HEALTHCAREHORIZONS®
CONSULTING GROUP, INC.

June 26, 2023

FINAL HEALTHCARE CLAIMS AUDIT REPORT

City of Virginia Beach – Optima

AUDIT PERIOD: JANUARY – DECEMBER 2022

Healthcare Horizons Consulting Group, Inc.
800 S. Gay St., Suite 1600, Knoxville, TN 37929

(800) 646-9987 or (865) 444-2607
HHAdmin@healthcarehorizons.com

HEALTHCAREHORIZONS.COM

Table of Contents

Executive Summary

The City of Virginia Beach (the City) engaged Healthcare Horizons to perform an audit of claims processed by Optima Health (Optima) for paid dates of January through December 2022. Healthcare Horizons received $103,516,966.68 in paid claims data from Optima and performed a full electronic review of claims processing. Of this total amount, $59,862,615.52 was paid for the school system and $43,654,351.16 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 200 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 a recoverable amount of $143,820.99 from the sample claims, representing above average performance by Optima based on our experience with similar projects. The majority of sample findings are related to ambulatory surgical center (ASC) pricing, the out-of-network allowable charge, and duplicate payments. We also identified $4,651.69 in overpayments with a refund requested prior to the audit for eligibility terminations and coordination with other insurance. Healthcare Horizons is also citing a single disputed finding of $19.16 based on our interpretation of the hearing aid benefit maximum. 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 51 additional out-of-sample claims related to a benefit exclusion for administrative examinations (paid at $3,102.18). These additional out-of-sample claims are detailed in Appendix B.

Our findings for the audit are summarized on the following page.

All

Issue	Sample Recovery Amount	Sample Refund Requested Prior	Sample Disputed Amount	Out-of-Sample Recovery Amount	Total Audit Potential (Excluding Refund Requested Prior and Disputed)
ASC Pricing	$82,376.60	$0.00	$0.00	$0.00	$82,376.60
Out-of-Network Allowed Amount	$34,694.46	$0.00	$0.00	$0.00	$34,694.46
Duplicates	$13,659.93	$0.00	$0.00	$0.00	$13,659.93
Pre-Admission Testing	$4,718.29	$0.00	$0.00	$0.00	$4,718.29
Benefit Exclusion - Administrative Exams	$1,231.99	$0.00	$0.00	$3,102.18	$4,334.17
Multiple Procedure Reductions	$3,082.89	$0.00	$0.00	$0.00	$3,082.89
Benefit Exclusion - Bariatric Surgery	$3,051.45	$0.00	$0.00	$0.00	$3,051.45
Benefit Exclusion - Foot Orthotics	$465.22	$0.00	$0.00	$0.00	$465.22
Surgery Global	$328.91	$0.00	$0.00	$0.00	$328.91
Out-of-Network Over Billed	$168.80	$0.00	$0.00	$0.00	$168.80
Eligibility	$40.00	$2,747.36	$0.00	$0.00	$40.00
Benefit Exclusion - Blood Pressure Monitor	$36.12	$0.00	$0.00	$0.00	$36.12
Other Insurance	$0.00	$1,904.33	$0.00	$0.00	$0.00
Benefit Maximum - Hearing Aids	$0.00	$0.00	$19.16	$0.00	$0.00
ESRD	-$33.67	$0.00	$0.00	$0.00	-$33.67
Totals	**$143,820.99**	**$4,651.69**	**$19.16**	**$3,102.18**	**$146,923.17**

City

Issue	Site Visit Recovery Amount	Refund Requested Prior	Site Visit Disputed Amount	Out-of-Sample Recovery Amount	Total Audit Potential (Excluding Disputed)
ASC Pricing	$37,306.80	$0.00	$0.00	$0.00	$37,306.80
Out-of-Network Allowed Amount	$5,832.45	$0.00	$0.00	$0.00	$5,832.45
Duplicates	$6,565.54	$0.00	$0.00	$0.00	$6,565.54
Pre-Admission Testing	$1,565.45	$0.00	$0.00	$0.00	$1,565.45
Benefit Exclusion - Administrative Exams	$226.28	$0.00	$0.00	$1,146.17	$1,372.45
Multiple Procedure Reductions	$1,691.50	$0.00	$0.00	$0.00	$1,691.50
Benefit Exclusion - Foot Orthotics	$340.22	$0.00	$0.00	$0.00	$340.22
Eligibility	$0.00	$160.05	$0.00	$0.00	$0.00
Benefit Maximum - Hearing Aids	$0.00	$0.00	$19.16	$0.00	$0.00
ESRD	-$33.67	$0.00	$0.00	$0.00	-$33.67
Totals	**$53,494.57**	**$160.05**	**$19.16**	**$1,146.17**	**$54,640.74**

Schools

Issue	Site Visit Recovery Amount	Refund Requested Prior	Site Visit Disputed Amount	Out-of-Sample Recovery Amount	Total Audit Potential (Excluding Disputed)
ASC Pricing	$45,069.80	$0.00	$0.00	$0.00	$45,069.80
Out-of-Network Allowed Amount	$28,862.01	$0.00	$0.00	$0.00	$28,862.01
Duplicates	$7,094.39	$0.00	$0.00	$0.00	$7,094.39
Pre-Admission Testing	$3,152.84	$0.00	$0.00	$0.00	$3,152.84
Benefit Exclusion - Administrative Exams	$1,005.71	$0.00	$0.00	$1,956.01	$2,961.72
Multiple Procedure Reductions	$1,391.39	$0.00	$0.00	$0.00	$1,391.39
Benefit Exclusion - Bariatric Surgery	$3,051.45	$0.00	$0.00	$0.00	$3,051.45
Benefit Exclusion - Foot Orthotics	$125.00	$0.00	$0.00	$0.00	$125.00
Surgery Global	$328.91	$0.00	$0.00	$0.00	$328.91
Out-of-Network Over Billed	$168.80	$0.00	$0.00	$0.00	$168.80
Eligibility	$40.00	$2,587.31	$0.00	$0.00	$40.00
Benefit Exclusion - Blood Pressure Monitor	$36.12	$0.00	$0.00	$0.00	$36.12
Other Insurance	$0.00	$1,904.33	$0.00	$0.00	$0.00
Totals	**$90,326.42**	**$4,491.64**	**$0.00**	**$1,956.01**	**$92,282.43**

Process Overview

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

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

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

Site Visit Selection

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

Issue	Audit Items	Recovery		Refund Requested Prior		Disputed	
		Items	Amount	Items	Amount	Items	Amount
Duplicates - Claim Level	17	9	$5,833.52	0	$0.00	0	$0.00
Duplicates - Line Level	50	26	$7,826.41	0	$0.00	0	$0.00
Eligibility - After Termination	5	1	$40.00	4	$2,747.36	0	$0.00
Other Insurance	9	0	$0.00	1	$1,904.33	0	$0.00
ESRD	6	1	-$33.67	0	$0.00	0	$0.00
Facility Pricing	10	0	$0.00	0	$0.00	0	$0.00
Professional Pricing	1	0	$0.00	0	$0.00	0	$0.00
Out-of-Network Allowed Amount	10	4	$34,694.46	0	$0.00	0	$0.00
Out-of-Network Over Billed	3	3	$168.80	0	$0.00	0	$0.00
Transfers	2	0	$0.00	0	$0.00	0	$0.00
ASC Pricing	27	27	$82,376.60	0	$0.00	0	$0.00
Multiple Procedure Reductions	6	5	$3,082.89	0	$0.00	0	$0.00
Surgery Global	6	3	$328.91	0	$0.00	0	$0.00
Pre-Admission Testing	18	9	$4,718.29	0	$0.00	0	$0.00
Benefit Maximum - Hearing Aids	2	0	$0.00	0	$0.00	1	$19.16
Benefit Exclusion - Bariatric Surgery	2	2	$3,051.45	0	$0.00	0	$0.00
Benefit Exclusion - Blood Pressure Monitor	2	1	$36.12	0	$0.00	0	$0.00
Benefit Exclusion - Foot Orthotics	9	6	$465.22	0	$0.00	0	$0.00
Benefit Exclusion - Administrative Exams	15	15	$1,231.99	0	$0.00	0	$0.00
Totals	**200**	**112**	**$143,820.99**	**5**	**$4,651.69**	**1**	**$19.16**

Recoverable Findings

1. Healthcare Horizons identified a minimal volume of duplicate payments. 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. Including both claim-level and line-level duplicate submissions, Optima agreed with 35 overpayments totaling $13,659.93 (audit items 2, 3, 5, 7, 9, 11, 13, 15, 17, 18, 21, 23, 25, 26, 27, 28, 30, 32, 36, 38, 40, 42, 44, 46, 47, 49, 51, 53, 55, 57, 59, 61, 63, 65, and 67). In terms of any trends identified for the duplicates, Healthcare Horizons noted that several of the overpayments involved a systemic error including audit items 2, 3, 5, 18, 21, 23, 32, 51, 53, 55, 57, 59, 61, 63, and 65. Specifically, Optima noted that during a project to rework incorrectly denied claims, duplicate claim edits did not fire during the adjustments. This issue was previously identified by the Optima System Configuration Team and applicable system enhancements are in process. We recommend that Optima provide a full impact report to the City for this issue including claim count and dollar impact. Healthcare Horizons also notes that audit items 36 and 38 ($1,699.99 paid in total) were disputed as errors by Optima, however the claims are recoverable as duplicates. These overpayments were due to provider billing errors as the same rendering provider submitted duplicate claims with different tax identification numbers and national provider identifiers. Finally, the remaining duplicate payments were likely due to manual processor errors.

> ***Optima Response**: The primary issue was the system did not flag the claim as possible duplicates for review. Root cause was conducted, and the identified issue has been corrected. Testing was conducted to confirm this is not an ongoing issue. As noted by Healthcare Horizons Optima Health is actively working to make updates to configuration in an effort to significantly reduce the likelihood of duplicate payments being made. Additionally policies and procedures were immediately put into place to exclude specific claim scenarios from reprocessing efforts that would be at risk for unnecessary reprocessing. Claim Level feedback is being gathered by the claims department and will be shared with the City upon completion.*
>
> **Healthcare Horizons' Final Comment:** Per the Optima response, the systemic issue preventing the application of duplicate claim edits on adjustments has been corrected. In terms of the manual errors, Optima will be conducting refresher training for its claims processors.

2. A minimal number of recoverable claims were identified due to retroactive eligibility terminations. Healthcare Horizons utilized eligibility data provided by Optima to test coverage for all claims in the dataset and only five claims were identified with a service date after the eligibility termination date (audit items 68-72). For audit items 68-71 with a total paid amount of $2,747.36, Optima responded that refund requests were initiated prior to the audit. We request for Optima to provide a cash collection update on these items. For audit item 72 paid at $40.00, a prior refund request was not found, and the claim should be adjusted for recovery on behalf of the City.

***Optima Response**: Claims were correct at the time of processing; the claims are now recoverable due to retroactive eligibility terminations. 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. We will continue to work with our recovery team to identify ways to continue to strengthen this process.*

*For **Sample 72** money was retracted on 3.14.23.*

Healthcare Horizons' Final Comment: We will continue to assist in the collections tracking on behalf of the City for the recoverable claims.

3. A single claim was identified with a refund request prior to the audit based on missed coordination with Medicare. Healthcare Horizons utilizes the claims data to identify members with other primary insurance based on a coordination of benefits (COB) savings amount present on certain claims. We then test claims for the same members with no COB savings to determine if coordination with the primary carrier was missed. For audit item 74, Optima responded that the claim paid at $1,904.33 was adjusted prior to the audit to coordinate with Medicare primary coverage. We request for Optima to provide a cash collection update on this item as part of the draft report response. Otherwise, the remaining items in this category were dismissed as correct as the claims were either correctly coordinated or the other primary insurance was not in effect on the service date.

***Optima Response**: As described a single claim was identified and adjusted prior to the audit engagement as a part of internal controls. Please refer to document 2022 Final Report Response Document for claim details.*

Healthcare Horizons' Final Comment: We will track the collection of this overpayment on behalf of the City.

4. Healthcare Horizons identified isolated overpayments as part of the out-of-network allowable charge review. 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.

In testing out-of-network claims allowed at full billed charges, Healthcare Horizons identified overpayments due to multiple reasons as shown in the following table:

Audit Item	Overpayment	Description
99	$26,885.01	Missed allowable charge pricing after being denied in error by the system – originally priced correctly at allowable charge
102	$4,907.00	Missed applicable PHCS pricing – actual overpayment to be determined
104	$1,977.00	Should have processed on behavioral health side with fee schedule rate
106	$925.45	Missed surprise bill payment reduction

Given the one-off nature of these overpayments, our impression is that Optima is correctly administering the allowable charge for out-of-network providers.

> ***Optima Response**: In regards to the manual processing errors they have been followed up with educational reminders for the team and with the individuals specifically responsible for the processing errors made. The health plan is actively working on improving control measures associated with repricing through PHCS to promote consistency and reduce/eliminate errors associated with this process.*
>
> ***For Audit Item 99** this error was submitted to System Configuration for review where it was determined to be an isolated incident where no additional claims were impacted.*

Healthcare Horizons' Final Comment: We will continue to assist in the collections tracking on behalf of the City for these recoverable claims.

5. Healthcare Horizons identified isolated instances of professional out-of-network claims reimbursed more than the billed charge amount. Optima agreed with overpayments totaling $168.80 on audit items 109, 110, and 111. While these are likely manual, one-off errors, Optima should review the root cause on these claims to rule out a systemic issue.

> ***Optima Response**: In regards to the manual processing errors they have been followed up with educational reminders for the team and with the individuals specifically responsible for the processing errors made. As there was no pattern in the errors made this does not seem to be systematic in nature or indicative of a more widespread issue.*
>
> **Healthcare Horizons' Final Comment:** Optima confirmed manual processor error as the root cause with no indication of a systemic issue.

6. Similar to prior audits, overpayments were identified for an ambulatory surgical center due to the incorrect payment of secondary surgical procedures. For a certain facility tested during the audit, the Optima contract only allows payment for the primary surgical procedure with all other lines to be denied for payment. Healthcare Horizons identified 27 overpayments totaling $82,376.60 for this issue (audit items 114-140). Our understanding is that this particular reimbursement agreement requires manual intervention, and that Optima has provided refresher training related to this issue. Note that all potential overpayments were submitted in the sample selection.

> ***Optima Response**: Based on 2021's audit results, we added warnings to all CHKD ASC surgery claims, and updated policy. There was also a refresher training conducted about the topic. There was one processor who made 14 of 27. That processor has received individualized training and corrective action.*
>
> **Healthcare Horizons' Final Comment:** Optima confirmed manual processor error as the root cause of the overpayments. In response to the audit finding, enhanced refresher training has been conducted.

7. Healthcare Horizons identified overpayments due to missed multiple procedure reductions. 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 item 142 was agreed as overpaid by $380.37 due to fragmented billing by the provider. The remaining missed multiple procedure reductions on audit items 143-146 ($2,702.52 overpayment) involved single claim submissions. We recommend for Optima to review these missed reductions (same claim) to ensure the root cause is not a systemic issue. Note that all potential overpayments were submitted in the sample selection.

***Optima Response**: In regards to the manual processing errors they have been followed up with educational reminders for the team and with the individuals specifically responsible for the processing errors made. As there was no pattern in the errors made this does not seem to be systematic in nature or indicative of a more widespread issue*

Healthcare Horizons' Final Comment: Optima confirmed manual processor error as the root cause with no indication of a systemic issue.

8. 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 147, 149, and 151 paid a total of $328.91, Optima agreed the evaluations should be included as part of the global surgical package with no separate reimbursement. Note that Optima disputes an error on audit item 147 as the surgery claim was not on file at the time of processing, however, the claim is recoverable. Note that all potential overpayments were submitted in the sample selection.

***Optima Response**: Optima agrees with the auditors' findings that evaluations should be included as part of the global surgical package with no separate reimbursement. These were manual processing errors where follow up education has been conducted with those team members associated with these findings as well as reminders distributed to the team.*

Healthcare Horizons' Final Comment: Optima confirmed manual processor error as the root cause of the overpayments. In response to the audit finding, enhanced refresher training has been conducted.

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 nine claims paid in error for this issue for a total of $4,718.29 (audit items 153, 155, 157, 159, 161, 163, 165, 167, and 169). With the exception of audit item 167 (agreed error as inpatient claim was on file), Optima disputes an error on these items as the associated inpatient claims were not yet on file at the time of processing. However, these claims are recoverable on behalf of the City. Note that all potential overpayments were submitted in the sample selection.

***Optima Response**: The root cause of these overpayments can be attributed to a provider billing error. 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.*

***For audit item 167** this was a manual processing errors where follow up education has been conducted with the team member associated with this finding.*

Healthcare Horizons' Final Comment: While the primary root cause of the overpayments is provider billing error, the claims are recoverable on behalf of the City. Optima is also conducting provider education to prevent future overpayments.

10. Healthcare Horizons identified a bariatric surgery case allowed in error. Based on a review of the 2022 plan documents, bariatric surgery is not a covered benefit. As such, audit items 173 and 174 (same member) were submitted for review and Optima agreed to a total overpayment amount of $3,051.45 as the services were authorized in error by the clinical department. 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 Response**: As stated by the auditor based on the 2022 plan documents, morbid obesity treatment including surgery is not a covered benefit. An exception report has been established to run monthly, to catch claims paid incorrectly so that they can be reversed and as evidenced by the consistently low error rate is largely effective in controlling mis payment. The Clinical department has provided the appropriate education to the team member responsible for this error.*

Healthcare Horizons' Final Comment: Optima has a monthly post-payment audit process to identify any claims allowed in error for bariatric surgery. Only a single case was allowed in error in 2022 due to a manual processor mistake.

11. A single non-covered blood pressure monitor was agreed as paid in error per the plan design. The plan document notes blood pressure monitors as a benefit exclusion unless authorized by the plan. For audit item 175, the blood pressure monitor was authorized as medically necessary. However, audit item 176 was agreed as an overpayment of $36.12 as no authorization was granted. All blood pressure monitors were submitted in the sample selection; therefore, no additional out-of-sample review is warranted. Note that recovery of this claim will likely cause adverse member impact due to balance billing.

***Optima Response**: Non-covered blood pressure monitors for audit sample 176 was agreed as paid in error per the plan design. The plan document notes blood pressure monitors as a benefit exclusion unless authorized by the plan. An exception report has been established to run monthly, to catch claims paid incorrectly so that they can be reversed. Defined procedures continue to be in place to monitor benefit exclusions to ensure they are configured to deny appropriately, the effectiveness of this process is evidence by the consistently low error rate associated with these findings.*

Healthcare Horizons' Final Comment: Optima has a monthly post-payment audit process to identify any claims allowed in error for non-authorized blood pressure monitors. Only a single payment was allowed in error in 2022 due to a manual processor mistake.

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 against 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 $465.22 for this issue (audit items 178, 180, 182, 183, 184, and 185). Note that the sample claims deemed as correct were for members with a history of diabetes. 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. Finally, Optima should ensure appropriate system configuration to deny these supplies moving forward.

> ***Optima Response**: Non-covered foot orthotics were agreed as paid in error per the plan design. 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. Education has been provided to team members responsible for the errors associated with these claims.*
>
> **Healthcare Horizons' Final Comment:** Per the Optima response, these overpayments were due to manual processor error with no cause for systemic concern. Optima has also conducted refresher training based on the audit finding.

13. 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, Healthcare Horizons submitted fifteen claims for review, and all were agreed as paid in error for a total of $1,231.99. 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

In terms of additional out-of-sample impact for 2022, Healthcare Horizons has delivered 51 additional claims to Optima for review and potential recovery of $3,102.18. Note that adjustment of these claims will likely cause adverse member impact due to balance billing. Finally, Optima should ensure appropriate system configuration to deny these services moving forward.

> ***Optima Response**: All errors were made by our contracted processing partners Exela. They have received education by email and web based training. Based on 2021 results we added warnings to all diagnosis for encounter exams and updated our policy.*
>
> **Healthcare Horizons' Final Comment:** We recommend for the City to provide Optima with direction on review and recovery efforts for the out-of-sample claims provided by Healthcare Horizons.

Disputed Findings

1. **Healthcare Horizons requests plan intent clarification on the hearing aid benefit maximum.** The 2022 Summary of Benefits contains the following language for hearing aids:

Covered Services include the following up to the annual maximum benefit of $2,000 per ear:

- *the hearing aid(s);*
- *audiometric specialist office visits for fitting, including molds and dispensing;*
- *repair, replacement or refurbishment of the hearing aid(s)*

Based on this language, audit item 172 was presented as an error for $19.16 as the dollars for HCPCS V5011 (hearing aid fitting/checking) were allowed in excess of the dollar maximum. Optima responded that this code is not included in the hearing aid benefit maximum. We request plan intent clarification from the City.

> ***Optima Response**: Optima agrees with Health Horizons that plan intent is needed. Per summary of benefits-After the deductible, the member has a responsibility of 40.00. The corrected claim had a maximum allowed of $59.16, and $40.00 went to the member's deductible. The remaining $19.16 was paid to the provider.*
>
> **Healthcare Horizons' Final Comment:** We request for the City to confirm if HCPCS V5011 (hearing aid fitting/checking) should be included in the hearing aid benefit maximum. Based on our interpretation of the plan document and experience with other projects, our recommendation is to include this code in the benefit maximum.

Informational Findings

1. Healthcare Horizons identified several members on dialysis due to end stage renal disease (ESRD) with no Medicare coverage information on file with Optima. Healthcare Horizons suggests that the City and Optima work to confirm the dialysis start date and the resulting Medicare primary effective date for the members identified on audit items 83, 85, 86, and 87. We are glad to provide the member information upon request.

> ***Optima Response**: Claim Details have been submitted to the claims department to conduct research, responses will be made available once research is complete.*
>
> **Healthcare Horizons' Final Comment:** We have confirmed that these are active employees that are not on retiree plans.

2. Healthcare Horizons recommends clarification on the applicable regulations for surprise bills beginning in 2022. On 1/1/2021, the state of Virginia passed a law preventing patient balance billing by out-of-network providers for surprise bills (such as the involuntary use of an anesthesiologist or emergency services). The law included guidelines for initial payments to providers along with a negotiation / dispute resolution process for these provider payments. On 1/1/2022, the federal No Surprises Act was passed with similar guidelines. Based on initial communications with both Optima and the City, our impression is that both sets of regulations apply. As there may be differences in the regulations (such as the reimbursement methodology applied for the initial payment), it may be prudent to clarify how the regulations apply to the City.

> ***Optima Response**: Both CSC and policy has been updated to support Federal and State no balance billing laws.*
>
> **Healthcare Horizons' Final Comment:** As there could be a difference in the initial payment under the state and federal guidelines, we recommend for the City to clarify which regulations take precedence.

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 to maximize the effectiveness of the audit:

- Optima should initiate recovery on all agreed overpayments **and report any negative potential member impact to both Healthcare Horizons and the City prior to any recovery activity**.
- The City and Optima should work to identify the Medicare primary effective dates for the ESRD members cited with no Medicare information on file with Optima.
- Optima should confirm cash collection for the audit items noted as already adjusted prior to the audit.
- Optima should ensure system configuration to deny non-covered services and supplies.
- The City and Optima should confirm the applicable laws for surprise bills beginning 1/1/2022 as both state and federal laws are in effect.

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 – Sample Claims Detail

Audit Item	Issue	Recovery Amount	Refund Requested Prior	Disputed Amount	Comment	Group
1	Duplicates - Claim Level	$0.00	$0.00	$0.00	Correct claim for 1/2/3 combo	City
2	Duplicates - Claim Level	$276.25	$0.00	$0.00	Agreed duplicate error - system issue during a project to correct denied claims - enhancement underway	City
3	Duplicates - Claim Level	$276.25	$0.00	$0.00	Agreed duplicate error - system issue during a project to correct denied claims - enhancement underway	City
4	Duplicates - Claim Level	$0.00	$0.00	$0.00	Correct claim for 4/5 combo	City
5	Duplicates - Claim Level	$212.50	$0.00	$0.00	Agreed duplicate error - system issue during a project to correct denied claims - enhancement underway	City
6	Duplicates - Claim Level	$0.00	$0.00	$0.00	Correct claim for 6/7 combo	Schools
7	Duplicates - Claim Level	$648.00	$0.00	$0.00	Agreed duplicate error	Schools
8	Duplicates - Claim Level	$0.00	$0.00	$0.00	Correct claim for 8/9 combo	City
9	Duplicates - Claim Level	$450.00	$0.00	$0.00	Agreed duplicate error	City
10	Duplicates - Claim Level	$0.00	$0.00	$0.00	Correct claim for 10/11 combo	Schools
11	Duplicates - Claim Level	$504.00	$0.00	$0.00	Agreed duplicate error	Schools
12	Duplicates - Claim Level	$0.00	$0.00	$0.00	Correct claim for 12/13 combo	City
13	Duplicates - Claim Level	$1,984.55	$0.00	$0.00	Agreed duplicate error	City
14	Duplicates - Claim Level	$0.00	$0.00	$0.00	Correct claim for 14/15 combo	Schools
15	Duplicates - Claim Level	$1,348.90	$0.00	$0.00	Agreed duplicate error	Schools
16	Duplicates - Claim Level	$0.00	$0.00	$0.00	Correct claim for 16/17 combo	City
17	Duplicates - Claim Level	$133.07	$0.00	$0.00	Agreed duplicate error	City
18	Duplicates - Line Level	$65.68	$0.00	$0.00	Agreed duplicate error - system issue during a project to correct denied claims - enhancement underway	Schools
19	Duplicates - Line Level	$0.00	$0.00	$0.00	Correct claim for 18/19 combo	Schools
20	Duplicates - Line Level	$0.00	$0.00	$0.00	Correct claim for 20/21 combo	City
21	Duplicates - Line Level	$65.68	$0.00	$0.00	Agreed duplicate error - system issue during a project to correct denied claims - enhancement underway	City
22	Duplicates - Line Level	$0.00	$0.00	$0.00	Correct claim for 22/23 combo	City
23	Duplicates - Line Level	$55.83	$0.00	$0.00	Agreed duplicate error - system issue during a project to correct denied claims - enhancement underway	City
24	Duplicates - Line Level	$0.00	$0.00	$0.00	Correct claim for 24/25/26/27/28 combo	City
25	Duplicates - Line Level	$206.03	$0.00	$0.00	Agreed duplicate error	City
26	Duplicates - Line Level	$131.36	$0.00	$0.00	Agreed duplicate error	City
27	Duplicates - Line Level	$80.21	$0.00	$0.00	Agreed duplicate error	City
28	Duplicates - Line Level	$94.37	$0.00	$0.00	Agreed duplicate error	City
29	Duplicates - Line Level	$0.00	$0.00	$0.00	Correct claim for 29/30 combo	Schools
30	Duplicates - Line Level	$61.65	$0.00	$0.00	Agreed duplicate error	Schools
31	Duplicates - Line Level	$0.00	$0.00	$0.00	Correct claim for 31/32 combo	Schools
32	Duplicates - Line Level	$61.95	$0.00	$0.00	Agreed duplicate error - system issue during a project to correct denied claims - enhancement underway	Schools
33	Duplicates - Line Level	$0.00	$0.00	$0.00	Twins	Schools
34	Duplicates - Line Level	$0.00	$0.00	$0.00	Twins	Schools
35	Duplicates - Line Level	$0.00	$0.00	$0.00	Correct claim for 35/36 combo	City
36	Duplicates - Line Level	$121.84	$0.00	$0.00	Different TINs and NPIs but recoverable as rendering provider is the same.	City
37	Duplicates - Line Level	$0.00	$0.00	$0.00	Correct claim for 37/38 combo	City
38	Duplicates - Line Level	$1,578.15	$0.00	$0.00	Different TINs and NPIs but recoverable as rendering provider is the same.	City
39	Duplicates - Line Level	$0.00	$0.00	$0.00	Correct claim for 39/40 combo	Schools
40	Duplicates - Line Level	$34.10	$0.00	$0.00	Agreed duplicate error	Schools
41	Duplicates - Line Level	$0.00	$0.00	$0.00	Correct claim for 41/42 combo	City
42	Duplicates - Line Level	$313.65	$0.00	$0.00	Agreed duplicate error	City
43	Duplicates - Line Level	$0.00	$0.00	$0.00	Correct claim for 43/44 combo	Schools
44	Duplicates - Line Level	$132.95	$0.00	$0.00	Agreed duplicate error	Schools
45	Duplicates - Line Level	$0.00	$0.00	$0.00	Correct claim for 45/46 combo	City
46	Duplicates - Line Level	$26.80	$0.00	$0.00	Agreed duplicate error	City
47	Duplicates - Line Level	$160.00	$0.00	$0.00	Agreed duplicate error	Schools
48	Duplicates - Line Level	$0.00	$0.00	$0.00	Correct claim for 47/48/49 combo	Schools
49	Duplicates - Line Level	$160.00	$0.00	$0.00	Agreed duplicate error	Schools
50	Duplicates - Line Level	$0.00	$0.00	$0.00	Correct claim for 50/51 combo	City
51	Duplicates - Line Level	$69.79	$0.00	$0.00	Agreed duplicate error - system issue during a project to correct denied claims - enhancement underway	City
52	Duplicates - Line Level	$0.00	$0.00	$0.00	Correct claim for 52/53 combo	City
53	Duplicates - Line Level	$70.47	$0.00	$0.00	Agreed duplicate error - system issue during a project to correct denied claims - enhancement underway	City

Audit Item	Issue	Recovery Amount	Refund Requested Prior	Disputed Amount	Comment	Group
54	Duplicates - Line Level	$0.00	$0.00	$0.00	Correct claim for 54/55 combo	City
55	Duplicates - Line Level	$69.79	$0.00	$0.00	Agreed duplicate error - system issue during a project to correct denied claims - enhancement underway	City
56	Duplicates - Line Level	$0.00	$0.00	$0.00	Correct claim from 56/57 combo	City
57	Duplicates - Line Level	$69.79	$0.00	$0.00	Agreed duplicate error - system issue during a project to correct denied claims - enhancement underway	City
58	Duplicates - Line Level	$0.00	$0.00	$0.00	Correct claim for 58/59 combo	City
59	Duplicates - Line Level	$69.79	$0.00	$0.00	Agreed duplicate error - system issue during a project to correct denied claims - enhancement underway	City
60	Duplicates - Line Level	$0.00	$0.00	$0.00	Correct claim for 60/61 combo	City
61	Duplicates - Line Level	$69.79	$0.00	$0.00	Agreed duplicate error - system issue during a project to correct denied claims - enhancement underway	City
62	Duplicates - Line Level	$0.00	$0.00	$0.00	Correct claim for 62/63 combo	City
63	Duplicates - Line Level	$69.79	$0.00	$0.00	Agreed duplicate error - system issue during a project to correct denied claims - enhancement underway	City
64	Duplicates - Line Level	$0.00	$0.00	$0.00	Correct claim for 64/65 combo	City
65	Duplicates - Line Level	$69.79	$0.00	$0.00	Agreed duplicate error - system issue during a project to correct denied claims - enhancement underway	City
66	Duplicates - Line Level	$0.00	$0.00	$0.00	Correct claim for 66/67 combo	Schools
67	Duplicates - Line Level	$3,917.16	$0.00	$0.00	Agreed duplicate	Schools
68	Eligibility - After Termination	$0.00	$146.11	$0.00	Retro-termination - refund requested prior to audit	Schools
69	Eligibility - After Termination	$0.00	$2,186.00	$0.00	Retro-termination - refund requested prior to audit	Schools
70	Eligibility - After Termination	$0.00	$255.20	$0.00	Retro-termination - refund requested prior to audit	Schools
71	Eligibility - After Termination	$0.00	$160.05	$0.00	Retro-termination - refund requested prior to audit	City
72	Eligibility - After Termination	$40.00	$0.00	$0.00	Retro-termination - claim not adjusted prior to recover	Schools
73	Other Insurance	$0.00	$0.00	$0.00	Primary carrier denied services - coordinated correctly	Schools
74	Other Insurance	$0.00	$1,904.33	$0.00	Refund requested prior to audit	Schools
75	Other Insurance	$0.00	$0.00	$0.00	Medicare primary 8/1/22 (DOS prior)	Schools
76	Other Insurance	$0.00	$0.00	$0.00	Other insurance primary 5/1/22 (DOS prior)	Schools
77	Other Insurance	$0.00	$0.00	$0.00	Medicare primary 8/1/21 (DOS prior)	City
78	Other Insurance	$0.00	$0.00	$0.00	Primary carrier denied services - coordinated correctly	City
79	Other Insurance	$0.00	$0.00	$0.00	Dual enrollment - coordinated correctly	City
80	Other Insurance	$0.00	$0.00	$0.00	Medicare primary 5/1/22 (DOS prior)	Schools
81	Other Insurance	$0.00	$0.00	$0.00	Primary carrier paid $0 (all to deductible) - coordinated correctly	Schools
82	ESRD	$0.00	$0.00	$0.00	Medicare primary 8/1/22 (DOS prior)	Schools
83	ESRD	$0.00	$0.00	$0.00	No record of Medicare - informational finding	Schools
84	ESRD	-$33.67	$0.00	$0.00	Missed coordination with Medicare - underpaid	City
85	ESRD	$0.00	$0.00	$0.00	No record of Medicare - informational finding	Schools
86	ESRD	$0.00	$0.00	$0.00	No record of Medicare - informational finding	Schools
87	ESRD	$0.00	$0.00	$0.00	No record of Medicare - informational finding	City
88	Facility Pricing	$0.00	$0.00	$0.00	Priced correctly - DRG plus stop loss	Schools
89	Facility Pricing	$0.00	$0.00	$0.00	Priced correctly - single case agreement	City
90	Facility Pricing	$0.00	$0.00	$0.00	Priced correctly - letter of agreement	City
91	Facility Pricing	$0.00	$0.00	$0.00	Priced correctly - DRG	City
92	Facility Pricing	$0.00	$0.00	$0.00	Priced correctly - DRG plus stop loss	City
93	Facility Pricing	$0.00	$0.00	$0.00	Priced correctly - DRG plus stop loss	Schools
94	Facility Pricing	$0.00	$0.00	$0.00	Priced correctly - DRG	Schools
95	Facility Pricing	$0.00	$0.00	$0.00	Priced correctly - DRG	Schools
96	Facility Pricing	$0.00	$0.00	$0.00	Priced correctly - percent of charges	City
97	Facility Pricing	$0.00	$0.00	$0.00	Claim processed per Optum pricing	Schools
98	Professional Pricing	$0.00	$0.00	$0.00	Claim processed per Optum pricing	City
99	Out-of-Network Allowed Amount	$26,885.01	$0.00	$0.00	Agreed error - missed OON allowable charge	Schools
100	Out-of-Network Allowed Amount	$0.00	$0.00	$0.00	Paid via Virginia balance billing law (commercially reasonable amount) - Should Federal No Surprises Act rules apply with payment at the QPA rate?	City
101	Out-of-Network Allowed Amount	$0.00	$0.00	$0.00	Paid via Virginia balance billing law (commercially reasonable amount) - Should Federal No Surprises Act rules apply with payment at the QPA rate?	City
102	Out-of-Network Allowed Amount	$4,907.00	$0.00	$0.00	Missed PHCS pricing - overpayment to be determined	City
103	Out-of-Network Allowed Amount	$0.00	$0.00	$0.00	Paid via Virginia balance billing law (commercially reasonable amount) - Should Federal No Surprises Act rules apply with payment at the QPA rate?	City
104	Out-of-Network Allowed Amount	$1,977.00	$0.00	$0.00	Processed incorrectly as medical and missed negotiated rate under behavioral health	Schools
105	Out-of-Network Allowed Amount	$0.00	$0.00	$0.00	Paid via Virginia balance billing law (commercially reasonable amount) - Should Federal No Surprises Act rules apply with payment at the QPA rate?	Schools
106	Out-of-Network Allowed Amount	$925.45	$0.00	$0.00	Agreed error - missed VA OON pricing - should Federal NSA rules apply?	City
107	Out-of-Network Allowed Amount	$0.00	$0.00	$0.00	Priced by PHCS	City
108	Out-of-Network Allowed Amount	$0.00	$0.00	$0.00	Paid via Virginia balance billing law (commercially reasonable amount) - Should Federal No Surprises Act rules apply with payment at the QPA rate?	Schools

Audit Item	Issue	Recovery Amount	Refund Requested Prior	Disputed Amount	Comment	Group
109	Out-of-Network Over Billed	$56.60	$0.00	$0.00	Agreed error	Schools
110	Out-of-Network Over Billed	$56.60	$0.00	$0.00	Agreed error	Schools
111	Out-of-Network Over Billed	$55.60	$0.00	$0.00	Agreed error	Schools
112	Transfers	$0.00	$0.00	$0.00	Priced correctly at per diem rate	Schools
113	Transfers	$0.00	$0.00	$0.00	Priced correctly at per diem rate	Schools
114	ASC Pricing	$3,164.77	$0.00	$0.00	Agreed error - should only reimburse most extensive procedure	Schools
115	ASC Pricing	$2,939.30	$0.00	$0.00	Agreed error - should only reimburse most extensive procedure	Schools
116	ASC Pricing	$2,939.30	$0.00	$0.00	Agreed error - should only reimburse most extensive procedure	City
117	ASC Pricing	$2,939.30	$0.00	$0.00	Agreed error - should only reimburse most extensive procedure	City
118	ASC Pricing	$2,766.40	$0.00	$0.00	Agreed error - should only reimburse most extensive procedure	Schools
119	ASC Pricing	$3,180.70	$0.00	$0.00	Agreed error - should only reimburse most extensive procedure	Schools
120	ASC Pricing	$2,766.40	$0.00	$0.00	Agreed error - should only reimburse most extensive procedure	Schools
121	ASC Pricing	$2,161.55	$0.00	$0.00	Agreed error - should only reimburse most extensive procedure	City
122	ASC Pricing	$1,408.45	$0.00	$0.00	Agreed error - should only reimburse most extensive procedure	City
123	ASC Pricing	$2,939.30	$0.00	$0.00	Agreed error - should only reimburse most extensive procedure	City
124	ASC Pricing	$9,021.90	$0.00	$0.00	Agreed error - should only reimburse most extensive procedure	Schools
125	ASC Pricing	$1,408.45	$0.00	$0.00	Agreed error - should only reimburse most extensive procedure	Schools
126	ASC Pricing	$2,939.30	$0.00	$0.00	Agreed error - should only reimburse most extensive procedure	Schools
127	ASC Pricing	$2,939.30	$0.00	$0.00	Agreed error - should only reimburse most extensive procedure	City
128	ASC Pricing	$2,766.40	$0.00	$0.00	Agreed error - should only reimburse most extensive procedure	Schools
129	ASC Pricing	$2,939.30	$0.00	$0.00	Agreed error - should only reimburse most extensive procedure	Schools
130	ASC Pricing	$3,993.30	$0.00	$0.00	Agreed error - should only reimburse most extensive procedure	City
131	ASC Pricing	$3,522.40	$0.00	$0.00	Agreed error - should only reimburse most extensive procedure	City
132	ASC Pricing	$5,370.30	$0.00	$0.00	Agreed error - should only reimburse most extensive procedure	City
133	ASC Pricing	$2,862.80	$0.00	$0.00	Agreed error - should only reimburse most extensive procedure	Schools
134	ASC Pricing	$2,862.80	$0.00	$0.00	Agreed error - should only reimburse most extensive procedure	City
135	ASC Pricing	$766.16	$0.00	$0.00	Agreed error - should only reimburse most extensive procedure	Schools
136	ASC Pricing	$1,371.90	$0.00	$0.00	Agreed error - should only reimburse most extensive procedure	Schools
137	ASC Pricing	$2,862.80	$0.00	$0.00	Agreed error - should only reimburse most extensive procedure	Schools
138	ASC Pricing	$3,368.00	$0.00	$0.00	Agreed error - should only reimburse most extensive procedure	City
139	ASC Pricing	$2,862.80	$0.00	$0.00	Agreed error - should only reimburse most extensive procedure	City
140	ASC Pricing	$3,313.22	$0.00	$0.00	Agreed error - should only reimburse most extensive procedure	Schools
141	Multiple Procedure Reductions	$0.00	$0.00	$0.00	Primary procedure - informational only	City
142	Multiple Procedure Reductions	$380.37	$0.00	$0.00	Agreed error - missed reduction	City
143	Multiple Procedure Reductions	$1,311.13	$0.00	$0.00	Agreed error - missed reduction	City
144	Multiple Procedure Reductions	$532.69	$0.00	$0.00	Agreed error - missed reduction	Schools
145	Multiple Procedure Reductions	$375.67	$0.00	$0.00	Agreed error - missed reduction	Schools
146	Multiple Procedure Reductions	$483.03	$0.00	$0.00	Agreed error - missed reduction	Schools
147	Surgery Global	$112.64	$0.00	$0.00	Optima states as correct at the time of processing (surgery claim not yet on file), but the claim is recoverable	Schools
148	Surgery Global	$0.00	$0.00	$0.00	Surgery claim - informational only	Schools
149	Surgery Global	$136.71	$0.00	$0.00	Agreed error	Schools
150	Surgery Global	$0.00	$0.00	$0.00	Surgery claim - informational only	Schools
151	Surgery Global	$79.56	$0.00	$0.00	Agreed error	Schools
152	Surgery Global	$0.00	$0.00	$0.00	Surgery claim - informational only	Schools
153	Pre-Admission Testing	$188.70	$0.00	$0.00	Optima states as correct at the time of processing (inpatient claim not yet on file), but the claim is recoverable	City
154	Pre-Admission Testing	$0.00	$0.00	$0.00	Inpatient claim - informational only	City
155	Pre-Admission Testing	$222.00	$0.00	$0.00	Optima states as correct at the time of processing (inpatient claim not yet on file), but the claim is recoverable	City
156	Pre-Admission Testing	$0.00	$0.00	$0.00	Inpatient claim - informational only	City
157	Pre-Admission Testing	$141.10	$0.00	$0.00	Optima states as correct at the time of processing (inpatient claim not yet on file), but the claim is recoverable	City
158	Pre-Admission Testing	$0.00	$0.00	$0.00	Inpatient claim - informational only	City
159	Pre-Admission Testing	$598.16	$0.00	$0.00	Optima states as correct at the time of processing (inpatient claim not yet on file), but the claim is recoverable	Schools
160	Pre-Admission Testing	$0.00	$0.00	$0.00	Inpatient claim - informational only	Schools
161	Pre-Admission Testing	$188.70	$0.00	$0.00	Optima states as correct at the time of processing (inpatient claim not yet on file), but the claim is recoverable	Schools
162	Pre-Admission Testing	$0.00	$0.00	$0.00	Inpatient claim - informational only	Schools
163	Pre-Admission Testing	$468.57	$0.00	$0.00	Optima states as correct at the time of processing (inpatient claim not yet on file), but the claim is recoverable	City
164	Pre-Admission Testing	$0.00	$0.00	$0.00	Inpatient claim - informational only	City
165	Pre-Admission Testing	$467.10	$0.00	$0.00	Optima states as correct at the time of processing (inpatient claim not yet on file), but the claim is recoverable	Schools
166	Pre-Admission Testing	$0.00	$0.00	$0.00	Inpatient claim - informational only	Schools
167	Pre-Admission Testing	$545.08	$0.00	$0.00	Agreed error	City
168	Pre-Admission Testing	$0.00	$0.00	$0.00	Inpatient claim - informational only	City
169	Pre-Admission Testing	$1,898.88	$0.00	$0.00	Optima states as correct at the time of processing (inpatient claim not yet on file), but the claim is recoverable	Schools
170	Pre-Admission Testing	$0.00	$0.00	$0.00	Inpatient claim - informational only	Schools

Audit Item	Issue	Recovery Amount	Refund Requested Prior	Disputed Amount	Comment	Group
171	Benefit Maximum - Hearing Aids	$0.00	$0.00	$0.00	Under maximum - informational	City
172	Benefit Maximum - Hearing Aids	$0.00	$0.00	$19.16	Optima states HCPCS V5011 (fitting) is not included in maximum - need plan intent	City
173	Benefit Exclusion - Bariatric Surgery	$1,360.45	$0.00	$0.00	Clinical authorization in error	Schools
174	Benefit Exclusion - Bariatric Surgery	$1,691.00	$0.00	$0.00	Clinical authorization in error	Schools
175	Benefit Exclusion - Blood Pressure Monitor	$0.00	$0.00	$0.00	Authorized as medically necessary	City
176	Benefit Exclusion - Blood Pressure Monitor	$36.12	$0.00	$0.00	Agreed error	Schools
177	Benefit Exclusion - Foot Orthotics	$0.00	$0.00	$0.00	Member is diabetic - covered	Schools
178	Benefit Exclusion - Foot Orthotics	$42.50	$0.00	$0.00	Agreed error	Schools
179	Benefit Exclusion - Foot Orthotics	$0.00	$0.00	$0.00	Member is diabetic - covered	Schools
180	Benefit Exclusion - Foot Orthotics	$38.25	$0.00	$0.00	Agreed error	City
181	Benefit Exclusion - Foot Orthotics	$0.00	$0.00	$0.00	Member is diabetic - covered	Schools
182	Benefit Exclusion - Foot Orthotics	$42.50	$0.00	$0.00	Agreed error	Schools
183	Benefit Exclusion - Foot Orthotics	$40.00	$0.00	$0.00	Agreed error	Schools
184	Benefit Exclusion - Foot Orthotics	$207.33	$0.00	$0.00	Agreed error	City
185	Benefit Exclusion - Foot Orthotics	$94.64	$0.00	$0.00	Agreed error	City
186	Benefit Exclusion - Administrative Exams	$202.00	$0.00	$0.00	Agreed error	Schools
187	Benefit Exclusion - Administrative Exams	$70.96	$0.00	$0.00	Agreed error	Schools
188	Benefit Exclusion - Administrative Exams	$51.19	$0.00	$0.00	Agreed error	City
189	Benefit Exclusion - Administrative Exams	$170.38	$0.00	$0.00	Agreed error	Schools
190	Benefit Exclusion - Administrative Exams	$123.15	$0.00	$0.00	Agreed error	Schools
191	Benefit Exclusion - Administrative Exams	$92.49	$0.00	$0.00	Agreed error	Schools
192	Benefit Exclusion - Administrative Exams	$58.22	$0.00	$0.00	Agreed error	Schools
193	Benefit Exclusion - Administrative Exams	$58.22	$0.00	$0.00	Agreed error	City
194	Benefit Exclusion - Administrative Exams	$58.22	$0.00	$0.00	Agreed error	Schools
195	Benefit Exclusion - Administrative Exams	$58.22	$0.00	$0.00	Agreed error	City
196	Benefit Exclusion - Administrative Exams	$58.22	$0.00	$0.00	Agreed error	Schools
197	Benefit Exclusion - Administrative Exams	$58.22	$0.00	$0.00	Agreed error	Schools
198	Benefit Exclusion - Administrative Exams	$58.65	$0.00	$0.00	Agreed error	City
199	Benefit Exclusion - Administrative Exams	$58.65	$0.00	$0.00	Agreed error	Schools
200	Benefit Exclusion - Administrative Exams	$55.20	$0.00	$0.00	Agreed error	Schools
		$143,820.99	**$4,651.69**	**$19.16**		

Appendix B – Out-of-Sample Claims Detail

Audit Item	Issue	Recovery Amount	Comment	Group
201	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	City
202	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	City
203	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	City
204	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	City
205	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	City
206	Benefit Exclusion - Administrative Exams	$60.92	Non-covered exam for participation in sport	City
207	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	City
208	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	City
209	Benefit Exclusion - Administrative Exams	$55.20	Non-covered exam for participation in sport	City
210	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	City
211	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	City
212	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	City
213	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	City
214	Benefit Exclusion - Administrative Exams	$41.65	Non-covered exam for participation in sport	City
215	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	City
216	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	City
217	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	City
218	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	City
219	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	City
220	Benefit Exclusion - Administrative Exams	$50.00	Non-covered exam for participation in sport	City
221	Benefit Exclusion - Administrative Exams	$72.48	Non-covered exam for employment	Schools
222	Benefit Exclusion - Administrative Exams	$55.48	Non-covered exam for employment	Schools
223	Benefit Exclusion - Administrative Exams	$76.47	Non-covered exam for employment	Schools
224	Benefit Exclusion - Administrative Exams	$58.22	Non-covered exam for participation in sport	Schools
225	Benefit Exclusion - Administrative Exams	$58.22	Non-covered exam for participation in sport	Schools
226	Benefit Exclusion - Administrative Exams	$58.22	Non-covered exam for participation in sport	Schools
227	Benefit Exclusion - Administrative Exams	$58.22	Non-covered exam for participation in sport	Schools
228	Benefit Exclusion - Administrative Exams	$58.22	Non-covered exam for participation in sport	Schools
229	Benefit Exclusion - Administrative Exams	$58.22	Non-covered exam for participation in sport	Schools
230	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	Schools
231	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	Schools
232	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	Schools
233	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	Schools
234	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	Schools
235	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	Schools
236	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	Schools
237	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	Schools
238	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	Schools
239	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	Schools
240	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	Schools
241	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	Schools
242	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	Schools
243	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	Schools
244	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	Schools
245	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	Schools
246	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	Schools
247	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	Schools
248	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	Schools
249	Benefit Exclusion - Administrative Exams	$170.61	Non-covered exam for participation in sport	Schools
250	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	Schools
251	Benefit Exclusion - Administrative Exams	$58.65	Non-covered exam for participation in sport	Schools
		$3,102.18		