Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employees' Benefit Plan Plans Administered by UMR

Audit Period: October 1, 2025 – December 31, 2025
Audit Number 1.FY26.Q2

Presented to

State of Nevada Public Employees' Benefit Plan

July 23, 2026

CTI Audit Solutions

Proprietary and Confidential

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EXECUTIVE SUMMARY

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

Scope

CTI performed an audit for the period of October 1, 2025 through December 31, 2025 (quarter 2 (Q2) 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	$71,592,539
Total Number of Claims Paid/Denied/Adjusted	269,326

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 Financial Accuracy, Overall Accuracy and 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 Financial Accuracy, Overall Accuracy and Claim Turnaround Time within 30 days in Q2 FY2026 and a penalty is assessed. The penalty is 3.5% of the quarter's total administrative fees of $1,473,410.65. 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 – 99.16%	1.5%	$22,101.16
Overall Accuracy	98.0%	Not Met – 97.5%	1.0%	$14,734.11
Claim Turnaround Time	92% in 14 Days	Met – 92.9%	NA	$0.00
	99% in 30 Days	Not Met – 98.6%	1.0%	$14,734.11
		Total Penalty	**3.5%**	**$51,569.38**

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	Q3 FY25	Q4 FY25	Q1 FY26	Q2 FY26
Financial Accuracy	99.4%	99.56%	99.20%	99.84%	99.16%
Overall Accuracy	98.0%	99.00%	97.00%	98.00%	97.50%
Claim Turnaround Time	92% in 14 Days	93.10%	92.60%	92.00%	92.90%
	99% in 30 Days	97.50%	98.10%	98.10%	98.60%

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 Q2 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	96.1%	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	95.7%	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%	0.9%	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%	96.4%	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% 99.7%	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%	98.5%	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/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%	99.1%	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/accessible on all major browsers 99% of time.	99.00%	100%	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				
34	$1,312.60	Agree.	Procedural deficiencies and overpayments remain. UMR paid duplicate charges.	☒ M ☐ S
35	$312.13			☒ M ☐ S
38	$140.00			☒ M ☐ S
Plan Limitations				
Hearing Aids $1,500 Per Device Per Ear				
40	$1,800.00	Agree. This claim was adjusted on 1/22/26 to apply the correct maximum allowable.	Procedural deficiency and overpayment remain. Hearing aids were limited to $1,500 per unit every three years for a maximum of $3,000.00. UMR reimbursed $4,800.00.	☒ M ☐ S
Bitewing X-Rays Two Per Plan Year				
42	$26.00	Disagree. UMR's standard processing guidelines do not apply a frequency limit to procedure code D0270. Based on internal subject-matter expertise, D0270 is considered comparable to a periapical x-ray, which also does not carry a frequency limitation under UMR's current dental processing standards. Therefore, original processing is correct in accordance with established guidelines.	Procedural deficiency and overpayment remain. Bitewings were limited to two per year. UMR paid for bitewings for this member on service dates 7/1/25, 10/2/25, and 11/25/25 exceeding the plan limit. Dental code D0270 refers to a single bitewing radiographic image. The Dental MPD, page 15, limits bitewing x-rays to two per plan year.	☒ M ☐ S
Enteral Formula $2,500 Per Plan Year				
43	$1,127.29	Agree. The maximum allowed amount for Enteral Formulas and Special Food Products was exceeded. Claim will be adjusted at the completion of the audit.	Procedural deficiency and overpayment remain. Enteral formula was limited to $2,500 per year. UMR paid $3,637.29 during the plan year.	☒ M ☐ S
Paid Greater Than Charged				
17	$66.49	Agree. The claim should not have allowed greater than billed charges. Claim will be adjusted at the completion of the audit.	Procedural deficiency and overpayment remain. The claim paid greater than the charge amount billed.	☒ M ☐ S
Office Visit – Specialist				
7	$50.00	Agree. Based on provider specialty, specialist copay should have applied. 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

Diagnostic Mammography				
10	$3.45	Agree. A $40 copay should have applied on this claim. The claim was adjusted on 1/21/2026.	Procedural deficiency and overpayment remain. The diagnostic mammography copay of $40.00 should have been applied and coinsurance of $36.55 was applied in error.	☒ M ☐ S
Behavioral Health Counseling				
12	$20.00	Agree. A separate copay should have been applied on claim as patient had two distinct and separate visits on same day. Claim will be adjusted at the completion of the audit.	Procedural deficiency and overpayment remain. A $20.00 copay was applicable for behavioral health counseling, and none was applied.	☒ M ☐ S
Preventive Services				
Denied				
1	($418.00)	Disagree. The claim was denied correctly. The denial is based on the CPT code billed as an initial comprehensive preventive medicine evaluation for a new patient for 18-39 age range. The member previously established care with this group and provider should have been billed accordingly. UMR utilizes a Claims Editing System (CES) as an automated pre-payment auditing tool to support claim accuracy, policy compliance, and payment integrity prior to adjudication. CES applies standardized clinical, coding, and billing rules at both the claim-line and claim-header levels to identify discrepancies based on industry-accepted guidelines. In this case, the CES edit correctly flagged the billed CPT code as inappropriate because the patient does not meet the criteria for a new patient visit. Records confirm that the patient was previously evaluated by the same provider group (same TIN) on 05/21/25 under claim number xxxx9944. Therefore, the patient should have billed as an established patient, not a new patient. Based on this information, the original claim processing was accurate.	Procedural deficiency and underpayment remain. In reviewing member claim history, there was no indication member saw this provider, Amelia Porciuncula, in 2023, 2024, or 2025 with the exception of the sampled claim dated 11/10/25. Amelia Porciuncula is part of the University Medical Center (UMC) group of facilities and physicians that use the same TIN. The provider of service on 5/21/25 was Quick Care; an Urgent Care facility that is also part of the UMC and uses the same TIN. The claim should have been paid as a preventive visit but was denied.	☐ M ☒ S
With Coinsurance Applied				
2	($32.91)	Agree. This service should have been allowed at 100%.	Procedural deficiency and underpayment remain. The charge should have been allowed without patient cost-share.	☒ M ☐ S
With Deductible Applied				
3	($8.26)	Agree. Service should have been considered at 100% of the allowed amount. Claim was corrected and adjusted on 1/16/26.	Procedural deficiency and underpayment remain. The charge should have been allowed without patient cost-share.	☒ 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 $1,609,117.86. The claims sampled and reviewed revealed $28.19 in underpayments and $989.80 in overpayments. This reflects a weighted Financial Accuracy rate of 99.16% over the stratified sample. This is a decrease in performance from the prior period. Details are provided in the following Random Sample Findings Detail Report.

UMR did not meet the Performance Guarantee for PEBP in Q2 FY2026 of 99.40% for this measure and the penalty owed is 1.5% of the administrative fees of $1,473,410.65 or $22,101.16.

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 5 incorrectly paid claims and 195 correctly paid claims. This is a decrease 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	2	3	97.5%

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 decreased from the prior period, and UMR did not meet the Performance Guarantee for PEBP in Q2 FY2026 of 98.00% for this measure. The penalty owed is 1.0% of the administrative fees of $1,473,410.65 or $14,734.11. Detail is provided in the Random Sample Findings Detail Report below.

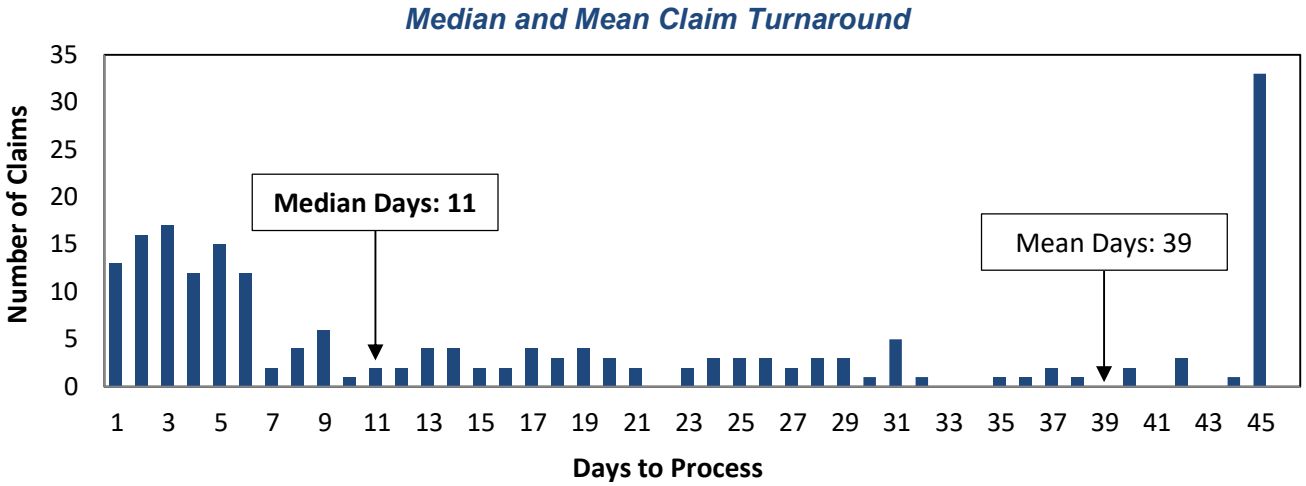
Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
196	1	4	97.5%

Random Sample Findings Detail Report				
Audit No.	**Under/ Overpaid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Incorrect Provider Discount				
1059	$262.61	Agree. The original allowed amounts and adjustments associated with the surprise bill were reviewed, along with the additional allowed amounts applied through the appeal and IDR authorization. Based on this complete review, the correct overpaid amount is $262.61.	Procedural error and overpayment remain. An incorrect amount was allowed due to incorrect pricing from an appeal and IDR authorization.	☒ M ☐ S
Deductible Error				
1079	($18.19)	Agree. An incorrect deductible amount was applied to this claim because the required internal review and release process was not followed. The claim will be adjusted to apply the correct copay.	Procedural error and underpayment remain. The deductible applied should have been $500.00, and it was $518.19.	☒ M ☐ S
Coinsurance Error				
1139	$182.03	Disagree. The claim was submitted with a combination of routine and non-routine services; however, the provider selected a routine primary diagnosis code. Per standard processing guidelines, the primary diagnosis drives the classification of the claim. Accordingly, the claim was correctly processed as routine based on the primary diagnosis submitted by the provider.	Procedural error and overpayment remain. There was incorrect coinsurance on this claim. The sample claim included a routine mammogram, however, line 1 of the claim was an x-ray of the abdomen and should not have been paid as routine. The abdominal x-ray was a diagnostic service to evaluate symptoms (acute cystitis). The professional component of the claim was paid correctly applying coinsurance.	☐ M ☒ S
Denied Eligible Expense				
1140	($10.00)	Agree. The claim meets the requirements for reimbursement under the fifty-mile rule and should have allowed accordingly. The claim was adjusted on 3/23/26, resulting in an underpayment of $10.00.	Procedural error and underpayment remain. An eligible expense for lab test was denied. The claim was denied *service provided by a non-approved medical facility*. The sample claim was not routine/preventive and therefore not excluded based on place of service (outpatient hospital). It should have been allowed under general lab service plan provision on page 38 of the LDMPD as the tests performed on 9/11/25 were diagnostic.	☒ M ☐ S
Incorrect Copay Applied				
1145	$545.16	Agree. Manual processor error for an ER visit. We should have applied a $750 copay, not coinsurance. The out-of-pocket maximum is met with this claim, however, so we only applied $545.16 against copay amount. Total overpayment is $545.16.	Procedural error and overpayment remain. The sample claim was an emergency room (ER) visit *without admission* and therefore an ER copay should have applied.	☒ 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 Q2 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 $1,473,410.65 or $14,734.11.

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
2040	CTI notes the incorrect allowable was used to process the sample claim creating a $5.00 overpayment. Prior to sending the data file for audit to CTI, the sample claim was corrected, and a refund has been requested.

CONCLUSION

UMR did not meet the performance metric for PEBP for financial accuracy, overall accuracy and claim turnaround time within 30 days in the second quarter of FY2026. A penalty of $51,569.38, or 3.5% 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.

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April 7, 2026

Thank you for the opportunity to respond to the recent review of the State of Nevada Public Employees' Benefit Program Q2Y26 audit draft report. The following is our response to the draft report completed by CTI.

ESAS Targeted Sample Analysis

Duplicate Payments
QID 34 – Medical [redacted]3200 is a duplicate to claim [redacted]9540. The claim was adjusted on 1-26-2026, resulting in an overpayment of $1312.60.
QID 35 – Medical claim [redacted]3575 is a duplicate to claim [redacted]7190. The claim was adjusted on 1-26-2026, resulting in an overpayment of $312.13.
QID 38 – Medical claim [redacted]0998 was allowed twice in error. The claim was adjusted on 3-23-2026, resulting in an overpayment of $140.00.

Plan Limitations – Hearing Aids $1,500 Per Device Per Ear
QID 40 – UMR agrees with this finding. The binaural benefit was not processed correctly. With two copays applied, the member owes $100.00. The plan language specifies a maximum plan payment of $1500.00 not to exceed $3000.00. The claim was adjusted on 1-22-2026, resulting in an overpayment of $1800.00.

Plan Limitations – Bitewing X-Rays Two Per Plan Year
QID 42 – UMR disagrees with this finding. UMR's standard processing guidelines do not apply a frequency limit to procedure code D0270. Based on internal subject-matter expertise, D0270 is considered comparable to a periapical X-ray, which also does **not** carry a frequency limitation under UMR's current dental processing standards. Therefore, the original processing is correct in accordance with UMR's established guidelines.
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Plan Limitations – Enteral Formula $2,500 Per Plan Year
QID 43 – UMR agrees with this finding. An incorrect maximum allowed amount was applied to this claim. This claim was adjusted on 3-23-2026, resulting in an overpayment of $1,127.29.

Paid Greater than Charged
QID 17 – UMR agrees with this finding. The claim should not have allowed greater than billed charges. The claim was adjusted on 3-26-2026, resulting in an overpayment of $66.49.

Copay Application – Occupational Therapy
QID 6 – After further review, UMR continues to disagree with this finding. This claim was submitted with diagnosis code F84.0 (Autistic Disorder). Therefore, with UMR's standard claim-processing guidelines, this diagnosis is classified within the Autism Spectrum and is

therefore considered a mental health condition. Based on this classification, the original claim processing is accurate.

Copay Application – Office Visit – Specialist
QID 7 - UMR agrees with this finding. Specialist office visit co-pay should apply to this claim. The claim was adjusted on 3-20-2026, resulting in an overpayment of $50.00.

Copay Application – Diagnostic Mammography
QID 10 – UMR agrees with this finding. Diagnostic mammography co-pay should apply to this claim. The claim was adjusted on 1-21-2026, resulting in an overpayment of $3.45.

Copay Application – Behavioral Health Counseling
QID 12 - UMR agrees with this finding. A separate co-pay should have applied to this claim as there were two distinct and separate visits on the same day. The claim was adjusted on 3-27-2026, resulting in an overpayment of $20.00.

Preventive Services – Denied
QID 1 – After further review, UMR continues to disagree with this finding. UMR utilizes a Claims Editing System (CES) as an automated pre-payment auditing tool to support claim accuracy, policy compliance, and payment integrity prior to adjudication. CES applies standardized clinical, coding, and billing rules at both the claim-line and claim-header levels to identify discrepancies based on industry-accepted guidelines.
In this case, the CES edit correctly flagged the billed CPT code as inappropriate because the patient does not meet the criteria for a new patient visit. Records confirm that the patient was previously evaluated by the same provider group (same TIN) on 05/21/2025 under claim number [redacted]9944. Therefore, the patient should have been billed as an established patient, not a new patient. Based on this information, the original claim processing was accurate.

Preventive Services – With Coinsurance Applied
QID 2 – UMR agrees with this finding. This service should have allowed at 100%. The claim was adjusted on 3-23-2026, resulting in an underpayment of $32.91.

Preventive Services – With Deductible Applied
QID 3 - UMR agrees with this finding. This service should have allowed at 100% of the allowed amount. The claim was adjusted on 1-16-2026, resulting in an underpayment of $8.26.

Random Sample Findings

Incorrect Provider Discount
Sample 1059 – UMR agrees with this finding. An incorrect allowed amount applied to this claim due to incorrect pricing from an appeal and IDR authorization. The claim was adjusted on 3-24-2026, resulting in an overpayment of $262.61.

Deductible Error
Sample 1079 – UMR agrees with this finding. An incorrect deductible amount applied to this claim because the required internal review and release process was not followed by the claim processor. The claim was adjusted on 3-23-2026, resulting in an underpayment of $18.19.

Coinsurance Error

Sample 1139 – After further review, UMR disagrees with this finding. The claim was submitted with a combination of routine and non-routine services; however, the provider selected a routine primary diagnosis code. Per standard processing guidelines, the primary diagnosis drives the classification of the claim. Accordingly, the claim was correctly processed as routine based on the primary diagnosis submitted by the provider.

Denied Eligible Expense

Sample 1140 – After further review, UMR agrees with this finding. The claim meets the requirements for reimbursement under the fifty-mile rule and should have been allowed accordingly. The claim was adjusted on 3-23-2026, resulting in an underpayment of $10.00.

Incorrect Copay Applied

Sample 1145 - UMR agrees with this finding. An emergency room co-pay of $750.00 should have been applied to this claim. The claim was adjusted on 3-3-2026, resulting in an overpayment of $545.16.

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,

[redacted]
Sr. UMR External Audit Coordinator
[redacted]

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

Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employees' Benefit Plans
Administered by UMR

Audit Period: January 1, 2026 – March 31, 2026
Audit Number 1.FY26.Q3

Presented to

State of Nevada Public Employees' Benefit Plans

July 23, 2026

CTI Audit Solutions

Proprietary and Confidential

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EXECUTIVE SUMMARY

This ***Quarterly Findings Report*** is a compilation of the detailed information, findings, and conclusions drawn from CTI Audit Solutions' (CTI's) audit of UMR's administration of the State of Nevada Public Employees' Benefit Plans (PEBP) medical and dental plans.

Scope

CTI performed an audit for the period of January 1, 2026 through March 31, 2026 (quarter 3 (Q3) 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	$77,640,150
Total Number of Claims Paid/Denied/Adjusted	250,452

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 Financial Accuracy and Overall Accuracy 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 Financial Accuracy and Overall Accuracy in Q3 FY2026 and a penalty is assessed. The penalty is 2.5% of the quarter's total administrative fees of $1,479,542.69. 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 – 98.78%	1.5%	$22,193.14
Overall Accuracy	98.0%	Not Met – 97.00%	1.0%	$14,795.43
Claim Turnaround Time	92% in 14 Days	Met – 96.10%	NA	$0.00
	99% in 30 Days	Met – 99.10%	NA	$0.00
		Total Penalty	**2.5%**	**$36,988.57**

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	Q4 FY25	Q1 FY26	Q2 FY26	Q3 FY26
Financial Accuracy	99.4%	99.20%	99.84%	99.16%	98.78%
Overall Accuracy	98.0%	97.00%	98.00%	97.50%	97.00%
Claim Turnaround Time	92% in 14 Days	92.60%	92.00%	92.90%	96.10%
	99% in 30 Days	98.10%	98.10%	98.60%	99.10%

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 Q3 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	95.6%	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	94.7%	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%	97.2%	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	98.9% 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%	97.7%	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/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	99.6% 99.8%	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%	99.14%	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/accessible on all major browsers 99% of time.	99.00%	99.99%	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				
40	$1,755.97	Agree. Claim will be adjusted at the end of the audit.	Procedural deficiencies and overpayment remain. UMR paid duplicate charges.	☒ M ☐ S
Plan Exclusions				
Experimental Treatment				
36	$80.00	Agree. CPT code 0055T should have been denied as unbundled. The claim was adjusted on 6/11/26, resulting in an overpayment of $80.00.	Procedural deficiency and overpayment remain. The information provided did not support payment of procedure code 0055T. It stated procedure 0055T is a component of the main procedure 27447. Procedure 0055T should have denied as unbundled from 27447.	☒ M ☐ S
Plan Limitations				
Chiropractic Care 20 Visits Per Plan Year				
44	$63.44	Agree. This claim was adjusted on 6/11/26, resulting in an overpayment of $63.44.	Procedural deficiency and overpayment remain. The visit on 12/23/25 (processed on 2/6/26) was the 22nd chiropractic visit paid for the plan year and should have been denied. The services on 12/31/25 (processed 2/5/26) and 2/26/26 (processed 3/23/26) should have also been denied as over the plan limit; creating an additional $71.06 overpayment on this member's file. The first 20 visits were on: 7/3, 7/8, 7/24, 7/31, 8/6, 8/13, 8/20, 9/4, 9/10, 9/18, 9/25, 10/2, 10/9, 10/15, 10/22, 10/29, 11/6, 11/12, 12/4 and 12/11.	☒ M ☐ S
Enteral Formula $2,500 Per Plan Year				
46	$762.60	Agree. More than $2,500 has been allowed for the plan year under code B4153.	Procedural deficiency and overpayment remain. Enteral formula was limited to $2,500 per year. UMR exceeded the limitation on this member by $762.60.	☒ M ☐ S
Provider Discount Error				
21	$10,651.20	Agree. Incorrect pricing was received for newborn services. Claim should have fully discounted as newborn delivery charges are included in the mother's per diem rate per provider contract. An adjustment will be completed upon completion of the review.	Procedural deficiency and overpayment remain. The contract rate was not applied to this claim.	☒ M ☐ S

ESAS Findings Detail Report				
QID	**(Under)/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Prior Authorization Error				
48	$940.96	Agree. There is no authorization on file.	Procedural deficiency and overpayment remain. This genetic testing service required prior authorization, and it was not obtained prior to payment of the claim.	☒ M ☐ S
Paid Greater Than Charged				
19	$450.79	Agree. The claim should not have allowed greater than billed charges.	Procedural deficiency and overpayment remain. The claim paid greater than the charge amount billed.	☐ M ☒ S
Copay Application				
Speech Therapy				
16	$50.00	Agree. A copayment of $50.00 should have applied. Claim will be adjusted at the end of the audit.	Procedural deficiency and overpayment remain. A $50.00 copay was applicable for speech therapy, and none was applied.	☒ M ☐ S
Fraud, Waste and Abuse				
Specialty Medications				
23	$2,352.88	Agree. The claim did not obtain the correct out of network Medicare pricing, as it should have applied the rate of 40 x 140%. The claim was adjusted on 5-7-26, resulting in an overpayment of $2352.88.	Procedural deficiency and overpayment remain. The specialty medication J0878 did not pay the correct Medicare out of network rate.	☒ M ☐ S
Maternity Ante-Partum Unbundling				
35	$730.08	Agree. The provider should not have billed for both CPT 59425 and CPT 59426. The claim was adjusted on 6-11-26, resulting in an overpayment of $730.08.	Procedural deficiency and overpayment remain. The provider billed and was reimbursed for both CPT 59425 (4 – 6 antepartum visits) and CPT 59426 (7+ antepartum visits), in addition to billing for a cesarean delivery and postpartum care. Billing both 59425 and 59426 is only appropriate when a patient transfers care between providers and there is a documented break in services. There was no evidence to support a transfer of care in this case. Accordingly, the provider should have billed only CPT 59426 for 7+ antepartum visits, along with the cesarean delivery and postpartum care. The current billing reflects duplicative antepartum charges and represents an overpayment.	☒ 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 $1,423,695.16. The claims sampled and reviewed revealed $2,539.60 in underpayments and $15,588.86 in overpayments. This reflects a weighted Financial Accuracy rate of 98.78% over the stratified sample. This is a decrease in performance from the prior period. Details are provided in the following Random Sample Findings Detail Report.

UMR did not meet the Performance Guarantee for PEBP in Q3 FY2026 of 99.40% for this measure and the penalty owed is 1.5% of the administrative fees of $1,479,542.69 or $22,193.14.

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 5 incorrectly paid claims and 195 correctly paid claims. This is a decrease 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	1	4	97.50%

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 decreased from the prior period, and UMR did not meet the Performance Guarantee for PEBP in Q3 FY2026 of 98.00% for this measure. The penalty owed is 1.0% of the administrative fees of $1,479,542.69 or $14,795.43. Detail is provided in the Random Sample Findings Detail Report below.

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
194	0	6	97.00%

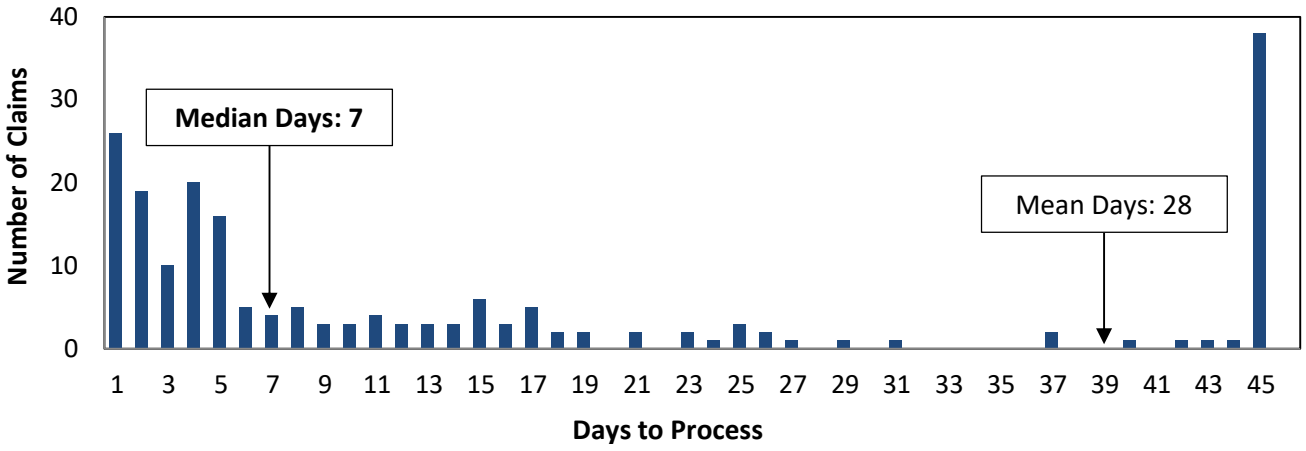
Random Sample Findings Detail Report				
Audit No.	**Under/ Overpaid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Incorrect Provider Discount				
1026	$14,029.08	Agree. This claim was processed at billed charges in error. Claim paid $24,950.28, however the discount is $14,029.08 and therefore should have allowed $10,921.20. The claim will be adjusted upon completion of the audit.	Procedural error and overpayment remain. The discount amount was processed on the claim as $0.00 and it should have been $14,029.08.	☒ M ☐ S
1038	($2,539.60)	Agree. This claim was processed with the incorrect allowed amount. The claim should be priced with the below MRU pricing as noted, and per outcome of Zelis review. Underpayment of $2,539.60. The claim will be adjusted upon completion of the audit.	Procedural error and underpayment remain. The discount should have been processed according to the contract and Zelis review.	☒ M ☐ S
1041	NA	Agree. The processor originally entered the incorrect allowable amount. The claim was adjusted on 5/1/26 to correct.	Procedural error remains. The allowed amount on the claim was processed as $1,170.02 and it should have been $1,755.03; this caused under application of $585.01 to the member's deductible. Claim was adjusted and correct benefit applied.	☒ M ☐ S
1127	$523.09	Agree. This claim was manually processed with the incorrect SHO pricing, as it should have been routed to UHC for pricing. Overpayment $523.09.	Procedural error and overpayment remain. The sample claim was processed with the incorrect SHO pricing, it should have been routed to UHC for pricing.	☒ M ☐ S
1135	$129.38	Agree. The claim was denied as a total discount in error. The correct allowable is $157.84. The claim was adjusted on 5/14/26 with a payment of $129.38.	Procedural error and overpayment remain. The discount amount was processed on the claim as $1,151.00 and it should have been $993.16. The claim was adjusted by UMR on 5/14/26 with payment of $129.38.	☒ M ☐ S
Coinsurance Error				
1145	$907.31	Agree. This claim is manually processed; the claim will be adjusted upon completion of the audit.	Procedural error and overpayment remain. The coinsurance applied should have been $907.31 and it was $0.00. Billing for an observation room over 23 hours should have been processed under the inpatient benefit provision at 80% coinsurance.	☒ 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.

Median and Mean Claim Turnaround



UMR met the Performance Guarantees for PEBP in Q3 FY2026 of 92% processed within 14 days and 99% processed within 30 days and no penalty is due.

CONCLUSION

UMR did not meet the performance metric for PEBP for Financial Accuracy and Overall Accuracy in the third quarter of FY2026. A penalty of $36,988.57, or 2.5% 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.

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Wausau, WI 54401

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

June 15, 2026

Thank you for the opportunity to respond to the recent review of the State of Nevada Public Employees' Benefit Program Q3Y26 audit draft report. The following is our response to the draft report completed by CTI.

ESAS Targeted Sample Analysis

Duplicate Payments
QID 40 – UMR agrees with this finding. Medical claim [redacted]4154 is a duplicate to claim [redacted]9900. The claim was adjusted on 5-21-26, resulting in an overpayment of $1755.97.

Plan Exclusions – Experimental Treatment
QID 36 – Upon the further review, UMR agrees with this finding. CPT code 0055T should have been denied as unbundled. The claim was adjusted on 6-11-26, resulting in an overpayment of $80.00

Plan Limitations – Timely Filing
QID 9 and 10 – UMR disagrees with this finding. An LOA is on file approving a waiver of timely filing requirements. PEBP's QC Officer also previously advised that, if documentation could be provided demonstrating timely efforts to resolve the issue from a filing perspective, the claim could be reviewed and reconsidered. It was subsequently determined that the initial LOA contained an incorrect TIN for claim submissions. Based on this, these claims are processed appropriately.

Plan Limitations – Chiropractic Care
QID 44 – Upon further review, UMR agrees with this finding. This claim was adjusted on 6-11-26, resulting in an overpayment of $63.44.

Plan Limitations – Enteral Formula
QID 46 – UMR agrees with this finding. More than $2500 has been allowed for the plan year under code B4153. The claim was adjusted on 6-11-26, resulting in an overpayment of $762.60.

Provider Discount Error
QID 21 – UMR agrees with this finding. The claim should have been fully discounted as newborn delivery charges are included in the mother's per diem rate per the provider contract. The claim was adjusted on 5-6-26, resulting in an overpayment of $10651.20.

Prior-Authorization Error

QID 48 – UMR agrees with this finding. There is no authorization on file for these services. This claim was adjusted on 6-11-26, resulting in an overpayment of $940.96.

Paid Greater than Charged

QID 19 – UMR agrees with this finding. The claim should not have allowed greater than billed charges. The claim was adjusted on 6-3-26, resulting in an overpayment of $521.79.

Copay Application – Speech Therapy

QID 16 – UMR agrees with this finding. A copayment of $50.00 should have applied. The claim was adjusted on 4-29-26, resulting in an overpayment of $37.00.

Preventive Services – Denied

QID 8 – UMR disagrees with this finding. The member does not meet the age requirements for preventive coverage under HCR guidelines. Please see below for additional support documentation. Based on this information, the claim was processed appropriately. Per plan guidelines routine lab services from independent labs may not be recognized as preventive care unless there is a corresponding wellness office visit within a reasonable number of days prior to or after lab date. This member did not have any other services on file for the plan year except for the independent lab service.

Population	Recommendation	Grade
Adults aged 40 to 75 years who have 1 or more cardiovascular risk factors and an estimated 10-year cardiovascular disease (CVD) risk of 10% or greater	The USPSTF recommends that clinicians prescribe a statin for the primary prevention of CVD for adults aged 40 to 75 years who have 1 or more CVD risk factors (i.e. dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year risk of a cardiovascular event of 10% or greater.	B

Per Master Plan Document outlined below.

> Annual check-ups, including related screening lab and x-rays.
>
> - Note: routine lab services from independent labs may not be recognized as preventive care unless there is a corresponding wellness office visit within a reasonable number of days prior to or after lab date

Fraud, Waste and Abuse – Specialty Medications

QID 23 – UMR agrees with this finding. The claim did not obtain the correct out of network Medicare pricing, as it should have applied the rate of 40 x 140%. The claim was adjusted on 5-7-26, resulting in an overpayment of $2352.88.

Fraud, Waste and Abuse – Applied Behavioral Analysis

QID 32 – UMR disagrees with this finding. The correct authorization number for these approved services is documented below.

Line # 3 [redacted]

Begin Date 01/01/26	End Date 07/01/26	Reason Code M	Approval APPR
Place of Service OP	Procedure Code 97153	Level of Care	Modifier
Diagnosis F840		Occurrences 0072	Appeals
Precert# [redacted]	Type of Vendor S	Allowed $ .00	
Provider Name [redacted]			

Fraud, Waste and Abuse – Maternity
QID 35 – Upon further review, UMR agrees with this finding. The provider should not have billed for both CPT 59425 and CPT 59426. The claim was adjusted on 6-11-26, resulting in an overpayment of $730.08.

Observations
QID 1 and 2 - These claims are paid correctly and were handled according to the specific provider contracts for services rendered.
[redacted]9110 was priced as a case rate for revenue code 450 in which CPT code 74177 TC is inclusive of this case rate.
[redacted]6904 was priced according to the provider contract which excludes CPT codes with NDC numbers from editing, in this case CPT code J1568 was billed.

Random Sample Findings

Incorrect Provider Discount
Sample 1026 – UMR agrees with this finding. This claim was processed at billed charges in error. The discount is $14029.08 and therefore should have allowed $10921.20. The claim was adjusted on 6/10/26, resulting in an overpayment of $14259.08.
Sample 1038 – UMR agrees with this finding. This claim was processed with the incorrect allowed amount. The claim was adjusted on 5-13-26, resulting in an underpayment of $2539.60.
Sample 1041 – UMR agrees with this finding. The processor originally entered the incorrect allowed amount. The claim was adjusted on 5-1-26, resulting in underpayment of $585.02.
Sample 1127 – UMR agrees with this finding. This claim was manually processed with incorrect network pricing. The claim was adjusted on 6/15/26, resulting in an overpayment of $523.09.
Sample 1135 – UMR agrees with this finding. The claim was denied as total discount in error. The claim was adjusted on 5-14-26, with a payment of $129.38.

Coinsurance Error
Sample 1145 – UMR agrees with this finding. The claim was adjusted on 6-4-26, and the overpayment is only $750, due to the patient's out of pocket being met.

Service Not Medically Necessary / Ineligible Expense
Sample 1148 – UMR disagrees with this finding. The claim was considered without member cost share due the ER claim on file for a non-routine diagnosis. The physician billed for the read of the CT scan that was provided in the ER.

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,

Miranda McCullough
Sr. UMR External Audit Coordinator
303-993-1713

CTI 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

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