HEALTHCAREHORIZONS
CONSULTING GROUP, INC.

September 29, 2020

FINAL HEALTHCARE CLAIMS AUDIT REPORT

City of Virginia Beach – Optima

AUDIT PERIOD: JANUARY – DECEMBER 2019

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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 2019 through December 2019. Healthcare Horizons received $107,882,510.78 in paid claims data from Optima and performed a full electronic review of claims processing. Of this total amount, $65,328,356.96 was paid for the school system and $42,554,153.82 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 180 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 $74,420.40 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 ambulatory surgical center (ASC) pricing, coordination with other insurance, and duplicate payments. 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 resulting in the delivery of eight additional out-of-sample claims in the coordination with other insurance category (paid at $11,110.92). These additional out-of-sample claims are detailed in Appendix B. Finally, Healthcare Horizons is citing $138,592.25 in disputed findings from the sample claims with the majority related to the administration of the out-of-network allowable charge as defined in the plan document.

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 responses.

Our findings for the audit are summarized as follows.

Issue	Site Visit Recovery Amount	Site Visit Disputed Amount	Out-of-Sample Recovery Potential	Total Audit Potential (Excluding Disputed)
ASC Pricing	$48,696.51	$0.00	$0.00	$48,696.51
Other Insurance	$8,682.65	$0.00	$11,110.92	$19,793.57
Duplicates	$11,252.38	$0.00	$0.00	$11,252.38
Outpatient with Admission	$1,977.19	$0.00	$0.00	$1,977.19
Multiple Procedure Reductions	$1,100.62	$0.00	$0.00	$1,100.62
Pre-Admission Testing	$1,072.09	$0.00	$0.00	$1,072.09
Out-of-Network Allowable Charge	$781.50	$57,719.65	$0.00	$781.50
PHCS Pricing	$0.00	$80,872.60	$0.00	$0.00
Surgery Global	$857.46	$0.00	$0.00	$857.46
Totals	**$74,420.40**	**$138,592.25**	**$11,110.92**	**$85,531.32**

City

Issue	Site Visit Recovery Amount	Site Visit Disputed Amount	Out-of-Sample Recovery Potential	Total Audit Potential (Excluding Disputed)
ASC Pricing	$28,898.00	$0.00	$0.00	$28,898.00
Duplicates	$5,741.61	$0.00	$0.00	$5,741.61
Outpatient with Admission	$1,977.19	$0.00	$0.00	$1,977.19
Pre-Admission Testing	$730.87	$0.00	$0.00	$730.87
PHCS Pricing	$0.00	$48,996.34	$0.00	$0.00
Out-of-Network Allowable Charge	$0.00	$18,669.86	$0.00	$0.00
Surgery Global	$176.30	$0.00	$0.00	$176.30
Totals	**$37,523.97**	**$67,666.20**	**$0.00**	**$37,523.97**

Schools

Issue	Site Visit Recovery Amount	Site Visit Disputed Amount	Out-of-Sample Recovery Potential	Total Audit Potential (Excluding Disputed)
ASC Pricing	$19,798.51	$0.00	$0.00	$19,798.51
Other Insurance	$8,682.65	$0.00	$11,110.92	$19,793.57
Duplicates	$5,510.77	$0.00	$0.00	$5,510.77
Multiple Procedure Reductions	$1,100.62	$0.00	$0.00	$1,100.62
Out-of-Network Allowable Charge	$781.50	$39,049.79	$0.00	$781.50
Pre-Admission Testing	$341.22	$0.00	$0.00	$341.22
PHCS Pricing	$0.00	$31,876.26	$0.00	$0.00
Surgery Global	$681.16	$0.00	$0.00	$681.16
Totals	**$36,896.43**	**$70,926.05**	**$11,110.92**	**$48,007.35**

Process Overview

Healthcare Horizons systematically reviews 100% of claims payments by the administrator on behalf of our clients via our proprietary electronic claim 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	$600.00	0	$0.00
Duplicates - Line Level	64	20	$10,652.38	0	$0.00
Other Insurance	4	3	$8,682.65	0	$0.00
ESRD	9	0	$0.00	0	$0.00
Assistant Surgeon	2	0	$0.00	0	$0.00
Multiple Procedure Reductions	6	3	$1,100.62	0	$0.00
ER with Admission	4	0	$0.00	0	$0.00
Outpatient with Admission	4	1	$1,977.19	0	$0.00
Pre-Admission Testing	6	3	$1,072.09	0	$0.00
Medical Edits	4	0	$0.00	0	$0.00
Surgery Global	10	5	$857.46	0	$0.00
Readmissions	8	0	$0.00	0	$0.00
ASC Pricing	19	15	$48,696.51	0	$0.00
Optima Pricing	5	0	$0.00	0	$0.00
PHCS Pricing	7	0	$0.00	5	$80,872.60
J Code Pricing	3	0	$0.00	0	$0.00
Dialysis Case Management	3	0	$0.00	0	$0.00
Out-of-Network Allowable Charge	10	1	$781.50	7	$57,719.65
Benefit Maximum - Hearing Aids	2	0	$0.00	0	$0.00
Totals	**180**	**53**	**$74,420.40**	**12**	**$138,592.25**

Recoverable Findings

A minimal volume of agreed duplicate payment errors were identified. Healthcare Horizons performs a number of 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 six duplicate payment errors totaling $6,988.60 (audit items 18, 26, 48, 53, 61, and 64) with a likely root cause of manual processor error.

> ***Optima Response:*** *Agreed, for the 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.*
>
> **Healthcare Horizons' Final Comment:** Optima should initiate recovery on these claims. Healthcare Horizons will track the overpayment collections activity on behalf of the group.

Retroactive notification of other primary insurance resulted in the identification of recoverable claims. Healthcare Horizons utilizes the claims data to identify members with other primary insurance based on a coordination of benefits (COB) savings amount present on certain claims. We then test claims for the same members with no COB savings to determine if coordination with the primary carrier was missed. For audit items 75 and 77, Optima responded that other insurance notification was received after the claim had adjudicated and that an EOB was not attached to the claim. Our interpretation of this response is that the claims are now recoverable for $8,533.96. For audit item 78, Optima agreed to a manual error for missed coordination in the amount of $148.69. Based on the other insurance primary noted, Healthcare Horizons has delivered eight additional out-of-sample claims for review and recovery with an estimated potential of $11,110.92. We request claim-level feedback on these claims from Optima along with the written audit response. Finally, Optima should speak to processes in place to identify and adjust claims impacted by the receipt of retroactive other primary insurance information.

> ***Optima Response:*** *Agreed, for samples 75 and 77 the claims were adjudicated correctly at the time of receipt. The member's information was updated on 10.16.19 which was 5 months post receipt date. Shared Services will work with the Claims Department in ensuring policies and procedures are in place to reconcile any overpayments from the missed coordination of benefits.*
>
> *Agreed, for sample 78 education was provided to the claims processor. Optima will continue to work with the Claims Department to enhance their knowledge on how to accurately process these claims.*
>
> **Healthcare Horizons' Final Comment:** Optima should initiate recovery on these claims including the out-of-sample items supplied by Healthcare Horizons. Healthcare Horizons will track the overpayment collections activity on behalf of the group.

Healthcare Horizons identified overpayments due to missed multiple procedure reductions caused by fragmented billing. When multiple surgical procedures are performed in the same operative session, it is industry standard to allow the primary procedure at the full fee schedule rate and secondary procedures at a reduced rate (usually 50% of the full fee). These reductions are taken since the primary procedure payment accounts for patient preparation and other services. Healthcare Horizons often finds that payers fail to implement systems to combine procedures across claims when payments are processed on different claims for the same surgical case. Audit items 91, 93, and 95 were agreed as overpaid for a total of $1,100.62 due to fragmented billing by the providers. As all potential errors were submitted in the sample selection, no additional claims were delivered to Optima for review.

> ***Optima Response:*** *Agreed, feedback and refresher training has been provided to the responsible claims processors.*
>
> **Healthcare Horizons' Final Comment:** Optima should initiate recovery on these claims. Healthcare Horizons will track the overpayment collections activity on behalf of the group.

A single outpatient claim was billed and paid in error due to a subsequent same-day inpatient admission. Providers should generally not submit separate outpatient bills when a patient is subsequently admitted on the same day since the inpatient case rate or per diem reimbursement covers all services for the day. Audit item 102 was agreed as overpaid by $1,977.19 as all services rendered should have been included on the inpatient claim. The root cause of this overpayment can be attributed to a provider billing error.

> ***Optima Response:*** *Agreed, for the one error received; feedback and refresher training has been provided to the responsible claims processor.*
>
> **Healthcare Horizons' Final Comment:** Optima should initiate recovery on this claim. Healthcare Horizons will track the overpayment collection activity on behalf of the group.

A minimal 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 paid separately from the subsequent inpatient reimbursement (based on case rate or per diem). Healthcare Horizons identified three claims paid in error for this issue for a total of $1,072.09 (audit items 104, 106, and 108). Note that all potential errors were submitted in the sample selection.

> ***Optima Response:*** *Agreed, Optima agrees with the assigning of these errors as pre-op was within the 10 day window of the facility charges. We will continue to work with Operations in identifying possible system enhancements that may address this issue and or lessen the likelihood of it occurring.*

Healthcare Horizons' Final Comment: Optima should initiate recovery on these claims. Healthcare Horizons will track the overpayment collections activity on behalf of the group.

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 fifteen overpayments totaling $48,696.51 for this issue (audit items 133, 134, 135, 136, 137, 138, 141, 142, 143, 144, 145, 147, 148, 149, and 150). As this issue has been present in prior audits, we request that Optima address any planned root cause correction to prevent future overpayments.

***Optima Response**: Agreed, for the claims identified Optima worked collaboratively with Operations August 2020 to update policy to be more reflective of the current practices in the processing of these claims. Additionally, system enhancements were made to add a warning to the system notifying the claims processors to refer to the specified policy that is applicable to this claim type and scenario. Education of this update has been provided to the Claims department in an effort to reinforce and remediate future errors of this type.*

Healthcare Horizons' Final Comment: Optima should initiate recovery on these claims. Healthcare Horizons will track the overpayment collections activity on behalf of the group**.**

Disputed Findings

Healthcare Horizons requests a second review for duplicate payments caused by providers billing under different identification numbers. For audit items 4, 6, 16, 24, 26, 32, 44, 50, 60, 66, 72, and 74 (currently disputed at $2,761.56), the provider name on the duplicate combinations were equal, however, the provider number, vendor number, and/or tax identification numbers were not equal. In each instance, Optima disagreed with an error as the system did not flag the claims as duplicates due to different identification numbers. We request a second review on these claims as they are likely recoverable on behalf of the group. In addition, Optima may choose to utilize these examples in order to modify its duplicate logic.

> ***Optima Response:*** *Optima disagrees with the assigning of these errors. 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:** We appreciate the updated response from Optima in that the claims are recoverable. As such, we will update all applicable charts to reflect these dollars as recoverable on behalf of the group. We recommend that the group instruct Optima to recover these overpayments as there will be no adverse impact to its members.

Healthcare Horizons requests a second review for duplicate payments processed on both medical and mental health systems. For audit items 22, 42, 58, and 70 currently disputed at $1,502.22, Optima responded that the claims were processed on different systems (medical and mental health), therefore, no duplicate claim edits were applicable. We request a second review on these claims as they are likely recoverable on behalf of the group. In addition, Optima may choose to utilize these examples in order capture duplicate payments across these claims processing systems.

> ***Optima Response:*** *Optima disagrees with the assigning of these errors however Optima agrees the claims are recoverable. Due to existing restraints within the system the claims did not flag as duplicates, therefore the claims processor followed normal policies and procedures. Shared Services will work with Operations in reviewing claim edits and will make recommendations for system enhancements, and or revisions to manual procedures to lessen the likelihood of these scenarios from occurring.*
>
> **Healthcare Horizons' Final Comment:** We appreciate the updated response from Optima in that the claims are recoverable. As such, we will update all applicable charts to reflect these dollars as recoverable on behalf of the group. We recommend that the group instruct Optima to recover these overpayments as there will be no adverse impact to its members.

Healthcare Horizons requests clarification on the physician evaluations submitted during the surgery global period. For many surgical procedures, the professional fee is inclusive of any visits that occur between one day prior to the surgery and up to 90 days after the surgery for follow-ups. For audit items 114, 116, 118, 120, and 122 currently disputed at $857.46, Optima responded that "there is one day of preoperative care, so the global period starts the day prior to the surgery." As the evaluation and management examples provided by Healthcare Horizons were all on the day prior to surgery, our impression is that these claims are recoverable. Note that this issue has resulted in agreed overpayments in prior audits.

> ***Optima Response:*** *Optima disagrees with the assigning of these errors. At the time of the audit, no surgical claims were on file, identifying services were global. Optima does agree these claims are now recoverable. Shared Services will evaluate current policies to determine if efforts can be made from a processing perspective to mitigate these scenarios. Once we receive approval from Virginia Beach, we will forward the recommended claims for review and recovery.*
>
> **Healthcare Horizons' Final Comment:** We appreciate the updated response from Optima in that the claims are recoverable. As such, we will update all applicable charts to reflect these dollars as recoverable on behalf of the group. We recommend that the group instruct Optima to recover these overpayments as there will be no adverse impact to its members.

Healthcare Horizons identified out-of-network claims not limited to the Allowable Charge limitation as outlined in the plan document. Regarding the Allowable Charge limit for out-of-network claims, the Benefit Information Guide states the following:

> *Doctors, hospitals, and other healthcare professionals who do not have a signed agreement with Optima Health are considered non-Plan, or out-of-network providers. Typically, Plan members enrolled in a POSA or POS plan have out-of-network benefits. When they receive covered services from out-of-network providers, Optima Health will pay a set percentage, or an allowable charge, of the amount paid to in-network providers for the same service. The member will pay the rest. If the out-of-network provider charges more than what Optima Health pays, the provider may bill you, the member, for the difference between the two 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.

In testing claims for this issue, Healthcare Horizons selected a number of out-of-network claims allowed at full billed charges and requested that Optima address the Allowable Charge limitation described above. For each claim presented in the PHCS Pricing and Out-of-Network Allowable Charge categories, Optima stated that payment at full billed charges was appropriate based on the following rationale:

- PHCS priced at billed (100%) – We request clarification from Optima on claims with PHCS pricing returned at 100%. Specifically, is this indicative of no available PHCS contract and unsuccessful fee negotiation? We suggest plan intent clarification for the application of Allowable Charge when PHCS returns 100% of billed pricing (audit items 156, 157, 159, and 160).

  Optima Response: *Optima disagrees with the assigning of these as errors. According to the plans SPD : 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.*
  When the claim is repriced, PHCS sends Optima the allowable fees. PHCS is an extended network for the City of Virginia Beach and all claims requiring repricing have been reimbursed per PHCS's agreement, as further supported by the plans benefit documents PHCS is an extension of our in-network providers.

  Healthcare Horizons' Final Comment: We recommend further clarification of plan intent for this scenario as PHCS did not return a usable allowable fee on these claims – full billed charge was allowed in each instance.

- Fee negotiation unsuccessful – Based on our interpretation of the Allowable Charge limitation, if fee negotiation is unsuccessful, the paid amount should be limited to typical reimbursement for in-network providers for the same service. We suggest plan intent clarification for the application of Allowable Charge when fee negotiation is unsuccessful (audit items 158, 172, 173, 174, and 177).

  Optima Response: *For Audit 158 Optima disagrees with the assigning of this error. The claim was not repriced, cost share would be limited to the member's in-network benefit level and processing using 100% of charges, balance billing will not apply.*

  For Audit 172 Optima disagrees with the assigning of this error. The claim was processed at charges per an appeals decision at the request of the member. Per the plans documents the member contacted the Health Plan to notify of balance billing where directives were then given to the Claims Department to reprocess the claims accordingly relieving the member of additional cost not associated with their normal cost share.

  For Audit 173,174, and 177 Optima disagrees with the assigning of these errors. Per the SPD Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency at a Plan Facility, or during an authorized Admission to a Plan Facility, will be covered under In-Network benefits. Per claims processing guidelines Non-Par Anesthesia Physicians performing services in a PAR facility or Emergent services in a Non-Par facility are processed at the in-network benefit level and members are not subject to balance billing.

  Healthcare Horizons' Final Comment: Plan intent verification is required for audit items 158, 173, 174, and 177 as our interpretation of the plan document does indicate that member balance billing is applicable. Based on the member appeal and subsequent decision by Optima, we are removing the disputed finding for audit item 172 as the plan document does appear to grant this flexibility.

- Authorized for in-network benefit – Our understanding is that the Allowable Charge limitation still applies when an in-network benefit exception is granted for out-of-network providers. We suggest plan intent clarification for the application of Allowable Charge when in-network benefit exceptions are granted (audit items 175, 176, and 178).

  Optima Response: *Optima disagrees with the assigning of these errors. For audits 176 & 178 at the time the services were authorized, per the Clinical Department, under coverage rules pertaining to the member's participation in a clinical trial. Coverage includes participation in the approved clinical trial and coverage for routine patient costs for items and services furnished in connection with participation in the clinical trial therefor claims processing procedures are applied at the in network benefit level.*

  Healthcare Horizons' Final Comment: Plan intent verification is required for audit items 176 and 178 as there is no exception to the out-of-network allowable charge for clinical trials noted in the plan document.

- Emergent claim – The Allowable Charge language specifically includes emergency services. We suggest plan intent clarification for the application of Allowable Charge when emergency services are involved (audit items 169).

  Optima Response: *Optima disagrees with the assigning of this error. This error type was assigned in the 2019 audit and was removed subsequent to clarification from the group. As of 4/2019, Optima received clarification from the group and documents were updated effective 1.1.19 to reflect the group's intent. Please refer to the below language:*

  ALLOWABLE CHARGE

  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. <u>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.</u> 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. <u>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.</u> 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.

  Healthcare Horizons' Final Comment: Plan intent clarification is required as the language above provided by Optima supports an out-of-network allowable charge limitation cited by Healthcare Horizons (see underlined text).

Pending additional Allowable Charge plan intent clarification by the group, we are citing the entire paid amount on these claims as disputed including $80,872.60 for the PHCS Pricing category and $57,719.65 for the Out-of-Network Allowable Charge category.

Informational Findings

Healthcare Horizons requests confirmation of dollars returned to the group for a number of claims cited as already adjusted by Optima. For several claims presented by Healthcare Horizons in the Duplicates category, Optima noted a prior reversal and denial in 2019. However, based on our paid claims data through 12/31/2019, no negatives are present for these claims. For the items listed below, we request that Optima supply documentation to confirm return of the overpaid dollars to the group.

Audit Item	Issue	Amount	Optima Reversal Date
1	Duplicates	$83,017.17	12/15/2019
11	Duplicates	$2,467.11	12/15/2019
19	Duplicates	$8,563.05	12/29/2019
29	Duplicates	$195,175.08	12/15/2019
39	Duplicates	$3,237.69	7/28/2019
67	Duplicates	$58.39	7/17/2019

Healthcare Horizons' Final Comment: The Optima response did not include a confirmation of dollars returned to the group for the duplicate payments noted above. Our impression is that the claims were adjusted in 2019; however, no cash collection occurred in 2019. The group should request confirmation of cash collection on these claims. Healthcare Horizons can provide additional details on these claims upon request by the group.

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 group and Optima work to confirm the dialysis start date and the resulting Medicare primary effective date for the members identified on audit items 79, 84, 85, 86, and 87. We are glad to provide the member information to the group upon request.

The Optima inpatient readmission policy only combines admissions if the first three digits of the diagnosis code are equal. It is common for facility contracts to contain language that allows payers to combine inpatient readmissions within a certain timeframe for pricing calculations. It is possible that a single case rate payment would cover both inpatient stays if related. Healthcare Horizons submitted four inpatient readmission cases and Optima responded that the first three digits of the diagnosis code must be equal in order for the admissions to be combined. In our experience, this requirement is more stringent than we typically see in facility contracts that normally only require a related illness in order to combine the stays. As an example, two of the readmissions presented by Healthcare Horizons were for complications resulting from the prior stay. Optima may choose to reexamine its current policy for combining readmissions into a single claim for pricing.

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 group prior to any collections activity.
- Optima should engage in discussions with the group to clarify plan intent for Allowable Charge.
- The group and Optima should work to identify the Medicare primary effective dates for the ESRD members cited with no Medicare information on file with Optima.
- Optima should confirm cash collection for the audit items noted as already reversed and denied.

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 Amount	Disputed Amount	Comment	Group
1	Duplicates - Claim Level	$0.00	$0.00	Claim reversed and denied on 12/15/19 - no negative in data through 12/31/19 - confirm with Optima	Schools
2	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 1/2 combo	Schools
3	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 3/4 combo	City
4	Duplicates - Claim Level	$300.00	$0.00	Same rendering provider but different provider ID / vendor ID / TIN - disputed as errors but recoverable per Optima	City
5	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 5/6 combo	Schools
6	Duplicates - Claim Level	$300.00	$0.00	Same rendering provider but different provider ID / vendor ID / TIN - disputed as errors but recoverable per Optima	Schools
7	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 7/8 combo	Schools
8	Duplicates - Claim Level	$0.00	$0.00	Denied for duplicate on 2/9/20	Schools
9	Duplicates - Claim Level	$0.00	$0.00	Denied for duplicate on 1/26/20	City
10	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 9/10 combo	City
11	Duplicates - Line Level	$0.00	$0.00	Claim reversed and denied on 12/15/19 - no negative in data through 12/31/19 - confirm with Optima	Schools
12	Duplicates - Line Level	$0.00	$0.00	Correct claim for 11/12 combo	Schools
13	Duplicates - Line Level	$0.00	$0.00	Denied for duplicate on 1/31/20	Schools
14	Duplicates - Line Level	$0.00	$0.00	Correct claim for 13/14 combo	Schools
15	Duplicates - Line Level	$0.00	$0.00	Correct claim for 15/16 combo	Schools
16	Duplicates - Line Level	$50.05	$0.00	Same rendering provider but different provider ID / vendor ID / TIN - disputed as errors but recoverable per Optima	Schools
17	Duplicates - Line Level	$0.00	$0.00	Correct claim for 17/18 combo	Schools
18	Duplicates - Line Level	$849.78	$0.00	Agreed duplicate error	Schools
19	Duplicates - Line Level	$0.00	$0.00	Claim reversed and denied on 12/29/19 - no negative in data through 12/31/19 - confirm with Optima	Schools
20	Duplicates - Line Level	$0.00	$0.00	Correct claim for 19/20 combo	Schools
21	Duplicates - Line Level	$0.00	$0.00	Correct claim for 21/22 combo	Schools
22	Duplicates - Line Level	$221.19	$0.00	Claim processed on different systems (medical and mental health) - disputed as errors but recoverable per Optima	Schools
23	Duplicates - Line Level	$0.00	$0.00	Correct claim for 23/24 combo	City
24	Duplicates - Line Level	$84.40	$0.00	Same rendering provider but different provider ID / vendor ID / TIN - disputed as errors but recoverable per Optima	City
25	Duplicates - Line Level	$0.00	$0.00	Correct claim for 25/26 combo	City
26	Duplicates - Line Level	$95.41	$0.00	Same rendering provider but different provider ID / vendor ID / TIN - disputed as errors but recoverable per Optima	City
27	Duplicates - Line Level	$0.00	$0.00	Denied for duplicate on 1/5/20	Schools
28	Duplicates - Line Level	$0.00	$0.00	Correct claim for 27/28 combo	Schools
29	Duplicates - Line Level	$0.00	$0.00	Claim reversed and denied on 12/15/19 - no negative in data through 12/31/19 - confirm with Optima	Schools
30	Duplicates - Line Level	$0.00	$0.00	Correct claim for 29/30 combo	Schools
31	Duplicates - Line Level	$0.00	$0.00	Correct claim for 31/32 combo	City
32	Duplicates - Line Level	$86.13	$0.00	Same rendering provider but different provider ID / vendor ID / TIN - disputed as errors but recoverable per Optima	City
33	Duplicates - Line Level	$0.00	$0.00	Denied for duplicate on 4/26/20	Schools
34	Duplicates - Line Level	$0.00	$0.00	Correct claim for 33/34 combo	Schools
35	Duplicates - Line Level	$0.00	$0.00	Correct claim for 35/36 combo	Schools
36	Duplicates - Line Level	$0.00	$0.00	Denied for duplicate on 4/26/20	Schools
37	Duplicates - Line Level	$0.00	$0.00	Correct claim for 37/38 combo	City
38	Duplicates - Line Level	$0.00	$0.00	Denied for duplicate on 1/5/20	City
39	Duplicates - Line Level	$0.00	$0.00	Claim reversed and denied on 7/28/19 - no negative in data through 12/31/19 - confirm with Optima	Schools
40	Duplicates - Line Level	$0.00	$0.00	Correct claim for 39/40 combo	Schools
41	Duplicates - Line Level	$0.00	$0.00	Correct claim for 41/42 combo	City
42	Duplicates - Line Level	$460.00	$0.00	Claim processed on different systems (medical and mental health) - disputed as errors but recoverable per Optima	City

Audit Item	Issue	Recovery Amount	Disputed Amount	Comment	Group
43	Duplicates - Line Level	$0.00	$0.00	Correct claim for 43/44 combo	City
44	Duplicates - Line Level	$95.41	$0.00	Same rendering provider but different provider ID / vendor ID / TIN - disputed as errors but recoverable per Optima	City
45	Duplicates - Line Level	$0.00	$0.00	Correct claim for 45/46 combo	City
46	Duplicates - Line Level	$205.25	$0.00	Agreed duplicate error	City
47	Duplicates - Line Level	$0.00	$0.00	Correct claim for 47/48 combo	City
48	Duplicates - Line Level	$1,743.28	$0.00	Agreed duplicate error	City
49	Duplicates - Line Level	$0.00	$0.00	Correct claim for 49/50 combo	City
50	Duplicates - Line Level	$59.23	$0.00	Same rendering provider but different provider ID / vendor ID / TIN - disputed as errors but recoverable per Optima	City
51	Duplicates - Line Level	$0.00	$0.00	Correct claim for 51/52 combo	Schools
52	Duplicates - Line Level	$0.00	$0.00	Denied for duplicate on 1/9/20	Schools
53	Duplicates - Line Level	$1,191.47	$0.00	Agreed duplicate error	City
54	Duplicates - Line Level	$0.00	$0.00	Correct claim for 53/54 combo	City
55	Duplicates - Line Level	$0.00	$0.00	Denied for duplicate in 2020	City
56	Duplicates - Line Level	$0.00	$0.00	Correct claim for 55/56 combo	City
57	Duplicates - Line Level	$0.00	$0.00	Correct claim for 57/58 combo	City
58	Duplicates - Line Level	$140.00	$0.00	Claim processed on different systems (medical and mental health) - disputed as errors but recoverable per Optima	City
59	Duplicates - Line Level	$0.00	$0.00	Correct claim for 59/60 combo	City
60	Duplicates - Line Level	$300.00	$0.00	Same rendering provider but different provider ID / vendor ID / TIN - disputed as errors but recoverable per Optima	City
61	Duplicates - Line Level	$732.50	$0.00	Agreed duplicate error	Schools
62	Duplicates - Line Level	$0.00	$0.00	Correct claim for 61/62 combo	Schools
63	Duplicates - Line Level	$0.00	$0.00	Correct claim for 63/64 combo	Schools
64	Duplicates - Line Level	$2,266.32	$0.00	Agreed duplicate error	Schools
65	Duplicates - Line Level	$0.00	$0.00	Correct claim for 65/66 combo	Schools
66	Duplicates - Line Level	$823.52	$0.00	Same rendering provider but different provider ID / vendor ID / TIN - disputed as errors but recoverable per Optima	Schools
67	Duplicates - Line Level	$0.00	$0.00	Claim reversed and denied on 7/17/19 - no negative in data through 12/31/19 - confirm with Optima	Schools
68	Duplicates - Line Level	$0.00	$0.00	Correct claim for 67/68 combo	Schools
69	Duplicates - Line Level	$0.00	$0.00	Correct claim for 69/70 comb0	City
70	Duplicates - Line Level	$681.03	$0.00	Claim processed on different systems (medical and mental health) - disputed as errors but recoverable per Optima	City
71	Duplicates - Line Level	$0.00	$0.00	Correct claim for 71/72 combo	Schools
72	Duplicates - Line Level	$267.41	$0.00	Same rendering provider but different provider ID / vendor ID / TIN - disputed as errors but recoverable per Optima	Schools
73	Duplicates - Line Level	$0.00	$0.00	Correct claim for 73/74 combo	City
74	Duplicates - Line Level	$300.00	$0.00	Same rendering provider but different provider ID / vendor ID / TIN - disputed as errors but recoverable per Optima	City
75	Other Insurance	$6,703.95	$0.00	Retroactive notification of other primary insurance - recoverable	Schools
76	Other Insurance	$0.00	$0.00	Other insruance termed 11/30/18 (DOS after)	Schools
77	Other Insurance	$1,830.01	$0.00	Retroactive notification of other primary insurance - recoverable	Schools
78	Other Insurance	$148.69	$0.00	Manual processor error	Schools
79	ESRD	$0.00	$0.00	No other insurance on file	Schools
80	ESRD	$0.00	$0.00	Medicare primary 2/1/20 (DOS prior)	City
81	ESRD	$0.00	$0.00	Medicare primary 8/1/21 (DOS prior)	City
82	ESRD	$0.00	$0.00	Medicare primary 4/1/21 (DOS prior)	City
83	ESRD	$0.00	$0.00	Medicare secondary per Optima	Schools
84	ESRD	$0.00	$0.00	No other insurance on file	Schools
85	ESRD	$0.00	$0.00	No other insurance on file	City
86	ESRD	$0.00	$0.00	No other insurance on file	Schools
87	ESRD	$0.00	$0.00	No other insurance on file	Schools
88	Assistant Surgeon	$0.00	$0.00	Primary surgeon - onformational only	City
89	Assistant Surgeon	$0.00	$0.00	Pricing correct per Optima	City
90	Multiple Procedure Reductions	$0.00	$0.00	Primary procedure - info only	Schools
91	Multiple Procedure Reductions	$79.67	$0.00	Agreed error due to fragmented billing	Schools
92	Multiple Procedure Reductions	$0.00	$0.00	Primary procedure - info only	Schools
93	Multiple Procedure Reductions	$405.07	$0.00	Agreed error due to fragmented billing	Schools
94	Multiple Procedure Reductions	$0.00	$0.00	Primary procedure - info only	Schools
95	Multiple Procedure Reductions	$615.88	$0.00	Agreed error due to fragmented billing	Schools

Audit Item	Issue	Recovery Amount	Disputed Amount	Comment	Group
96	ER with Admission	$0.00	$0.00	Not a direct admit from ER per Optima	Schools
97	ER with Admission	$0.00	$0.00	Inpatient claim - informational only	Schools
98	ER with Admission	$0.00	$0.00	Not a direct admit from ER per Optima	City
99	ER with Admission	$0.00	$0.00	Inpatient claim - informational only	City
100	Outpatient with Admission	$0.00	$0.00	Not a direct admit from OP per Optima	Schools
101	Outpatient with Admission	$0.00	$0.00	Inpatient claim - informational only	Schools
102	Outpatient with Admission	$1,977.19	$0.00	Agreed error - services should have been included on IP claim	City
103	Outpatient with Admission	$0.00	$0.00	Inpatient claim - informational only	City
104	Pre-Admission Testing	$108.22	$0.00	Agreed error - services should have been included on IP claim	Schools
105	Pre-Admission Testing	$0.00	$0.00	Inpatient claim - informational only	Schools
106	Pre-Admission Testing	$233.00	$0.00	Agreed error - services should have been included on IP claim	Schools
107	Pre-Admission Testing	$0.00	$0.00	Inpatient claim - informational only	Schools
108	Pre-Admission Testing	$730.87	$0.00	Agreed error - services should have been included on IP claim	City
109	Pre-Admission Testing	$0.00	$0.00	Inpatient claim - informational only	City
110	Medical Edits	$0.00	$0.00	Primary procedure - info only	City
111	Medical Edits	$0.00	$0.00	Code allowed per Optima edits	City
112	Medical Edits	$0.00	$0.00	Primary procedure - info only	City
113	Medical Edits	$0.00	$0.00	Code allowed per Optima edits	City
114	Surgery Global	$176.30	$0.00	Optima states global period begins one day prior - E/M is one day prior - disputed as errors but agreed as recoverable per Optima	City
115	Surgery Global	$0.00	$0.00	Surgery claim one day prior - informational	City
116	Surgery Global	$131.24	$0.00	Optima states global period begins one day prior - E/M is one day prior - disputed as errors but agreed as recoverable per Optima	Schools
117	Surgery Global	$0.00	$0.00	Surgery claim one day prior - informational	Schools
118	Surgery Global	$264.32	$0.00	Optima states global period begins one day prior - E/M is one day prior - disputed as errors but agreed as recoverable per Optima	Schools
119	Surgery Global	$0.00	$0.00	Surgery claim one day prior - informational	Schools
120	Surgery Global	$84.40	$0.00	Optima states global period begins one day prior - E/M is one day prior - disputed as errors but agreed as recoverable per Optima	Schools
121	Surgery Global	$0.00	$0.00	Surgery claim one day prior - informational	Schools
122	Surgery Global	$201.20	$0.00	Optima states global period begins one day prior - E/M is one day prior - disputed as errors but agreed as recoverable per Optima	Schools
123	Surgery Global	$0.00	$0.00	Surgery claim on same day - informational	Schools
124	Readmissions	$0.00	$0.00	Initial admission - informational only	City
125	Readmissions	$0.00	$0.00	Per Optima policy first three digits of diagnosis code must match to combine admissions	City
126	Readmissions	$0.00	$0.00	Initial admission - informational only	Schools
127	Readmissions	$0.00	$0.00	Per Optima policy first three digits of diagnosis code must match to combine admissions	Schools
128	Readmissions	$0.00	$0.00	Initial admission - informational only	City
129	Readmissions	$0.00	$0.00	Per Optima policy first three digits of diagnosis code must match to combine admissions	City
130	Readmissions	$0.00	$0.00	Initial admission - informational only	Schools
131	Readmissions	$0.00	$0.00	Per Optima policy first three digits of diagnosis code must match to combine admissions	Schools
132	ASC Pricing	$0.00	$0.00	Claim reversed prior to audit	City
133	ASC Pricing	$2,759.10	$0.00	Error - only highest procedure should be paid per contract	Schools
134	ASC Pricing	$3,485.31	$0.00	Error - only highest procedure should be paid per contract	Schools
135	ASC Pricing	$3,102.50	$0.00	Error - only highest procedure should be paid per contract	Schools
136	ASC Pricing	$1,780.75	$0.00	Error - only highest procedure should be paid per contract	City
137	ASC Pricing	$2,759.10	$0.00	Error - only highest procedure should be paid per contract	Schools
138	ASC Pricing	$2,759.10	$0.00	Error - only highest procedure should be paid per contract	Schools
139	ASC Pricing	$0.00	$0.00	Colonoscopy and endoscopy are separately payable per Optima policy	Schools
140	ASC Pricing	$0.00	$0.00	Colonoscopy and endoscopy are separately payable per Optima policy	Schools

Audit Item	Issue	Recovery Amount	Disputed Amount	Comment	Group
141	ASC Pricing	$3,246.00	$0.00	Error - only highest procedure should be paid per contract	City
142	ASC Pricing	$2,827.95	$0.00	Error - only highest procedure should be paid per contract	City
143	ASC Pricing	$6,654.00	$0.00	Error - only highest procedure should be paid per contract	City
144	ASC Pricing	$2,759.10	$0.00	Error - only highest procedure should be paid per contract	City
145	ASC Pricing	$2,495.25	$0.00	Error - only highest procedure should be paid per contract	City
146	ASC Pricing	$0.00	$0.00	Colonoscopy and endoscopy are separately payable per Optima policy	City
147	ASC Pricing	$2,105.45	$0.00	Error - only highest procedure should be paid per contract	Schools
148	ASC Pricing	$2,827.95	$0.00	Error - only highest procedure should be paid per contract	Schools
149	ASC Pricing	$6,307.00	$0.00	Error - only highest procedure should be paid per contract	City
150	ASC Pricing	$2,827.95	$0.00	Error - only highest procedure should be paid per contract	City
151	Optima Pricing	$0.00	$0.00	Stop loss pricing correct per Optima	Schools
152	Optima Pricing	$0.00	$0.00	Stop loss pricing correct per Optima	Schools
153	Optima Pricing	$0.00	$0.00	Stop loss pricing correct per Optima	Schools
154	Optima Pricing	$0.00	$0.00	Stop loss pricing correct per Optima	Schools
155	Optima Pricing	$0.00	$0.00	Transplant pricing correct per Optima	Schools
156	PHCS Pricing	$0.00	$41,739.28	PHCS returned 100% of billed - should OON Allowable Charge apply?	City
157	PHCS Pricing	$0.00	$7,257.06	PHCS returned 100% of billed - should OON Allowable Charge apply?	City
158	PHCS Pricing	$0.00	$19,932.26	Fee negotiation unsuccessful - should OON Allowable Charge apply?	Schools
159	PHCS Pricing	$0.00	$8,544.00	PHCS returned 100% of billed - should OON Allowable Charge apply?	Schools
160	PHCS Pricing	$0.00	$3,400.00	PHCS returned 100% of billed - should OON Allowable Charge apply?	Schools
161	PHCS Pricing	$0.00	$0.00	PHCS per discount correct	Schools
162	PHCS Pricing	$0.00	$0.00	PHCS per discount correct	Schools
163	J Code Pricing	$0.00	$0.00	Processed per LOA on file per Optima	City
164	J Code Pricing	$0.00	$0.00	Processed per LOA on file per Optima	City
165	J Code Pricing	$0.00	$0.00	Processed per LOA on file per Optima	City
166	Dialysis Case Management	$0.00	$0.00	OON provider processed at negotiated rate - provider now INN	City
167	Dialysis Case Management	$0.00	$0.00	OON provider processed at negotiated rate - provider now INN	City
168	Dialysis Case Management	$0.00	$0.00	OON provider processed at negotiated rate - provider now INN	City
169	Out-of-Network Allowable Charge	$0.00	$25,212.00	Processed at billed charges for OON emergency services	Schools
170	Out-of-Network Allowable Charge	$781.50	$0.00	Agreed overpayment	Schools
171	Out-of-Network Allowable Charge	$0.00	$0.00	Cruise ship services reimbursed to member	Schools
172	Out-of-Network Allowable Charge	$0.00	$0.00	Payment at charges approved after member appeal	City
173	Out-of-Network Allowable Charge	$0.00	$7,173.79	Fee negotiation unsuccessful - should OON Allowable Charge apply?	Schools
174	Out-of-Network Allowable Charge	$0.00	$6,664.00	Fee negotiation unsuccessful - should OON Allowable Charge apply?	Schools
175	Out-of-Network Allowable Charge	$0.00	$5,300.00	Authorized for INN benefit - should OON Allowable Charge apply?	City
176	Out-of-Network Allowable Charge	$0.00	$4,700.00	Authorized for INN benefit - should OON Allowable Charge apply?	City
177	Out-of-Network Allowable Charge	$0.00	$4,369.86	Fee negotiation unsuccessful - should OON Allowable Charge apply?	City
178	Out-of-Network Allowable Charge	$0.00	$4,300.00	Authorized for INN benefit - should OON Allowable Charge apply?	City
179	Benefit Maximum - Hearing Aids	$0.00	$0.00	Reversed in 2020	City
180	Benefit Maximum - Hearing Aids	$0.00	$0.00	Under maximum	City
		$74,420.40	**$138,592.25**		

Appendix B – Out-of-Sample Claims

Audit Item	Issue	Estimated Recovery Amount	Comment	Group
181	Other Insurance	$3,474.04	Per sample item #75	Schools
182	Other Insurance	$1,285.20	Per sample item #75	Schools
183	Other Insurance	$261.43	Per sample item #77	Schools
184	Other Insurance	$338.79	Per sample item #77	Schools
185	Other Insurance	$1,830.01	Per sample item #77	Schools
186	Other Insurance	$1,830.01	Per sample item #77	Schools
187	Other Insurance	$1,830.01	Per sample item #77	Schools
188	Other Insurance	$261.43	Per sample item #77	Schools
	Total	**$11,110.92**		