Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT
and Annual Operational Review

State of Nevada Public Employees' Benefits Program Plans

Administered by UMR

Audit Period: April 1, 2025 – June 30, 2025
Audit Number 1.FY25.Q4

Presented to

State of Nevada Public Employees' Benefits Program

November 20, 2025

CLAIM TECHNOLOGIES INCORPORATED

TABLE OF CONTENTS

EXECUTIVE SUMMARY

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

Scope

CTI performed an audit for the period of April 1, 2025 through June 30, 2025 (quarter 4 (Q4) for Fiscal Year (FY) 2025). The population of claims and amount paid during the audit period reported by UMR:

Medical and Dental	
Total Paid Amount	$73,400,268
Total Number of Claims Paid/Denied/Adjusted	244,958

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
- 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 did not meet the service objective, and a penalty is owed (breakdown in summary below).
3. CTI recommends UMR:
   - Review errors identified in our Random Sample audit as well as the additional observations and determine if procedures, system changes, or claim processor training could help reduce or eliminate errors of a similar nature in the future.
   - Review the 100% Electronic Screening with Targeted Sample results and focus on the most material findings.
   - Where appropriate, verify claim processor coaching, feedback, and retraining have occurred because most errors were manually processed.

Random Sample Audit Performance Guarantee Summary

Based on CTI's Random Sample Audit results, UMR did not meet the claim processing measurements for PEBP in Q4 FY2025 and owes a penalty. Reported administrative fees for the quarter totaled $1,404,474.33.

Quarterly Metric	Guarantee	Met/Not Met	Penalty	Calculated Penalty
Financial Accuracy	99.40%	Not Met – 99.20%	1.5%	$21,067.12
Overall Accuracy	98.00%	Not Met – 97.00%	1%	$14,040.74
Claim Turnaround Time	92% in 14 Days 99% in 30 Days	Met – 92.60% Not Met – 98.10%	NA 1%	$0.00 $14,040.74
		Total Penalty	3.5%	$49,149.60

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

Measure	Guarantee	FY 2025			
		Quarter 1	Quarter 2	Quarter 3	Quarter 4
Financial Accuracy	**99.40%**	98.68%	99.99%	99.56%	99.20%
Overall Accuracy	**98.00%**	98.00%	99.00%	99.00%	97.00%
Claim Turnaround Time	**92% in 14 Days**	94.20%	95.60%	93.10%	92.60%
	99% in 30 Days	99.00%	99.30%	97.50%	98.10%

AUDIT OBJECTIVES

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

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

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

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

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

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 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, 2024 to December 31, 2024. A bridge letter dated July 7, 2025 was also provided noting no material changes were made to internal controls.
- UMR stated it had incorporated all CMS National Correct Coding Initiative edits into its unbundling software.
- UMR stated it did not require an additional review and approval before issuing large claim checks over a pre-determined amount.
- UMR batched provider payments and issued payments to providers twice weekly for PEBP claim payments.
- UMR reported it honored assignment of benefits for non-network providers which allowed non-network providers to receive payment directly from UMR versus having to pay the member who would then have to pay the non-network provider. This is a best practice.
- UMR had adequately documented training, workflow, procedures, and systems.
- UMR used ClearHealth grouper software to perform prepayment Diagnostic Related Grouping (DRG) verification. It also used Optum Credit Balance Recovery for post-payment DRG validation.
- 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 total allowable amount. UMR did not provide a report on COB savings for the PEBP plans for FY2025.
- UMR reported 94.4% of claims were received electronically during the audit period and 75.05% of claims received were auto adjudicated.
- 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. An overpayment adjustment report was provided to CTI for FY2025 showed $1,032,929 overpayments identified for adjustment.
- 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 FY2025. It showed 260 appeals received; 175 appeals had the original determination upheld, 81 were overturned, one was partially overturned, and five were pending at the time of reporting. Twenty-two appeals took more than 20 days to resolve.
- UMR created system edits, developed review procedures, and provided special training to its claim professionals to help identify potential fraudulent situations.

- 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 identified the following sanctioned provider who received payment from the UMR during the audit period.

NPI	Exclusion Date	Reinstatement Date	Exclusion Type	Provider Name	Claim Count	Total Charged	Total Allowed	Total Paid
1669412243	20181120	20250416	1128a1	CONNER,BYRON,MD	1	$5,014	$4,764	$4,458
				Totals	**1**	**$5,014**	**$4,764**	**$4,458**

- UMR reported it received 99.1% of PEBP's eligible charges from in-network providers. To help drive additional provider savings, UMR participated in programs such as Cancer Resource Programs and Centers of Excellence.
- PEBP's members under age 65 had utilization of network or secondary network providers at 96.6% of all allowed charges and 95.6% of all claims.

Total of All Claims for Members Under Age 65		
Claim Type	**Provider Discount**	
Ancillary	$2,742,783.09	46.9%
Non-Facility	$48,534,647.12	55.9%
Facility Inpatient	$38,174,447.36	69.6%
Facility Outpatient	$63,445,601.17	67.5%
Total	**$152,897,478.74**	**63.3%**

- UMR put policies and procedures in place to comply with the Transparency in Coverage Act (No Surprises Billing) effective January 1, 2022. UMR reported 25 appeals, and 12 inquiries received for allowances made for out-of-network services. Twelve appeals were overturned and 13 were upheld.
- All new employees were required to complete HIPAA training, and all employees were required to complete the training annually. UMR reported no breeches during the audit period.

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 Q4 FY2025 as well as annual metrics 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	96.2%	Met
1.5	**Telephone Service Factor:** Defined as the percentage of the Client telephone inquiries answered by facility Customer Service Representatives (CSRs) within 30 seconds. Measured from the time the caller completes the prompts of the automated telephone system to the time the caller reaches a CSR.	85.00% Calls answered within 30 seconds	91.6%	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%	0.6%	Met
1.7	**First Call Resolution Rate:** the percentage of telephone inquiries completely resolved within a 'window period' of time. A call is considered 'resolved' when the same participant or a family member under the same subscriber ID has not contacted the administrator's customer service facility again regarding the same issue within 60 calendar days of the initial call.	95.00%	96.8%	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	98.7% 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%	98.1%	Met
1.10	**CSR Callback Performance:** measured from the CSR commitment data in hours and/or days to the time the actual callback was placed to the participant.	90.00% Within 24 Hours	100%	Met
1.11	**Participant Email Response Performance:** measured from the time an email is received by the administrator's response team to the time in hours or days to the time the actual email response is sent to the participant.	90.00% Within 8 Hours 95.00% Within 24 Hours	100% 100%	Met Met
1.12	**Member Satisfaction:** At least 95%-member satisfaction with the services. Measured as the number of satisfied to highly satisfied survey ratings divided by the total number of survey responses. Survey tool and survey methodology to be mutually agreed upon by Offeror and PEBP.	95.0%	96.55%	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	4.375	Met
	Responsiveness – All calls returned within at most 24 hours; along with an alternate person identified who can assist with service issues when account representative is unavailable.			

	Metric	Service Objective	Actual	Met/ Not Met
	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 or conference calls.			
	Guarantee measured with staff responses to internal questionnaire. A scale from 1 to 5 will be used to measure performance, where 1 means 'very dissatisfied' and 5 means 'very satisfied'; and 2 through 4 are defined, respectively.			
	Periodic program reports will be provided and presented with recommended actions. Standard program reports, within 30 days to quarter-end. Year-end activity report, within 45 days of program year end.			
	Open Enrollment Support: Accurate materials will be provided at least 60 days prior to the open enrollment period starting on April 1 each year. Representatives 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 receipt of eligibility information, given that information is complete and accurate.	98.00% 2 Business Days	100%	Met
1.15	**Data Reporting:** Offeror will provide PEBP with 100% of the applicable reports (within 10 business days for standard reports and within 10 business days of Plan year-end for Annual Reports and Regulatory documents).	100% 10 Business Days	100%	Met
1.17	**ID Card Production and Distribution – within 10 Business Days**	100%	100%	Met
1.18	**Disclosure of Subcontractors:** Offeror will provide the identity of the subcontractors who have access to PEBP member PHI. Provide identity of subcontractors who have access to PHI within 30 calendar days of the subcontractors' gaining access.	100% 30 Calendar Days	No new subcontractors	Met
1.19	**PHI:** Offeror will store PEBP member PHI data on designated servers. Must remove PEBP member PHI within 3 business days after offeror knows or should have known using commercially reasonable efforts that such PHI is not stored on a designated server.	100% 30 Business Days	No issues	Met
NETWORK ADMINISTRATION – SERVICES AND PERFORMANCE GUARANTEES				
2.1	**EDI Claims Re-Pricing Turnaround Time:** At least 97% of medical claims covered under the PEBP Medical PPO Network must be electronically re-priced within business 3 days and 99% within business 5 days.	97.00% 3 Business Days 99.00% 5 Business Days	99.5% 99.5%	Met Met
2.2	**EDI Claims Re-Pricing Accuracy:** At least 97% of claims re-priced by the PPO Network must be accurate and must not cause a claim adjustment by PEBP's TPA.	97.00%	98.48%	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 Issues	Met
2.6	**Website:** A website hosting a reasonably accurate and updated Provider directory must be available and accessible on all major browsers 99% of time.	99.00%	99.99%	Met

	Metric	Service Objective	Actual	Met/ Not Met
UTILIZATION MANAGEMENT/CASE MANAGEMENT – SERVICES AND PERFORMANCE GUARANTEES				
3.1	**Data Reporting – Standard Reports (Quarterly reporting to include Service Performance Standards, Guarantee, Method of Measurement, Actual Performance Results, and Pass/Fail indicator.)** Standard reports must be delivered within 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 single claim or treatment plan expected to exceed $100,000.00.** Designated PEBP staff will be notified within 5 business days of 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	99.96%	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	99.92%	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 notification of discharge with clinical coaching and discharge planning assistance.	95.00% 3 Business Days	97.09%	Met
3.9	**Large Case Management:** CM will identify and initiate case management for chronic disease, high dollar claims, and ER usage.	95.00%	100%	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 issues	Met

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

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

Scope

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

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

Methodology

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

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

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

Findings

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

Categories for Process Improvement

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

For each potential error, we sent an ESAS Questionnaire with an identification number (QID) to UMR for written response. After 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				
1	$23,609.66	Agree. Sample claim xxxxxxx6917 is a duplicate to xxxxxxx0552. This claim will be adjusted at the completion of the audit.	Procedural deficiencies and overpayments remain. UMR paid a duplicate charge.	☐ M ☒ S
2	$66.11	Agree. sample claim xxxxxxx0003 is a duplicate to xxxxxxx3414. This claim will be adjusted at the completion of the audit.		☒ M ☐ S
3	$1,125.71	Agree. Sample claim xxxxxxx1591 is a duplicate to xxxxxxx0842. This claim will be adjusted at the completion of the audit.		☒ M ☐ S
4	$48.00	Agree. Sample claim xxxxxxxx3592 is a duplicate to xxxxxxx1483. Claim xxxxxxxx3592 was adjusted and reimbursement was received from the provider on 7-2-2025.		☒ M ☐ S
5	$98.25	Agree. Sample claim xxxxxxxx9945 is a duplicate to xxxxxxxx9962. This claim will be adjusted at the completion of the audit.		☒ M ☐ S

ESAS Findings Detail Report				
QID	**(Under)/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
7	$95.00	Agree. There was a second payment made in error. This claim will be adjusted at the completion of the audit and results in a $95.00 overpayment.		☒ M ☐ S
Preventive Services				
Deductible Applied				
14	($146.55)	Agree. These services are allowed at 100% per the plan benefit.	Procedural deficiency and underpayment remain. The preventive service was applied to the deductible in error.	☒ M ☐ S
Service Not Medically Necessary				
42	$1,169.28	Agree. Medical records were reviewed but did not support the medical necessity of this claim.	Procedural deficiency and underpayment remain. Services were reviewed and determined to be not medically necessary by UMR's clinical coordinator. The claim should have been denied as not medically necessary.	☒ M ☐ S
Plan Exclusions				
Experimental/Investigational				
46	$494.00	Agree. There is no authorization on file. The claims will be adjusted at the completion of the audit.	Procedural deficiencies and overpayments remain. Experimental services require prior authorization to be eligible for coverage.	☒ M ☐ S
47	$653.12			☒ M ☐ S
Dental Paid Under Medical				
44	$79.50	Agree. Services should have been processed under member's dental plan, not medical plan. This results in a $79.50 overpayment. Claim has now processed under dental benefit on 7/22/25.	Procedural deficiency and overpayment remain. This is a three-surface resin (D2332) and should have been covered under the dental plan but was paid under medical.	☒ M ☐ S
Biofeedback				
48	$60.00	Agree. Code 90901 is not a covered service and was allowed in error. An adjustment will be done at the completion of the audit.	Procedural deficiency and overpayment remain. Biofeedback is excluded by the plan.	☒ M ☐ S
Incorrect Preferred Provider Discount Applied				
30	$8,919.60	Agree. Incorrect allowed amount was applied to this claim. This claim will be adjusted at the completion of the audit.	Procedural deficiency and overpayment remain. Provider discount was not applied to the claim in error.	☒ M ☐ S
34	$257.11	Agree. Original manual pricing by MRU was ASP $2.68 – 20% = $2.144 x 6 units = $12.86. UMR received a corrected claim with additional units and adjusted without updated pricing. Due to the error on no updated repricing this claim is overpaid $257.11. The claim was adjusted on 7/31/2025.	Procedural deficiency and overpayment remain. Correct provider discount pricing was not used on the claim.	☒ M ☐ S
35	$6,088.00	Agree. An incorrect allowable was used to process J0585. This claim was adjusted on 9/2/25 and resulted in a $6,088.00 overpayment.	Procedural deficiency and overpayment remain. Correct provider discount pricing was not applied to the claim.	☒ M ☐ S
40	14,006.61	Agree. Medicare pricing should have applied to claim. An incorrect allowable	Procedural deficiency and overpayment remain. The claim should have been priced at Medicare allowable and was paid at billed	☒ M ☐ S

ESAS Findings Detail Report				
QID	**(Under)/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
		was used to process. An adjustment will be done at the completion of this audit.	charges in error. The allowable of $235.93 should have paid 80% = $188.74.	
Copay Application				
Office Visit				
25	$30.00	Agree. Claim should have applied a copay. Claim adjusted on 9/22/25 and resulted in a $30.00 overpayment.	Procedural deficiency and overpayment remain. The copay was not applied in error.	☐ M ☒ S

Annual Eligibility Verification

CTI electronically compared dates of service for FY2025 Q1 through Q4 and PEBP's electronic eligibility file from TELUS Health. The screening revealed that some services were paid during the audit period for potentially ineligible claimants. The output was provided to TELUS Health for its review and comment. At this time, potentially overpaid amounts have been flagged into one of the following categories:

Employee Eligibility Screening Subcategory	Amount Paid
No Identification Match to Any Eligible Employee	$161,329
Payments Prior to Effective Date	$285
Payments During Gaps in Coverage	$4,368
After Termination Date of Employee's Coverage	$51,774
Subtotal	$217,757
Dependent Eligibility Screening Subcategory	**Amount Paid**
No Identification Match to Any Eligible Employee	$572,448
Payments Prior to Effective Date	$1,768,000
Payments During Gaps in Coverage	$2,705
After Termination Date of Employee's Coverage	$29,912
Subtotal	$2,373,064
COMBINED TOTAL*	**$2,590,821**

**CTI notes that 0.93% 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 above normal compared to the 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 upon the principles of statistical process control with a management philosophy of continuous quality improvement. Our auditors reviewed each sample claim selected to ensure it conformed to plan specifications, agreements, and negotiated discounts. We recorded our findings in our proprietary audit system.

When applicable, we cited claim payment and processing errors identified by comparing the way a selected claim was paid and the information UMR had available at the time the transaction was processed**. It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so PEBP can discuss how to reduce errors and re-work in the future with UMR.**

CTI communicated with UMR in writing about any errors or observations using system-generated response forms. We sent UMR a preliminary report for its review and written response. We considered UMR's written response, as found in the Appendix, when producing our final reports. Note that the administrator responses have been copied directly from UMR's reply.

Financial Accuracy

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

The total paid in the 200-claim audit sample was $1,385,347.37. The claims sampled and reviewed revealed $651.13 in underpayments and $18,349.27 in overpayments. This reflects a weighted Financial Accuracy rate of 99.20% over the stratified sample. This is a decrease in performance from the prior period. Details are provided on the following table, Random Sample Findings Detail Report.

UMR did not meet the Performance Guarantee for PEBP in Q4 FY2025 of 99.40% for this measure. The penalty owed for this Performance Guarantee is 1.5% of the administrative fees of $1,404,474.33 or $21,067.12.

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 6 incorrectly paid claim and 194 correctly paid claims. This is a decrease in performance from the prior period. Detail is provided on the table below, Random Sample Findings Detail Report.

Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid Claims	Overpaid Claims	
200	3	3	97.00%

Overall Accuracy

CTI defines Overall Accuracy as the number of claims processed without errors compared to the total number of claims processed in the audit sample.

Performance declined from the prior period. UMR did not meet the Performance Guarantee for PEBP in Q4 FY2025 of 98.0% for this measure and a penalty is owed. The penalty owed for this Performance Guarantee is 1.0% of the administrative fees of $1,404,474.33 or $14,040.74. Detail is provided on the table below, Random Sample Findings Detail Report.

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

Random Sample Findings Detail Report				
Audit No.	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
PPO Discount				
1040	$145.50	Agree. This claim was manually priced and J7030 was priced incorrectly. Allowed billed charges and should be $2.50. This results in a $145.50 overpayment.	Procedural error and overpayment remain. Procedure code J7030 was priced incorrectly.	☒ M ☐ S
1045	$6,366.77	Agree. Claim manually priced incorrectly. This results in a $6366.77 overpayment.	Procedural error and overpayment remain. Incorrect provider discount applied.	☒ M ☐ S
1046	($43.50)	Agree. Incorrect pricing was used resulting in a payment error. Lessor of 125% 2024 NV Medicare or 60% billed charges.	Procedural error and underpayment remain. Incorrect provider discount applied.	☒ M ☐ S
1095	($431.99)	Agree. Incorrect allowable used to process claim. Results in $431.99 underpayment. The claim was adjusted on 8/26/25.	Procedural error and underpayment remain. An incorrect provider discount applied.	☒ M ☐ S
Paid Ineligible Procedure				
1092	$11,837.00	Agree. Prior authorization is not on file for this service and should have been denied. This results in a $11,837.00 overpayment and the claim will be adjusted at the completion of the audit.	Procedural error and overpayment remain. Claim was not eligible for benefits, procedure code 0211U was not authorized and should have been denied.	☒ M ☐ S
Coinsurance Error				
1096	($175.64)	Agree. The coinsurance should be $0.00 for the outpatient surgery related services. This results in $175.64 underpayment. An adjustment will be done at the completion	Procedural error and underpayment remain. The coinsurance applied should have been $0.00 for outpatient surgery related services and it was $175.64.	☒ M ☐ S

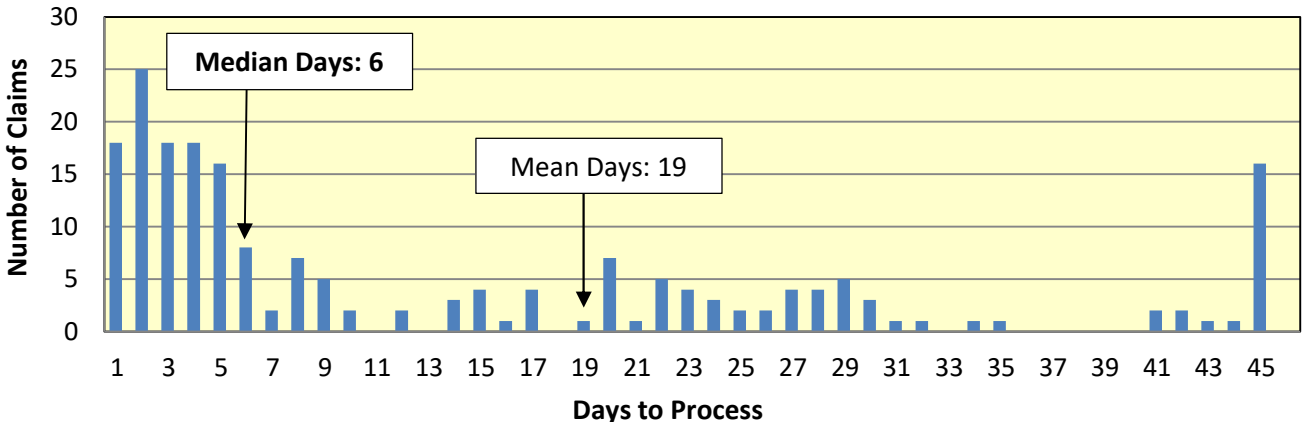
Random Sample Findings Detail Report				
Audit No.	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
		of this audit.		

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 did meet the Performance Guarantee for PEBP in Q4 FY2025 of 92% processed within 14 days but did not meet 99% processed within 30 days. This performance decreased from the prior period. The penalty owed for this Performance Guarantee is 1.0% of the administrative fees of $1,404,474.33 or $14,040.74.

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
2041	Page 14 of the dental MPD states *If payment is requested for temporary appliances, the cost of the temporary appliance will be deducted from the benefits payable for the permanent appliance, meaning the Plan will not pay for both a temporary and a permanent appliance*. UMR states its system logic does not support combining a temporary and permanent appliance and allows these codes individually. PEBP should ensure this procedure meets the intent of the plan, and if so, consider updating the plan language.

FY2025 REVIEW AND RECOMMENDATIONS

CTI has the following recommendations that represent recurring issues identified in the FY2025 quarterly audits:

1. UMR should review each of the financial errors identified in our FY2025 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.
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.
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 did not meet the performance metrics for financial accuracy, overall accuracy and claim turnaround in the fourth quarter of FY2025. A penalty of $49,149.60, 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 appears on the following page.

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

115 West Wausau Ave
Wausau, WI 54401

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

September 24, 2025

[redacted]

Thank you for the opportunity to respond to the recent review of the State of Nevada Public Employees' Benefit Program Q4Y25 audit draft report. The following is our response to the draft report completed by CTI.

ESAS Targeted Sample Analysis

Duplicate Payments

QID 1 – Medical claim [redacted]6917 is a duplicate to claim [redacted]0552. This claim will be adjusted at the completion of the audit and results in a $23,609.66.

QID 2 – Medical claim [redacted]0003 is a duplicate to claim [redacted]3414. This claim will be adjusted at the completion of the audit and results in a $66.11 overpayment.

QID 3 – Medical claim [redacted]1591 is a duplicate to claim [redacted]0842. This claim will be adjusted at the completion of the audit and results in a $1125.71 overpayment.

QID 4 – Dental claim UMR agrees sample claim [redacted]3592 is a duplicate to claim [redacted]1483. Claim [redacted]3592 was adjusted and reimbursement was received from the provider on 7-2-2025.

QID 5 – Medical claim [redacted]9945 is a duplicate claim to [redacted]9962. This claim will be adjusted at the completion of the audit and results in a $98.25 overpayment.

QID 7 – After further review, UMR agrees there was a second payment made in error. This claim will be adjusted at the completion fo the audit and results in a $95.00 overpayment.

Preventive Services – Deductible Applied

QID 14 – UMR agrees with this finding. These services should be allowed at 100% per the plan benefit. This claim will be adjusted at the completion of the audit and results in a $146.55 overpayment.

Service Not Medically Necessary

QID 42 - UMR agrees with this finding. The review of medical records did not support these services, and payment should not have been made. This claim will be adjusted at the completion of the audit and results in a $1169.28 overpayment.

Plan Exclusions – Experimental/Investigational

QID 46 – UMR agrees with this finding. Authorization for services is not on file. The Customer First Representative should have denied this claim. This claim will be adjusted at the completion of the audit and results in a $494.00 overpayment.

715-841-7262 www.UMR.com [redacted]@UMR.com

QID 47 – UMR agrees with this finding. This claim was allowed in error and should have denied as excluded on the plan – Experimental/Investigational. The claim will be adjusted at the completion of the audit and results in a $653.12 overpayment.

Plan Exclusions – Dental paid Under Medical

QID 44 – After further review, UMR agrees with this finding. These services should have been processed under the members' dental plan, not the medical plan. This results in a $79.50 overpayment. This claim has now been processed under the dental benefit on 7-22-225.

Plan Exclusions – Biofeedback

QID 48 – UMR agrees with this finding. Biofeedback is excluded by this plan. The services should have been denied. This claim will be adjusted at the completion of the audit and results in a $60.00 overpayment.

Incorrect Preferred Provider Discount Applied

QID 30 – UMR agrees with this finding. An incorrect allowable amount applied to this claim. This claim will be adjusted at the completion of the audit and results in a $8919.60 overpayment.
QID 34 – UMR agrees with this finding. An incorrect allowable amount applied to this corrected claim. This claim was adjusted on 7-31-2025 and resulted in a $257.11 overpayment.
QID 35 – UMR agrees with this finding. An incorrect allowed amount applied to this claim. This claim was adjusted on 9-2-2025 and resulted in a $6,088.00 overpayment.
QID 40 - UMR agrees with this error. An incorrect allowable amount applied to this claim. This claim will be adjusted at the completion of the audit and results in a $14,006.61 overpayment.

Copay Application - Office Visit

QID 25 – UMR agrees with this finding. Office visit copay should apply to this claim. This claim was adjusted on 9-22-2025 and resulted in a $30.00 overpayment.

Random Sample Findings

PPO Discount

Sample 1033 – UMR disagrees with this finding. There was no change in the contracted rate and no additional payment made on 1/30/2025. This claim is processed correctly.
Sample 1040 - UMR agrees with this finding. An incorrect allowable amount applied to this claim. This claim will be adjusted at the completion of the audit and results in a $145.50 overpayment.
Sample 1044 – UMR disagrees with this finding. This claim is repriced correctly per the contract. Additional pricing breakdown of the allowed and payment were provided to CTI. The allowed amount of $13,529.90 is correct for this claim.
Sample 1045 – UMR agrees with this finding. An incorrect allowed amount applied to this claim. This claim will be adjusted at the completion of the audit and results in a $6366.77 overpayment.
Sample 1046 – UMR agrees with this error. An incorrect allowed amount applied to this claim. This claim will be adjusted at the completion of the audit and results in a $43.50 underpayment.
Sample 1072 – UMR disagrees with this finding. Both sample 1072 and 1073 allowable amount are correct. Sample 1072 pricing is based on a percentage of billed charges as outlined in the Other Medical Services Rate. Sample 1073 pricing is based on a percentage of billed charges as outlined in the Transplant Period Case Rate.
Sample 1095 – UMR agrees with this finding. An incorrect allowed amount applied to this claim. This claim will be adjusted at the completion of the audit and results in a $431.99 underpayment.

Paid Ineligible Procedure

Sample 1092 – UMR agrees with this finding. Authorization for services is not on file. The Customer First Representative should have denied this claim. This claim will be adjusted at the completion of the audit and results in a $11,837.00 overpayment.

Coinsurance Error

Sample 1096 – UMR agrees with this finding. Incorrect coinsurance applied to this outpatient surgery claim. This claim will be adjusted at the completion of the audit and results in a 4175.64 underpayment.

UMR is dedicated to improving the overall experience for the State of Nevada PEBP members and will continue to work diligently on addressing any issues highlighted by this review. Coaching and ongoing training is held with our dedicated processors. We continue to meet with the staff daily to go over quality reports, identifying trending errors, initiating refresher training for skill gaps, and using this data to improve the overall quality of the staff.
If you have any questions or concerns regarding our responses, please feel free to contact me at 715-841-7262.

Sincerely,

[redacted]
Sr. UMR External Audit Coordinator

Claim Technologies Incorporated representatives may from time to time provide observations regarding certain tax and legal requirements including the requirements of federal and state health care reform legislation. These observations are based on our good-faith interpretation of laws and regulations currently in effect and are not intended to be a substitute for legal or tax advice. Please contact your legal counsel and tax accountant for advice regarding legal and tax requirements.

CLAIM TECHNOLOGIES INCORPORATED

100 Court Avenue – Suite 306 • Des Moines, IA 50309
(515) 244-7322 • claimtechnologies.com