September 2, 2021

FINAL HEALTHCARE CLAIMS AUDIT REPORT

City of Virginia Beach – Optima

AUDIT PERIOD: JANUARY – DECEMBER 2020

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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 through December 2020. Healthcare Horizons received $95,666,857.22 in paid claims data from Optima and performed a full electronic review of claims processing. Of this total amount, $55,890,391.95 was paid for the school system and $39,776,465.27 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 300 targeted sample claims to Optima as potential errors (based on mining of the data) or higher-dollar items in need of review. 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 $338,138.72 from the sample claims, representing an average percentage of overpayments based on our experience with similar projects. The majority of sample findings are related to coordination with other insurance, out-of-network allowable charge, ambulatory surgical center (ASC) pricing, inpatient readmissions, transfer pricing, and the morbid obesity benefit exclusion. 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. Optima agreed with five recoverable claims totaling $4,496.63. These additional out-of-sample claims are detailed in Appendix B.

Our findings for the audit are summarized as follows.

Issue	Sample Recovery Amount	Sample Disputed Amount	Out-of-Sample Recovery Amount	Total Audit Potential (Excluding Disputed)
Other Insurance	$79,963.47	$0.00	$4,496.63	$84,460.10
Allowable Charge - Out-of-Network	$66,988.25	$0.00	$0.00	$66,988.25
ASC Pricing	$65,096.90	$0.00	$0.00	$65,096.90
Readmissions	$43,619.70	$0.00	$0.00	$43,619.70
Transfers	$42,315.69	$0.00	$0.00	$42,315.69
Benefit Exclusion - Morbid Obesity	$19,547.45	$0.00	$0.00	$19,547.45
Duplicates	$8,939.12	$0.00	$0.00	$8,939.12
Medically Unlikely Edits	$3,406.92	$0.00	$0.00	$3,406.92
Pre-Admission Testing	$1,890.54	$0.00	$0.00	$1,890.54
Benefit Exclusion - Administrative Exams	$1,605.60	$0.00	$0.00	$1,605.60
Benefit Exclusion - Foot Orthotics	$987.26	$0.00	$0.00	$987.26
Benefit Exclusion - Genetic Testing	$960.98	$0.00	$0.00	$960.98
Benefit Exclusion - Sexual Dysfunction	$869.40	$0.00	$0.00	$869.40
Surgery Global	$826.66	$0.00	$0.00	$826.66
Allowable Charge - In-Network	$693.75	$0.00	$0.00	$693.75
Outpatient with Admission	$175.10	$0.00	$0.00	$175.10
Multiple Procedure Reductions	$162.88	$0.00	$0.00	$162.88
Benefit Exclusion - Blood Pressure Monitors	$49.05	$0.00	$0.00	$49.05
Copayments - Office Visit	$40.00	$0.00	$0.00	$40.00
Totals	**$338,138.72**	**$0.00**	**$4,496.63**	**$342,635.35**

City

Issue	Site Visit Recovery Amount	Site Visit Disputed Amount	Out-of-Sample Recovery Amount	Total Audit Potential (Excluding Disputed)
Readmissions	$43,619.70	$0.00	$0.00	$43,619.70
ASC Pricing	$30,078.65	$0.00	$0.00	$30,078.65
Transfers	$29,469.97	$0.00	$0.00	$29,469.97
Benefit Exclusion - Morbid Obesity	$10,263.35	$0.00	$0.00	$10,263.35
Duplicates	$5,630.63	$0.00	$0.00	$5,630.63
Allowable Charge - Out-of-Network	$955.14	$0.00	$0.00	$955.14
Pre-Admission Testing	$801.43	$0.00	$0.00	$801.43
Benefit Exclusion - Sexual Dysfunction	$556.04	$0.00	$0.00	$556.04
Benefit Exclusion - Genetic Testing	$517.63	$0.00	$0.00	$517.63
Surgery Global	$488.48	$0.00	$0.00	$488.48
Benefit Exclusion - Administrative Exams	$453.23	$0.00	$0.00	$453.23
Allowable Charge - In-Network	$327.51	$0.00	$0.00	$327.51
Benefit Exclusion - Foot Orthotics	$258.37	$0.00	$0.00	$258.37
Multiple Procedure Reductions	$90.34	$0.00	$0.00	$90.34
Benefit Exclusion - Blood Pressure Monitors	$49.05	$0.00	$0.00	$49.05
Totals	**$123,559.52**	**$0.00**	**$0.00**	**$123,559.52**

Schools

Issue	Site Visit Recovery Amount	Site Visit Disputed Amount	Out-of-Sample Recovery Amount	Total Audit Potential (Excluding Disputed)
Other Insurance	$79,963.47	$0.00	$4,496.63	$84,460.10
Allowable Charge - Out-of-Network	$66,033.11	$0.00	$0.00	$66,033.11
ASC Pricing	$35,018.25	$0.00	$0.00	$35,018.25
Transfers	$12,845.72	$0.00	$0.00	$12,845.72
Benefit Exclusion - Morbid Obesity	$9,284.10	$0.00	$0.00	$9,284.10
Medically Unlikely Edits	$3,406.92	$0.00	$0.00	$3,406.92
Duplicates	$3,308.49	$0.00	$0.00	$3,308.49
Benefit Exclusion - Administrative Exams	$1,152.37	$0.00	$0.00	$1,152.37
Pre-Admission Testing	$1,089.11	$0.00	$0.00	$1,089.11
Benefit Exclusion - Foot Orthotics	$728.89	$0.00	$0.00	$728.89
Benefit Exclusion - Genetic Testing	$443.35	$0.00	$0.00	$443.35
Allowable Charge - In-Network	$366.24	$0.00	$0.00	$366.24
Surgery Global	$338.18	$0.00	$0.00	$338.18
Benefit Exclusion - Sexual Dysfunction	$313.36	$0.00	$0.00	$313.36
Outpatient with Admission	$175.10	$0.00	$0.00	$175.10
Multiple Procedure Reductions	$72.54	$0.00	$0.00	$72.54
Copayments - Office Visit	$40.00	$0.00	$0.00	$40.00
Totals	**$214,579.20**	**$0.00**	**$4,496.63**	**$219,075.83**

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. The complete Optima response is included as Appendix C – note that protected health information (PHI) has been redacted.

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 claims selection as well as the errors identified.

Issue	Audit Items	Recovery		Disputed	
		Items	Amount	Items	Amount
Duplicates - Claim Level	18	6	$1,573.98	0	$0.00
Duplicates - Line Level	53	20	$7,365.14	0	$0.00
Eligibility - After Termination	1	0	$0.00	0	$0.00
Other Insurance	15	1	$79,963.47	0	$0.00
ESRD	7	0	$0.00	0	$0.00
Secondary Payments	5	0	$0.00	0	$0.00
Pricing - Optima Facility	9	0	$0.00	0	$0.00
Pricing - PHCS	2	0	$0.00	0	$0.00
Allowable Charge - In-Network	11	5	$693.75	0	$0.00
Allowable Charge - Out-of-Network	6	4	$66,988.25	0	$0.00
Transfers	5	2	$42,315.69	0	$0.00
Readmissions	6	1	$43,619.70	0	$0.00
ASC Pricing	19	17	$65,096.90	0	$0.00
Multiple Procedure Reductions	6	2	$162.88	0	$0.00
Home Health During Inpatient	2	0	$0.00	0	$0.00
Outpatient During Inpatient	2	0	$0.00	0	$0.00
ER with Admission	3	0	$0.00	0	$0.00
Outpatient with Admission	3	1	$175.10	0	$0.00
Pre-Admission Testing	7	7	$1,890.54	0	$0.00
Surgery Global	9	9	$826.66	0	$0.00
Medically Unlikely Edits	2	2	$3,406.92	0	$0.00
Out-of-Network Benefit	8	0	$0.00	0	$0.00
Copayments - Office Visit	5	1	$40.00	0	$0.00
Copayments - Telemedicine	8	0	$0.00	0	$0.00
COVID-19 Treatment Cost Share	5	0	$0.00	0	$0.00
Benefit Maximum - Hearing Aids	4	0	$0.00	0	$0.00
Benefit Exclusion - Blood Pressure Monitors	1	1	$49.05	0	$0.00
Benefit Exclusion - Breast	3	0	$0.00	0	$0.00
Benefit Exclusion - Foot Orthotics	11	11	$987.26	0	$0.00
Benefit Exclusion - Morbid Obesity	9	9	$19,547.45	0	$0.00
Benefit Exclusion - Orthoptic	12	0	$0.00	0	$0.00
Benefit Exclusion - Sexual Dysfunction	5	5	$869.40	0	$0.00
Benefit Exclusion - Genetic Testing	11	5	$960.98	0	$0.00
Benefit Exclusion - Other the Counter Supplies	2	0	$0.00	0	$0.00
Benefit Exclusion - Administrative Exams	25	19	$1,605.60	0	$0.00
Totals	**300**	**128**	**$338,138.72**	**0**	**$0.00**

Recoverable Findings

1. A minimal dollar amount of agreed duplicate payment errors was identified. Healthcare Horizons performs a number of queries to identify potential duplicate payments and our initial analysis yielded a minimal volume of potential duplicates that were all submitted in the sample selection. Optima agreed with 27 duplicate payment errors totaling $9,083.84 (audit items 2, 4, 8, 9, 12, 14, 16, 20, 22, 25, 27, 29, 30, 32, 35, 39, 43, 45, 48, 50, 52, 54, 57, 59, 67, 69, and 71) with a primary response that the system did not flag the claims as duplicates. Optima may choose to utilize the audit findings to determine why current duplicate edit logic did not flag these claims.

> ***Optima Response:*** *Upon further review, we found audit item 8 was not a duplicate. The provider billed the reading fee with a 59 modifier. Our bundling software indicates the 59 modifier in this situation indicates a distinct and separate specimen. We agree with all other audit items listed above. The primary issue was the system did not flag the claim as possible duplicates for review. The issue has been corrected and we conducted testing to confirm this is not an ongoing issue. Upon final agreement, we will reprocess the agreed upon claims for retraction.*
>
> **Healthcare Horizons' Final Comment:** We accept the revised response for audit item 8 and have updated all applicable charts to reflect no error. As recovery will not create adverse member impact, the City should instruct Optima to initiate claims reprocessing.

2. Retroactive notification of other commercial 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. With the exception of one claim, all items were dismissed as correct as the claims were either coordinated correctly or no other primary coverage was in effect on the service date. For audit item 77, Optima responded that the other primary insurance information was received after the claim was processed, however, the claim is now recoverable for $79,963.47 (final amount pending coordination). Based on the other insurance primary effective date noted, Healthcare Horizons delivered eight additional out-of-sample claims for review and recovery with an estimated potential of $6,525.68. 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:*** *We have several processes in place to assist with identifying claims impacted by the receipt of retroactive other primary insurance information. Our recovery team runs reports weekly to identify any claims impacted by the receipt of retroactive other primary insurance information and our special projects team manages any adjustments needed. To add an additional layer of review, we now have a vendor partner that scans our claims to look for any claims paid as primary with other health insurance listed that was instituted in the fall of 2020 to have a second sweep of claims to ensure we did*

not miss any recoveries. Feedback will be provided on the eight additional out-of-sample claims identified once claim details, including claim numbers, are provided by Health Care Horizons. Upon final agreement, we will reprocess the agreed upon claims for retraction.

Healthcare Horizons' Final Comment: Optima agreed that five of the out-of-sample claims were recoverable totaling $4,496.63. The three remaining claims were recovered prior to the audit.

3. Healthcare Horizons identified overpayments related to the allowable charge for both in-network and out-of-network providers. The plan document describes the allowable charge as follows:

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.

For audit items 111-115, Optima agreed to a total overpayment of $693.75 as the claims should have been limited to the in-network physicians' actual charge which was less than the fee schedule amount. For audit items 122 and 124, Optima agreed to overpayments totaling $54,636.84 as the out-of-network facility claims should have been limited to Optima's in-network contracted rate for similar services as fee negotiation was unsuccessful. Note that

adjustment and recovery of these claims (audit items 122 and 124) will result in adverse member impact. For audit item 125, an available PHCS discount was omitted resulting in a recoverable amount of $1,844.74. Finally, audit item 127 should be denied ($10,506.67) as the provider billed an incorrect tax identification number causing in-network pricing to be missed. Note that Healthcare Horizons submitted all questionable allowable charge claims in the sample selection.

> ***Optima Response:*** *Audit items 111 – 115 were related to a system issue that occurred where our lessor of logic was not applied correctly. The system issue has been corrected and tested to ensure this is not continuing to impact claims.*
>
> *At the Auditors request the Health Plan was asked to speak to medical necessity or any preauthorization for audit item #122. There was an authorization on file for the claim in question for an abdominoplasty procedure (CPT 15830 & 15847) which was approved by the Medical Director, other services (CPT 15832) were denied, not medically necessary. We agree with the comments regarding audit items 124, 125, and 127 including the result of adverse member impact due to retractions.*
>
> *Upon final agreement, we will reprocess the agreed upon claims for retraction.*
>
> **Healthcare Horizons' Final Comment:** We appreciate the additional details on audit item 122 regarding medical necessity for CPT 15830 (excision, excessive skin and subcutaneous tissue) and CPT 15847 (excision, excessive skin and subcutaneous tissue, abdomen). Note that these out-of-network services were rendered in Beverly Hills, CA with $123,733.15 paid to the ambulatory surgical center and $3,509.85 paid to the surgeon. We recommend additional discussion between Optima and the City to determine coverage by the plan as well as the missed application of Allowable Charge resulting in an overpayment of $53,681.70 (recovery would result in member balance billing) for audit item 122. We also recognize that balance billing would likely occur should Optima pursue the overpayment amount of $955.14 on audit item 124. We recommend that the City request reprocessing for audit items 125 (need to apply available PHCS discount) and 127 (provider is in-network and should bill as such) as member balance billing should not occur if handled correctly.

4. Testing of inpatient transfer claims yielded two pricing errors. It is common for facility contracts with DRG case rate reimbursement to include special pricing terms for transfer claims. If a patient is transferred to another acute care facility, the transfer from facility has not treated the case, therefore, a full case rate payment is not justified. In lieu of a full case rate payment, transfers are often priced at a percent of billed charges or a per diem rate. For audit items 129 and 130, Optima agreed that transfer pricing was missed resulting in a total overpayment of $42,315.69. The remaining claims submitted in this category were found to be priced correctly. As all questionable transfer claims were submitted in the sample selection, no additional out-of-sample review is warranted.

Optima Response: *Additional system logic has been added to flag claims as transfers with the disposition is greater than 01 for review. Upon final agreement, we will reprocess the agreed upon claims for retraction.*

Healthcare Horizons' Final Comment: As recovery will not create adverse member impact, the City should instruct Optima to initiate claims reprocessing.

5. A single inpatient readmission for a similar diagnosis was allowed in error. 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 three inpatient readmission cases for review by Optima to determine if the second payment was permitted per the contract. For audit items 133/134 and 135/136, Optima responded that the first three digits of the primary diagnosis code must be equal in order for the admissions to be combined. On the final combination (audit items 137/138), Optima agreed to a readmission overpayment of $43,619.70 on audit item 138 as the primary diagnosis codes were the same on both admissions. As all questionable readmission claims were submitted in the sample selection, no additional out-of-sample review is warranted.

Optima Response: *Audit item 138 was a manual processing error and education has been provided to the claims processor as well as a reminder regarding readmissions to all claims processor who handle inpatient claims. Upon final agreement, we will reprocess the agreed upon claims for retraction.*

Healthcare Horizons' Final Comment: As recovery will not create adverse member impact, the City should instruct Optima to initiate claims reprocessing.

6. 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 seventeen overpayments totaling $65,096.90 for this issue (audit items 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 151, 152, 154, 155, 156, and 157). 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: *All of these audit items are related to a single facility, CHKD. Currently this adjustment is a manual process and it is not routine. We are going through a detailed system review to identify automation opportunities and implement them as soon as possible. In the meantime, we will also add a focused audit to review these claims. Upon final agreement, we will reprocess the agreed upon claims for retraction.*

Healthcare Horizons' Final Comment: We agree the contracting language for this provider is non-standard based on our experience. As recovery will not create adverse member impact, the City should instruct Optima to initiate claims reprocessing.

7. 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 159 and 163 were agreed as overpaid for a total of $162.88 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: *We agree with the findings on audit items 159 and 163. Upon final agreement, we will reprocess the agreed upon claims for retraction.*

Healthcare Horizons' Final Comment: As recovery will not create adverse member impact, the City should instruct Optima to initiate claims reprocessing.

8. A single outpatient claim was billed and paid in error due to a subsequent same-day inpatient admission. In general**,** facilities should 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 171 was agreed as overpaid by $175.10 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: *We agree with the findings on audit items 171. Upon final agreement, we will reprocess the agreed upon claims for retraction.*

Healthcare Horizons' Final Comment: As recovery will not create adverse member impact, the City should instruct Optima to initiate claims reprocessing.

9. Several 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). As such, all services should be billed on a single inpatient claim. Healthcare Horizons identified seven claims paid in error for this issue for a total of $1,890.54 (audit items 174-

180). The root cause of these overpayments can be attributed to a provider billing error. Note that all potential overpayments were submitted in the sample selection.

> ***Optima Response:*** *We agree with the findings on audit items 174-180. We will also follow up with additional education for the claims processors regarding looking for these items when processing an inpatient claim as well as provider education. Upon final agreement, we will reprocess the agreed upon claims for retraction.*
>
> **Healthcare Horizons' Final Comment:** As recovery will not create adverse member impact, the City should instruct Optima to initiate claims reprocessing.

10. Recoverable claims were identified for evaluation and management procedures billed and paid 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 or up to 90 days after the surgery for follow-ups. For audit items 181-189 paid a total of $826.66, the claims were correct at the time of processing as the surgery claims had not yet been received, however, the claims are now recoverable (evaluations were performed one day prior to the surgery). As all questionable claims were submitted in the sample selection, no additional out-of-sample review is warranted.

> ***Optima Response:*** *We agree with the findings on audit items 181-189, the claims were processed correctly at the time of receipt but are recoverable at this time. Upon final agreement, we will reprocess the agreed upon claims for retraction.*
>
> **Healthcare Horizons' Final Comment:** As recovery will not create adverse member impact, the City should instruct Optima to initiate claims reprocessing.

11. Two claims were agreed as overpaid due to billing of medically unlikely units. As part of the comprehensive audit process, all claims are evaluated for billing of medically unlikely unit counts based on various industry sources. Audit items 190 and 191 were agreed as overpaid by $3,406.92 as the claims were billed with 59 units of procedure code 96372 (therapeutic, prophylactic, or diagnostic injection). This code should only be billed with 1 unit, and it is likely that 59 was intended for the procedure modifier to indicate a distinct service. As all potential errors were submitted in the sample selection, no additional claims were delivered to Optima for review.

> ***Optima Response:*** *We agree with the findings on audit items 190-191. The errors were related to manual processing and we will follow up with educational reminders for the team and with the individuals specifically. Upon final agreement, we will reprocess the agreed upon claims for retraction.*

Healthcare Horizons' Final Comment: Optima may also choose to explore system enhancements to limit the unit count paid for CPT 96372. As recovery will not create adverse member impact, the City should instruct Optima to initiate claims reprocessing.

12. Non-covered foot orthotics were agreed as paid in error per the plan design. As part of our comprehensive benefits testing, Healthcare Horizons evaluates all claims again benefit exclusions present in the plan document. Based on a review of the plan documents, foot orthotics of any kind are excluded from coverage including customized or non-customized shoes, boots, and inserts. Optima agreed to overpayments totaling $987.26 for this issue (audit items 226-236). As all foot orthotic claims were submitted in the sample selection, no additional out-of-sample review is warranted. Note that recovery of these claims will likely cause adverse member impact due to balance billing. Optima should ensure appropriate system configuration to deny these supplies moving forward.

Optima Response: *We agree with the findings on audit items 226-236. The errors were related to manual processing and we will follow up with educational reminders for the team and with the individuals specifically. Upon final agreement, we will reprocess the agreed upon claims for retraction.*

Healthcare Horizons' Final Comment: Optima may choose to explore systemic options to deny these charges moving forward. As reprocessing to deny will create adverse member impact, Optima should consider a direct settlement credit to the City for these claims.

13. Based on a change in benefits, claims were identified for non-covered morbid obesity treatment including gastric bypass surgery. Based on a review of the 2020 plan documents, morbid obesity treatment including surgery is no longer a covered benefit. As such, audit items 237-245 were submitted for review and Optima agreed to a total overpayment amount of $19,547.45 as the plan no longer has the morbid obesity rider. As all obesity surgery claims were submitted in the sample selection, no additional out-of-sample review is warranted. Note that recovery of these claims will likely cause adverse member impact due to balance billing. Optima should ensure appropriate system configuration to deny these services moving forward.

Optima Response: *We agree with the findings on audit items 237-245. The system configuration is being reviewed and additional edits added to address the non-covered benefit payments. We agree that the recovery will likely cause adverse member impact. Upon final agreement, we will reprocess the agreed upon claims for retraction.*

Healthcare Horizons' Final Comment: Optima should update the City when configuration changes are complete to deny these claims. As reprocessing to deny will create adverse member impact, Optima should consider a direct settlement credit to the City for these claims.

14. Non-covered sexual dysfunction treatment was agreed as paid in error per the plan design. The plan design cites sexual dysfunction as a benefit exclusion including treatment related to sexual organ function, dysfunction, or inadequacies, including but not limited to, impotency. Optima agreed to overpayments totaling $869.40 for this issue (audit items 258-262). As all questionable claims were submitted in the sample selection, no additional out-of-sample review is warranted. Note that recovery of these claims will likely cause adverse member impact due to balance billing. Optima should ensure appropriate system configuration to deny these services moving forward.

> ***Optima Response:*** *We agree with the findings on audit items 258-262. The system configuration is being reviewed and additional edits added to address the non-covered benefit payments. We agree that the recovery will likely cause adverse member impact. Upon final agreement, we will reprocess the agreed upon claims for retraction.*
>
> **Healthcare Horizons' Final Comment:** Optima should update the City when configuration changes are complete to deny these claims. As reprocessing to deny will create adverse member impact, Optima should consider a direct settlement credit to the City for these claims.

15. Healthcare Horizons identified limited instances of genetic testing not pre-authorized by Optima. Per the plan design, genetic testing is only covered if pre-authorized by the plan. For audit items 268, 269, 270, 271, and 273, Optima agreed to overpayments totaling $960.98 as no authorization was on file for genetic testing services. Note that recovery of these claims will likely cause adverse member impact due to balance billing. Audit items 264, 265, and 267 were closed as correct as the services were authorized. Three remaining items are discussed in the disputed findings section. Based on the limited agreed findings, no additional out-of-sample claims have been submitted for review. Note that the highest dollar genetic claims were covered in the sample selection.

> ***Optima Response:*** *We agree with the findings on audit items 268, 269, 270, 271 and 273. The system configuration is being reviewed and additional edits added to address the payments that were not pre-authorized. We agree that the recovery will likely cause adverse member impact. Upon final agreement, we will reprocess the agreed upon claims for retraction.*
>
> **Healthcare Horizons' Final Comment:** Optima should update the City when configuration changes are complete to deny these claims if not authorized appropriately. As reprocessing to deny will create adverse member impact, Optima should consider a direct settlement credit to the City for these claims.

16. Healthcare Horizons identified overpayments due to non-covered administrative exams. Per the plan document, physicals for employment, insurance or recreational activities are not covered services**.** Based on this exclusion, audit items 276, 277, 278, 280, 282, 284, 285, 286, 288, 289, 290, 291, 292, 293, 294, 295, 296, 299, and 300 were agreed as overpaid by a total of $1,605.60. The diagnosis codes for the findings were as follows:

- Z02.1 - Encounter for pre-employment examination
- Z02.5 - Encounter for examination for participation in sport

The claims closed as correct for this category involved immunizations. As all questionable claims were submitted in the sample selection, no additional out-of-sample review is warranted. Note that recovery of these claims will likely cause adverse member impact due to balance billing. Optima should ensure appropriate system configuration to deny these services moving forward.

> ***Optima Response:*** *We agree with the findings on audit items 276, 277, 278, 280, 282, 284, 285, 286, 288, 289, 290, 291, 292, 293, 294, 295, 296, 299 and 300. The system configuration is being reviewed and additional edits added to flag the claims processors more clearly regarding review for these diagnoses. We agree that the recovery will likely cause adverse member impact. Upon final agreement, we will reprocess the agreed upon claims for retraction.*
>
> **Healthcare Horizons' Final Comment:** Optima should update the City when configuration changes are complete to deny these claims. As reprocessing to deny will create adverse member impact, Optima should consider a direct settlement credit to the City for these claims.

Disputed Findings

1. Healthcare Horizons requests additional clarification on genetic testing claims repriced by Optum. For audit items 263, 266, and 272, we inquired about a required pre-authorization for genetic testing services. Optima responded that "Optum repricing trumps all system edits." We request clarification on whether genetic claims without an authorization are allowed if repriced by Optum.

> ***Optima Response:*** *For audit items 263, 266 and 272 where we have an agreement with Optum to manage transplants. Our agreement with Optum is to allow them to manage, authorize services, and price claims according to their agreement with the transplant providers as they specialize in this service. Therefore genetic testing is paid when Optum approves and authorizes payment for the service.*

> **Healthcare Horizons' Final Comment:** Based on the additional information provided by Optima, we are dismissing these claims as disputed items and consider this as informational only for the City. We have updated all charts to reflect no error for these items.

Informational Findings

1. Healthcare Horizons requests confirmation of dollars returned to the group for two of claims cited as already adjusted by Optima. 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
65	Duplicates	$17,236.07
87	Other Insurance	$9,105.20

Healthcare Horizons' Final Comment: Per the Optima response, these claims have been retracted with a credit to the City.

2. 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 88, 89, 93, and 94. We are glad to provide the member information to the group upon request.

Optima Response: *Yes we agree, the Health Plan will work to obtain member information to validate the dialysis start date.*

Healthcare Horizons' Final Comment: The member information was sent to the City for follow-up.

3. MinuteClinic is considered as a facility (versus professional) by Optima when considering allowable charge. As in-network professional claims are limited to billed charge per the allowable charge language, Healthcare Horizons submitted audit items 116-121 as the MinuteClinic office visit procedures were allowed more than billed charges. Optima responded that MinuteClinic claims are considered as facility and that case rate reimbursement is applicable even if greater than billed. While we do not disagree with this assessment, further discussion between the City and Optima may be warranted as we estimate a total impact of $36,027 (allowed more than billed) in 2020.

Optima Response: *Yes we agree, further discussion would be beneficial to confirm the agreement on the case rate reimbursement exceeding the billed amount is agreeable to the City.*

Healthcare Horizons' Final Comment: Optima and the City should revisit this arrangement to see if limiting payment to billed charges is appropriate based on the MinuteClinic agreement.

Conclusion

Healthcare Horizons appreciates the opportunity to perform this claims audit on behalf of The City of Virginia Beach. 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:

- The City should instruct Optima to pursue recoveries on all categories where reprocessing will not result in adverse member impact.
- Optima should consider a direct settlement credit for benefit exclusion categories in which recovery would result in member balance billing.
- The City should instruct Optima on recovery related to the Allowable Charge category as member balance billing will occur.
- Optima should notify the City when system configuration changes are complete for benefit exclusions identified.
- Optima should provide periodic cash collection updates to the City for claims placed into recovery.

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	Correct claim for 1/2 combo	Schools
2	Duplicates - Claim Level	$199.00	$0.00	Agreed duplicate error	Schools
3	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 3/4 combo	City
4	Duplicates - Claim Level	$124.00	$0.00	Agreed duplicate error	City
5	Duplicates - Claim Level	$0.00	$0.00	Recovered prior to audit	Schools
6	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 6/7 combo	Schools
7	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 7/8 combo	Schools
8	Duplicates - Claim Level	$0.00	$0.00	Correct based on modifier 59	Schools
9	Duplicates - Claim Level	$116.28	$0.00	Agreed duplicate error	City
10	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 9/10 combo	City
11	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 11/12 combo	Schools
12	Duplicates - Claim Level	$736.70	$0.00	Agreed duplicate error	Schools
13	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 13/14 combo	Schools
14	Duplicates - Claim Level	$199.00	$0.00	Agreed duplicate error	Schools
15	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 15/16 combo	City
16	Duplicates - Claim Level	$199.00	$0.00	Agreed duplicate error	City
17	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 17/18 combo	Schools
18	Duplicates - Claim Level	$0.00	$0.00	Recovered prior to audit	Schools
19	Duplicates - Line Level	$0.00	$0.00	Correct claim for 19/20 combo	Schools
20	Duplicates - Line Level	$31.50	$0.00	Agreed duplicate error	Schools
21	Duplicates - Line Level	$0.00	$0.00	Correct claim for 21/22 combo	Schools
22	Duplicates - Line Level	$116.28	$0.00	Agreed duplicate error	Schools
23	Duplicates - Line Level	$0.00	$0.00	Correct claim for 24/25/26 combo	Schools
24	Duplicates - Line Level	$0.00	$0.00	Correct claim for 24/25/26 combo	Schools
25	Duplicates - Line Level	$232.56	$0.00	Agreed duplicate error	Schools
26	Duplicates - Line Level	$0.00	$0.00	Correct claim for 26/27 combo	City
27	Duplicates - Line Level	$89.70	$0.00	Agreed duplicate error	City
28	Duplicates - Line Level	$0.00	$0.00	Correct claim for 28/29 combo	Schools
29	Duplicates - Line Level	$76.16	$0.00	Agreed duplicate error	Schools
30	Duplicates - Line Level	$4,216.82	$0.00	Agreed duplicate error	City
31	Duplicates - Line Level	$0.00	$0.00	Correct claim for 30/31 combo	City
32	Duplicates - Line Level	$490.91	$0.00	Agreed duplicate error	Schools
33	Duplicates - Line Level	$0.00	$0.00	Correct claim for 32/33 combo	Schools
34	Duplicates - Line Level	$0.00	$0.00	Correct claim for 34/35 combo	Schools
35	Duplicates - Line Level	$77.43	$0.00	Agreed duplicate error	Schools
36	Duplicates - Line Level	$0.00	$0.00	Correct claim for 36/37 combo	Schools
37	Duplicates - Line Level	$0.00	$0.00	Optima states different vendor	Schools
38	Duplicates - Line Level	$0.00	$0.00	Correct claim for 38/39 combo	Schools
39	Duplicates - Line Level	$348.84	$0.00	Agreed duplicate error	Schools
40	Duplicates - Line Level	$0.00	$0.00	Correct claim for 40/41 combo	Schools
41	Duplicates - Line Level	$0.00	$0.00	Recovered prior to audit	Schools
42	Duplicates - Line Level	$0.00	$0.00	Correct claim for 42/43 combo	Schools
43	Duplicates - Line Level	$116.28	$0.00	Agreed duplicate error	Schools
44	Duplicates - Line Level	$0.00	$0.00	Correct claim for 44/45 combo	City
45	Duplicates - Line Level	$146.49	$0.00	Agreed duplicate error	City
46	Duplicates - Line Level	$0.00	$0.00	Correct claim for 46/47/48 combo	City
47	Duplicates - Line Level	$0.00	$0.00	Correct claim for 46/47/48 combo	City
48	Duplicates - Line Level	$130.00	$0.00	Agreed duplicate error	City
49	Duplicates - Line Level	$0.00	$0.00	Correct claim for 49/50 combo	Schools
50	Duplicates - Line Level	$200.53	$0.00	Agreed duplicate error	Schools
51	Duplicates - Line Level	$0.00	$0.00	Correct claim for 51/52 combo	City
52	Duplicates - Line Level	$129.75	$0.00	Agreed duplicate error	City
53	Duplicates - Line Level	$0.00	$0.00	Correct claim for 53/54 combo	City
54	Duplicates - Line Level	$129.75	$0.00	Agreed duplicate error	City
55	Duplicates - Line Level	$0.00	$0.00	Correct claim for 55/56/57 combo	City
56	Duplicates - Line Level	$0.00	$0.00	Correct claim for 55/56/57 combo	City
57	Duplicates - Line Level	$232.56	$0.00	Agreed duplicate error	City
58	Duplicates - Line Level	$0.00	$0.00	Correct claim for 58/59 combo	City
59	Duplicates - Line Level	$116.28	$0.00	Agreed duplicate error	City
60	Duplicates - Line Level	$0.00	$0.00	Correct claim for 60/61 combo	City
61	Duplicates - Line Level	$0.00	$0.00	Recovered prior to audit	City

Audit Item	Issue	Recovery Amount	Disputed Amount	Comment	Group
62	Duplicates - Line Level	$0.00	$0.00	Correct claim for 62/63 combo	City
63	Duplicates - Line Level	$0.00	$0.00	Recovered prior to audit	City
64	Duplicates - Line Level	$0.00	$0.00	Correct claim for 64/65 combo	City
65	Duplicates - Line Level	$0.00	$0.00	Recovered prior to audit - informational	City
66	Duplicates - Line Level	$0.00	$0.00	Correct claim for 66/67 combo	Schools
67	Duplicates - Line Level	$117.75	$0.00	Agreed duplicate error	Schools
68	Duplicates - Line Level	$0.00	$0.00	Correct claim for 68/69 combo	Schools
69	Duplicates - Line Level	$120.82	$0.00	Agreed duplicate error	Schools
70	Duplicates - Line Level	$0.00	$0.00	Correct claim for 70/71 combo	Schools
71	Duplicates - Line Level	$244.73	$0.00	Agreed duplicate error	Schools
72	Eligibility - After Termination	$0.00	$0.00	Recovered prior to audit	Schools
73	Other Insurance	$0.00	$0.00	Recovered prior to audit	Schools
74	Other Insurance	$0.00	$0.00	Medicare primary 2/1/20 - DOS prior	City
75	Other Insurance	$0.00	$0.00	Medicare primary 2/1/20 - DOS prior	City
76	Other Insurance	$0.00	$0.00	Coordinated correctly	Schools
77	Other Insurance	$79,963.47	$0.00	Anthem primary 4/5/20 (notified 7/23/20)	Schools
78	Other Insurance	$0.00	$0.00	Coordinated correctly	Schools
79	Other Insurance	$0.00	$0.00	Medicare Part A only - plan does not estimate	City
80	Other Insurance	$0.00	$0.00	Medicare Part A only - plan does not estimate	City
81	Other Insurance	$0.00	$0.00	Medicare Part A only - plan does not estimate	City
82	Other Insurance	$0.00	$0.00	Other insurance is secondary	Schools
83	Other Insurance	$0.00	$0.00	Other insurance is secondary	Schools
84	Other Insurance	$0.00	$0.00	Coordinated correctly	City
85	Other Insurance	$0.00	$0.00	Other coverage termed 8/12/20 - DOS after	City
86	Other Insurance	$0.00	$0.00	Other insurance is secondary	City
87	Other Insurance	$0.00	$0.00	Recovered prior to audit - informational	Schools
88	ESRD	$0.00	$0.00	No Medicare information on file - informational	Schools
89	ESRD	$0.00	$0.00	No Medicare information on file - informational	City
90	ESRD	$0.00	$0.00	Medicare secondary	City
91	ESRD	$0.00	$0.00	Medicare primary 12/1/21 - DOS prior	City
92	ESRD	$0.00	$0.00	Medicare secondary	Schools
93	ESRD	$0.00	$0.00	No Medicare information on file - informational	Schools
94	ESRD	$0.00	$0.00	No Medicare information on file - informational	Schools
95	Secondary Payments	$0.00	$0.00	Coordinated correctly	Schools
96	Secondary Payments	$0.00	$0.00	Coordinated correctly	City
97	Secondary Payments	$0.00	$0.00	Coordinated correctly	Schools
98	Secondary Payments	$0.00	$0.00	Coordinated correctly	City
99	Secondary Payments	$0.00	$0.00	Coordinated correctly	Schools
100	Pricing - Optima Facility	$0.00	$0.00	Pricing correct per Optima - stop loss	Schools
101	Pricing - Optima Facility	$0.00	$0.00	Pricing correct per Optima - transplant rate	City
102	Pricing - Optima Facility	$0.00	$0.00	Pricing correct per Optima - stop loss	City
103	Pricing - Optima Facility	$0.00	$0.00	Pricing correct per Optima - stop loss	City
104	Pricing - Optima Facility	$0.00	$0.00	Pricing correct per Optima - stop loss	Schools
105	Pricing - Optima Facility	$0.00	$0.00	Pricing correct per Optima - transplant rate	City
106	Pricing - Optima Facility	$0.00	$0.00	Pricing correct per Optima - stop loss	City
107	Pricing - Optima Facility	$0.00	$0.00	Pricing correct per Optima - stop loss	City
108	Pricing - Optima Facility	$0.00	$0.00	Pricing correct per Optima - stop loss	Schools
109	Pricing - PHCS	$0.00	$0.00	PHCS pricing correct per Optima - percent of charges	Schools
110	Pricing - PHCS	$0.00	$0.00	PHCS pricing correct per Optima - percent of charges	City
111	Allowable Charge - In-Network	$34.74	$0.00	Agreed error - should limit to billed charges	Schools
112	Allowable Charge - In-Network	$32.00	$0.00	Agreed error - should limit to billed charges	Schools
113	Allowable Charge - In-Network	$28.01	$0.00	Agreed error - should limit to billed charges	City
114	Allowable Charge - In-Network	$299.50	$0.00	Agreed error - should limit to billed charges	City
115	Allowable Charge - In-Network	$299.50	$0.00	Agreed error - should limit to billed charges	Schools
116	Allowable Charge - In-Network	$0.00	$0.00	MinuteClinic considered as facility - informational	Schools
117	Allowable Charge - In-Network	$0.00	$0.00	MinuteClinic considered as facility - informational	Schools
118	Allowable Charge - In-Network	$0.00	$0.00	MinuteClinic considered as facility - informational	Schools
119	Allowable Charge - In-Network	$0.00	$0.00	MinuteClinic considered as facility - informational	Schools
120	Allowable Charge - In-Network	$0.00	$0.00	MinuteClinic considered as facility - informational	Schools
121	Allowable Charge - In-Network	$0.00	$0.00	MinuteClinic considered as facility - informational	Schools
122	Allowable Charge - Out-of-Network	$53,681.70	$0.00	Agreed error - should limit to allowable charge	Schools
123	Allowable Charge - Out-of-Network	$0.00	$0.00	Allowed correctly per authorization	Schools
124	Allowable Charge - Out-of-Network	$955.14	$0.00	Agreed error - should limit to allowable charge	City
125	Allowable Charge - Out-of-Network	$1,844.74	$0.00	Agreed error - missed PHCS pricing	Schools
126	Allowable Charge - Out-of-Network	$0.00	$0.00	Transplant rate	Schools
127	Allowable Charge - Out-of-Network	$10,506.67	$0.00	Should have denied - billed under incorrect TIN an missed pricing	Schools
128	Transfers	$0.00	$0.00	Priced correctly	Schools
129	Transfers	$29,469.97	$0.00	Agreed error - missed transfer rate	City
130	Transfers	$12,845.72	$0.00	Agreed error - missed transfer rate	Schools
131	Transfers	$0.00	$0.00	Priced correctly	Schools
132	Transfers	$0.00	$0.00	Priced correctly	Schools

Audit Item	Issue	Recovery Amount	Disputed Amount	Comment	Group
133	Readmissions	$0.00	$0.00	Initial admission - informational only	City
134	Readmissions	$0.00	$0.00	Readmission allowed for different diagnosis	City
135	Readmissions	$0.00	$0.00	Initial admission - informational only	Schools
136	Readmissions	$0.00	$0.00	Readmission allowed for different diagnosis	Schools
137	Readmissions	$0.00	$0.00	Initial admission - informational only	City
138	Readmissions	$43,619.70	$0.00	Agreed error - readmission within 3 days for same diagnosis	City
139	ASC Pricing	$4,992.00	$0.00	Agreed error - only highest procedure is reimbursed per contract	City
140	ASC Pricing	$4,652.90	$0.00	Agreed error - only highest procedure is reimbursed per contract	Schools
141	ASC Pricing	$4,379.20	$0.00	Agreed error - only highest procedure is reimbursed per contract	Schools
142	ASC Pricing	$1,824.95	$0.00	Agreed error - only highest procedure is reimbursed per contract	Schools
143	ASC Pricing	$4,182.85	$0.00	Agreed error - only highest procedure is reimbursed per contract	City
144	ASC Pricing	$4,652.90	$0.00	Agreed error - only highest procedure is reimbursed per contract	City
145	ASC Pricing	$6,135.38	$0.00	Agreed error - only highest procedure is reimbursed per contract	Schools
146	ASC Pricing	$4,025.60	$0.00	Agreed error - only highest procedure is reimbursed per contract	Schools
147	ASC Pricing	$4,025.60	$0.00	Agreed error - only highest procedure is reimbursed per contract	Schools
148	ASC Pricing	$2,827.95	$0.00	Agreed error - only highest procedure is reimbursed per contract	City
149	ASC Pricing	$2,827.95	$0.00	Agreed error - only highest procedure is reimbursed per contract	City
150	ASC Pricing	$0.00	$0.00	Both procedures allowed separately	Schools
151	ASC Pricing	$2,827.95	$0.00	Agreed error - only highest procedure is reimbursed per contract	Schools
152	ASC Pricing	$243.10	$0.00	Agreed error - only highest procedure is reimbursed per contract	Schools
153	ASC Pricing	$0.00	$0.00	Both procedures allowed separately	City
154	ASC Pricing	$2,475.00	$0.00	Agreed error - only highest procedure is reimbursed per contract	City
155	ASC Pricing	$5,306.07	$0.00	Agreed error - only highest procedure is reimbursed per contract	Schools
156	ASC Pricing	$8,120.00	$0.00	Agreed error - only highest procedure is reimbursed per contract	City
157	ASC Pricing	$1,597.50	$0.00	Agreed error - only highest procedure is reimbursed per contract	Schools
158	Multiple Procedure Reductions	$0.00	$0.00	Primary procedure - informational only	City
159	Multiple Procedure Reductions	$90.34	$0.00	Agreed error - missed reduction	City
160	Multiple Procedure Reductions	$0.00	$0.00	Primary procedure - informational only	Schools
161	Multiple Procedure Reductions	$0.00	$0.00	Reduction not applicable	Schools
162	Multiple Procedure Reductions	$0.00	$0.00	Primary procedure - informational only	Schools
163	Multiple Procedure Reductions	$72.54	$0.00	Agreed error - missed reduction	Schools
164	Home Health During Inpatient	$0.00	$0.00	Correct - scheduled delivery of nutritional supplies	Schools
165	Home Health During Inpatient	$0.00	$0.00	Correct - scheduled delivery of nutritional supplies	Schools
166	Outpatient During Inpatient	$0.00	$0.00	Separate payments correct per Optima	Schools
167	Outpatient During Inpatient	$0.00	$0.00	Separate payments correct per Optima	City
168	ER with Admission	$0.00	$0.00	Correct - different facilities	Schools
169	ER with Admission	$0.00	$0.00	Correct - different facilities	City
170	ER with Admission	$0.00	$0.00	Correct - different facilities	Schools
171	Outpatient with Admission	$175.10	$0.00	Agreed error	Schools
172	Outpatient with Admission	$0.00	$0.00	Recovered prior to audit	Schools
173	Outpatient with Admission	$0.00	$0.00	Recovered prior to audit	City
174	Pre-Admission Testing	$323.35	$0.00	Agreed error	City
175	Pre-Admission Testing	$311.82	$0.00	Agreed error	City
176	Pre-Admission Testing	$328.84	$0.00	Agreed error	Schools
177	Pre-Admission Testing	$166.26	$0.00	Agreed error	City
178	Pre-Admission Testing	$470.32	$0.00	Agreed error	Schools
179	Pre-Admission Testing	$83.95	$0.00	Agreed error	Schools
180	Pre-Admission Testing	$206.00	$0.00	Agreed error	Schools
181	Surgery Global	$136.30	$0.00	Correct at the time of processing but recoverable	City
182	Surgery Global	$37.76	$0.00	Correct at the time of processing but recoverable	Schools
183	Surgery Global	$78.80	$0.00	Correct at the time of processing but recoverable	City
184	Surgery Global	$84.40	$0.00	Correct at the time of processing but recoverable	Schools
185	Surgery Global	$71.25	$0.00	Correct at the time of processing but recoverable	Schools
186	Surgery Global	$136.69	$0.00	Correct at the time of processing but recoverable	City
187	Surgery Global	$136.69	$0.00	Correct at the time of processing but recoverable	City
188	Surgery Global	$51.77	$0.00	Correct at the time of processing but recoverable	Schools
189	Surgery Global	$93.00	$0.00	Correct at the time of processing but recoverable	Schools
190	Medically Unlikely Edits	$1,703.46	$0.00	Agreed error - units incorrect	Schools
191	Medically Unlikely Edits	$1,703.46	$0.00	Agreed error - units incorrect	Schools
192	Out-of-Network Benefit	$0.00	$0.00	In-network benefit granted	Schools
193	Out-of-Network Benefit	$0.00	$0.00	In-network benefit granted	Schools
194	Out-of-Network Benefit	$0.00	$0.00	In-network benefit granted	Schools
195	Out-of-Network Benefit	$0.00	$0.00	In-network benefit granted	Schools
196	Out-of-Network Benefit	$0.00	$0.00	In-network benefit granted	Schools
197	Out-of-Network Benefit	$0.00	$0.00	In-network benefit granted	City
198	Out-of-Network Benefit	$0.00	$0.00	In-network benefit granted	City
199	Out-of-Network Benefit	$0.00	$0.00	In-network benefit granted	Schools
200	Copayments - Office Visit	$0.00	$0.00	Telemedicine copay waiver	City
201	Copayments - Office Visit	$0.00	$0.00	Telemedicine copay waiver	City
202	Copayments - Office Visit	$40.00	$0.00	Agreed error	Schools
203	Copayments - Office Visit	$0.00	$0.00	Telemedicine copay waiver	Schools
204	Copayments - Office Visit	$0.00	$0.00	Telemedicine copay waiver	Schools

Audit Item	Issue	Recovery Amount	Disputed Amount	Comment	Group
205	Copayments - Telemedicine	$0.00	$0.00	Telemedicine copay waiver	City
206	Copayments - Telemedicine	$0.00	$0.00	Telemedicine copay waiver	Schools
207	Copayments - Telemedicine	$0.00	$0.00	Telemedicine copay waiver	Schools
208	Copayments - Telemedicine	$0.00	$0.00	Telemedicine copay waiver	Schools
209	Copayments - Telemedicine	$0.00	$0.00	Telemedicine copay waiver	Schools
210	Copayments - Telemedicine	$0.00	$0.00	Telemedicine copay waiver	City
211	Copayments - Telemedicine	$0.00	$0.00	Telemedicine copay waiver	City
212	Copayments - Telemedicine	$0.00	$0.00	Telemedicine copay waiver	City
213	COVID-19 Treatment Cost Share	$0.00	$0.00	Plan opted in for COVID treatment cost share waiver	City
214	COVID-19 Treatment Cost Share	$0.00	$0.00	Plan opted in for COVID treatment cost share waiver	City
215	COVID-19 Treatment Cost Share	$0.00	$0.00	Plan opted in for COVID treatment cost share waiver	Schools
216	COVID-19 Treatment Cost Share	$0.00	$0.00	Plan opted in for COVID treatment cost share waiver	Schools
217	COVID-19 Treatment Cost Share	$0.00	$0.00	Plan opted in for COVID treatment cost share waiver	City
218	Benefit Maximum - Hearing Aids	$0.00	$0.00	Hearing aid assessment not included in maximum	City
219	Benefit Maximum - Hearing Aids	$0.00	$0.00	Hearing aid assessment not included in maximum	Schools
220	Benefit Maximum - Hearing Aids	$0.00	$0.00	Hearing aid assessment not included in maximum	Schools
221	Benefit Maximum - Hearing Aids	$0.00	$0.00	Hearing aid assessment not included in maximum	City
222	Benefit Exclusion - Blood Pressure Monitors	$49.05	$0.00	Agreed error	City
223	Benefit Exclusion - Breast	$0.00	$0.00	Correct - authorized	Schools
224	Benefit Exclusion - Breast	$0.00	$0.00	Correct - authorized	Schools
225	Benefit Exclusion - Breast	$0.00	$0.00	Correct - authorized	Schools
226	Benefit Exclusion - Foot Orthotics	$205.65	$0.00	Agreed error	Schools
227	Benefit Exclusion - Foot Orthotics	$109.25	$0.00	Agreed error	Schools
228	Benefit Exclusion - Foot Orthotics	$241.64	$0.00	Agreed error	Schools
229	Benefit Exclusion - Foot Orthotics	$100.00	$0.00	Agreed error	City
230	Benefit Exclusion - Foot Orthotics	$79.85	$0.00	Agreed error	Schools
231	Benefit Exclusion - Foot Orthotics	$85.00	$0.00	Agreed error	Schools
232	Benefit Exclusion - Foot Orthotics	$7.50	$0.00	Agreed error	Schools
233	Benefit Exclusion - Foot Orthotics	$81.61	$0.00	Agreed error	City
234	Benefit Exclusion - Foot Orthotics	$17.59	$0.00	Agreed error	City
235	Benefit Exclusion - Foot Orthotics	$14.14	$0.00	Agreed error	City
236	Benefit Exclusion - Foot Orthotics	$45.03	$0.00	Agreed error	City
237	Benefit Exclusion - Morbid Obesity	$1,260.02	$0.00	Agreed error - plan no longer has obesity rider	City
238	Benefit Exclusion - Morbid Obesity	$522.77	$0.00	Agreed error - plan no longer has obesity rider	City
239	Benefit Exclusion - Morbid Obesity	$261.38	$0.00	Agreed error - plan no longer has obesity rider	City
240	Benefit Exclusion - Morbid Obesity	$1,591.78	$0.00	Agreed error - plan no longer has obesity rider	Schools
241	Benefit Exclusion - Morbid Obesity	$5,865.16	$0.00	Agreed error - plan no longer has obesity rider	Schools
242	Benefit Exclusion - Morbid Obesity	$1,827.16	$0.00	Agreed error - plan no longer has obesity rider	Schools
243	Benefit Exclusion - Morbid Obesity	$1,402.96	$0.00	Agreed error - plan no longer has obesity rider	City
244	Benefit Exclusion - Morbid Obesity	$5,789.46	$0.00	Agreed error - plan no longer has obesity rider	City
245	Benefit Exclusion - Morbid Obesity	$1,026.76	$0.00	Agreed error - plan no longer has obesity rider	City
246	Benefit Exclusion - Orthoptic	$0.00	$0.00	Treatment of convergence insufficiency covered	Schools
247	Benefit Exclusion - Orthoptic	$0.00	$0.00	Treatment of convergence insufficiency covered	Schools
248	Benefit Exclusion - Orthoptic	$0.00	$0.00	Treatment of convergence insufficiency covered	Schools
249	Benefit Exclusion - Orthoptic	$0.00	$0.00	Treatment of convergence insufficiency covered	Schools
250	Benefit Exclusion - Orthoptic	$0.00	$0.00	Treatment of convergence insufficiency covered	Schools
251	Benefit Exclusion - Orthoptic	$0.00	$0.00	Treatment of convergence insufficiency covered	Schools
252	Benefit Exclusion - Orthoptic	$0.00	$0.00	Treatment of convergence insufficiency covered	Schools
253	Benefit Exclusion - Orthoptic	$0.00	$0.00	Treatment of convergence insufficiency covered	Schools
254	Benefit Exclusion - Orthoptic	$0.00	$0.00	Treatment of convergence insufficiency covered	Schools
255	Benefit Exclusion - Orthoptic	$0.00	$0.00	Treatment of convergence insufficiency covered	Schools
256	Benefit Exclusion - Orthoptic	$0.00	$0.00	Treatment of convergence insufficiency covered	Schools
257	Benefit Exclusion - Orthoptic	$0.00	$0.00	Treatment of convergence insufficiency covered	Schools
258	Benefit Exclusion - Sexual Dysfunction	$166.68	$0.00	Agreed error	Schools
259	Benefit Exclusion - Sexual Dysfunction	$146.68	$0.00	Agreed error	Schools
260	Benefit Exclusion - Sexual Dysfunction	$192.68	$0.00	Agreed error	City
261	Benefit Exclusion - Sexual Dysfunction	$180.68	$0.00	Agreed error	City
262	Benefit Exclusion - Sexual Dysfunction	$182.68	$0.00	Agreed error	City
263	Benefit Exclusion - Genetic Testing	$0.00	$0.00	Optima authorized	Schools
264	Benefit Exclusion - Genetic Testing	$0.00	$0.00	Authorization on file	Schools
265	Benefit Exclusion - Genetic Testing	$0.00	$0.00	Authorization on file	Schools
266	Benefit Exclusion - Genetic Testing	$0.00	$0.00	Optima authorized	Schools
267	Benefit Exclusion - Genetic Testing	$0.00	$0.00	Authorization on file	Schools
268	Benefit Exclusion - Genetic Testing	$135.72	$0.00	Agreed error - no authorization on file	Schools
269	Benefit Exclusion - Genetic Testing	$72.75	$0.00	Agreed error - no authorization on file	City
270	Benefit Exclusion - Genetic Testing	$315.01	$0.00	Agreed error - no authorization on file	Schools
271	Benefit Exclusion - Genetic Testing	$370.60	$0.00	Agreed error - no authorization on file	City
272	Benefit Exclusion - Genetic Testing	$0.00	$0.00	Optima authorized	Schools
273	Benefit Exclusion - Genetic Testing	$66.90	$0.00	Agreed error - no authorization on file	Schools
274	Benefit Exclusion - Other the Counter Supplies	$0.00	$0.00	Recovered prior to audit	Schools
275	Benefit Exclusion - Other the Counter Supplies	$0.00	$0.00	Recovered prior to audit	Schools

Audit Item	Issue	Recovery Amount	Disputed Amount	Comment	Group
276	Benefit Exclusion - Administrative Exams	$309.00	$0.00	Agreed error	Schools
277	Benefit Exclusion - Administrative Exams	$79.23	$0.00	Agreed error	Schools
278	Benefit Exclusion - Administrative Exams	$91.25	$0.00	Agreed error	Schools
279	Benefit Exclusion - Administrative Exams	$0.00	$0.00	Immunization is covered	Schools
280	Benefit Exclusion - Administrative Exams	$59.23	$0.00	Agreed error	Schools
281	Benefit Exclusion - Administrative Exams	$0.00	$0.00	Immunization is covered	Schools
282	Benefit Exclusion - Administrative Exams	$15.45	$0.00	Agreed error	Schools
283	Benefit Exclusion - Administrative Exams	$0.00	$0.00	Immunization is covered	City
284	Benefit Exclusion - Administrative Exams	$58.22	$0.00	Agreed error	Schools
285	Benefit Exclusion - Administrative Exams	$58.22	$0.00	Agreed error	City
286	Benefit Exclusion - Administrative Exams	$58.22	$0.00	Agreed error	City
287	Benefit Exclusion - Administrative Exams	$0.00	$0.00	Immunization is covered	Schools
288	Benefit Exclusion - Administrative Exams	$58.22	$0.00	Agreed error	City
289	Benefit Exclusion - Administrative Exams	$123.17	$0.00	Agreed error	Schools
290	Benefit Exclusion - Administrative Exams	$134.94	$0.00	Agreed error	Schools
291	Benefit Exclusion - Administrative Exams	$58.22	$0.00	Agreed error	Schools
292	Benefit Exclusion - Administrative Exams	$58.22	$0.00	Agreed error	Schools
293	Benefit Exclusion - Administrative Exams	$58.22	$0.00	Agreed error	Schools
294	Benefit Exclusion - Administrative Exams	$58.22	$0.00	Agreed error	Schools
295	Benefit Exclusion - Administrative Exams	$162.13	$0.00	Agreed error	City
296	Benefit Exclusion - Administrative Exams	$49.00	$0.00	Agreed error	Schools
297	Benefit Exclusion - Administrative Exams	$0.00	$0.00	Immunization is covered	City
298	Benefit Exclusion - Administrative Exams	$0.00	$0.00	Immunization is covered	Schools
299	Benefit Exclusion - Administrative Exams	$58.22	$0.00	Agreed error	City
300	Benefit Exclusion - Administrative Exams	$58.22	$0.00	Agreed error	City
		$338,138.72	**$0.00**		

Appendix B – Out-of-Sample Claims

Audit Item	Issue	Recovery Amount	Comment	Group
301	Other Insurance	$1,731.93	Anthem primary 4/5/20	Schools
302	Other Insurance	$2,176.15	Anthem primary 4/5/20	Schools
303	Other Insurance	$225.45	Anthem primary 4/5/20	Schools
304	Other Insurance	$0.00	Recovered prior to audit	Schools
305	Other Insurance	$225.45	Anthem primary 4/5/20	Schools
306	Other Insurance	$0.00	Recovered prior to audit	Schools
307	Other Insurance	$0.00	Recovered prior to audit	Schools
308	Other Insurance	$137.65	Anthem primary 4/5/20	Schools
	Total	**$4,496.63**		

Appendix C – Optima Response to Draft Audit Report

(PHI Redacted from Audit Response)

Virginia Beach City & Schools 2020 Audit
Responses to Recoverable Findings

1. A minimal dollar amount of agreed duplicate payment errors was identified. Healthcare Horizons performs a number of queries to identify potential duplicate payments and our initial analysis yielded a minimal volume of potential duplicates that were all submitted in the sample selection. Optima agreed with 27 duplicate payment errors totaling $9,083.84 (audit items 2, 4, 8, 9, 12, 14, 16, 20, 22, 25, 27, 29, 30, 32, 35, 39, 43, 45, 48, 50, 52, 54, 57, 59, 67, 69, and 71) with a primary response that the system did not flag the claims as duplicates. Optima may choose to utilize the audit findings to determine why current duplicate edit logic did not flag these claims.

Response: Upon further review, we found audit item 8 was not a duplicate. The provider billed the reading fee with a 59 modifier. Our bundling software indicates the 59 modifier in this situation indicates a distinct and separate specimen. We agree with all other audit items listed above. The primary issue was the system did not flag the claim as possible duplicates for review. The issue has been corrected and we conducted testing to confirm this is not an ongoing issue. Upon final agreement, we will reprocess the agreed upon claims for retraction.

2. Retroactive notification of other commercial 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. With the exception of one claim, all items were dismissed as correct as the claims were either coordinated correctly or no other primary coverage was in effect on the service date. For audit item 77, Optima responded that the other primary insurance information was received after the claim was processed, however, the claim is now recoverable for $79,963.47 (final amount pending coordination). Based on the other insurance primary effective date noted, Healthcare Horizons delivered eight additional out-of-sample claims for review and recovery with an estimated potential of $6,525.68. 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.

Response: We have several processes in place to assist with identifying claims impacted by the receipt of retroactive other primary insurance information. Our recovery team runs reports weekly to identify any claims impacted by the receipt of retroactive other primary insurance information and our special projects team manages any adjustments needed. To add an additional layer of review, we now have a vendor partner that scans our claims to look for any claims paid as primary with other health insurance listed that was instituted in the fall of 2020 to have a second sweep of claims to ensure we did not miss any recoveries. Feedback will be provided on the eight additional out-of-sample claims identified once claim details, including claim numbers, are provided by Health Care Horizons. Upon final agreement, we will reprocess the agreed upon claims for retraction.

3. Healthcare Horizons identified overpayments related to the allowable charge for both in-network and out-of-network providers. The plan document describes the allowable charge as follows:
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.
For audit items 111-115, Optima agreed to a total overpayment of $693.75 as the claims should have been limited to the in-network physicians' actual charge which was less than the fee schedule amount. For audit items 122 and 124, Optima agreed to overpayments totaling $54,636.84 as the out-of-network facility claims should have been limited to Optima's in-network contracted rate for similar services as fee negotiation was unsuccessful. Note that adjustment and recovery of these claims (audit items 122 and 124) will result in adverse member impact. For audit item 125, an available PHCS discount was omitted resulting in a recoverable amount of $1,844.74. Finally, audit item 127 should be denied ($10,506.67) as the provider billed an incorrect tax identification number causing in-network pricing to be missed. Note that Healthcare Horizons submitted all questionable allowable charge claims in the sample claim selection.

Response: Audit items 111 – 115 were related to a system issue that occurred where our lessor of logic was not applied correctly. The system issue has been corrected and tested to ensure this is not continuing to impact claims.

At the Auditors request the Health Plan was asked to speak to medical necessity or any preauthorization for audit item #122. There was an authorization on file for the claim in question for an abdominoplasty procedure (CPT 15830 & 15847) which was approved by the Medical Director, other services (CPT 15832) were denied, not medically necessary. We agree with the comments regarding audit items 124, 125, and 127 including the result of adverse member impact due to retractions.

Upon final agreement, we will reprocess the agreed upon claims for retraction.

4. Testing of inpatient transfer claims yielded two pricing errors. It is common for facility contracts with DRG case rate reimbursement to include special pricing terms for transfer claims. If a patient is transferred to another acute care facility, the transfer from facility has not treated the case, therefore, a full case rate payment is not justified. In lieu of a full case rate payment, transfers are often priced at a

percent of billed charges or a per diem rate. For audit items 129 and 130, Optima agreed that transfer pricing was missed resulting in a total overpayment of $42,315.69. The remaining claims submitted in this category were found to be priced correctly. As all questionable transfer claims were submitted in the sample selection, no additional out-of-sample review is warranted.

Response: Additional system logic has been added to flag claims as transfers with the disposition is greater than 01 for review. Upon final agreement, we will reprocess the agreed upon claims for retraction.

5. A single inpatient readmission for a similar diagnosis was allowed in error. 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 three inpatient readmission cases for review by Optima to determine if the second payment was permitted per the contract. For audit items 133/134 and 135/136, Optima responded that the first three digits of the primary diagnosis code must be equal in order for the admissions to be combined. On the final combination (audit items 137/138), Optima agreed to a readmission overpayment of $43,619.70 on audit item 138 as the primary diagnosis codes were the same on both admissions. As all questionable readmission claims were submitted in the sample selection, no additional out-of-sample review is warranted.

Response: Audit item 138 was a manual processing error and education has been provided to the claims processor as well as a reminder regarding readmissions to all claims processor who handle inpatient claims. Upon final agreement, we will reprocess the agreed upon claims for retraction.

6. 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 seventeen overpayments totaling $65,096.90 for this issue (audit items 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 151, 152, 154, 155, 156, and 157). As this issue has been present in prior audits, we request that Optima address any planned root cause correction to prevent future overpayments.

Response: All of these audit items are related to a single facility, CHKD. Currently this adjustment is a manual process and it is not routine. We are going through a detailed system review to identify automation opportunities and implement them as soon as possible. In the meantime, we will also add a focused audit to review these claims. Upon final agreement, we will reprocess the agreed upon claims for retraction.

7. 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 159 and 163 were agreed as overpaid for a total of $162.88 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.

Response: We agree with the findings on audit items 159 and 163. Upon final agreement, we will reprocess the agreed upon claims for retraction.

8. A single outpatient claim was billed and paid in error due to a subsequent same-day inpatient admission. In general, facilities should 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 171 was agreed as overpaid by $175.10 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.

Response: We agree with the findings on audit items 171. Upon final agreement, we will reprocess the agreed upon claims for retraction.

9. Several 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). As such, all services should be billed on a single inpatient claim. Healthcare Horizons identified seven claims paid in error for this issue for a total of $1,890.54 (audit items 174-180). The root cause of these overpayments can be attributed to a provider billing error. Note that all potential overpayments were submitted in the sample selection.

Response: We agree with the findings on audit items 174-180. We will also follow up with additional education for the claims processors regarding looking for these items when processing an inpatient claim as well as provider education. Upon final agreement, we will reprocess the agreed upon claims for retraction.

10. Recoverable claims were identified for evaluation and management procedures billed and paid 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 or up to 90 days after the surgery for follow-ups. For audit items 181-189 paid a total of $826.66, the claims were correct at the time of processing as the surgery claims had not yet been received, however, the claims are now recoverable (evaluations were performed one day prior to the surgery). As all questionable claims were submitted in the sample selection, no additional out-of-sample review is warranted.

Response: We agree with the findings on audit items 181-189, the claims were processed correctly at the time of receipt but are recoverable at this time. Upon final agreement, we will reprocess the agreed upon claims for retraction.

11. Two claims were agreed as overpaid due to billing of medically unlikely units. As part of the comprehensive audit process, all claims are evaluated for billing of medically unlikely unit counts based on various industry sources. Audit items 190 and 191 were agreed as overpaid by $3,406.92 as the claims were billed with 59 units of procedure code 96372 (therapeutic, prophylactic, or diagnostic injection). This code should only be billed with 1 unit, and it is likely that 59 was intended for the procedure modifier to indicate a distinct service. As all potential errors were submitted in the sample selection, no additional claims were delivered to Optima for review.

Response: We agree with the findings on audit items 190-191. The errors were related to manual processing and we will follow up with educational reminders for the team and with the individuals specifically. Upon final agreement, we will reprocess the agreed upon claims for retraction.

12. Non-covered foot orthotics were agreed as paid in error per the plan design. As part of our comprehensive benefits testing, Healthcare Horizons evaluates all claims again benefit exclusions present in the plan document. Based on a review of the plan documents, foot orthotics of any kind are excluded from coverage including customized or non-customized shoes, boots, and inserts. Optima agreed to overpayments totaling $987.26 for this issue (audit items 226-236). As all foot orthotic claims were submitted in the sample selection, no additional out-of-sample review is warranted. Note that recovery of these claims will likely cause adverse member impact due to balance billing. Optima should ensure appropriate system configuration to deny these supplies moving forward.

Response: We agree with the findings on audit items 226-236. The errors were related to manual processing and we will follow up with educational reminders for the team and with the individuals specifically. Upon final agreement, we will reprocess the agreed upon claims for retraction.

13. Based on a change in benefits, claims were identified for non-covered morbid obesity treatment including gastric bypass surgery. Based on a review of the 2020 plan documents, morbid obesity treatment including surgery is no longer a covered benefit. As such, audit items 237-245 were submitted for review and Optima agreed to a total overpayment amount of $19,547.45 as the plan no longer has the morbid obesity rider. As all obesity surgery claims were submitted in the sample selection, no additional out-of-sample review is warranted. Note that recovery of these claims will likely cause adverse member impact due to balance billing. Optima should ensure appropriate system configuration to deny these services moving forward.

Response: We agree with the findings on audit items 237-245. The system configuration is being reviewed and additional edits added to address the non-covered benefit payments. We agree that the recovery will likely cause adverse member impact. Upon final agreement, we will reprocess the agreed upon claims for retraction.

14. Non-covered sexual dysfunction treatment was agreed as paid in error per the plan design. The plan design cites sexual dysfunction as a benefit exclusion including treatment related to sexual organ function, dysfunction, or inadequacies, including but not limited to, impotency. Optima agreed to overpayments totaling $869.40 for this issue (audit items 258-262). As all questionable claims were submitted in the sample selection, no additional out-of-sample review is warranted. Note that recovery of these claims will likely cause adverse member impact due to balance billing. Optima should ensure appropriate system configuration to deny these services moving forward.

Response: We agree with the findings on audit items 258-262. The system configuration is being reviewed and additional edits added to address the non-covered benefit payments. We agree that the recovery will likely cause adverse member impact. Upon final agreement, we will reprocess the agreed upon claims for retraction.

15. Healthcare Horizons identified limited instances of genetic testing not pre-authorized by Optima. Per the plan design, genetic testing is only covered if pre-authorized by the plan. For audit items 268, 269, 270, 271, and 273, Optima agreed to overpayments totaling $960.98 as no authorization was on file for genetic testing services. Note that recovery of these claims will likely cause adverse member impact

due to balance billing. Audit items 264, 265, and 267 were closed as correct as the services were authorized. Three remaining items are discussed in the disputed findings section. Based on the limited agreed findings, no additional out-of-sample claims have been submitted for review. Note that the highest dollar genetic claims were covered in the sample selection.

Response: We agree with the findings on audit items 268, 269, 270, 271 and 273. The system configuration is being reviewed and additional edits added to address the payments that were not pre-authorized. We agree that the recovery will likely cause adverse member impact. Upon final agreement, we will reprocess the agreed upon claims for retraction.

16. Healthcare Horizons identified overpayments due to non-covered administrative exams. Per the plan document, physicals for employment, insurance or recreational activities are not covered services. Based on this exclusion, audit items 276, 277, 278, 280, 282, 284, 285, 286, 288, 289, 290, 291, 292, 293, 294, 295, 296, 299, and 300 were agreed as overpaid by a total of $1,605.60. The diagnosis codes for the findings were as follows:

- • Z02.1 - Encounter for pre-employment examination
- • Z02.5 - Encounter for examination for participation in sport

The claims closed as correct for this category involved immunizations. As all questionable claims were submitted in the sample selection, no additional out-of-sample review is warranted. Note that recovery of these claims will likely cause adverse member impact due to balance billing. Optima should ensure appropriate system configuration to deny these services moving forward.

Response: We agree with the findings on audit items 276, 277, 278, 280, 282, 284, 285, 286, 288, 289, 290, 291, 292, 293, 294, 295, 296, 299 and 300. The system configuration is being reviewed and additional edits added to flag the claims processors more clearly regarding review for these diagnoses. We agree that the recovery will likely cause adverse member impact. Upon final agreement, we will reprocess the agreed upon claims for retraction.

Disputed Findings

1. **Healthcare Horizons requests additional clarification on genetic testing claims repriced by Optum.** For audit items 263, 266, and 272, we inquired about a required pre-authorization for genetic testing services. Optima responded that "Optum repricing trumps all system edits." We request clarification on whether genetic claims without an authorization are allowed if repriced by Optum.

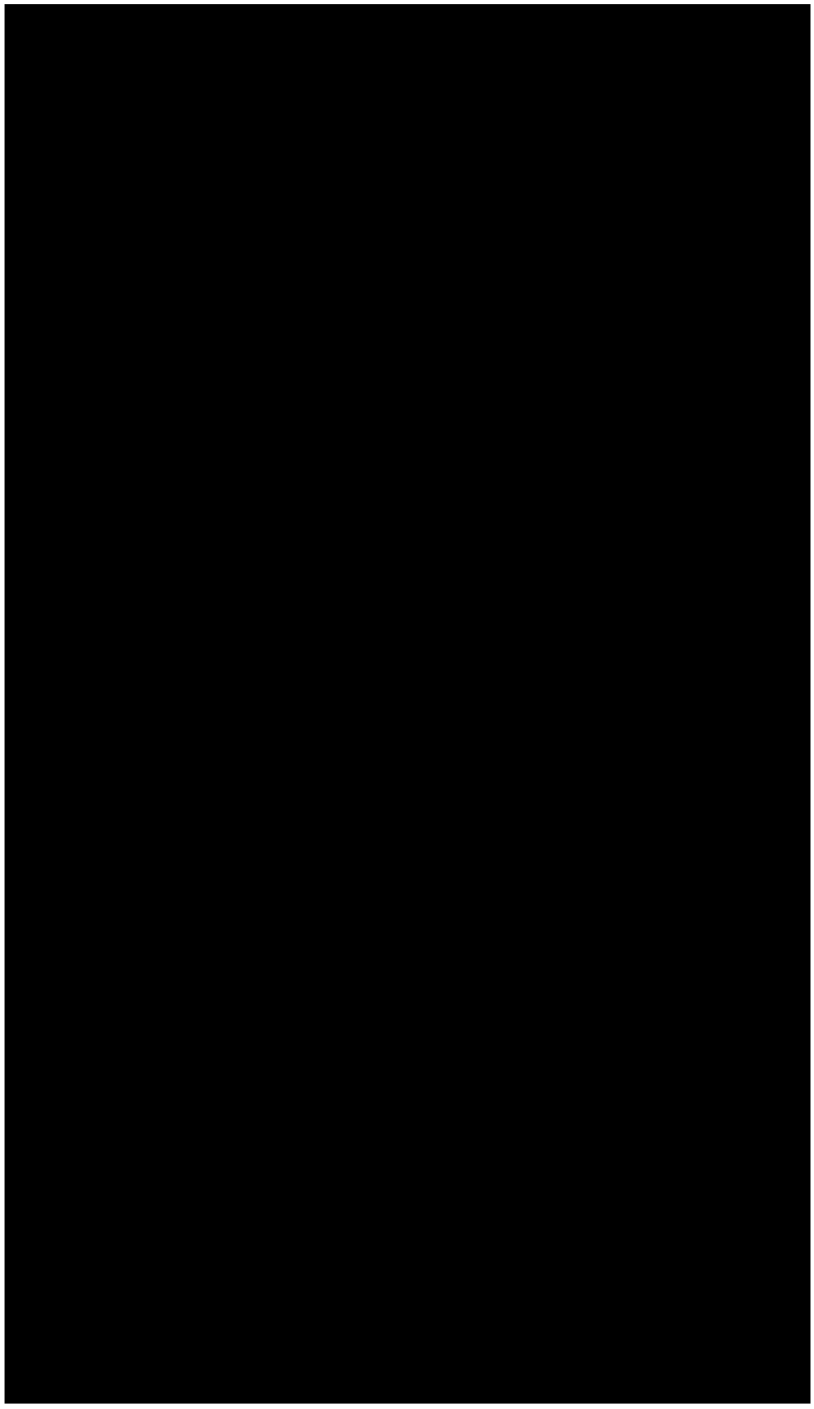
   Response: For audit items 263, 266 and 272 where we have an agreement with Optum to manage transplants. Our agreement with Optum is to allow them to manage, authorize services, and price claims according to their agreement with the transplant providers as they specialize in this service. Therefore genetic testing is paid when Optum approves and authorizes payment for the service.

Informational Findings

1. Healthcare Horizons requests confirmation of dollars returned to the group for two of claims cited as already adjusted by Optima. For the items listed below, we request that Optima supply documentation to confirm return of the overpaid dollars to the group.

Response:

Audit Item	Issue	Amount	
65	Duplicates	$17,236.07	See Attachment
87	Other Insurance	$9,105.20	See Attachment



2. **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 88, 89, 93, and 94. We are glad to provide the member information to the group upon request.
   Response: Yes we agree, the Health Plan will work to obtain member information to validate the dialysis start date.

3. **MinuteClinic is considered as a facility (versus professional) by Optima when considering allowable charge.** As in-network professional claims are limited to billed charge per the allowable charge language, Healthcare Horizons submitted audit items 116-121 as the MinuteClinic office visit procedures were allowed more than billed charges. Optima responded that MinuteClinic claims are considered as facility and that case rate reimbursement is applicable even if greater than billed. While we do not disagree with this assessment, further discussion between the City and Optima may be warranted as we estimate a total impact of $36,027 (allowed more than billed) in 2020.

   Response: Yes we agree, further discussion would be beneficial to confirm the agreement on the case rate reimbursement exceeding the billed amount is agreeable to the City.