Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employees' Benefit Plan
Administered by UMR

Audit Period: April 1, 2026 – June 30, 2026
Audit Number 1.FY26.Q4

Presented to

State of Nevada Public Employees' Benefit Plan

November 17, 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 Plan (PEBP) medical and dental plans.

Scope

CTI performed an audit for the period of April 1, 2026 through June 30, 2026 (quarter 4 (Q4) 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	$87,687,803
Total Number of Claims Paid/Denied/Adjusted	258,806

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

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

Auditor's Opinion

Based on these findings, and in our opinion:

1. UMR met all 34 self-reported performance guarantees in which CTI reviewed UMR's summary reports.

2. UMR's Financial Accuracy, Overall Accuracy and Claim Turnaround Time met the service objective, and no penalty is owed.

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 met its target for Financial Accuracy, Overall Accuracy and Claim Turnaround Time in Q4 FY2026 and no penalty is assessed.

Quarterly Metric	Guarantee	Met/Not Met	Penalty	Calculated Penalty
Financial Accuracy	99.4%	Met – 99.64%	NA	$0.00
Overall Accuracy	98.0%	Met – 98.50%	NA	$0.00
Claim Turnaround Time	92% in 14 Days	Met – 98.10%	NA	$0.00
	99% in 30 Days	Met – 99.10%	NA	$0.00
		Total Penalty	NA	**$0.00**

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

Measure	Guarantee	Q1 FY26	Q2 FY26	Q3 FY26	Q4 FY26
Financial Accuracy	99.4%	99.84%	99.16%	98.78%	99.64%
Overall Accuracy	98.0%	98.00%	97.50%	97.00%	98.50%
Claim Turnaround Time	92% in 14 Days	92.00%	92.90%	96.10%	98.10%
	99% in 30 Days	98.10%	98.60%	99.10%	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.

ANNUAL OPERATIONAL REVIEW

Objective
CTI's Operational Review evaluates UMR's claim administration systems, staffing, and procedures to identify any deficiencies that materially affect its ability to control risk and pay claims accurately on behalf of the plans.

Scope
The scope of the Operational Review included:

- Claim administrator information
  - Insurance and bonding
  - Conflicts of interest
  - Financial reporting
  - Business continuity planning
  - Claim payment system and coding protocols
  - Data and system security
- Claim funding
  - Claim funding mechanism
  - Check processing and security
  - Large claim payment process
- Claim adjudication, customer service, and eligibility maintenance procedures
  - Exception claim processing
  - Eligibility maintenance and investigation
  - Other insurance coverage and adjudication
  - Overpayment recovery
  - Network utilization
  - Utilization review, case management, and disease management
  - Subrogation and other third-party liability
  - Appeals processing
- HIPAA compliance

Methodology
CTI used an Operational Review Questionnaire to gather information from UMR. We modeled our questionnaire after the audit tool used by certified public accounting firms when conducting a Systems and Organization Controls (SOC) audit of a service administrator. We modified that tool to elicit information specific to the administration of your plans.

We reviewed UMR's responses and any supporting documentation supplied to gain an understanding of the procedures, staffing, and systems used to administer PEBP's plans. This allowed us to conduct the audit more effectively.

Findings
We observed the following from UMR's response to the operational review questionnaire:

- UMR indicated it maintains levels and types of insurance reasonable and customary for a health services organization with comparable size and market presence.

- UMR was audited by Baker Tilly for compliance with the standards of the American Institute of Certified Public Accountants through the issuance of a Service Organization Controls (SOC) 1 Report. Under SOC 1, the administrator was required to provide a description of its system and controls, which the service auditor validated. CTI received a copy of the report for the period of January 1, 2025 to December 31, 2025. A bridge letter dated April 7, 2026 was also provided noting no material changes were made to internal controls.
- UMR stated it incorporated all CMS National Correct Coding Initiative edits into its unbundling software.
- UMR had adequately documented training, workflow, procedures, and systems.
- UMR used ClearHealth to perform prepayment Diagnostic Related Grouping (DRG) verification. They used its DRG grouper software to determine if an alternate DRG code was applicable for the services billed. It also used Optum Credit Balance Recovery for post-payment DRG validation though comparison of medical records and DRG coding billed.
- Verification of initial or continued coordination of benefits (COB) by UMR was not required by PEBP. When UMR was the secondary payor, it would never pay more than the UMR total allowable amount. UMR reduced the allowable amount by the amount paid by the primary payor. UMR provided a report detailing $2,927,051 in COB savings for the PEBP plans in FY2026.
- UMR reported 97.2% of claims were received electronically during the audit period and 77.97% of claims received were auto adjudicated.
- UMR reported it used Artificial Intelligence (AI) and Machine Learning (ML) to expedite payment, reimbursement and appeals workflows as well as streamlining processes. UMR was not using AI or ML in the claim denial process.
- UMR reported it had a $100.00 minimum dollar threshold to recoup an overpayment and could automatically recoup a refund from the next payment made to the same provider. UMR reported it used vendors to perform overpayment recovery. No fee was charged back to PEBP for recoveries from Optum Payment Recovery Services. Optum also pursued credit balance recoveries, and a 20% fee was charged back to PEBP for those recoveries. UMR reported to CTI that it had an overpayment recovery rate of 57% and for FY2026 it reported overpayment recoveries of $935,120. UMR stated it identified 1,537 overpayments in FY26 with an outstanding balance of $1,214,045.
- UMR pursued direct reimbursement on cases still open after 120 days. Cases with totals of $100 to $350 were sent two letters and if no response was received after 61 days, the case was closed. Cases exceeding $350 were referred to its specialized recovery area for more aggressive follow-up for a minimum of 12 months. Cases exceeding $50,000 were referred to the legal department if the specialized recovery area was not successful in obtaining the refund.
- UMR used the OnBase appeal tracking system. UMR leadership monitored tracking daily to ensure timely responses to member appeals. UMR provided a member appeal tracking report to CTI for January through June 2026. It showed 193 appeals received; 128 appeals had the original determination upheld, 56 were overturned, two were partially overturned, and seven were pending at the time of reporting. Twenty appeals took more than 20 days to resolve.
- UMR stated its Special Investigations Unit (SIU) took a proactive approach to fraud and abuse to identify and monitor trends. The SIU created system edits, developed review procedures, and provided special training to UMR claim professionals to help them identify potential fraudulent circumstances. UMR SIU stated they worked alongside UMR Legal to collaborate with federal and state law enforcement authorities to combat fraud, waste and abuse and it appropriately referred suspected fraud, waste and abuse to law enforcement authorities for criminal prosecution and/or civil enforcement.

- We screened 100% of non-facility claims against the Office of the Inspector General's List of Excluded Individuals and Entities (OIG's LEIE) and confirmed no sanctioned providers received payment from the UMR during the audit period.
- UMR reported it received 99.87% of PEBP's eligible charges from in-network providers. To help drive additional provider savings, UMR participated in the Cancer Resource Program.
- UMR provided its network savings report showing 99.9% of all dollars paid were in network with a discount savings of 68.8%. Based on the claim data provided by UMR, PEBP's members under age 65 had utilization of network or secondary network providers at 97.2% of all allowed charges and 96.0% of all claims. Discount savings indicated below:

Total of all Claims for Members Under Age 65		
Claim Type	**Provider Discount**	
Ancillary	$11,135,289.58	42.8%
Non-Facility	$194,461,055.47	55.3%
Facility Inpatient	$204,253,956.72	73.4%
Facility Outpatient	$310,311,155.24	69.3%
TOTAL	**$720,161,457.01**	**65.2%**

- UMR put policies and procedures in place to comply with the Transparency in Coverage Act (No Surprises Billing) effective January 1, 2022. UMR reported 39 NSA appeals, and 36 inquiries received for allowances made for out-of-network services. Of those, 15 appeals were overturned and 22 were upheld.
- All new employees were required to complete HIPAA training, and all employees were required to complete computer based HIPAA training annually. UMR reported no breeches during FY2026.

QUARTERLY PERFORMANCE GUARANTEE VALIDATION

As part of CTI's quarterly audit of PEBP, we reviewed Performance Guarantees included in its contract with UMR. The results for Q4 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	95.8%	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	92.6%	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%	96.9%	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% 99.6%	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%	98.7%	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	99.5% 99.6%	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%	99.18%	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
3.3	**Pre-Certification Requests:** Precertification requests from healthcare providers shall be completed in accordance with URAC/NCQA standards and turn-around timeframes; completed Pre-certifications shall be communicated to PEBP's Third Party Administrator using an approved method e.g., electronically, within 5 business days of UM completing Precertification determination.	98.00% 5 Business Days	100%	Met
3.4	**Concurrent Hospital Reviews:** Concurrent hospital reviews shall be completed in accordance with URAC/NCQA standards; completed reviews shall be communicated to provider using approved method e.g., electronically within 2 business days of determination decision.	98.00% 2 Business Days	100%	Met
3.5	**Retrospective Hospital Reviews:** Retrospective reviews must be completed in accordance with URAC/NCQA standards; completed reviews shall be communicated using an approved method e.g., electronically within 5 business days of determination decision.	98.00% 5 Business Days	100%	Met
3.8	**Hospital Discharge Planning:** CM will contact or attempt to contact 95% of patients discharged from any facility within 3 business days of	95.00%	98.91%	Met

	Metric	Service Objective	Actual	Met/ Not Met
	notification of discharge with clinical coaching and discharge planning assistance.	3 Business Days		
3.9	**Large Case Management:** CM will identify and initiate case management for chronic disease, high dollar claims, and ER usage.	95.00%	95%	Met
3.10	**Utilization Management for Medical Necessity and Center of Excellence Usage:** UM review to determine medical necessity in accordance with the MPDs. Services to be performed at a Center of Excellence to be managed through the Case Management process.	98.00%	100%	Met
3.11	**Return On Investment (ROI) Guarantee – Utilization Management/Case Management:** 2:1 Savings to Fees for Utilization Management/Case Management.	100%	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				
2	$1,020.24	Agree. Procedure was paid on both 05/14/26 and 06/15/26. *From UMR's 9/15/26 response to the draft report: UMR agrees with this finding. Upon second review, a system issue appears to have inadvertently generated two payments for the same claim on separate dates. IT is reviewing the issue to identify the cause of the duplicate payment and prevent future occurrences.*	Procedural deficiencies and overpayments remain. The services were paid twice creating a duplicate payment.	☒ M ☐ S
3	$234.48	Agree. Claim xxxx8688 submitted with bill type 137, and was a corrected claim to replace original claim xxxx2331. *From UMR's 9/15/26 response to the draft report: UMR agrees with this finding. Claim xxxx8688 has been adjusted to deny as a duplicate. Impact report identified two additional corrected claims that were paid in error, resulting in an overpayment of $1,558.74. A reporting process has been implemented to identify corrected claims that may have been paid in error. Additionally, the duplicate claims process is under review for potential system and workflow enhancements to strengthen controls and prevent similar issues from recurring.*		☒ M ☐ S
Plan Exclusions				
Reverse Sterilization				
45	$21.43	Agree. The claim will be adjusted to deny upon completion of the audit. *From UMR's 9/15/26 response to the draft report: UMR agrees with this finding. The claim has been adjusted to deny the excluded service. Impact report confirmed that the error was limited to a single claim, with no additional claims identified. A system enhancement is being implemented to*	Procedural deficiency and overpayment remain. Payment was made for an excluded expense, reversal of sterilization.	☒ M ☐ S

ESAS Findings Detail Report				
QID	**(Under)/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
		flag claims with applicable diagnosis codes for review prior to processing.		
Marriage Counseling				
47	$75.00	Agree. The claim will be adjusted to deny upon completion of the audit. *From UMR's 9/15/26 response to the draft report: UMR agrees with this finding. The claim has been adjusted to deny the excluded service. Impact report confirmed that the error was limited to a single claim, with no additional claims identified. A system enhancement is being implemented to flag claims with applicable diagnosis codes for review prior to processing.*	Procedural deficiency and overpayment remain. Payment was made for an excluded expense, marriage counseling.	☒ M ☐ S
Plan Limitations				
Timely Filing				
21	$385.48	Agree. Claim allowed incorrectly past timely filing. *From UMR's 9/15/26 response to the draft report: UMR agrees with finding. Upon second review, original claim was received timely and denied for primary EOB. Provider did not submit requested primary EOB until 06/1/26. Primary EOB should have been submitted 180 days from the original denial date. Claim has been adjusted and denied as past timely filing. Impact report confirmed error was limited to a single claim, with no additional claims identified. Coaching and education provided on the timely filing provisions outlined in the master plan document.*	Procedural deficiency and overpayment remain. The claim was past paid the timely filing limitation.	☒ M ☐ S
Provider Discount Error				
31	$4,645.39	Agree. Claim paid at greater than billed charges. Please see screenshot of SHO pricing below. *From UMR's 9/15/26 response to the draft report: UMR agrees with this finding. The claim has been adjusted with correct pricing. Impact report identified 13 additional claims with pricing discrepancies, resulting in an overpayment of $19,871.99. Staff education was completed and repricing has been restricted to senior staff.*	Procedural deficiency and overpayment remain. The contract rate was not applied to this claim. UMR allowed greater than billed charges. The allowable should have been $1,606.61 instead of $6,252.00.	☒ M ☐ S
34	Unknown	Agree. Claim paid in full at billed charges in error. *From UMR's 9/15/26 response to the draft report: UMR agrees with finding. Impact report remains in progress, and claims are continuing to be reviewed to determine the extent of any additional impact. A reporting process has been implemented to identify claims paid in full at billed charges in error.*	Procedural deficiency and overpayment remain. The in-network discount was not applied.	☒ M ☐ S
36	$299.25	Agree. Methodology used for this provider is Lesser 60% of billed or Sierra fee schedule. *From UMR's 9/15/26 response to the draft report: UMR agrees with this finding. The claim has been adjusted with in-network discount applied. Impact report confirmed that the error was limited to a single claim, with no additional claims identified. Additional training was provided for processing staff to address the identified error and reinforce correct processing procedures.*	Procedural deficiency and overpayment remain. The in-network discount was not applied. The rate should have been $0.75 and billed charges were paid.	☒ M ☐ S

ESAS Findings Detail Report				
QID	**(Under)/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Preventive Services				
Denied				
16	($102.06)	Agree. Services performed in VA Medial Center should have been allowed. *From UMR's 9/15/26 response to the draft report: UMR agrees with this finding. The claim has been adjusted to allow charges. Impact report confirmed that the error was limited to a single claim, with no additional claims identified. Staff received coaching and education on the proper handling of routine vision services provided at VA facilities, ensuring they are covered as in-network.*	Procedural deficiency and underpayment remain. The preventive service was denied in error.	☒ M ☐ S
With Deductible Applied				
17	($500.00)	Agree. Preventive colorectal screenings should not apply a copay. *From UMR's 9/15/26 response to the draft report: UMR agrees with this finding. A review found that the diagnostic procedure qualified as a preventive service; however, the outpatient surgical facility copayment was incorrectly applied during processing. The claim has been adjusted to remove the copay. Impact analysis confirms that the error was limited to a single claim, with no additional claims identified.*	Procedural deficiency and underpayment remain. A copayment was applied to the preventive service in error.	☒ M ☐ S

Preliminary Annual Eligibility Verification

CTI electronically compared dates of service for FY2026 Q1 through Q4 and PEBP's electronic eligibility file from TELUS Health. CTI's screening revealed some services were paid during the audit period for potentially ineligible claimants. The output was provided to TELUS Health and UMR for review and comment. At this time, potentially overpaid amounts have been flagged into the following categories:

Employee Eligibility Screening Subcategory	Amount Paid
No Identification Match to Any Eligible Employee	$22,666.86
Payments Prior to Effective Date	$1,471.52
Payments During Gaps in Coverage	$9,735.43
After Termination Date of Employee's Coverage	$101,698.44
Subtotal	$135,572.25
Dependent Eligibility Screening Subcategory	**Amount Paid**
No Identification Match to Any Eligible Employee	$16,502.05
Payments Prior to Effective Date	$26,601.50
Payments During Gaps in Coverage	$898.54
After Termination Date of Employee's Coverage	$79,434.94
Subtotal	$123,437.03
COMBINED TOTAL*	**$259,009.28**

**CTI notes that 0.08% of the PEBP's total medical expense processed by UMR was identified as paid for members who may not have been eligible for coverage. These results are less than 0.5% CTI generally reports.*

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 $5,987,146.65. The claims sampled and reviewed revealed $32.37 in underpayments and $28,779.68 in overpayments. This reflects a weighted Financial Accuracy rate of 99.64% 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 Q4 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	2	1	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 Q4 FY2026 of 98.00% for this measure. No penalty is owed. Detail is provided in the Random Sample Findings Detail Report below.

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
197	0	3	98.50%

Random Sample Findings Detail Report				
Audit No.	**Under/ Overpaid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Incorrect Provider Discount				
1095	($2.00)	Agree. The incorrect allowed amount entered resulting in an underpayment of $2.00. *From UMR's 9/15/26 response to the draft report:* *UMR agrees with finding. This was a manual keying error. The claim has been adjusted to correct the allowed amount.*	Procedural error and underpayment remain. The allowed amount was processed on the claim as $14,110.95 and it should have been $14,112.95.	☒ M ☐ S
1107	($30.37)	Agree. We under allowed $37.96 and under paid by $30.37. *From UMR's 9/15/26 response to the draft report:* *UMR agrees with finding. Incorrect pricing applied, resulting in an underpayment of $30.37. As the observation stay exceeded 23 hours, services should have been processed using inpatient benefits. Claim has been adjusted.*	Procedural error and underpayment remain. The allowed amount was processed on the claim as $18,035.37 and it should have been $18,073.34.	☒ M ☐ S
Coordination of Benefits Error				
1133	$28,779.68	Agree. Other insurance information was not coordinated correctly resulting in overpayment of $28,779.68. We should have paid no more than $344.58. *From UMR's 9/15/26 response to the draft report:* *UMR agrees with this finding. As the member has Medicare Part B as the primary payer, benefits should have been coordinated with Medicare and only the applicable Medicare patient responsibility amount should have been allowed. Additional training was provided for processing staff to address the identified error and reinforce correct processing procedures. Claim has been adjusted.*	Procedural error and overpayment remain. The primary insurance carrier's EOB reflect the member responsibility was $344.58. The sample claim paid $29,124.26.	☒ M ☐ S

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.

Number	Observation
2004	The provider billed D1355 (Caries-Preventive Medicament Application) 24 times for this 14-year-old member, resulting in total payments of $1,350. Based on American Dental Association (ADA) coding guidance, a standard full-mouth preventive treatment would generally be reported using D1206 (Topical Application of Fluoride Varnish) or D1208 (Topical Application of Fluoride Excluding Varnish), which typically has an allowance of approximately $50-$60 per application. Prior to payment of 24 units of D1355, supporting documentation should have been obtained to substantiate each tooth was individually treated with a non-fluoride caries-preventive medicament

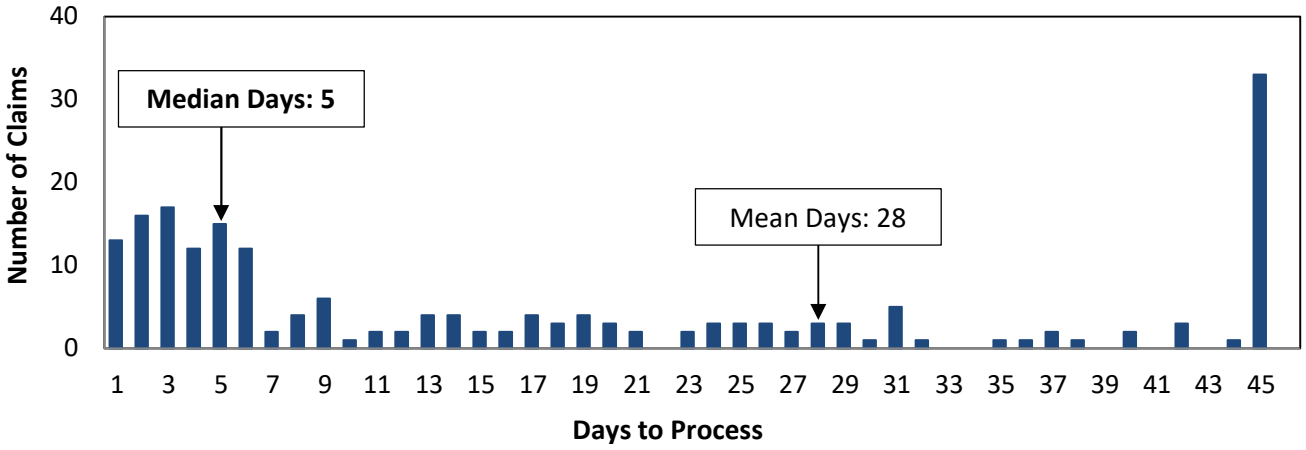
Number	Observation
	(such as silver diamine fluoride, silver nitrate, chlorhexidine varnish, or a similar agent) and that each treated tooth met the applicable clinical criteria for separate reimbursement. Documentation should also clearly demonstrate the services provided were distinct from a routine full-mouth fluoride application, which would generally be more appropriately reported using D1206 or D1208. Obtaining this documentation would be consistent with the Dental Master Policy Document (MPD), which states on page 11 – *A medical or dental service or supply will be cost-efficient if it is no costlier than any alternative appropriate service or supply when considered in relation to health care expenses incurred in connection with the service or supply.* Absent documentation supporting the necessity of 24 separately billable D1355 applications, the payment may not meet the Dental MPD's cost-efficiency standard. UMR should consider obtaining and reviewing such documentation prior to payment of similar future claims to confirm the services meet the criteria for separate reimbursement. *From UMR's 9/15/26 response to the draft report:* *UMR disagrees with this observation. Procedure code D1355 (Caries Preventive Medicament Application - per tooth) does not require the application of dental necessity criteria. UMR's Book of Business configuration supports coverage of D1355 for eligible permanent teeth (1-32) and primary teeth (A-T). The claim adjudication aligns with configured business rules and established benefit administration guidelines.*

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 Q4 FY2026 of 92% processed within 14 days and 99% processed within 30 days and no penalty is due.

FY2026 REVIEW AND RECOMMENDATIONS

CTI has the following recommendations that represent recurring issues identified in the FY2026 quarterly audits:

1. UMR should review each of the financial errors identified in our FY2026 random sample audits and determine if system changes or additional claim processor training could help reduce or eliminate errors of similar nature in the future. It should focus specifically on steps necessary to improve Financial Accuracy on a consistent basis.
    - The most frequent error in FY2026 was the incorrect application of provider discount and was most commonly a manual processing error.

2. UMR should conduct a focused analysis of the errors identified through ESAS to determine if overpayment recovery and/or system improvements are possible and to reduce or eliminate similar errors going forward. For the issues identified by ESAS, CTI can prepare claim detail for UMR to use in its analysis.
    - The most frequent improvement opportunities were identified in the categories of duplicate payments, incorrect provider discount application, and incorrect copayment application.

3. PEBP should review the results of the eligibility screening and perform causal analysis to identify workflow and/or system improvements to reduce or eliminate paying claims on ineligible claimants.

CONCLUSION

UMR's performance in Q4 improved and met the performance metrics for PEBP for Financial Accuracy, Overall Accuracy and Claim Turnaround in the fourth quarter of FY2026.

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 can be found on the following pages. 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

September 25, 2026

Thank you for the opportunity to respond to the review of the State of Nevada Public Employees' Benefit Program Q4Y26 audit draft report. The following is our response to the draft report completed by CTI. As part of our ongoing commitment to service excellence, UMR leadership is evaluating the resources supporting the PEBP account to ensure we have the optimal team structure in place to meet PEBP's needs and to deliver exceptional client experience.

ESAS Targeted Sample Findings

Duplicate Payments
QID 2 – UMR agrees with this finding. Upon second review, a system issue appears to have inadvertently generated two payments for the same claim on separate dates. IT is reviewing the issue to identify the cause of the duplicate payment and prevent future occurrences.

QID 3 – UMR agrees with this finding. Claim [redacted] has been adjusted to deny as a duplicate. Impact report identified two additional corrected claims that were paid in error, resulting in an overpayment of $1,558.74. A reporting process has been implemented to identify corrected claims that may have been paid in error. Additionally, the duplicate claims process is under review for potential system and workflow enhancements to strengthen controls and prevent similar issues from recurring.

Plan Exclusions – Reverse Sterilization
QID 45 – UMR agrees with this finding. The claim has been adjusted to deny the excluded service. Impact report confirmed that the error was limited to a single claim, with no additional claims identified. A system enhancement is being implemented to flag claims with applicable diagnosis codes for review prior to processing.

Plan Exclusions – Marriage Counseling
QID 47 – UMR agrees with this finding. The claim has been adjusted to deny the excluded service. Impact report confirmed that the error was limited to a single claim, with no additional claims identified. A system enhancement is being implemented to flag claims with applicable diagnosis codes for review prior to processing.

Plan Limitations – Timely Filing
QID 21 – UMR agrees with this finding. Upon second review, the original claim was received timely and denied for primary EOB. The provider did not submit the requested primary EOB until 06/1/26. The primary EOB should have been submitted 180 days from the original denial date. The claim has been adjusted and denied as past timely filing. Impact report confirmed that the error was limited to a single claim, with no additional claims identified. Coaching and education provided on the timely filing provisions outlined in the master plan document.

Provider Discount Error
QID 31 – UMR agrees with this finding. The claim has been adjusted with correct pricing. Impact report identified 13 additional claims with pricing discrepancies, resulting in an overpayment of $19,871.99. Staff education was completed and repricing has been restricted to senior staff.

QID 34 – UMR agrees with this finding. Impact report remains in progress, and claims are continuing to be reviewed to determine the extent of any additional impact. A reporting process has been implemented to identify claims paid in full at billed charges in error.

QID 36 – UMR agrees with this finding. The claim has been adjusted with in-network discount applied. Impact report confirmed that the error was limited to a single claim, with no additional claims identified. Additional training was provided for processing staff to address the identified error and reinforce correct processing procedures.

Preventive Services – Denied
QID 16 – UMR agrees with this finding. The claim has been adjusted to allow charges. Impact report confirmed that the error was limited to a single claim, with no additional claims identified. Staff received coaching and education on the proper handling of routine vision services provided at VA facilities, ensuring they are covered as in-network.

Preventive Services – Denied
QID 17 – UMR agrees with this finding. A review found that the diagnostic procedure qualified as a preventive service; however, the outpatient surgical facility copayment was incorrectly applied during processing. The claim has been adjusted to remove the copay. Impact analysis confirms that the error was limited to a single claim, with no additional claims identified.

Random Sample Findings

Incorrect Provider Discount
Sample 1095 – UMR agrees with this finding. This was a manual keying error. The claim has been adjusted to correct the allowed amount.

Sample 1107 – UMR agrees with this finding. Incorrect pricing was applied, resulting in an underpayment of $30.37. As the observation stay exceeded 23 hours, the services should have been processed using inpatient benefits. The claim has been adjusted.

Coordination of Benefits Error
Sample 1133 – UMR agrees with this finding. As the member has Medicare Part B as the primary payer, benefits should have been coordinated with Medicare only allowing the applicable Medicare patient responsibility amount. Additional training was provided for processing staff to address the identified error and reinforce correct processing procedures. The claim has been adjusted.

Observations
Sample 2004 - UMR disagrees with this observation. Procedure code D1355 (Caries Preventive Medicament Application - per tooth) does not require the application of dental necessity criteria. UMR's Book of Business configuration supports coverage of D1355 for eligible permanent teeth (1-32) and primary teeth (A-T). The claim adjudication aligns with configured business rules and established benefit administration guidelines.

Eligibility Audit

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UMR is working with CTI, Telus Health, and PEBP to review and validate the potentially overpaid amounts identified in the annual eligibility audit. UMR will share its findings directly with PEBP Executive Staff in advance of the Board Meeting.

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,

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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