HEALTHCAREHORIZONS
CONSULTING GROUP, INC.

September 24, 2019

HEALTHCARE CLAIMS AUDIT REPORT (FINAL)

City of Virginia Beach – Optima

AUDIT PERIOD: JANUARY – DECEMBER 2018

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Executive Summary

The City of Virginia Beach engaged Healthcare Horizons to perform an audit of claims processed by Optima Health (Optima) for paid dates of January 2018 through December 2018. Healthcare Horizons received $94,303,791 in paid claims data from Optima and performed a full electronic review of claims processing. Of this total amount, $55,918,057 was paid for the school system and $38,385,734 for city employees. The purpose of the audit was to identify claim errors resulting in incorrect payments and to assess underlying conditions contributing to any errors identified. Healthcare Horizons delivered 160 targeted sample claims to Optima as potential errors (based on mining of the data) or higher-dollar items in need of review. A site visit was not necessary as Optima provided detailed feedback on all sample claim submissions with minimal follow-up questions required during the process.

Healthcare Horizons identified an agreed recovery amount of $56,543.45 from the sample claims, representing a minimal dollar percentage of errors given the overall size of the data set. The majority of sample findings are related to duplicates, the hearing aid benefit maximum, and ambulatory surgical center (ASC) pricing. The detailed results of all sample claims are presented in Appendix A. Based on the agreed in-sample findings, Healthcare Horizons queried the full claims population for additional claims with similar errors and no additional out-of-sample claims were identified for submission to Optima. Finally, Healthcare Horizons is citing $156,005.51 in disputed findings from the sample claims related to the administration of the Allowed Charge as defined in the Summary of Benefits.

The Optima responses to the draft audit report are incorporated into the report text by issue. Where appropriate, Healthcare Horizons has added a final audit comment to address the response.

Our findings for the audit are summarized below.

Issue	Site Visit Recovery Amount	Site Visit Disputed Amount
Duplicates	$21,452.42	$0.00
Benefit Maximum - Hearing Aid	$14,489.72	$0.00
ASC Pricing	$13,711.31	$0.00
Allowable Charge - In Network	$4,089.13	$0.00
Assistant Surgeon Pricing	$941.89	$0.00
Surgery Global	$911.27	$0.00
Pre-Admission Testing	$760.08	$0.00
Eligibility	$187.63	$0.00
Allowable Charge - Out of Network	$0.00	$156,005.51
Totals	**$56,543.45**	**$156,005.51**

City

Issue	Site Visit Recovery Amount	Site Visit Disputed Amount
Duplicates	$18,284.49	$0.00
Benefit Maximum - Hearing Aid	$3,244.34	$0.00
ASC Pricing	$2,577.60	$0.00
Allowable Charge - In Network	$4,089.13	$0.00
Assistant Surgeon Pricing	$941.89	$0.00
Surgery Global	$105.58	$0.00
Pre-Admission Testing	$639.38	$0.00
Allowable Charge - Out of Network	$0.00	$60,946.56
Totals	**$29,882.41**	**$60,946.56**

Schools

Issue	Site Visit Recovery Amount	Site Visit Disputed Amount
Duplicates	$3,167.93	$0.00
Benefit Maximum - Hearing Aid	$11,245.38	$0.00
ASC Pricing	$11,133.71	$0.00
Surgery Global	$805.69	$0.00
Pre-Admission Testing	$120.70	$0.00
Eligibility	$187.63	$0.00
Allowable Charge - Out of Network	$0.00	$95,058.95
Totals	**$26,661.04**	**$95,058.95**

Process Overview

Healthcare Horizons systematically reviews 100% of claims payments by the administrator on behalf of our clients via our proprietary electronic claims edits. A series of standard algorithms are utilized to identify potential areas of claims overpayments in areas such as eligibility, pricing, duplicates and medical edits. In addition, customized queries are created specific to each client based on variable factors such as benefits design.

Based on the results of our electronic analysis, Healthcare Horizons targets areas with significant overpayment potential based on the dollar amount and our experience with the categories in question. Many areas are resolved by Healthcare Horizons without inclusion in the claims sample due to low findings from the electronic analysis or our determination that the claims flagged are exceptions rather than errors. For the areas that warrant additional research, a sample of claims is selected for review during the site visit with the administrator. Within each category, Healthcare Horizons strives to select a sample that is representative of all claims identified for the particular issue and covers significant potential errors. The goal of the site visit is to work with the administrator to verify the presence of an error on each claim and to solidify the logic used to identify the claims for full reports. Healthcare Horizons recommends the delivery of additional claims beyond the site visit sample for review and recovery by the administrator if warranted by the site visit findings. For example, if Healthcare Horizons and the administrator agreed that nineteen of twenty eligibility claims were recoverable overpayments, Healthcare Horizons would deliver a full report from the entire data set meeting the same criteria.

Once an agreed listing of overpaid claims has been identified and placed into recovery by the administrator, Healthcare Horizons monitors the collections process to a point of completion that is satisfactory to both Healthcare Horizons and our client.

Site Visit Selection

The following chart details the composition of the site visit claims selection as well as the errors identified during the site visit.

Issue	Audit Items	Recovery		Disputed	
		Items	Amount	Items	Amount
Duplicates - Claim Level	10	2	$644.58	0	$0.00
Duplicates - Line Level	22	5	$20,807.84	0	$0.00
Eligibility - After Termination	2	2	$187.63	0	$0.00
Eligibility - Not on File	3	0	$0.00	0	$0.00
Other Insurance	6	0	$0.00	0	$0.00
ESRD	8	0	$0.00	0	$0.00
Assistant Surgeon Pricing	2	1	$941.89	0	$0.00
Assistant Surgeon Not Allowed	1	0	$0.00	0	$0.00
ASC Pricing	12	3	$13,711.31	0	$0.00
Home Health During Inpatient	2	0	$0.00	0	$0.00
Readmissions	6	0	$0.00	0	$0.00
Outpatient with Admission	10	0	$0.00	0	$0.00
Pre-Admission Testing	8	4	$760.08	0	$0.00
Surgery Global	16	8	$911.27	0	$0.00
Optima Pricing	5	0	$0.00	0	$0.00
PHCS Pricing	3	0	$0.00	0	$0.00
Transfer Pricing	4	0	$0.00	0	$0.00
Allowable Charge - In Network	1	1	$4,089.13	0	$0.00
Allowable Charge - Out of Network	10	0	$0.00	8	$156,005.51
Benefit Maximum - Hearing Aid	21	21	$14,489.72	0	$0.00
Benefit Exclusion - Dental	1	0	$0.00	0	$0.00
Benefit Exclusion - Vision	7	0	$0.00	0	$0.00
Totals	**160**	**47**	**$56,543.45**	**8**	**$156,005.51**

Recoverable Findings

Optima has effective system edits in place to prevent duplicate payment errors. Healthcare Horizons performs several queries to identify potential duplicate payments, and our initial analysis yielded a small volume of potential duplicates that were all submitted in the sample selection. Optima agreed with three duplicate payment errors totaling $2,723.15 (audit items 2, 4, and 27) with a root cause of manual processor error.

> ***Optima's Response: Duplicate Claim Errors***
>
> *Agreed, for the three duplicate claims identified; education was provided to the claims processors. Optima will continue to work with the Claims Department to enhance their knowledge on how to accurately process these claims.*

A minimal number of recoverable claims were identified due to retroactive eligibility terminations. Healthcare Horizons utilized eligibility data provided by Optima to test coverage for all claims in the data set, and only two claims were identified as paid outside of eligibility effective dates (audit items 33 and 34 for $187.63). In each instance, a retroactive eligibility termination had occurred. Based on the limited findings, our impression is that the City is sending terminations timely and that Optima is identifying and recovering any claims impacted by retroactive terminations.

> ***Optima's Response:***
>
> *Agreed, for the two claims identified; education was provided to the Recovery Department.*

A single overpayment was identified for incorrect assistant surgeon pricing. When it is determined that an assistant surgeon is required for a surgical procedure, the provider is normally reimbursed at a reduced percentage of the full fee schedule rate. Healthcare Horizons tests all assistant surgeon payments by comparing the allowed amount to the full fee schedule rate present on the primary surgeon claim to identify possible missed assistant surgeon reductions. A single claim was identified and agreed as an overpayment for this issue (audit item 53 for $941.89). As all other assistant surgeon claims in the data set appeared to price correctly, our impression is that a manual or one-off error occurred on this claim.

> ***Optima's Response:***
>
> *Agreed, for the one error received; feedback and refresher training has been provided to the responsible claims processor.*

Similar to prior audits, overpayments were identified for ambulatory surgical centers due to the incorrect payment of secondary surgical procedures. For certain facilities, the Optima contract only allows payment for the primary surgical procedure with all other lines denied for payment. Healthcare Horizons identified three overpayments totaling $13,711.31 for this issue (audit items 56, 57, and 64). While the number of claims has been minimal, this error has been identified in prior Optima audits. Finally, Healthcare Horizons requests that Optima confirm the overpayment amounts for audit items 56 and 57 as our figures differ slightly.

Optima's Response:

Agreed, Optima Health agrees with the assigning of this error. This was a processing error and the responsible claims processors has received education and additional training.

Healthcare Horizons' Final Comment: We will continue to monitor this issue on future audits and will utilize our original estimated overpayment amounts for the claims identified.

A small number of pre-admission testing claims were paid in error as the provider contract prohibits separate payment of this testing prior to a planned inpatient admission. It is common for hospital contracts to state that pre-admission testing services (such as lab, X-ray, or EKG) are not to be paid separately from the subsequent inpatient reimbursement. Healthcare Horizons identified four claims paid in error for this issue for a total of $760.08 (audit items 85, 87, 89, and 91). Note that all potential errors were submitted in the sample selection.

Optima's Response:

Agreed, Optima agrees with the assigning of these errors as pre-op was within the 10 day window of the facility charges. We are currently working with System Administration to identify these claims to auto deny in the system which will be driven by the diagnosis. We expect this change to be implemented, barring any unforeseen barriers, by end of year. In the interim, the claims will continue to be monitored through a manual audit conducted by Shared Services.

Healthcare Horizons' Final Comment: We will utilize future testing to ensure the system enhancement by Optima is effective.

Healthcare Horizons identified incorrect separate payments for physician evaluations that should be inclusive of the global surgery rate. For many surgical procedures the fee for the professional surgery claim is inclusive of any visits that occur one day prior to the surgery or up to 90 days after the surgery (global period) for follow-ups. Optima agreed with eight overpayments for this issue totaling $911.27 on the sample claims selection (audit items 93, 95, 97, 99, 101, 103, 105, and 107). Healthcare Horizons notes that all errors were for pre-operative evaluations so Optima may consider this when evaluating for root cause correction.

Optima's Response:

After additional review Optima disagrees with the assigning of errors 93, 95, 97, 99, 101, 103, 105, and 107*. At the time of the audit, no surgical claims were on file, identifying services were global. After additional review, these sample claims are now recoverable. Shared services will evaluate conducting an additional audit to capture these scenarios in an effort to recoup any overpayments. Once we receive approval from Virginia Beach, we will forward the recommended claims for review and recovery.*

Healthcare Horizons' Final Comment: While Optima disputes an error on these claims, there is agreement that the claims are recoverable. We recommend that the City instruct Optima to recover these claims as there will be no adverse member impact.

Based on clarification from prior audits, Healthcare Horizons identified recoverable claims related to the hearing aid benefit maximum. The maximum benefit for hearing aids is $1,250 per ear every 36 months. Based on prior audit findings, it was determined that Optima was not including charges related to fitting, molding, dispensing, and repair of hearing aids in the maximum. Based on review of the hearing aid rider in effect, it was determined that these additional charges should be included in the benefit maximum. For the 2018 audit period, Healthcare Horizons identified 21 cases in which the member had exceeded the maximum with a total overpayment of $14,489.72 (audit items 132-152). Per the Optima response, the Summary of Benefits was updated as of 1/1/2019 to specify that fitting, molding, dispensing, and repair are included in the $1,250 maximum per ear. Optima further commented that the group had not requested recovery for claims prior to 1/1/2019. We request that the City provide direction on whether 2018 claims should be recovered as collections activity will likely result in adverse member impact.

Optima's Response:

Agreed, Optima Health agrees direction needs to be given on recovery of claims prior to 1/1/19. Additionally we agree if recovery efforts are required, that this would have a negative impact on members.

Healthcare Horizons' Final Comment: Given the Optima error in benefit setup, we recommend that Optima consider a direct credit of $14,489.72 to settle these claims.

Disputed Findings

Healthcare Horizons requests a second review for duplicate payments that are likely recoverable. For audit items 12, 25, 30, and 32, Healthcare Horizons is disputing duplicate payments totaling $18,729.27 and the details are as follows:

Audit Item	Optima Response	HH Position	Amount
12	Different provider ID	Provider name is the same	$429.00
25	Different provider ID	Same DME paid twice	$444.78
30	Different provider ID	Same DME paid twice	$288.03
32	Different provider ID	Same chemotherapy paid twice	$17,567.46

The Optima responses for the items above included "system will not recognize as a duplicate" and "provider should have billed as a corrected claim or reconsideration." While we agree that provider billing errors contributed to these duplicate payments, our position is that the claims are recoverable on behalf of the group. We request that Optima provide feedback on whether recovery is warranted on these claims.

> ***Optima's Response:***
> *Disagree, Optima Health agrees the claims are recoverable but does not agree with assigning this as an error, due to it being a provider billing error. Optima's position is that these amounts are recoverable and will wait on direction from the group before proceeding with recovery efforts*
>
> **Healthcare Horizons' Final Comment:** Per the Optima response, these claims are recoverable; therefore, all applicable charts will be updated to reflect recoverable findings. As no adverse member impact will occur, the City should instruct Optima to adjust these claims. Finally, Optima should consider enhanced system edits to capture duplicate payments for the same services due to provider billing errors.

Healthcare Horizons requests clarification on an in-network professional claim that was not limited to the Allowable Charge per the plan design. The Benefit Information Guide defines Allowable Charge as follows:

> ***Allowable Charge*** *is the amount Optima Health determines should be paid to a Provider for a Covered Service. When You use In-Network benefits from Plan Providers Allowable Charge is the Provider's contracted rate with Optima Health or the Provider's actual charge for the service, whichever is less. Plan Providers accept this amount as payment in full.*

Healthcare Horizons raised this issue on prior audits and our understanding is that the language above only applies to professional or physician claims as it is common for facility contracts to include case rates that are not

subject to lesser of billed charges. In testing in-network Allowable Charge for professional providers, Healthcare Horizons submitted a single claim for an independent lab with billed charges of $310.00 and a payment of $4,399.13. The Optima response simply stated that the laboratory services were paid at a case rate which is uncommon based on our experience. We request that Optima provide additional details on both the pricing of this claim as well as the application of Allowable Charge per the plan design. Pending further information, we are disputing audit item 121 for $4,089.13.

> ***Optima Response:***
> *After additional review and root cause analysis, we agree with the assigning of this error. There was an identified set up issue within the system logic at the time the claim was processed. That issue has since been resolved and the claim has been corrected.*
>
> **Healthcare Horizons' Final Comment:** Based on the updated response, we have updated all applicable charts to reflect an agreed recovery amount of $4,089.13 for this claim.

Optima is not administering the Allowable Charge language present in the plan design for out-of-network claims. Regarding the Allowable Charge limit for out-of-network claims, the Benefit Information Guide states the following:

> *When You use Out-of-Network benefits from Non-Plan Providers Allowable Charge may be a negotiated rate; or if there is no negotiated rate Allowable Charge is Optima Health's In-Network contracted rate for the same service performed by the same type of Provider or the Provider's actual charge for the service, whichever is less. Non-Plan Providers may not accept this amount as payment in full. If You use a Non-Plan Provider who charges more than our allowable amount the Provider may balance bill You for the difference. You will have to pay the difference to the Provider in addition to Your Copayment or Coinsurance amount. Charges from Non-Plan Providers will be higher than the Plan's Allowable Charge so You will usually pay more out of pocket when You use Out of Network benefits.*

In addition, the Benefit Information Guide specially address emergency cases:

> *Members who receive Emergency Services from Non-Plan Providers may be responsible for charges in excess of what would have been paid had the Emergency Services been received from Plan Providers.*

In testing claims for this issue, Healthcare Horizons selected several out-of-network claims allowed at full billed charges and requested that Optima address the Allowable Charge limitation described above. In general, Optima responded that the claims were allowed at full billed charges to prohibit balance billing situations for the member.

In addition, Optima noted that several of the claims were for emergent situations. We understand that the City and Optima are evaluating plan intent related to this issue. Pending additional clarification or direction from the City, Healthcare Horizons is disputing the entire paid amount of $156,005.51 on the out-of-network claims allowed at full billed charges (audit items 122, 123, 124, 125, 126, 128, 130, and 131).

Optima Response Out of Network Allowable Charge:

Optima disagrees with the assigning of this error. As of 4/2019, Optima received clarification from the group and documents were retroactively updated effective 1.1.19 to reflect the group's intent. These changes were not completed during this audit period. See below the revised language:

***ALLOWABLE CHARGE** is the amount the Plan determines will be paid to a Provider for a Covered Service. When you receive Covered Services from an In-Network Physician the Allowable Charge is the lesser of: (1) the Physician's contracted rate with the Plan or its third party administrator or (2) the Physician's actual charge for the Covered Service. When you receive Covered Services from an In-Network facility the Allowable Charge will be the facility's contracted rate with Plan. In-Network Providers will accept our Allowable Charge as payment in full. You will be responsible for any applicable In-network Deductible, Copayment or Coinsurance amounts. When you use Out-of-Network benefits from Non-Plan Providers the Allowable Charge may be a negotiated rate; or if there is no negotiated rate the Allowable Charge is Optima's In-Network contracted rate for the same service performed by the same type of Provider or the Provider's actual charge for the service, whichever is less.*

Medically Necessary Covered Services provided by a Non-Plan Provider during an authorized Admission to a Plan Facility, will be covered under In-Network Benefits. Emergency Care You get Out-of-Network from a Non-Plan Provider will be covered at the In-Network Copayment or Coinsurance level. Cost sharing amounts you pay out of pocket for Out-of-Network Emergency Care will accumulate toward Your Plan's In-Network Deductible and Maximum Out-of-Pocket amounts. However, you may have to pay the difference between what the Non-Plan Provider charges and the Plan's Allowable Charge in addition to your in-network copayment, coinsurance and deductible amounts. Participants should notify Optima immediately if a balance bill is received.

All other Covered Services You receive from Non-Plan Providers will be Covered under Out of Network Benefits. However, You may have to pay the difference between what the Non-Plan Provider charges and the Plan's Allowable Charge in addition to Your Out-of-Network Copayment, Coinsurance and Deductible amounts. When you use an Out-of-Network Provider, the Allowable Charge is the lesser of the usual and customary rate for the service as determined by the Plan. Amounts you pay as a result of balance billing will not accumulate toward any Deductible and Maximum Out-of-Pocket amounts.

Cont. Optima Response: *Optima was not directed by the group to make any recovery efforts for claims prior to 1.1.19. We request the city provide direction on whether claims should be recovered as this could produce negative impacts to the member.*

Healthcare Horizons' Final Comment: The language cited above by Optima, effective 1/1/2019, does provide clarification on the administration of the Allowable Charge benefit maximum for out-of-network services. The City should instruct Optima on whether to adjust 2018 paid claims as these recovery attempts will result in adverse member impact.

Informational Findings

Healthcare Horizons requests confirmation of dollars returned to the City for a number of claims cited as already adjusted by Optima. For several claims presented by Healthcare Horizons in the duplicates and ASC pricing categories, Optima noted that the claim was already reversed and denied. For the items listed below, we request that Optima supply documentation to confirm return of the overpaid dollars to the City. Note that for the 2018 adjustments below, Healthcare Horizons does not show any negative activity in the claims data.

Audit Item	Issue	Amount	Optima Adjustment Year
7	Duplicates	$27,211.00	2018
13	Duplicates	$5,366.00	2018
15	Duplicates	$31,656.00	2019
17	Duplicates	$21,458.00	2019
19	Duplicates	$6,861.11	2019
21	Duplicates	$9,546.00	2019
59	ASC Pricing	$6,143.80	2019
60	ASC Pricing	$2,859.40	2019
61	ASC Pricing	$5,718.80	2019
63	ASC Pricing	$2,523.00	2019

> **Healthcare Horizons' Final Comment:** Optima provided documentation to show collection of the above claims in 2019. Healthcare Horizons will utilize 2019 audit data to confirm these recoveries.

Healthcare Horizons identified several members on dialysis due to end stage renal disease (ESRD) with no Medicare coverage information on file with Optima. Healthcare Horizons suggests that the City and Optima work to confirm the dialysis start date and the resulting Medicare primary effective date for the members identified on audit items 44, 46, 47, 50, and 51. In addition, the Optima feedback indicated incomplete Medicare coverage information for the member submitted as audit item 49 which needs to be resolved. If it is determined that Medicare coverage is primary for any claims paid in 2018, Healthcare Horizons will deliver additional claims reporting to Optima for review and recovery.

> **Healthcare Horizons' Final Comment:** The City reviewed the members in question and no follow-up is required at this time.

Conclusion

Healthcare Horizons appreciates the opportunity to perform this claims audit on behalf of The City of Virginia Beach. The overall results continue to represent above average performance by Optima in the administration of healthcare claims. We would also like to recognize the cooperation exhibited by the entire Optima team during this process.

We recommend the following actions in order to maximize the effectiveness of the audit:

- Optima should initiate recovery on all agreed overpayments and report any negative potential member impact to both Healthcare Horizons and the City prior to any collections activity.
- Optima should engage in discussions with the City to clarify plan intent for Allowable Charge in 2018.
- Optima should consider a direct credit to the City to settle overpayments related to the hearing aid benefit maximum.
- The City should instruct Optima to pursue recovery on the surgery global and duplicate payments categories as no adverse member impact will occur.

Definitions - Areas of Testing

Duplicate Claims

Healthcare Horizons runs a series of duplicate claim edits across the claims data set to identify claims that have been billed and paid more than once. Healthcare Horizons identifies duplicate claims at both the claim level and individual procedure level. The duplicate claim queries vary with matches and mismatches on fields such as patient, provider, service date, billed charge, and procedure code. While most clients would expect duplicate claims to be rare, they are quite common in healthcare claims payments and usually result in recoveries on every project conducted by Healthcare Horizons.

Eligibility

In addition to claims data, Healthcare Horizons requests a full eligibility file from the administrator to validate coverage on the service date. Employer groups often submit retroactive terminations to the administrator, resulting in an opportunity for overpayments unless the administrator has a process in place to identify and recover these claims. Every administrator should have a process for identifying and recovering claims affected by a retroactive termination as they are common in the claims industry. In addition to claims paid after the termination date, Healthcare Horizons identifies claims paid during a gap in coverage and claims paid without an eligibility record on file.

Contract Audit

Healthcare Horizons normally requests a review of the signed provider contracts for the top 30 utilized hospitals for each group. While on-site at the administrator, Healthcare Horizons uses the claims data to test pricing and other contractual terms present in the contract for all claims paid to that provider in the claims data set. Other terms in the contract may include readmissions, outpatient services on the day of admission, pre-admission testing, timely filing, and transfers.

Some administrators do not allow this type of comprehensive audit of provider contracts in which Healthcare Horizons tests all claims according to the terms present in the contracts. If this is not made available, Healthcare Horizons selects site visit sample claims to test pricing and the following items on a more limited basis.

- Readmissions - If provider contracts have Diagnosis-Related Group (DRG) case rate reimbursement, readmissions to treat the same illness may not be allowed if the patient is readmitted within a certain number of days. This prevents facilities from being compensated a greater amount for an inappropriate discharge.

- Outpatient Services on Day of Admission - If a patient receives outpatient services such as an emergency room visit, and is later admitted on the same day, these charges should be combined with the inpatient claim

according to most provider contracts. If the provider is reimbursed based on per diems or DRG case rate, no additional payment is made for the outpatient services.

- Pre-admission Testing - If a patient undergoes tests related to a scheduled admission within 24 to 72 hours, these services may be included with the inpatient claim and not paid in addition to the inpatient stay for per diem or DRG case rate reimbursement. Examples of these tests include lab work and a baseline chest x-ray.

- Timely Filing - Provider contracts often state that claims must be submitted to the administrator within a certain time period (such as one year) to be eligible for payment. Otherwise the claim should be denied and the patient is held harmless.

- Transfers - Provider contracts based on DRG case rate inpatient reimbursement often contain special pricing if the patient is transferred to another acute care hospital for treatment. Since the patient was transferred, the initial hospital is not due the full case rate amount to treat the illness. Transfer payments are often based on a specific per diem rate in the contract.

Assistant Surgeon

In some circumstances, a procedure may require the services of an assistant in addition to the primary surgeon. Healthcare Horizons tests two common areas of overpayments for assistant surgeons: pricing and coding. Assistant surgeons usually receive 20-25% of the normal fee schedule rate for the codes used with assistant modifiers. Healthcare Horizons utilizes the claims data to identify the payment to the primary surgeon and then isolates assistant surgeon claims paid greater than 20-25% of this rate. In our experience, this analysis yields a high rate of assistant surgeon lines that are overpaid. In addition, The Center for Medicare Services produces a publicly available listing of procedure codes for which it does not allow a payment for assistant surgery. These are services that, by their nature, do not lend themselves to requiring an assistant. Healthcare Horizons identifies assistant surgeon claims for these procedures as possible overpayments. Although this Medicare guideline is not a requirement that must be followed by commercial insurance carriers, most administrators should have some similar list of codes not payable for assistants.

Multiple Procedure Reductions

When multiple services are performed in the same session, secondary procedures are priced at a reduced percentage (usually 50%) of the normal contract rate to account for economies and efficiency gained by not having to duplicate preparation of the patient for each procedure. Healthcare Horizons flags claims that may have missed this standard discount by reviewing the secondary procedure allowance in relation to the primary procedure allowance for the session of care.

Benefits

Healthcare Horizons creates customized queries to model the benefits present in the summary plan documents (SPDs) provided by the employer group. Likely areas of testing for benefits are application of copayments and coinsurance, annual dollar or visit maximums, non-covered benefits, coordination of benefit rules, and other specific items flagged by our auditors as potential errors. A Healthcare Horizons auditor reviews the SPDs in full for each claims audit and selects the benefit areas where testing is possible. Some benefits do not lend themselves to systematic testing in the data and can only be reviewed on selected sample claims.

Pricing

Healthcare Horizons takes steps to verify accurate pricing of certain claims in the data set such as high dollar, no discount, and those with variability in pricing. These steps are described further below.

Healthcare Horizons selects the highest paid claims in the data set to ensure correct pricing by the administrator. Often these claims are more complex, which raises the possibility of error.

Claims priced at billed charges with no discount are targeted for pricing verification. Given the broad networks of the larger administrators, as well as the availability of national rental networks, the majority of claims should receive some type of discount. Healthcare Horizons verifies that pricing was not missed in error on higher paid claims.

Healthcare Horizons profiles top facilities and establishes payment patterns and trends. Claims that fall outside of the normal patterns will be questioned for payment errors. This area is especially important if a contract audit is not available as part of the audit process.

Since Healthcare Horizons has found that pricing of claims is one of the largest categories of errors at many administrators, we take aggressive steps to identify as many potential errors as possible for detailed review.

Other Insurance

The presence of other primary insurance usually reduces the payment due by the employer group if they are secondary. In some cases, a secondary policy will pay as primary, such as when primary benefits are exhausted or the primary policy does not cover a particular service. Healthcare Horizons utilizes the claims data to identify claims paid as primary that may have other insurance based on the following categories:

- **Other Claims Paid as Secondary** – Healthcare Horizons utilizes the claims data to create a date range for each patient where claims have been paid as secondary based on the presence of a coordination of benefits (COB) savings amount. Any claims paid within this date range without a COB amount may be questioned for the presence of other primary coverage.

- **ESRD** – After 33 months of treatment for ESRD, Medicare automatically becomes the primary insurer for the patient. Healthcare Horizons identifies patients with an extended period of treatment for ESRD to ensure the administrator is correctly tracking the Medicare primary effective date.
- **COBRA** – While exceptions do apply, Medicare should be the primary payer for members on COBRA coverage that are age-eligible for Medicare.
- **Retirees** – Medicare should be primary for members, age 65 and higher, on a retiree plan.

Healthcare Horizons also scrutinizes claims that are paid as secondary with a paid amount higher than that of the primary carrier. Normally, the secondary payment is lower than the primary plan payment as it likely only covers remaining member responsibility after the primary payment.

Fraud

Healthcare Horizons analyzes provider billing patterns to detect possible instances of fraud. While these cases may prove difficult to recover, it is important to identify these providers and stop future payments.

High Units

Healthcare Horizons queries the claims data for unit counts that are abnormally high for the procedure code billed. An error in units may cause the claim to default to billed charges as the fee schedule is multiplied by an incorrect unit count.

Medical Edits

Healthcare Horizons applies medical edits to the claims data to identify mutually exclusive procedures and cases of procedure unbundling. Mutually exclusive edits identify procedure combinations that cannot be reasonably performed on the same patient on the same day. Unbundling occurs when a provider bills multiple component codes versus a single comprehensive code, often resulting in higher reimbursement. Payers have much discretion over which medical edits to apply as there is not a commonly accepted group of these throughout the industry; therefore, Healthcare Horizons is generally looking for a reasonable application of a set of edits and questions selected claims that seem to be clear errors.

Overlapping Inpatient

Healthcare Horizons identifies cases where patients have claims reporting that they are inpatient at different facilities for the same service date. These are often the result of provider billing errors or manual data entry mistakes.

Subrogation

Healthcare Horizons queries the claims data for possible subrogation opportunities where third party liability (TPL) may exist. A common example is medical services related to an auto accident where the auto insurer is liable for a portion of the medical claims. These claims are identified via accident-related diagnosis codes.

Hospital Mistakes

Many payers across the country have adopted policies to investigate and subsequently deny payment for hospital mistakes and avoidable conditions, such as objects left in patient during surgery, fractures incurred in the hospital, blood incompatibility, and certain types of infections. Healthcare Horizons examines the claims data for these types of hospital errors and expects recovery opportunities for these errors as more administrators adopt such policies.

Cosmetic Surgery

Healthcare Horizons maintains a listing of procedure codes that may be considered as cosmetic, but judgments on these claims are highly subjective. Healthcare Horizons is usually looking at the total paid for these types of codes to make sure it is not excessive. If any of these claims are selected for the sample, we request that the administrator provide evidence that the claim was considered for medical review and that reasonable review took place. Medical necessity issues such as cosmetic surgery are not areas that result in significant recovery, but can be issues that our clients want to address proactively for future cost savings.

Reinsurance

If the employer group has stop loss or reinsurance coverage, Healthcare Horizons utilizes the claims data to identify members that should have resulted in a credit due back to the group. Healthcare Horizons verifies with the administrator that the credits have been issued to the group.

Appendix A – Site Visit Detail

Audit Item	Issue	Recovery	Disputed	Comment	Group
1	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 1/2 combo	Schools
2	Duplicates - Claim Level	$464.00	$0.00	Agreed manual error	Schools
3	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 3/4 combo	Schools
4	Duplicates - Claim Level	$180.58	$0.00	Agreed manual error	Schools
5	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 5/6 combo	Schools
6	Duplicates - Claim Level	$0.00	$0.00	Recovered prior to audit	Schools
7	Duplicates - Claim Level	$0.00	$0.00	Recovered prior to audit	Schools
8	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 7/8 combo	Schools
9	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 9/10 combo	Schools
10	Duplicates - Claim Level	$0.00	$0.00	Recovered prior to audit	Schools
11	Duplicates - Line Level	$0.00	$0.00	Correct claim for 11/12 combo	City
12	Duplicates - Line Level	$429.00	$0.00	Optima cites different TIN - same physician and service (agreed as recoverable)	City
13	Duplicates - Line Level	$0.00	$0.00	Recovered prior to audit	Schools
14	Duplicates - Line Level	$0.00	$0.00	Correct claim for 13/14 combo	Schools
15	Duplicates - Line Level	$0.00	$0.00	Recovered prior to audit	City
16	Duplicates - Line Level	$0.00	$0.00	Correct claim for 15/16 combo	City
17	Duplicates - Line Level	$0.00	$0.00	Recovered prior to audit	City
18	Duplicates - Line Level	$0.00	$0.00	Correct claim for 17/18 combo	City
19	Duplicates - Line Level	$0.00	$0.00	Recovered prior to audit	Schools
20	Duplicates - Line Level	$0.00	$0.00	Correct claim for 19/20 combo	Schools
21	Duplicates - Line Level	$0.00	$0.00	Recovered prior to audit	City
22	Duplicates - Line Level	$0.00	$0.00	Correct claim for 21/22 combo	City
23	Duplicates - Line Level	$0.00	$0.00	Correct claim for 23/24 combo	City
24	Duplicates - Line Level	$0.00	$0.00	Recovered prior to audit	City
25	Duplicates - Line Level	$444.78	$0.00	Optima cites billing error under different provider IDs - same DME paid twice (agreed as recoverable)	Schools
26	Duplicates - Line Level	$0.00	$0.00	Correct claim for 25/26 combo	Schools
27	Duplicates - Line Level	$2,078.57	$0.00	Agreed duplicate error	Schools
28	Duplicates - Line Level	$0.00	$0.00	Correct claim for 27/28 combo	Schools
29	Duplicates - Line Level	$0.00	$0.00	Correct claim for 29/30 combo	City
30	Duplicates - Line Level	$288.03	$0.00	Optima cites billing error under different provider IDs - same DME paid twice (agreed as recoverable)	City
31	Duplicates - Line Level	$0.00	$0.00	Correct claim for 31/32 combo	City
32	Duplicates - Line Level	$17,567.46	$0.00	Optima cites billing error under different provider IDs - same chemotherapy paid twice (agreed as recoverable)	City
33	Eligibility - After Termination	$129.93	$0.00	Recoverable retro-term	Schools
34	Eligibility - After Termination	$57.70	$0.00	Recoverable retro-term	Schools
35	Eligibility - Not on File	$0.00	$0.00	Member eligible	Schools
36	Eligibility - Not on File	$0.00	$0.00	Member eligible	Schools
37	Eligibility - Not on File	$0.00	$0.00	Member eligible	City
38	Other Insurance	$0.00	$0.00	Medicare primary 9/1/18 (DOS prior)	Schools
39	Other Insurance	$0.00	$0.00	Medicare primary 5/1/18 (DOS prior)	City
40	Other Insurance	$0.00	$0.00	Medicare primary 3/1/18 (DOS prior)	City
41	Other Insurance	$0.00	$0.00	Medicare primary 10/1/17 (DOS prior)	Schools
42	Other Insurance	$0.00	$0.00	Medicare primary 10/1/17 (DOS prior)	Schools
43	Other Insurance	$0.00	$0.00	Optima primary	Schools
44	ESRD	$0.00	$0.00	No ESRD information on file - need inquiry	Schools
45	ESRD	$0.00	$0.00	Medicare primary 2/1/20 (DOS prior)	City
46	ESRD	$0.00	$0.00	No ESRD information on file - need inquiry	City
47	ESRD	$0.00	$0.00	No ESRD information on file - need inquiry	Schools
48	ESRD	$0.00	$0.00	Medicare primary 11/1/19 (DOS prior)	City
49	ESRD	$0.00	$0.00	Need to verify Medicare primary effective date	Schools
50	ESRD	$0.00	$0.00	No ESRD information on file - need inquiry	City
51	ESRD	$0.00	$0.00	No ESRD information on file - need inquiry	City

Audit Item	Issue	Recovery	Disputed	Comment	Group
52	Assistant Surgeon Pricing	$0.00	$0.00	Primary surgeon - informational	City
53	Assistant Surgeon Pricing	$941.89	$0.00	Agreed error	City
54	Assistant Surgeon Not Allowed	$0.00	$0.00	Recovered prior to audit	City
55	ASC Pricing	$0.00	$0.00	Priced correctly	Schools
56	ASC Pricing	$2,577.60	$0.00	Agreed error	City
57	ASC Pricing	$9,764.36	$0.00	Agreed error	Schools
58	ASC Pricing	$0.00	$0.00	Recovered prior to audit	City
59	ASC Pricing	$0.00	$0.00	Recovered prior to audit	City
60	ASC Pricing	$0.00	$0.00	Recovered prior to audit	Schools
61	ASC Pricing	$0.00	$0.00	Recovered prior to audit	City
62	ASC Pricing	$0.00	$0.00	Priced correctly	City
63	ASC Pricing	$0.00	$0.00	Recovered prior to audit	Schools
64	ASC Pricing	$1,369.35	$0.00	Agreed error	Schools
65	ASC Pricing	$0.00	$0.00	Priced correctly	City
66	ASC Pricing	$0.00	$0.00	Priced correctly	Schools
67	Home Health During Inpatient	$0.00	$0.00	Inpatient claim - informational	Schools
68	Home Health During Inpatient	$0.00	$0.00	Correct - scheduled nutrition service post discharge	Schools
69	Readmissions	$0.00	$0.00	Readmission greater than 72 hours - separately payable	Schools
70	Readmissions	$0.00	$0.00	Readmission greater than 72 hours - separately payable	Schools
71	Readmissions	$0.00	$0.00	Readmission greater than 72 hours - separately payable	Schools
72	Readmissions	$0.00	$0.00	Readmission greater than 72 hours - separately payable	Schools
73	Readmissions	$0.00	$0.00	Readmission greater than 72 hours - separately payable	City
74	Readmissions	$0.00	$0.00	Readmission greater than 72 hours - separately payable	City
75	Outpatient with Admission	$0.00	$0.00	Member discharged to home after CT	Schools
76	Outpatient with Admission	$0.00	$0.00	Inpatient claim - informational	Schools
77	Outpatient with Admission	$0.00	$0.00	Member discharged to home after CT	City
78	Outpatient with Admission	$0.00	$0.00	Inpatient claim - informational	City
79	Outpatient with Admission	$0.00	$0.00	Different providers for outpatient and inpatient	City
80	Outpatient with Admission	$0.00	$0.00	Inpatient claim - informational	City
81	Outpatient with Admission	$0.00	$0.00	Member discharged to home after CT	City
82	Outpatient with Admission	$0.00	$0.00	Inpatient claim - informational	City
83	Outpatient with Admission	$0.00	$0.00	Member discharged to home after CT	Schools
84	Outpatient with Admission	$0.00	$0.00	Inpatient claim - informational	Schools
85	Pre-Admission Testing	$301.19	$0.00	Agreed error	City
86	Pre-Admission Testing	$0.00	$0.00	Inpatient claim - informational	City
87	Pre-Admission Testing	$113.60	$0.00	Agreed error	City
88	Pre-Admission Testing	$0.00	$0.00	Inpatient claim - informational	City
89	Pre-Admission Testing	$120.70	$0.00	Agreed error	Schools
90	Pre-Admission Testing	$0.00	$0.00	Inpatient claim - informational	Schools
91	Pre-Admission Testing	$224.59	$0.00	Agreed error	City
92	Pre-Admission Testing	$0.00	$0.00	Inpatient claim - informational	City
93	Surgery Global	$26.49	$0.00	Agreed error	Schools
94	Surgery Global	$0.00	$0.00	Surgery claim - informational	Schools
95	Surgery Global	$141.20	$0.00	Agreed error	Schools
96	Surgery Global	$0.00	$0.00	Surgery claim - informational	Schools
97	Surgery Global	$132.29	$0.00	Agreed error	Schools
98	Surgery Global	$0.00	$0.00	Surgery claim - informational	Schools
99	Surgery Global	$132.29	$0.00	Agreed error	Schools
100	Surgery Global	$0.00	$0.00	Surgery claim - informational	Schools
101	Surgery Global	$102.84	$0.00	Agreed error	Schools
102	Surgery Global	$0.00	$0.00	Surgery claim - informational	Schools
103	Surgery Global	$105.58	$0.00	Agreed error	City
104	Surgery Global	$0.00	$0.00	Surgery claim - informational	City
105	Surgery Global	$132.29	$0.00	Agreed error	Schools
106	Surgery Global	$0.00	$0.00	Surgery claim - informational	Schools
107	Surgery Global	$138.29	$0.00	Agreed error	Schools
108	Surgery Global	$0.00	$0.00	Surgery claim - informational	Schools

Audit Item	Issue	Recovery	Disputed	Comment	Group
109	Optima Pricing	$0.00	$0.00	Priced correctly - stop loss percent of charges	Schools
110	Optima Pricing	$0.00	$0.00	Priced correctly - DRG case rate plus stop loss	City
111	Optima Pricing	$0.00	$0.00	Priced correctly - transplant rate	Schools
112	Optima Pricing	$0.00	$0.00	Priced correctly - DRG case rate plus stop loss	Schools
113	Optima Pricing	$0.00	$0.00	Priced correctly - stop loss percent of charges	Schools
114	PHCS Pricing	$0.00	$0.00	Priced correctly - percent of charges	Schools
115	PHCS Pricing	$0.00	$0.00	Priced correctly - percent of charges	Schools
116	PHCS Pricing	$0.00	$0.00	Priced correctly - percent of charges	Schools
117	Transfer Pricing	$0.00	$0.00	Transfer rate not applicable	City
118	Transfer Pricing	$0.00	$0.00	Transfer rate not applicable	Schools
119	Transfer Pricing	$0.00	$0.00	Transfer rate not applicable	Schools
120	Transfer Pricing	$0.00	$0.00	Transfer rate not applicable	City
121	Allowable Charge - In Network	$4,089.13	$0.00	Professional claim not limited to billed charges	City
122	Allowable Charge - Out of Network	$0.00	$57,647.24	Allowable charge limitation not administered - Optima states provider unwilling to negotiate (ASC)	Schools
123	Allowable Charge - Out of Network	$0.00	$53,412.56	Allowable charge limitation not administered - Optima states payment made at billed to avoid member balance billing (air ambulance)	City
124	Allowable Charge - Out of Network	$0.00	$11,716.08	Allowable charge limitation not administered - Optima states payment made at billed to avoid member balance billing (professional surgeon)	Schools
125	Allowable Charge - Out of Network	$0.00	$11,708.34	Allowable charge limitation not administered - Optima states payment made at billed to avoid member balance billing (ASC)	Schools
126	Allowable Charge - Out of Network	$0.00	$7,534.00	Allowable charge limitation not administered - Optima states payment made at billed to avoid member balance billing (lab)	City
127	Allowable Charge - Out of Network	$0.00	$0.00	PHCS pricing	Schools
128	Allowable Charge - Out of Network	$0.00	$5,332.00	Allowable charge limitation not administered - Optima states payment made at billed to avoid member balance billing (professional surgeon)	Schools
129	Allowable Charge - Out of Network	$0.00	$0.00	Paid per letter of agreement	City
130	Allowable Charge - Out of Network	$0.00	$4,426.56	Allowable charge limitation not administered - Optima states payment made at billed to avoid member balance billing (ER)	Schools
131	Allowable Charge - Out of Network	$0.00	$4,228.73	Allowable charge limitation not administered - Optima states payment made at billed to avoid member balance billing (anethesia)	Schools
132	Benefit Maximum - Hearing Aid	$806.62	$0.00	Summary of Benefits clarified 1/1/19 to include fitting, molding, dispensing, and repair in limit. Group to determine if 2018 claims to be recovered.	Schools
133	Benefit Maximum - Hearing Aid	$225.30	$0.00	Summary of Benefits clarified 1/1/19 to include fitting, molding, dispensing, and repair in limit. Group to determine if 2018 claims to be recovered.	Schools
134	Benefit Maximum - Hearing Aid	$806.62	$0.00	Summary of Benefits clarified 1/1/19 to include fitting, molding, dispensing, and repair in limit. Group to determine if 2018 claims to be recovered.	Schools
135	Benefit Maximum - Hearing Aid	$822.26	$0.00	Summary of Benefits clarified 1/1/19 to include fitting, molding, dispensing, and repair in limit. Group to determine if 2018 claims to be recovered.	Schools
136	Benefit Maximum - Hearing Aid	$1,103.12	$0.00	Summary of Benefits clarified 1/1/19 to include fitting, molding, dispensing, and repair in limit. Group to determine if 2018 claims to be recovered.	Schools
137	Benefit Maximum - Hearing Aid	$736.62	$0.00	Summary of Benefits clarified 1/1/19 to include fitting, molding, dispensing, and repair in limit. Group to determine if 2018 claims to be recovered.	Schools
138	Benefit Maximum - Hearing Aid	$976.84	$0.00	Summary of Benefits clarified 1/1/19 to include fitting, molding, dispensing, and repair in limit. Group to determine if 2018 claims to be recovered.	Schools

Audit Item	Issue	Recovery	Disputed	Comment	Group
139	Benefit Maximum - Hearing Aid	$251.06	$0.00	Summary of Benefits clarified 1/1/19 to include fitting, molding, dispensing, and repair in limit. Group to determine if 2018 claims to be recovered.	City
140	Benefit Maximum - Hearing Aid	$300.00	$0.00	Summary of Benefits clarified 1/1/19 to include fitting, molding, dispensing, and repair in limit. Group to determine if 2018 claims to be recovered.	City
141	Benefit Maximum - Hearing Aid	$806.62	$0.00	Summary of Benefits clarified 1/1/19 to include fitting, molding, dispensing, and repair in limit. Group to determine if 2018 claims to be recovered.	Schools
142	Benefit Maximum - Hearing Aid	$176.32	$0.00	Summary of Benefits clarified 1/1/19 to include fitting, molding, dispensing, and repair in limit. Group to determine if 2018 claims to be recovered.	Schools
143	Benefit Maximum - Hearing Aid	$414.18	$0.00	Summary of Benefits clarified 1/1/19 to include fitting, molding, dispensing, and repair in limit. Group to determine if 2018 claims to be recovered.	Schools
144	Benefit Maximum - Hearing Aid	$1,083.12	$0.00	Summary of Benefits clarified 1/1/19 to include fitting, molding, dispensing, and repair in limit. Group to determine if 2018 claims to be recovered.	City
145	Benefit Maximum - Hearing Aid	$333.00	$0.00	Summary of Benefits clarified 1/1/19 to include fitting, molding, dispensing, and repair in limit. Group to determine if 2018 claims to be recovered.	City
146	Benefit Maximum - Hearing Aid	$1,083.12	$0.00	Summary of Benefits clarified 1/1/19 to include fitting, molding, dispensing, and repair in limit. Group to determine if 2018 claims to be recovered.	Schools
147	Benefit Maximum - Hearing Aid	$806.62	$0.00	Summary of Benefits clarified 1/1/19 to include fitting, molding, dispensing, and repair in limit. Group to determine if 2018 claims to be recovered.	Schools
148	Benefit Maximum - Hearing Aid	$867.26	$0.00	Summary of Benefits clarified 1/1/19 to include fitting, molding, dispensing, and repair in limit. Group to determine if 2018 claims to be recovered.	Schools
149	Benefit Maximum - Hearing Aid	$842.26	$0.00	Summary of Benefits clarified 1/1/19 to include fitting, molding, dispensing, and repair in limit. Group to determine if 2018 claims to be recovered.	Schools
150	Benefit Maximum - Hearing Aid	$336.00	$0.00	Summary of Benefits clarified 1/1/19 to include fitting, molding, dispensing, and repair in limit. Group to determine if 2018 claims to be recovered.	City
151	Benefit Maximum - Hearing Aid	$771.62	$0.00	Summary of Benefits clarified 1/1/19 to include fitting, molding, dispensing, and repair in limit. Group to determine if 2018 claims to be recovered.	Schools
152	Benefit Maximum - Hearing Aid	$941.16	$0.00	Summary of Benefits clarified 1/1/19 to include fitting, molding, dispensing, and repair in limit. Group to determine if 2018 claims to be recovered.	City
153	Benefit Exclusion - Dental	$0.00	$0.00	Accidental injury covered	Schools
154	Benefit Exclusion - Vision	$0.00	$0.00	Optima states as covered for medical condition	Schools
155	Benefit Exclusion - Vision	$0.00	$0.00	Optima states as covered for medical condition	Schools
156	Benefit Exclusion - Vision	$0.00	$0.00	Optima states as covered for medical condition	City
157	Benefit Exclusion - Vision	$0.00	$0.00	Optima states as covered for medical condition	Schools
158	Benefit Exclusion - Vision	$0.00	$0.00	Optima states as covered for medical condition	City
159	Benefit Exclusion - Vision	$0.00	$0.00	Optima states as covered for medical condition	Schools
160	Benefit Exclusion - Vision	$0.00	$0.00	Optima states as covered for medical condition	Schools
		$56,543.45	**$156,005.51**		