Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

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

Audit Period: July 1, 2025 – September 30, 2025
Audit Number 1.FY26.Q1

Presented to

State of Nevada Public Employees' Benefits Program

January 20, 2026

CTI Audit Solutions

Proprietary and Confidential

TABLE OF CONTENTS

EXECUTIVE SUMMARY 3

AUDIT OBJECTIVES 5

QUARTERLY PERFORMANCE GUARANTEE VALIDATION 6

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS 8

RANDOM SAMPLE AUDIT 11

CONCLUSION 13

APPENDIX – Administrator's Response to Draft Report 14

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 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, 2025 through September 30, 2025 (quarter 1 (Q1) for Fiscal Year (FY) 2026). The population of claims and amount paid during the audit period reported by UMR:

Medical and Dental	
Total Paid Amount	$75,860,760
Total Number of Claims Paid/Denied/Adjusted	244,389

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's Claim Turnaround Time within 30 Days did not meet the service objectives 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 have 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 Claim Turnaround Time within 30 days in Q1 FY2026 and a penalty is assessed. The penalty is 1.0% of the quarter's total administrative fees of $1,467,771.08. 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%	Met – 99.84%	NA	$0.00
Overall Accuracy	98.0%	Met – 98.0%	NA	$0.00
Claim Turnaround Time	92% in 14 Days	Met – 92.0%	NA	$0.00
	99% in 30 Days	Not Met – 98.1%	1.0%	$14,677.71
		Total Penalty	**1.0%**	**$14,677.71**

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 FY25	Quarter 3 FY25	Quarter 4 FY25	Quarter 1 FY26
Financial Accuracy	99.4%	99.99%	99.56%	99.20%	99.84%
Overall Accuracy	98.0%	99.00%	99.00%	97.00%	98.00%
Claim Turnaround Time	92% in 14 Days	95.60%	93.10%	92.60%	92.00%
	99% in 30 Days	99.30%	97.50%	98.10%	98.10%

AUDIT OBJECTIVES

This report contains CTI's findings from our audit of UMR's administration of the 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 FY2026 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 percentage of Client telephone inquiries answered by facility Customer Service Representatives (CSRs) within 30 seconds. Measured from 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	92.2%	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%	0.6%	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%	97.2%	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	98.8% 99.7%	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%	98.8%	Met
1.10	**CSR Callback Performance:** measured from CSR commitment data in hours and/or days to 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	4.5	Met
	Responsiveness – All calls returned within at most 24 hours; along with an alternate person identified who can assist with service issues when account rep is unavailable.			
	Ability to meet deadlines – Supplying all requested materials accurately and in a timely manner, along with all necessary documentation (i.e., enrollment kits, rate confirmations, plan performance work plans, group contracts, ZIP code file, etc.).			
	Professionalism – Demonstrates objectivity and empathy with customer problems.			
	Flexibility – Ability to meet client-specific needs.			
	Participation in periodic meetings – Attendance at all required client meetings/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):	3.50		
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

	Metric	Service Objective	Actual	Met/ Not 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 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 stored 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% 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 10 business 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%	99.94%	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 10 calendar 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

ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

CTI's 100% 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 reviewing 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				
23	$174.40	Agree.	Procedural deficiencies and overpayments remain. UMR paid duplicate charges.	☒ M ☐ S
24	$3,222.24			☒ M ☐ S
25	$4,448.63			☒ M ☐ S
26	$112.90			☒ M ☐ S
Plan Exclusions				
Dental Services				
42	$75.00	Agree. D0120 is an oral exam and should have been denied under medical. Claim was adjusted on 10/28/2025.	Procedural deficiencies and overpayments remain. Dental services are excluded under the medical plan and should be covered under the dental plan.	☒ M ☐ S
43	$32.50	Agree. D1110 is for a prophy/cleaning and should have been denied under medical. The claim was adjusted on 10/23/2025		☒ M ☐ S
44	$658.10	Agree. The claim should have been denied for medical records, to verify the procedure performed.		☒ M ☐ S
Biofeedback				
49	$42.00	Agree. This code should have been denied. Adjustment done on 10/23/2025.	Procedural deficiency and overpayment remain. Biofeedback is excluded under the plan, and the claim should have been denied.	☒ M ☐ S
Prior Authorization Required				
CT/MRI/PET				
35	$1,136.63	Agree. There is no prior authorization on file.	Procedural deficiencies and overpayments remain. These services required prior authorization, which was not performed.	☐ M ☒ S
37	$534.86	Agree. No prior authorization on file for this provider and procedure code.		☒ M ☐ S
Genetic Testing				
39	$1,177.28	Agree. No prior authorization on file for this procedure code. The claim was adjusted on 10/22/2025.	Procedural deficiency and overpayment remain. The services required prior authorization, which was not performed.	☒ M ☐ S

ESAS Findings Detail Report				
QID	**(Under)/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Copay Application				
Speech Therapy				
15	$50.00	Agree. Speech therapy should apply a $50 copay per the member's plan. Claim will be adjusted at completion of the audit.	Procedural deficiencies and overpayments remain. A $50.00 copay is applicable for speech therapy, and none was applied.	☒ M ☐ S
17	$50.00			☒ M ☐ S
Office Visit – Specialist				
16	$50.00	Agree. Specialist office visits should apply $50 copay per the member's plan. This claim will be adjusted at 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				
Copay Applied				
5	($30.00)	Agree. No copay should have applied.	Procedural deficiency and underpayment remain. The copay should have been waived for this preventive service.	☒ M ☐ S

RANDOM SAMPLE AUDIT

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

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

- Financial Accuracy
- Claims Payment Accuracy
- Overall Accuracy

We also measured claim turnaround time, a commonly relied upon performance measure.

Methodology
Our Random Sample Audit ensures a high degree of consistency in methodology and is based on the principles of statistical process control with a 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 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 from UMR's reply.

Financial Accuracy
CTI defines Financial Accuracy as the total correct claim payments made compared to the total dollars of correct claim payments that should have been made for the audit sample.

The total paid in the 200-claim audit sample was $1,361,688.86. The claims sampled and reviewed revealed no underpayments and $1,865.41 in overpayments. This reflects a weighted Financial Accuracy rate of 99.84% over the stratified sample. This is an increase in performance from the prior period. Details are provided in the following Random Sample Findings Detail Report.

UMR met the Performance Guarantee for PEBP in Q1 FY2026 of 99.40% for this measure and no penalty is due.

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 in the Random Sample Findings Detail Report below.

Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid Claims	Overpaid Claims	
200	0	3	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.

Performance increased from the prior period, and UMR met the Performance Guarantee for PEBP in Q1 FY2026 of 98.00% for this measure and no penalty is due. Detail is provided in the Random Sample Findings Detail Report below.

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
196	0	4	98.0%

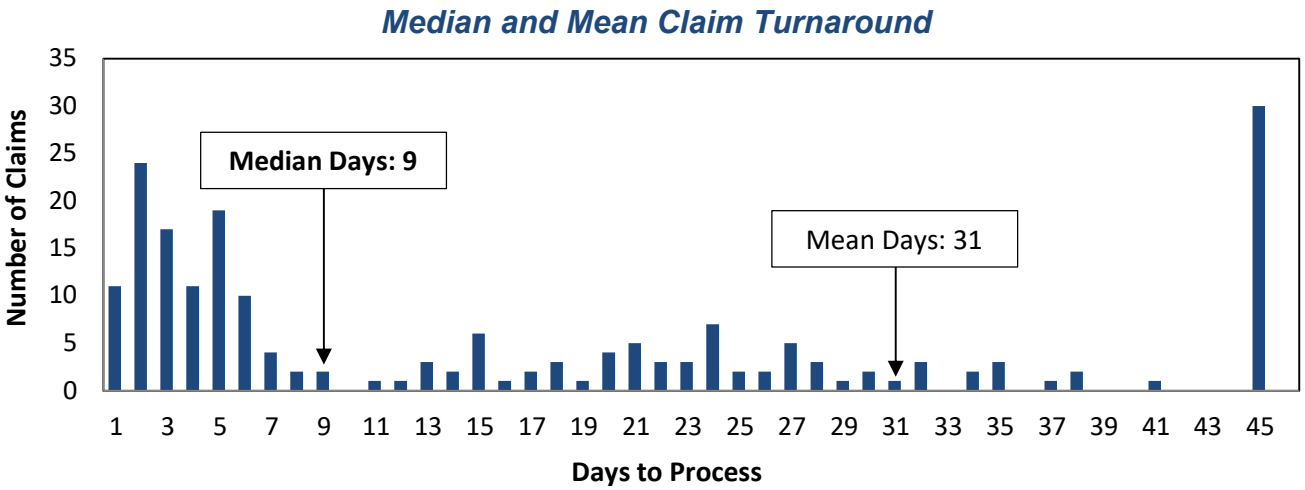
Random Sample Findings Detail Report

Audit No.	Under/ Overpaid	UMR Response	CTI Conclusion	Manual or System
PPO Discount				
1062	$336.81	Agree. The claim allowance was entered incorrectly. The original payment was $181,273.32 and should be $180,936.51. This results in a $336.81 overpayment.	Procedural error and overpayment remain. An incorrect PPO discount was applied. UMR paid $181,273.32 and should have paid $180,936.51.	☒ M ☐ S
1087	$1,500.60	Agree. Claim allowance was entered incorrectly. UHC pricing was omitted during processing. Original payment $17,793.40; the correct amount should be $12,292.80, resulting in an overpayment of $1,500.60.	Procedural error and overpayment remain. Billed charges were allowed on this claim in error.	☒ M ☐ S
Deductible Error				
2027	$28.00	Agree. An incorrect deductible amount applied to this claim. This claim will be adjusted at the completion of the audit.	Procedural error and overpayment remain. The deductible applied should have been $100.00, and it was $72.00. The member and family deductible had not been met.	☒ M ☐ S
Usual and Customary Calculation Error				
1075	NA	Agree. The CFR manually keyed an incorrect allowable. See pricing below. Patient balance applied to deductible. There is no dollar payment impact. Claim was adjusted on 11/19/25.	Procedural error remains. The allowed amount for this non-participating provider should have been $102.30, and it was $17.70. This applied to the member's deductible.	☒ M ☐ S

Claim Turnaround

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

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



UMR met the Performance Guarantee for PEBP in Q1 FY2026 of 92% processed within 14 days but did not meet the standard of 99% processed within 30 days. The penalty owed is 1.0% of the administrative fees of $1,467,771.08 or $14,677.71.

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
1045	The claim was received 4/20/24 and processed 5/8/24 which was within the timely filing period. The claim was then reprocessed 15 months later on 8/1/25 due to an update of contract pricing. CTI recommends UMR and PEBP discuss the timeliness of claim adjustment due to contract pricing changes in UMR's system.
1132	The claim was processed correctly as an emergency room (ER) visit with a $750.00 copayment applied after learning the hospital billed an inpatient stay in error. The review and discussion on this claim brought to light an issue in which UMR is applying the $750.00 ER copay in cases where a member is admitted to the hospital when 1) the ER claim comes in first or 2) when the inpatient stay is not authorized. This is in conflict with the MPD language which states the ER copay should be waived when the member is admitted. The procedure to apply an ER copay with a subsequent hospital admission was put into place many years ago and should be reviewed to ensure it aligns with PEBP's current intent. CTI recommends updating the MPD if the decision is to apply the ER copay if an inpatient stay is not authorized.
1144	CTI notes the sample claim was processed incorrectly. However, prior to the audit, the claim was adjusted to apply code editing and reflect the appropriate benefit.

CONCLUSION

UMR did not meet the performance metric for PEBP for claim turnaround time within 30 days in the first quarter of FY2026. A penalty of $14,677.71, or 1.0% of the administration fees for the quarter is owed.

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

APPENDIX – ADMINISTRATOR RESPONSE TO DRAFT REPORT

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

115 West Wausau Ave
Wausau, WI 54401

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

January 12, 2026

Joni,

Thank you for the opportunity to respond to the recent review of the State of Nevada Public Employees' Benefit Program Q1Y26 audit draft report. The following is our response to the draft report completed by CTI.

ESAS Targeted Sample Analysis

Duplicate Payments

QID 23 – Dental Claim [redacted]6137 is a duplicate to claim [redacted]9112. The claim was adjusted on 11-10-2025, resulting in an overpayment of $174.40.

QID 24 – Medical claim [redacted]0283 is a duplicate to claim [redacted]1157. The claim was adjusted on 12-19-2025, resulting in an overpayment of $3222.24.

QID 25 – Medical claim [redacted]3240 is a duplicate to claim [redacted]5277. The claim will be adjusted at the completion of the audit, resulting in an overpayment of $4448.63.

QID 26 – Medical claim [redacted]9323 is a duplicate to claim [redacted]9512. The claim was adjusted on 12-19-2025, resulting in an overpayment of $112.90.

Plan Exclusions - Dental Services

QID 42 – UMR agrees with this finding. This is an oral exam and should have been denied under medical. It was allowed in error. The claim was adjusted on 10-28-2025, resulting in an overpayment of $75.00.

QID 43 – UMR agrees with this finding. Prophy/cleaning should have been denied under medical. It was allowed in error. The claim was adjusted on 10-23-2025, resulting in an overpayment of $32.50.

QID 44 – UMR agrees with this finding. Procedure 41899 was allowed without verifying the actual procedure performed. Medical records are required to determine the correct allowance. The claim was adjusted on 12-17-2025, resulting in an overpayment of $658.10.

Plan Exclusions – Biofeedback

QID 49 – UMR agrees with this finding. Biofeedback is excluded by this plan. The services should have been denied. The claim was adjusted on 10-23-2025, resulting in an overpayment of $42.00.

Prior Authorization Required – CT/MRI/PET

QID 35 – UMR agrees with this finding. CPT 74170 was allowed in error without prior authorization on file. The claim was adjusted on 12-19-2025t, resulting in an overpayment of $1136.63.

QID 37 – UMR agrees with this finding. CPT 78815 was allowed in error without prior authorization on file. The claim was adjusted on 12-17-2025, resulting in an overpayment of $534.86.

Prior Authorization Required – Genetic Testing

QID 39 – UMR agrees with this finding. CPT 81408 was allowed in error without prior authorization on file. The claim was adjusted on 10-22-2025, resulting in an overpayment of $1177.28.

Copay Application – Speech Therapy

QID 15 – UMR agrees with this finding. Speech Therapy copay should apply to this claim. The claim was adjusted on 12-19-2025, resulting in an overpayment of $2.00.

QID 17 – UMR agrees with this finding. Speech Therapy copay should apply to this claim. The claim will be adjusted at the completion of the audit, resulting in an overpayment of $2.00.

Copay Application – Office Visit - Specialist

QID 16 – UMR agrees with this finding. Specialist office visit copay should apply to this claim. The claim was adjusted on 12-19-2025, resulting in an overpayment of $96.65.

Preventive Services – Copay Applied

QID 5 – UMR agrees with this finding. These services should be allowed at 100% per the plan benefit. The claim will be adjusted at the completion of the audit, resulting in an overpayment of $24.00.

Random Sample Findings

PPO Discount

Sample 1062 – UMR agrees with this finding. An incorrect allowed amount applied to this claim. The claim was adjusted on 11-18-2025, resulting in a $336.81 overpayment.
Sample 1087 – UMR agrees with this finding. An incorrect allowed amount applied to this claim. The claim was adjusted on 11-18-2025, resulting in an overpayment of $1500.60.
Sample 1096 – The intent is never to pay more than billed charges. UMR applied the correct allowable to the claim. Payment will not exceed the billed amount.
97155 – the fee is $30.00 x 21 units = $630.00. Total billed for 97155 was $525.00. UMR paid $525.00.
97153 – the fee is $19.00 x 82 units = $1558.00. The total billed for 97153 was $2050.00. UMR paid $1558.00.

Incorrect Copay

Sample 1132 – UMR does not agree with this finding. The provider originally submitted an inpatient claim for this member; however, the member was never admitted as an inpatient. The provider subsequently requested to void the incorrect claim ([redacted]7479). This voided claim was processed on 1/5/2026 and denied with the reason: *Charges Denied – Provider Voided Claim.* The original claim ([redacted]3486) was also denied on 1/5/2026 as a duplicate of the corrected claim. For reference, sample claim [redacted]5895 (Emergency Room) was processed correctly, applying the $750.00 ER copay in accordance with HSB processing guidelines for ER copay application.

Deductible Error

Sample 2027 – UMR agrees with this finding. The deductible amount was incorrectly applied to this claim. The claim will be adjusted at the completion of the audit, resulting in an overpayment of $28.00.

Usual and Customary Calculation Error

Sample 1075 - UMR agrees with this finding. An incorrect allowed amount applied to this claim. No payment was made during the initial processing. The claim was adjusted on 11-19-2025, resulting in a $0.00 payment error.

UMR remains committed to enhancing the overall experience for State of Nevada PEBP members and will continue working diligently to address any issues identified in this review. We provide ongoing coaching and training for our dedicated processing team, ensuring continuous improvement.

Our team meets daily to review quality reports, identify trending errors, and implement refresher training where skill gaps are observed. These insights are used to strengthen processes and improve overall service quality.

Sincerely,

Julie Frahm
Sr. UMR External Audit Coordinator
715-841-7262

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.

CTI Audit Solutions

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