Office Visit – Specialist				
17	($11.94)	Agree. Specialty copay of $40.00 should have applied.	Procedural deficiency and underpayment remain. The service should have had a $40.00 copay applied instead of coinsurance.	☒ M ☐ S
Preventive Services				
With Coinsurance Applied				
6	($20.50)	Agree. The coinsurance on this claim was applied in error. The claim should have paid at 100% of cost share. This claim will be adjusted at the completion of the audit.	Procedural deficiency and underpayment remain. The member cost share should have been waived for this preventive service.	☒ M ☐ S

Additional Observations

During the focused 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
39	Per page 109 of the CDHP MPD, vision therapy (orthoptics) was specifically excluded by the plan and should have been denied. UMR provided a memo where PEBP instructed UMR to allow expenses for vision therapy. PEBP should verify their coverage intent for vision therapy and ensure the MPD reflects that intent as well as communicate any change to UMR.

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 $2,855,721.25. The claims sampled and reviewed revealed no underpayments and $125.00 in overpayments. This reflects a weighted Financial Accuracy rate of 99.99% 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 met the Performance Guarantee for PEBP in Q2 FY2025 of 99.40% for this measure.

Claims Payment Accuracy

CTI defines Claims Payment Accuracy as the number of claims paid correctly compared to the total number of claims paid for the audit sample.

The audit sample revealed 1 incorrectly paid claim and 199 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	0	1	99.5%

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 Q2 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	
198	0	2	99.0%

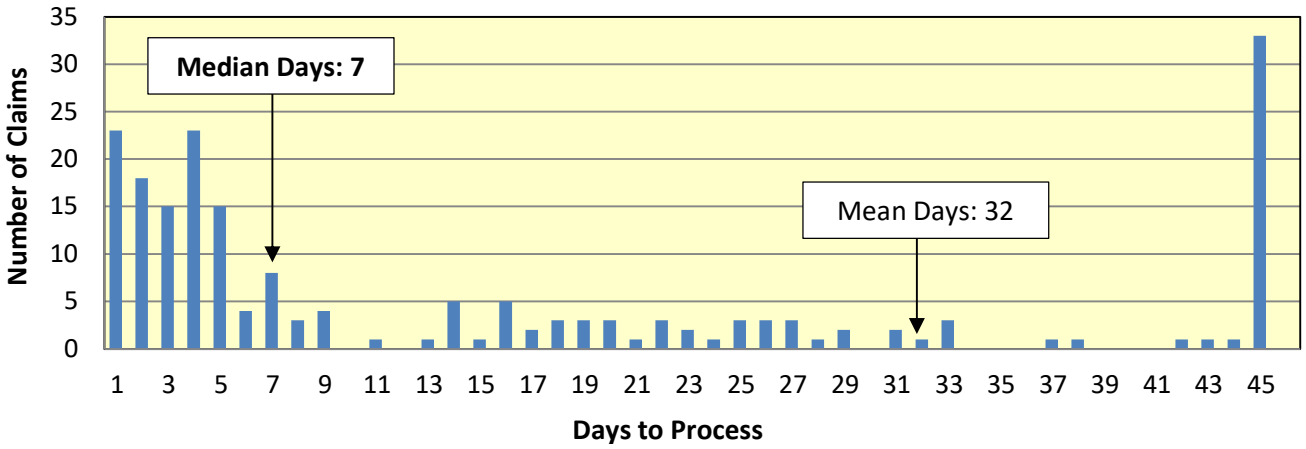
Random Sample Findings Detail Report				
Audit No.	Under/ Over Paid	UMR Response	CTI Conclusion	Manual or System
PPO Discount				
1038	$125.00	Agree. The processor allowed $150.00 for code S9379 and should have allowed $25.00. This results in a $125 overpayment.	Procedural error and overpayment remain. An incorrect PPO discount was applied to the sampled claim.	☒ M ☐ S
Paid Ineligible Procedure				
1114	NA	Agree. Gingival dental work is excluded on the Low Ded. Plan. This claim was allowed in error by the Customer First Representative.	Procedural error and overstatement of $100.55 to the deductible remains. This claim for dental services was not eligible for benefits based on page 96 of the plan document.	☒ 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 Q2 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
1083, 1091	CTI identified two claims in the random sample audit where payment for Esketamine nasal spray (Spravato) was allowed without prior authorization. Administration of the drug requires monitoring of the patient for two hours due to potential serious side-effects. Based on the medical claim data, PEBP spent in excess of $140,000 for this drug in FY2025. CTI recommended administration of this drug should require prior authorization. PEBP and UMR have since discussed and agreed prior authorization will be required going forward for coverage of Esketamine through both the medical and prescription drug plans.

CONCLUSION

UMR met all the performance metrics in the second quarter of FY2025. No penalty is owed.

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

APPENDIX – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Your administrator's response to the draft report follows.

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

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

March 18, 2025

Joni,

Thank you for the opportunity to respond to the recent review of the State of Nevada Public Employees' Benefit Program Q2Y25 audit draft report. The following is our response to the draft report completed by CTI.

ESAS Targeted Sample Analysis

Duplicate Payments

QID 45 – Dental claim 24291261705 is a duplicate to previously processed claim 24291261625. This results in a $91.00 overpayment. Adjustment was completed on 3-13-2025.

QID 47 – After further review, UMR disagrees with this duplicate payment error. The provider of service also confirmed this is not a duplicate billing. Patient had D0220 (X-Ray) and D9910 done on each tooth, # 2 and #3.

QID 50 – Medical Claim 24291266170 is a duplicate to previously processed claim 24282416643. This results in a $491.48 overpayment. Adjustment was completed on 1-23-2025.

QID 49 – After further review, Dental claim 24338017408 is a duplicate to previously processed claim 24277382456. Services for tooth # 7, an anterior tooth (lateral) was billed for procedure D2332 (3 surface resin-based composite, not an amalgam). UMR received two separate billings with the same code and billed amount. This results in a $207.20 overpayment. Adjustment was completed on 3-18-2025.

Services Not Authorized

QID 37 – After further review, UMR agrees with this finding. Prior authorization was not on file for CPT code 97151. This was a Customer First Representative (CFR) processing error. The claim was adjusted on 3-13-2025 and results in a $800.00 overpayment.

Plan Exclusions – Orthoptics (Vision Therapy)

QID 39 – UMR disagrees with this finding. Claims are reviewed based on the services billed. Procedure and Diagnosis selections are coded in the UMR system to identify the services and plan benefits. This claim is processed correctly.

Plan Exclusions – Experimental /Investigational

QID 40 – UMR disagrees with this finding. Claims are reviewed based on the services billed. Procedure and Diagnosis selections are coded in the UMR system to identify the services and plan benefits. This claim processed per the provider's UHC contract and case rate methodology. This claim is processed correctly.

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Plan Exclusions – Liposuction (Cosmetic Surgery)

QID 42 – UMR disagrees with this finding. Claims are reviewed based on the services billed. Procedure and Diagnosis selections are coded in the UMR system to identify the services and plan benefits. This claim processed per the provider's UHC contract and surgical case rate methodology. This claim is processed correctly.

Incorrect Preferred Provider Discount Applied

QID 21 – UMR agrees with this finding. The provider discount was omitted at the time this claim was processed. This was a CFR processing error. This claim was adjusted on 2-11-2025 and results in a $578.15 overpayment.

Copay Application – PCP

QID 15 – After further review, UMR agrees with this finding. The copayment applies per visit not per day. $30.00 copay should apply to this claim per the plan benefits. This claim was adjusted on 3-13-2025 and results in a $30.00 overpayment.

Copay Application – Office Visit – Specialist

QID 17 – UMR agrees with this finding. A $40.00 copay should apply for a specialist office visit. This claim was adjusted on 03-14-2025 and results in a $11.94 underpayment.

Preventive Services – With Coinsurance Applied

QID 6 – UMR agrees with this finding. Coinsurance was applied to this claim in error. This was a manual processing error. The claim was adjusted on 3-13-2025 and results in a $20.50 underpayment.

Random Sample Findings

PPO Discount

Sample 1038 – UMR agrees with this finding. An incorrect allowed amount was entered for code S9379. This claim was adjusted on 3-13-2025 and results in a $125.00 overpayment.

Paid Ineligible Procedure

Sample 1114 – UMR agrees with this finding. This service is excluded on the plan and was allowed in error by the CFR. The claim was adjusted to deny on 3/11/2025.

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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