August 5, 2024

FINAL HEALTHCARE CLAIMS AUDIT REPORT

City of Virginia Beach – Sentara

AUDIT PERIOD: JANUARY – DECEMBER 2023

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Executive Summary

The City of Virginia Beach (the City) engaged Healthcare Horizons to perform an audit of claims processed by Sentara Health Plans (Sentara) for paid dates of January through December 2023. Healthcare Horizons received $116,884,181.12 in paid claims data from Sentara and performed a full electronic review of claims processing. Of this total amount, $67,217,080.96 was paid for the school system and $49,667,100.16 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 250 targeted sample claims to Sentara as potential errors (based on mining of the data) or higher-dollar items in need of review. Sentara provided detailed feedback on all sample claim submissions with minimal follow-up questions required during the process.

Healthcare Horizons identified a recoverable amount of $205,503.19 from the sample claims, representing above average performance by Sentara based on our experience with similar projects. The majority of sample findings are related to the out-of-network allowable charge, duplicate payments, coordination of benefits with Medicare for an ESRD patient, multiple surgery pricing reductions, and non-covered gastric bypass surgery. 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 twenty additional out-of-sample claims related to coordination of benefits with Medicare for an ESRD patient and multiple surgery pricing reductions (total estimated recovery potential of $8,954.28). These additional out-of-sample claims are detailed in Appendix B.

Our findings for the audit are summarized on the following pages. Note that all Disputed / Plan Intent findings from the draft audit report have been moved to the Sample Recovery column.

All

Issue	Sample Recovery Amount	Sample Disputed / Plan Intent Amount	Out-of-Sample Recovery Potential	Total Audit Potential (Excluding Disputed / Plan Intent)
Out-of-Network Allowable Charge	$110,473.42	$0.00	$0.00	$110,473.42
Benefit Exclusion - Gastric Bypass	$34,124.18	$0.00	$0.00	$34,124.18
Duplicates	$21,908.25	$0.00	$0.00	$21,908.25
ESRD	$6,799.18	$0.00	$7,289.49	$14,088.67
Ambulatory Surgical Center Pricing	$12,433.77	$0.00	$0.00	$12,433.77
Multiple Procedure Reductions	$9,980.67	$0.00	$1,664.79	$11,645.46
Pre-Admission Testing	$4,857.69	$0.00	$0.00	$4,857.69
Surprise Bills	$3,098.24	$0.00	$0.00	$3,098.24
Eligibility	$1,127.57	$0.00	$0.00	$1,127.57
Benefit Exclusion - Administrative Exams	$187.37	$0.00	$0.00	$187.37
Surgery Global	$170.52	$0.00	$0.00	$170.52
Benefit Exclusion - Foot Orthotics	$85.00	$0.00	$0.00	$85.00
Benefit Exclusion - Blood Pressure Monitor	$82.76	$0.00	$0.00	$82.76
Benefit Exclusion - Acupuncture	$80.63	$0.00	$0.00	$80.63
Out-of-Network Greater Than Billed	$72.69	$0.00	$0.00	$72.69
Benefit Exclusion - Vision Training	$21.25	$0.00	$0.00	$21.25
Totals	**$205,503.19**	**$0.00**	**$8,954.28**	**$214,457.47**

City

Issue	Sample Recovery Amount	Sample Disputed / Plan Intent Amount	Out-of-Sample Recovery Potential	Total Audit Potential (Excluding Disputed / Plan Intent)
ESRD	$6,799.18	$0.00	$7,289.49	$14,088.67
Ambulatory Surgical Center Pricing	$5,207.09	$0.00	$0.00	$5,207.09
Multiple Procedure Reductions	$3,846.03	$0.00	$0.00	$3,846.03
Out-of-Network Allowable Charge	$1,078.42	$0.00	$0.00	$1,078.42
Duplicates	$1,068.70	$0.00	$0.00	$1,068.70
Pre-Admission Testing	$624.77	$0.00	$0.00	$624.77
Eligibility	$182.87	$0.00	$0.00	$182.87
Surgery Global	$170.52	$0.00	$0.00	$170.52
Benefit Exclusion - Administrative Exams	$132.98	$0.00	$0.00	$132.98
Benefit Exclusion - Acupuncture	$80.63	$0.00	$0.00	$80.63
Out-of-Network Greater Than Billed	$49.94	$0.00	$0.00	$49.94
Benefit Exclusion - Foot Orthotics	$42.50	$0.00	$0.00	$42.50
Surprise Bills	$0.00	$0.00	$0.00	$0.00
Totals	**$19,283.63**	**$0.00**	**$7,289.49**	**$26,573.12**

Schools

Issue	Sample Recovery Amount	Sample Disputed / Plan Intent Amount	Out-of-Sample Recovery Potential	Total Audit Potential (Excluding Disputed / Plan Intent)
Out-of-Network Allowable Charge	$109,395.00	$0.00	$0.00	$109,395.00
Benefit Exclusion - Gastric Bypass	$34,124.18	$0.00	$0.00	$34,124.18
Duplicates	$20,839.55	$0.00	$0.00	$20,839.55
Multiple Procedure Reductions	$6,134.64	$0.00	$1,664.79	$7,799.43
Ambulatory Surgical Center Pricing	$7,226.68	$0.00	$0.00	$7,226.68
Pre-Admission Testing	$4,232.92	$0.00	$0.00	$4,232.92
Surprise Bills	$3,098.24	$0.00	$0.00	$3,098.24
Eligibility	$944.70	$0.00	$0.00	$944.70
Benefit Exclusion - Blood Pressure Monitor	$82.76	$0.00	$0.00	$82.76
Benefit Exclusion - Administrative Exams	$54.39	$0.00	$0.00	$54.39
Benefit Exclusion - Foot Orthotics	$42.50	$0.00	$0.00	$42.50
Out-of-Network Greater Than Billed	$22.75	$0.00	$0.00	$22.75
Benefit Exclusion - Vision Training	$21.25	$0.00	$0.00	$21.25
Totals	**$186,219.56**	**$0.00**	**$1,664.79**	**$187,884.35**

The Sentara 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.

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.

Sample 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		Plan Intent / Disputed	
		Items	Amount	Items	Amount
Facility Pricing	10	0	$0.00	0	$0.00
Transfer Pricing	3	0	$0.00	0	$0.00
Professional Pricing	2	0	$0.00	0	$0.00
Out-of-Network Greater Than Billed	3	2	$72.69	0	$0.00
Out-of-Network Allowable Charge	6	4	$110,473.42	0	$0.00
Surprise Bills	6	1	$3,098.24	0	$0.00
Duplicates - Claim Level	52	2	$4,211.26	0	$0.00
Duplicates - Line Level	43	9	$17,696.99	0	$0.00
Overlapping Inpatient	6	0	$0.00	0	$0.00
Eligibility - After Termination	9	9	$1,127.57	0	$0.00
Eligibility - Not on File	3	0	$0.00	0	$0.00
Other Insurance	4	0	$0.00	0	$0.00
ESRD	12	1	$6,799.18	0	$0.00
Inpatient Readmissions	6	0	$0.00	0	$0.00
Pre-Admission Testing	10	5	$4,857.69	0	$0.00
Outpatient with Admission	4	0	$0.00	0	$0.00
Surgery Global	6	1	$170.52	0	$0.00
Home Health During Inpatient	2	0	$0.00	0	$0.00
Medically Unlikely Units	2	0	$0.00	0	$0.00
Multiple Procedure Reductions	13	13	$9,980.67	0	$0.00
Ambulatory Surgical Center Pricing	5	4	$12,433.77	0	$0.00
Out-of-Network Benefit	5	0	$0.00	0	$0.00
Benefit Maximum - Applied Behavioral Analysis	5	0	$0.00	0	$0.00
Benefit Maximum - Hearing Aids	9	0	$0.00	0	$0.00
Benefit Exclusion - Acupuncture	2	2	$80.63	0	$0.00
Benefit Exclusion - Foot Orthotics	4	2	$85.00	0	$0.00
Benefit Exclusion - Blood Pressure Monitor	1	1	$82.76	0	$0.00
Benefit Exclusion - Administrative Exams	3	2	$187.37	0	$0.00
Benefit Exclusion - Gastric Bypass	8	6	$34,124.18	0	$0.00
Benefit Exclusion - Vision Training	6	1	$21.25	0	$0.00
Totals	**250**	**65**	**$205,503.19**	**0**	**$0.00**

Recoverable Findings

1. Healthcare Horizons identified two isolated instances of payments greater than billed charges for an out-of-network provider. As part of our analysis of out-of-network pricing, Healthcare Horizons identified three claims that paid more than the billed charge amount. Audit item 16 was closed with no error as the overpayment was recovered prior to the audit in 2024. However, audit items 17 and 18 were agreed as overpayments totaling $72.69. We view these as isolated, one-off errors with no cause for systemic concern.

> ***Sentara's Response:***
>
> *For the two errors identified the health plan is an agreement these were isolated errors with no systematic concerns.*

2. A single agreed overpayment was identified for an out-of-network claim that was not limited to the Allowable Charge. For non-surprise bills, the plan document limits out-of-network provider reimbursement to a fee negotiation rate or Sentara's normal in-network rate for the services rendered. Audit item 24 (ground ambulance) was agreed as an overpayment of $1,078.42 as the claim was allowed at full billed charges in error. This appears to be a one-off or manual error with no systemic concern. Note that recovery of this claim will likely result in member balance billing.

> ***Sentara's Response:***
>
> *For the one error identified we are in agreement that this was an isolated manual error. The claims processor has been educated and the claim will be corrected.*

3. Healthcare Horizons identified a single surprise bill reimbursed at full billed charges in error. 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 prior communications with both Sentara and the City, our impression is that both sets of regulations are applicable. In testing surprise bills, Healthcare Horizons submitted six claims allowed at billed charges for review and response by Sentara. Five of the claims were dismissed as correct based on the following:

- Foreign claim
- Recovered prior to the audit in 2024
- Member payment

For audit item 29 involving an out-of-network emergency room facility claim, Sentara agreed to an overpayment of $3,098.24 as the claim priced at billed charges in error versus the applicable Virginia facility policy. Based on

the low volume of claims allowed at billed charges and the targeted sample findings, our impression is that Sentara is correctly administering reimbursement policies for surprise bills.

Sentara's Response:

For the one error identified we are in agreement that this was an isolated manual error. The claims processor has been educated and the claim will be corrected.

4. 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, Sentara agreed with eleven overpayments totaling $21,908.25 (audit items 32, 44, 94, 105, 107, 111, 113, 114, 118, 119, and 121). The majority of the claims closed as correct were reported to be identified and adjusted prior to the audit in 2024.

Sentara's Response:

One of the primary issues was the result of manual errors made, education has been to the Claims Department . The Health Plan continues to make strides towards continually improving our duplicate claims logic as evidenced by the minimal findings. Additionally, we have implemented several key controls that have significantly improved outcomes in the recovery of claims paid erroneously this is evidenced by findings from this audit were previously found and corrected.

Healthcare Horizons' Final Comment: We agree with a root cause of manual error with no cause for systemic concern.

5. A minimal number of recoverable claims were identified due to retroactive eligibility terminations. Healthcare Horizons utilized eligibility data provided by Sentara to test coverage for all claims in the dataset and only nine claims were identified with a service date after the eligibility termination date (audit items 132-140 with a total paid of $1,127.57). In each instance, Setara responded that the claims were correct at the time of processing and that a retroactive eligibility termination was transmitted by the City. These claims are recoverable should the City wish to pursue collections.

Sentara's Response

The claim was correct at the time of processing and is now recoverable due to a retroactive eligibility termination. 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.

Healthcare Horizons' Final Comment: Based on the minimal audit findings, our impression is that Sentara has effective procedures in place to identify and recover claims impacted by retroactive eligibility terminations.

6. Healthcare Horizons identified recoverable claims due to retroactive notification of Medicare primary coverage. After 33 months of dialysis for end stage renal disease (ESRD), Medicare becomes primary for the patient over employer-sponsored plans. For audit item 158, we determined that Medicare is primary on the service date due to a retroactive notification of the Medicare primary coverage. While the claim was correct at the time of processing, adjustment should occur to correct the claim to coordinate. We have cited the current paid amount of $6,799.18 as recoverable but the final recovery amount will likely be less as a secondary payment will be due from Sentara. Based on the Medicare primary effective date noted for this member, we have submitted thirteen additional out-of-sample claims paid at $7,289.49 for review and recovery by Sentara.

Sentara's Response

We agree that the claims are now recoverable but adjudicated correctly at the time of processing. The health plan will initiate recovery efforts for the impacted claims.

Healthcare Horizons' Final Comment: We request for Sentara to work the out-of-sample claims provided by Healthcare Horizons or produce its own impact report for the member in question.

7. Several pre-admission testing claims are recoverable as the provider contract prohibits separate payments 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 five recoverable claims for this issue for a total of $4,857.69 (audit items 166, 168, 170, 172, and 174). As the associated inpatient claims were not yet on file at the time of processing, Sentara disputes an error on these items. However, our understanding is that these claims are recoverable on behalf of the City. Note that all potential overpayments were submitted in the sample selection.

Sentara's 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.

Healthcare Horizons' Final Comment: We agree with a root cause of provider billing error and recommends for Sentara to initiate recovery on these claims.

8. A single recoverable claim was identified for an evaluation and management procedure 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. While the surgery claim was not on file at the time of processing, our understanding is that audit item 182 is recoverable for $170.52 based on surgery global guidelines. Note that all potential overpayments were submitted in the sample selection.

Sentara's Response

Sentara agrees with the auditors' findings that evaluations should be included as part of the global surgical package with no separate reimbursement. This was a manual processing error where follow up education has been conducted with those team member associated with these findings as well as reminders distributed to the team.

9. Healthcare Horizons identified overpayments due to missed multiple procedure reductions on professional claims. 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 there is often an overlap in pre-operative and post-operative services. Based on this policy, Sentara agreed with overpayments on all targeted sample items submitted by Healthcare Horizons (audit items 190-202 with a total overpayment amount of $9,980.67). As a result of the in-sample findings, Healthcare Horizons submitted seven additional out-of-sample claims for review by Sentara with an overpayment potential of $1,664.79. Finally, we recommend for Sentara to review these missed reduction examples to ensure the root cause is not a systemic issue.

Sentara's Response

After further investigation conducted by our Configuration Department we are disputing the auditors findings for this sample. Per System Configuration these codes should pay full pricing as they are unrelated. Below is an example of coding and there are not any conflicts with 29876RT and 29881RT so the second code would price in full.

Healthcare Horizons' Final Comment: The Sentara response references a screen shot from a leading medical edit software (omitted to avoid any terms of use violation) that is also utilized by Healthcare Horizons. The screen shot shows no correct coding initiative (CCI) relationship for the codes in question. Our understanding is that a CCI check only identifies instances in which procedures should be denied as incidental or mutually exclusive. The absence of a CCI relationship does not prohibit a 50% multiple procedure reduction opportunity per our understanding. In reviewing each procedure code for the sample claims, this software notes all as eligible for multiple procedure reductions. We respectfully request for Sentara to re-evaluate these claims for applicable 50% reductions on secondary procedures.

10. 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 Sentara contract only allows payment for the primary surgical procedure with all other lines to be denied for payment. Healthcare Horizons identified 4 overpayments totaling $12,433.77 for this issue (audit items 204-207). Note that this finding is significantly less than the 2022 audit finding of $82,376.60. We understand that this reimbursement arrangement requires manual intervention, and that Sentara has provided refresher training related to this issue. Note that all potential overpayments were submitted in the sample selection.

Sentara's Response:

We agree with the auditors feedback that the dollar impact is significantly less than in the previous audit period. We continue to provide ongoing feedback/education to the claims department in addition to a key control was implemented to perform quality monitoring specific to this claim scenario which has resulted in an improvement in performance.

Healthcare Horizons' Final Comment: We will continue to evaluate this area in future audits.

11. A limited number of overpayments were identified for non-covered acupuncture. According to the plan documents, acupuncture is an excluded benefit. In testing the entire paid claims dataset, only two instances of acupuncture were identified resulting in an agreed overpayment of $80.63 for audit items 227 and 228. Note that recovery of these claims will likely cause adverse member impact due to balance billing. Finally, Sentara should ensure appropriate system configuration to deny these services moving forward.

Sentara's Response:

We agree with the auditors findings the claim should have been denied as a non covered benefit. These were manual errors and appear to be isolated. Feedback has been provided to the claims processor responsible.

Healthcare Horizons' Final Comment: We agree with a root cause of manual error with no cause for systemic concern.

12. A small volume of 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 (except for members with diabetes or severe vascular problems) including customized or non-customized shoes, boots, and inserts. Sentara agreed to overpayments totaling $85.00 for this issue (audit items 230 and 232). 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, Sentara should ensure appropriate system configuration to deny these items moving forward.

Sentara's 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: We agree with a root cause of manual error with no cause for systemic concern.

13. 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. Based on this exclusion, audit item 233 was agreed as an overpayment of $82.76 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.

Sentara's Response:

Non-covered blood pressure monitors for audit sample 233 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: We agree that the post-payment review is effectively capturing blood pressure monitors that are not eligible for payment.

14. 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 identified two agreed overpayments totaling $187.37 (audit items 234 and 236). The primary diagnosis code on both claims was Z02.1 (encounter for pre-employment examination). 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. Finally, Sentara should ensure appropriate system configuration to deny these items moving forward.

Sentara's Response:

We agree with the auditors findings the claims should have been denied as a non covered benefit. These were manual errors and appear to be isolated. Feedback has been provided to the claims processors responsible.

Healthcare Horizons' Final Comment: We agree with a root cause of manual error with no cause for systemic concern.

15. Healthcare Horizons identified three members with gastric bypass services allowed in error. Upon review of the plan documents, gastric bypass surgery is not a covered benefit. Based on this exclusion, Sentara agreed with a total overpayment amount of $9,352.26 on audit items 237, 239, 240, 242, and 243. 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. Finally, Sentara should ensure appropriate system configuration to deny these services moving forward.

Sentara's Response:

As stated by the auditor based on the 2023 plan documents, morbid obesity treatment including surgery is not a covered benefit. An exception report continues to be in place 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.

Healthcare Horizons' Final Comment: Per the Sentara response, a post-payment report is in place to capture any gastric bypass services allowed in error. Sentara may choose to explore if the sample claims were captured on the exception report.

16. A single orthoptics (vision training) claim was paid in excess of the number of authorized visits. Healthcare Horizons submitted a number of claims for orthoptics for the same member based on a benefit exclusion found in the plan documents. Sentara responded that the services were authorized as medically necessary, however, audit item 250 paid at $21.25 exceeded the number of visits authorized and is therefore recoverable. Note that recovery of this claim will likely cause adverse member impact due to balance billing.

Sentara's Response:

We agree with the auditors findings the claim should have been denied as exceeded allowed visits. This was a manual error and appeared to be isolated. Feedback has been provided to the claims processor responsible.

Healthcare Horizons' Final Comment: We agree with a root cause of manual error with no cause for systemic concern.

Disputed / Plan Intent Findings

1. Healthcare Horizons requests a second pass review on three out-of-network claims allowed at full billed charges – plan intent clarification may also be required.

- Audit Item 19 – The claim involves a professional out-of-network breast reconstruction (CPT 19364) with a billed and allowed amount of $82,500.00. The Sentara response indicated that the claim was priced at charges via an external vendor. In comparison, another out-of-network surgeon on the same case (assumed to be a co-surgeon) was priced at $4,076.04 for the same procedure. We request that Sentara review the pricing on the sample claim to determine if the pricing is correct based on the Allowable Charge pricing limitation in the plan document.

  Sentara's Response:

  After an additional review we agree with the assigning of this manual error. The claims processor did not follow the no balance billing process to obtain rates and paid the claim incorrectly at charges. We will work with the Claims Department to ensure policies are clear and education is given to them.

  Healthcare Horizons' Final Comment: We appreciate the additional review by Sentara. All charts have been updated to reflect an estimated recovery amount of $82,500.00. The final overpayment amount is pending adjustment of the claim for application of applicable out-of-network rates.

- Audit Item 20 – The claim involves a professional out-of-network skin graft along with an evaluation with a billed and allowed amount of $17,965.00. Sentara responded that due to an emergent diagnosis, the claim should allow billed charges to avoid balance billing. We request a second pass review to determine if surprise billing reimbursement should apply.

  Sentara's Response:

  After an additional review we agree with the assigning of this manual error. The claims processor did not follow the no balance billing process to obtain rates and paid the claim incorrectly at charges. We will work with the Claims Department to ensure policies are clear and education is given to them.

  Healthcare Horizons' Final Comment: We appreciate the additional review by Sentara. All charts have been updated to reflect an estimated recovery amount of $17,965.00. The final overpayment amount is pending adjustment of the claim for application of applicable out-of-network rates.

- Audit Item 21 – The claim involves a professional out-of-network skull surgery with a billed and allowed amount of $8,930.00. Sentara responded that due to an emergent diagnosis, the claim should allow billed charges to avoid balance billing. We request a second pass review to determine if surprise billing reimbursement should apply.

Sentara's Response:

After an additional review we agree with the assigning of this manual error. The claims processor did not follow the no balance billing process to obtain rates and paid the claim incorrectly at charges. We will work with the Claims Department to ensure policies are clear and education is given to them.

Healthcare Horizons' Final Comment: We appreciate the additional review by Sentara. All charts have been updated to reflect an estimated recovery amount of $8,930.00. The final overpayment amount is pending adjustment of the claim for application of applicable out-of-network rates.

2. Healthcare Horizons is disputing the payment of an inpatient facility claim for gastric bypass surgery. Audit item 238 involves a one-day inpatient facility claim with the majority of charges related to operating and recovery rooms. The diagnosis code billed is K21.9 (gastro-esophageal reflux disease). The professional surgery and anesthesia claims during the stay involved a gastric bypass surgery with a diagnosis code of E66.01 (morbid obesity). Note that the professional surgery and anesthesia claims were agreed as overpayments by Sentara (audit items 237 and 239). For the associated inpatient stay, Sentara responded that the diagnosis is not considered as an excluded benefit. We request a second pass review to determine if the inpatient stay paid at $24,771.92 should be denied as well.

Sentara's Response:

Based on a second review of audit item 238, Sentara agrees this is an overpayment for a non-covered benefit. An exception report has been established to run monthly, to catch claims paid incorrectly so that they can be reversed. We will continue to work with the benefits configuration team to review/ enhance the configuration related to excluded benefits prior to the audit engagement. Defined procedures were put into place to ensure all benefit exclusions are configured to deny appropriately.

Healthcare Horizons' Final Comment: We appreciate the updated response from Sentara and have updated all charts to reflect a recovery amount of $24,771.92. Note that recovery of this claim will likely result in adverse member impact.

Informational Findings

1. Healthcare Horizons recommends for the City to confirm cash collection on several high-dollar adjustments performed primarily in 2024 by Sentara. For a number of items presented by Healthcare Horizons (mostly duplicates), Sentara responded that the overpayment was already identified and that a refund request adjustment was already completed. Note that the Healthcare Horizons data is only through 12/31/23. While these claims are not cited as audit findings, we recommend for the City to confirm recovery on these items via its group billing. We are glad to provide additional details on these claims upon request.

Audit Item	Issue	Overpayment	Adjustment Date
40	Duplicates	$15,044.80	1/23/24
48	Duplicates	$4,807.54	2/6/24
54	Duplicates	$32,020.44	1/9/24
58	Duplicates	$42,154.00	1/23/24
60	Duplicates	$14,400.82	1/9/24
62	Duplicates	$18,083.00	1/29/24
64	Duplicates	$8,813.61	1/23/24
70	Duplicates	$12,837.26	1/29/24
74	Duplicates	$3,764.28	1/29/24
86	Duplicates	$9,057.78	1/16/24
96	Duplicates	$10,372.29	1/16/24
103	Duplicates	$8,293.80	1/7/24
109	Duplicates	$6,545.12	1/21/24
125	Duplicates	$4,345.37	1/21/24
127	Overlapping Inpatient	$9,039.75	1/28/24
129	Overlapping Inpatient	$14,851.90	1/14/24
131	Overlapping Inpatient	$122,372.32	1/7/24
145	Other Insurance	$64,337.47	12/5/23

2. Healthcare Horizons recommends plan intent clarification on the hearing aid benefit maximum. The plan documents contain 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)*

In working to verify administration of this maximum, Healthcare Horizons noted that procedure code V5010 (assessment for hearing aid), was not part of the dollar maximum per Sentara administration. We recommend that the City clarify plan intent for this procedure code. The total dollar impact for this code on 2023 is $2,109.30.

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 Sentara team during this process.

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

- Sentara 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 should confirm cash collections for the audit items noted as already adjusted prior to the audit.
- Sentara should ensure system configuration to deny non-covered services and supplies.

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	Plan Intent / Disputed Amount	Comment	Group
1	Facility Pricing	$0.00	$0.00	Priced correctly - secondary stop loss	Schools
2	Facility Pricing	$0.00	$0.00	Priced correctly - secondary stop loss	Schools
3	Facility Pricing	$0.00	$0.00	Priced correctly - secondary stop loss	City
4	Facility Pricing	$0.00	$0.00	Priced correctly - DRG plus stop loss	Schools
5	Facility Pricing	$0.00	$0.00	Priced correctly - DRG plus stop loss	City
6	Facility Pricing	$0.00	$0.00	Priced correctly via Optum	City
7	Facility Pricing	$0.00	$0.00	Priced correctly via Optum	Schools
8	Facility Pricing	$0.00	$0.00	Priced correctly via Optum	Schools
9	Facility Pricing	$0.00	$0.00	Priced correctly - secondary stop loss	City
10	Facility Pricing	$0.00	$0.00	Priced correctly - secondary stop loss	City
11	Transfer Pricing	$0.00	$0.00	Transfer rate higher than billed - allowed lesser of billed charge	Schools
12	Transfer Pricing	$0.00	$0.00	Transfer rate higher than billed - allowed lesser of billed charge	City
13	Transfer Pricing	$0.00	$0.00	Transfer rate higher than billed - allowed lesser of billed charge	City
14	Professional Pricing	$0.00	$0.00	Priced correctly - transplant contract	City
15	Professional Pricing	$0.00	$0.00	Contract rate is 100% of billed charges	City
16	Out-of-Network Greater Than Billed	$0.00	$0.00	Recovered prior to audit ($56.60 on 3/29/24)	Schools
17	Out-of-Network Greater Than Billed	$22.75	$0.00	Agreed error	Schools
18	Out-of-Network Greater Than Billed	$49.94	$0.00	Agreed error	City
19	Out-of-Network Allowable Charge	$82,500.00	$0.00	Agreed manual error as processor did not follow no balance billing process for rates - allowed charges incorrectly	Schools
20	Out-of-Network Allowable Charge	$17,965.00	$0.00	Agreed manual error as processor did not follow no balance billing process for rates - allowed charges incorrectly	Schools
21	Out-of-Network Allowable Charge	$8,930.00	$0.00	Agreed manual error as processor did not follow no balance billing process for rates - allowed charges incorrectly	Schools
22	Out-of-Network Allowable Charge	$0.00	$0.00	PHCS pricing at billed charges	Schools
23	Out-of-Network Allowable Charge	$0.00	$0.00	PHCS pricing at billed charges	City
24	Out-of-Network Allowable Charge	$1,078.42	$0.00	Agreed error - should not allow billed charges	City
25	Surprise Bills	$0.00	$0.00	Sent for surprise billing pricing - allowed at billed due to Maryland facility policy	City
26	Surprise Bills	$0.00	$0.00	Member reimbursement claim	Schools
27	Surprise Bills	$0.00	$0.00	Out-of-country claim allowed at billed charges	City
28	Surprise Bills	$0.00	$0.00	Corrected prior to audit on 2/6/24	City
29	Surprise Bills	$3,098.24	$0.00	Agreed error - should not allow billed charges	Schools
30	Surprise Bills	$0.00	$0.00	Priced via external vendor	City
31	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 31/32 combo	Schools
32	Duplicates - Claim Level	$461.76	$0.00	Agreed duplicate	Schools
33	Duplicates - Claim Level	$0.00	$0.00	Adjusted to deny after audit period on 1/16/24 ($168.00)	Schools
34	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 33/34 combo	Schools
35	Duplicates - Claim Level	$0.00	$0.00	Adjusted to deny after audit period on 1/29/24 ($235.27)	City
36	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 35/36 combo	City
37	Duplicates - Claim Level	$0.00	$0.00	Adjusted to deny after audit period on 1/29/24 ($218.97)	Schools
38	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 37/38 combo	Schools
39	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 39/40 combo	City
40	Duplicates - Claim Level	$0.00	$0.00	Adjusted to deny after audit period on 1/23/24 ($15,044.80)	City
41	Duplicates - Claim Level	$0.00	$0.00	Adjusted to deny after audit period on 1/23/24 ($1,972.41)	Schools
42	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 41/42 combo	Schools
43	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 43/44 combo	Schools
44	Duplicates - Claim Level	$3,749.50	$0.00	Agreed error	Schools
45	Duplicates - Claim Level	$0.00	$0.00	Adjusted to deny after audit period on 1/23/24 ($558.45)	Schools
46	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 45/46 combo	Schools
47	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 47/48 combo	City
48	Duplicates - Claim Level	$0.00	$0.00	Adjusted to deny after audit period on 2/6/24 ($4,807.54)	City
49	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 49/50 combo	City
50	Duplicates - Claim Level	$0.00	$0.00	Adjusted to deny on 9/5/23 ($228.54) - dollars likely outstanding	City
51	Duplicates - Claim Level	$0.00	$0.00	Adjusted to deny after audit period on 1/23/24 ($312.67)	Schools
52	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 51/52 combo	Schools
53	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 53/54 combo	City
54	Duplicates - Claim Level	$0.00	$0.00	Adjusted to deny after audit period on 1/9/24 ($32,020.44)	City
55	Duplicates - Claim Level	$0.00	$0.00	Adjusted to deny after audit period on 2/6/24 ($135.23)	Schools
56	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 55/56 combo	Schools
57	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 57/58 combo	Schools
58	Duplicates - Claim Level	$0.00	$0.00	Adjusted to deny after audit period on 1/23/24 ($42,154.00)	Schools
59	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 59/60 combo	City
60	Duplicates - Claim Level	$0.00	$0.00	Adjusted to deny after audit period on 1/9/24 ($14,400.82)	City

Audit Item	Issue	Recovery Amount	Plan Intent / Disputed Amount	Comment	Group
61	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 61/62 combo	Schools
62	Duplicates - Claim Level	$0.00	$0.00	Adjusted to deny after audit period on 1/29/24 ($18,083.00)	Schools
63	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 63/64 combo	City
64	Duplicates - Claim Level	$0.00	$0.00	Adjusted to deny after audit period on 1/23/24 ($8,813.61)	City
65	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 65/66 combo	City
66	Duplicates - Claim Level	$0.00	$0.00	Adjusted to deny after audit period on 2/13/24 ($228.54)	City
67	Duplicates - Claim Level	$0.00	$0.00	Adjusted to deny after audit period on 1/23/24 ($668.18)	City
68	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 67/68 combo	City
69	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 69/70 combo	Schools
70	Duplicates - Claim Level	$0.00	$0.00	Adjusted to deny after audit period on 1/29/24 ($12,837.26)	Schools
71	Duplicates - Claim Level	$0.00	$0.00	Adjusted to deny after audit period on 1/9/24 ($231.00)	Schools
72	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 71/72 combo	Schools
73	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 73/74 combo	City
74	Duplicates - Claim Level	$0.00	$0.00	Adjusted to deny after audit period on 1/29/24 ($3,764.28)	City
75	Duplicates - Claim Level	$0.00	$0.00	Adjusted to deny after audit period on 1/16/24 ($698.26)	City
76	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 75/76 combo	City
77	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 77/78 combo	Schools
78	Duplicates - Claim Level	$0.00	$0.00	Adjusted to deny after audit period on 1/29/24 ($776.90)	Schools
79	Duplicates - Claim Level	$0.00	$0.00	Different anesthesia modifiers	City
80	Duplicates - Claim Level	$0.00	$0.00	Different anesthesia modifiers	City
81	Duplicates - Claim Level	$0.00	$0.00	Adjusted to deny after audit period on 1/23/24 ($1,534.70)	Schools
82	Duplicates - Claim Level	$0.00	$0.00	Correct claim for 81/82 combo	Schools
83	Duplicates - Line Level	$0.00	$0.00	Adjusted to deny after audit period on 1/21/24 ($1,944.00)	Schools
84	Duplicates - Line Level	$0.00	$0.00	Correct claim for 83/84 combo	Schools
85	Duplicates - Line Level	$0.00	$0.00	Correct claim for 85/86 combo	Schools
86	Duplicates - Line Level	$0.00	$0.00	Adjusted to deny after audit period on 1/16/24 ($9,057.78)	Schools
87	Duplicates - Line Level	$0.00	$0.00	Adjusted to deny on 12/26/23 ($521.93) - dollars likely outstanding	City
88	Duplicates - Line Level	$0.00	$0.00	Correct claim for 87/88 combo	City
89	Duplicates - Line Level	$0.00	$0.00	Correct claim for 89-94 combo	Schools
90	Duplicates - Line Level	$0.00	$0.00	Correct claim for 89-94 combo	Schools
91	Duplicates - Line Level	$0.00	$0.00	Correct claim for 89-94 combo	Schools
92	Duplicates - Line Level	$0.00	$0.00	Correct claim for 89-94 combo	Schools
93	Duplicates - Line Level	$0.00	$0.00	Correct claim for 89-94 combo	Schools
94	Duplicates - Line Level	$850.00	$0.00	Agreed error	Schools
95	Duplicates - Line Level	$0.00	$0.00	Correct claim for 95/96 combo	City
96	Duplicates - Line Level	$0.00	$0.00	Adjusted to deny after audit period on 1/16/24 ($10,372.29)	City
97	Duplicates - Line Level	$0.00	$0.00	Adjusted to deny after audit period on 2/18/24 ($483.13)	Schools
98	Duplicates - Line Level	$0.00	$0.00	Correct claim for 97/98 combo	Schools
99	Duplicates - Line Level	$0.00	$0.00	Correct claim for 99/100/101 combo	Schools
100	Duplicates - Line Level	$0.00	$0.00	Adjusted to deny after audit period ($1,140.78)	Schools
101	Duplicates - Line Level	$0.00	$0.00	Adjusted to deny after audit period ($123.50)	Schools
102	Duplicates - Line Level	$0.00	$0.00	Correct claim for 102/103 combo	Schools
103	Duplicates - Line Level	$0.00	$0.00	Adjusted to deny after audit period on 1/7/24 ($8,293.80)	Schools
104	Duplicates - Line Level	$0.00	$0.00	Correct claim for 104/105 combo	City
105	Duplicates - Line Level	$170.00	$0.00	Agreed duplicate	City
106	Duplicates - Line Level	$0.00	$0.00	Correct claim for 106/107 combo	City
107	Duplicates - Line Level	$170.00	$0.00	Agreed duplicate	City
108	Duplicates - Line Level	$0.00	$0.00	Correct claim for 108/109 combo	Schools
109	Duplicates - Line Level	$0.00	$0.00	Adjusted to deny after audit period on 1/21/24 ($6,545.12)	Schools
110	Duplicates - Line Level	$0.00	$0.00	Correct claim for 110/111 combo	City
111	Duplicates - Line Level	$306.00	$0.00	Agreed duplicate	City
112	Duplicates - Line Level	$0.00	$0.00	Correct claim for 112/113 combo	Schools
113	Duplicates - Line Level	$3,315.05	$0.00	Agreed duplicate	Schools
114	Duplicates - Line Level	$12,158.00	$0.00	Agreed duplicate	Schools
115	Duplicates - Line Level	$0.00	$0.00	Correct claim for 114/115 combo	Schools
116	Duplicates - Line Level	$0.00	$0.00	Correct claim for 116-119 combo	City
117	Duplicates - Line Level	$0.00	$0.00	Correct claim for 116-119 combo	City
118	Duplicates - Line Level	$132.68	$0.00	Agreed duplicate	City
119	Duplicates - Line Level	$290.02	$0.00	Agreed duplicate	City
120	Duplicates - Line Level	$0.00	$0.00	Correct claim for 120/121 combo	Schools
121	Duplicates - Line Level	$305.24	$0.00	Agreed duplicate	Schools
122	Duplicates - Line Level	$0.00	$0.00	Adjusted to deny after audit period on 1/7/24 ($1,880.40)	Schools
123	Duplicates - Line Level	$0.00	$0.00	Correct claim for 122/123 combo	Schools
124	Duplicates - Line Level	$0.00	$0.00	Correct claim for 124/125 combo	City
125	Duplicates - Line Level	$0.00	$0.00	Adjusted to deny after audit period on 1/21/24 ($4,345.37)	City
126	Overlapping Inpatient	$0.00	$0.00	Correct claim for 126/127 combo	City
127	Overlapping Inpatient	$0.00	$0.00	Adjusted to deny after audit period on 1/28/24 ($9,039.75)	City
128	Overlapping Inpatient	$0.00	$0.00	Correct claim for 128/129 combo	City
129	Overlapping Inpatient	$0.00	$0.00	Adjusted to deny after audit period on 1/14/24 ($14,851.90)	City
130	Overlapping Inpatient	$0.00	$0.00	Correct claim for 130/131 combo	City
131	Overlapping Inpatient	$0.00	$0.00	Adjusted to deny after audit period on 1/7/24 ($122,372.32)	City

Audit Item	Issue	Recovery Amount	Plan Intent / Disputed Amount	Comment	Group
132	Eligibility - After Termination	$214.84	$0.00	Correct at the time of processing but recoverable due to retroactive eligibility termination	Schools
133	Eligibility - After Termination	$65.75	$0.00	Correct at the time of processing but recoverable due to retroactive eligibility termination	Schools
134	Eligibility - After Termination	$130.82	$0.00	Correct at the time of processing but recoverable due to retroactive eligibility termination	Schools
135	Eligibility - After Termination	$130.82	$0.00	Correct at the time of processing but recoverable due to retroactive eligibility termination	Schools
136	Eligibility - After Termination	$150.34	$0.00	Correct at the time of processing but recoverable due to retroactive eligibility termination	Schools
137	Eligibility - After Termination	$133.33	$0.00	Correct at the time of processing but recoverable due to retroactive eligibility termination	Schools
138	Eligibility - After Termination	$118.80	$0.00	Correct at the time of processing but recoverable due to retroactive eligibility termination	Schools
139	Eligibility - After Termination	$112.68	$0.00	Correct at the time of processing but recoverable due to retroactive eligibility termination	City
140	Eligibility - After Termination	$70.19	$0.00	Correct at the time of processing but recoverable due to retroactive eligibility termination	City
141	Eligibility - Not on File	$0.00	$0.00	Member eligible	City
142	Eligibility - Not on File	$0.00	$0.00	Member eligible	City
143	Eligibility - Not on File	$0.00	$0.00	Member eligible	City
144	Other Insurance	$0.00	$0.00	Other insurance secondary - confirm as informational finding	Schools
145	Other Insurance	$0.00	$0.00	Adjusted to deny on 12/5/23 ($64,337.47) - dollars likely outstanding	Schools
146	Other Insurance	$0.00	$0.00	No other insurance	City
147	Other Insurance	$0.00	$0.00	Medicare secondary	City
148	ESRD	$0.00	$0.00	No other insurance - informational finding	City
149	ESRD	$0.00	$0.00	Medicare Part A only as of 3/1/23 - plan does not estimate (informational finding)	City
150	ESRD	$0.00	$0.00	Medicare Part A only as of 3/1/23 - plan does not estimate (informational finding)	City
151	ESRD	$0.00	$0.00	Medicare Part A only as of 3/1/23 - plan does not estimate (informational finding)	City
152	ESRD	$0.00	$0.00	Medicare Part A only as of 3/1/23 - plan does not estimate (informational finding)	City
153	ESRD	$0.00	$0.00	Medicare Part A only as of 3/1/23 - plan does not estimate (informational finding)	City
154	ESRD	$0.00	$0.00	Medicare Part A only as of 3/1/23 - plan does not estimate (informational finding)	City
155	ESRD	$0.00	$0.00	Medicare primary 9/1/25 (DOS prior)	Schools
156	ESRD	$0.00	$0.00	Medicare primary 7/1/25 (DOS prior)	Schools
157	ESRD	$0.00	$0.00	Medicare primary 7/1/25 (DOS prior)	Schools
158	ESRD	$6,799.18	$0.00	Medicare primary 12/1/22 - correct at the time of processing but recoverable due to retroactive notification on 10/19/23	City
159	ESRD	$0.00	$0.00	Medicare primary 11/1/24 (DOS prior)	City
160	Inpatient Readmissions	$0.00	$0.00	Original admit for 160/161 combo	City
161	Inpatient Readmissions	$0.00	$0.00	Unrelated readmission per Sentara	City
162	Inpatient Readmissions	$0.00	$0.00	Original admit for 162/163 combo	Schools
163	Inpatient Readmissions	$0.00	$0.00	Unrelated readmission per Sentara	Schools
164	Inpatient Readmissions	$0.00	$0.00	Original admit for 164/165 combo	Schools
165	Inpatient Readmissions	$0.00	$0.00	Unrelated readmission per Sentara	Schools
166	Pre-Admission Testing	$1,617.36	$0.00	Correct at the time of processing as inpatient claim was not yet on file, but recoverable	Schools
167	Pre-Admission Testing	$0.00	$0.00	Inpatient claim for 166/167 combo - informational only	Schools
168	Pre-Admission Testing	$428.42	$0.00	Correct at the time of processing as inpatient claim was not yet on file, but recoverable	City
169	Pre-Admission Testing	$0.00	$0.00	Inpatient claim for 168/169 combo - informational only	City
170	Pre-Admission Testing	$1,249.70	$0.00	Correct at the time of processing as inpatient claim was not yet on file, but recoverable	Schools
171	Pre-Admission Testing	$0.00	$0.00	Inpatient claim for 170/171 combo - informational only	Schools
172	Pre-Admission Testing	$196.35	$0.00	Correct at the time of processing as inpatient claim was not yet on file, but recoverable	City
173	Pre-Admission Testing	$0.00	$0.00	Inpatient claim for 172/173 combo - informational only	City
174	Pre-Admission Testing	$1,365.86	$0.00	Correct at the time of processing as inpatient claim was not yet on file, but recoverable	Schools
175	Pre-Admission Testing	$0.00	$0.00	Inpatient claim for 174/175 combo - informational only	Schools
176	Outpatient with Admission	$0.00	$0.00	Different providers	City
177	Outpatient with Admission	$0.00	$0.00	Different providers	City
178	Outpatient with Admission	$0.00	$0.00	Different providers	City
179	Outpatient with Admission	$0.00	$0.00	Different providers	City

Audit Item	Issue	Recovery Amount	Plan Intent / Disputed Amount	Comment	Group
180	Surgery Global	$0.00	$0.00	Evaluation allowed separately per Sentara	City
181	Surgery Global	$0.00	$0.00	Informational surgical claim for 180/181 combo	City
182	Surgery Global	$170.52	$0.00	Correct at the time of processing as surgical claim was not yet on file, but recoverable	City
183	Surgery Global	$0.00	$0.00	Informational surgical claim for 182/183 combo	City
184	Surgery Global	$0.00	$0.00	Evaluation allowed separately per Sentara	Schools
185	Surgery Global	$0.00	$0.00	Informational surgical claim for 184/185 combo	Schools
186	Home Health During Inpatient	$0.00	$0.00	Home health supplies - correct to allow	City
187	Home Health During Inpatient	$0.00	$0.00	Informational inpatient claim for 186/187 combo	City
188	Medically Unlikely Units	$0.00	$0.00	Sentara does not administer a unit limitation on this code - informational finding	City
189	Medically Unlikely Units	$0.00	$0.00	Sentara does not administer a unit limitation on this code - informational finding	Schools
190	Multiple Procedure Reductions	$405.07	$0.00	Agreed error - missed 50% reduction	Schools
191	Multiple Procedure Reductions	$575.93	$0.00	Agreed error - missed 50% reduction	City
192	Multiple Procedure Reductions	$841.66	$0.00	Agreed error - missed 50% reduction	City
193	Multiple Procedure Reductions	$381.24	$0.00	Agreed error - missed 50% reduction	Schools
194	Multiple Procedure Reductions	$913.89	$0.00	Agreed error - missed 50% reduction	Schools
195	Multiple Procedure Reductions	$1,015.41	$0.00	Agreed error - missed 50% reduction	Schools
196	Multiple Procedure Reductions	$871.37	$0.00	Agreed error - missed 50% reduction	City
197	Multiple Procedure Reductions	$293.31	$0.00	Agreed error - missed 50% reduction	Schools
198	Multiple Procedure Reductions	$841.66	$0.00	Agreed error - missed 50% reduction	City
199	Multiple Procedure Reductions	$715.41	$0.00	Agreed error - missed 50% reduction	City
200	Multiple Procedure Reductions	$1,142.36	$0.00	Agreed error - missed 50% reduction	Schools
201	Multiple Procedure Reductions	$1,142.36	$0.00	Agreed error - missed 50% reduction	Schools
202	Multiple Procedure Reductions	$841.00	$0.00	Agreed error - missed 50% reduction	Schools
203	Ambulatory Surgical Center Pricing	$0.00	$0.00	Corrected prior to audit	Schools
204	Ambulatory Surgical Center Pricing	$3,109.30	$0.00	Agreed error - secondary procedures reimbursed incorrectly	Schools
205	Ambulatory Surgical Center Pricing	$3,200.24	$0.00	Agreed error - secondary procedures reimbursed incorrectly	City
206	Ambulatory Surgical Center Pricing	$4,117.38	$0.00	Agreed error - secondary procedures reimbursed incorrectly	Schools
207	Ambulatory Surgical Center Pricing	$2,006.85	$0.00	Agreed error - secondary procedures reimbursed incorrectly	City
208	Out-of-Network Benefit	$0.00	$0.00	In-network benefit based on exception and/or extended network	City
209	Out-of-Network Benefit	$0.00	$0.00	In-network benefit based on exception and/or extended network	Schools
210	Out-of-Network Benefit	$0.00	$0.00	In-network benefit based on exception and/or extended network	Schools
211	Out-of-Network Benefit	$0.00	$0.00	In-network benefit based on exception and/or extended network	Schools
212	Out-of-Network Benefit	$0.00	$0.00	In-network benefit based on exception and/or extended network	City
213	Benefit Maximum - Applied Behavioral Analysis	$0.00	$0.00	Dollar limit no longer applicable	City
214	Benefit Maximum - Applied Behavioral Analysis	$0.00	$0.00	Dollar limit no longer applicable	City
215	Benefit Maximum - Applied Behavioral Analysis	$0.00	$0.00	Dollar limit no longer applicable	City
216	Benefit Maximum - Applied Behavioral Analysis	$0.00	$0.00	Dollar limit no longer applicable	City
217	Benefit Maximum - Applied Behavioral Analysis	$0.00	$0.00	Dollar limit no longer applicable	City
218	Benefit Maximum - Hearing Aids	$0.00	$0.00	V5010 (assessment for hearing aid) not included in dollar maximum per Sentara - informational finding for plan intent	City
219	Benefit Maximum - Hearing Aids	$0.00	$0.00	V5010 (assessment for hearing aid) not included in dollar maximum per Sentara - informational finding for plan intent	Schools
220	Benefit Maximum - Hearing Aids	$0.00	$0.00	V5010 (assessment for hearing aid) not included in dollar maximum per Sentara - informational finding for plan intent	Schools
221	Benefit Maximum - Hearing Aids	$0.00	$0.00	V5010 (assessment for hearing aid) not included in dollar maximum per Sentara - informational finding for plan intent	Schools
222	Benefit Maximum - Hearing Aids	$0.00	$0.00	V5010 (assessment for hearing aid) not included in dollar maximum per Sentara - informational finding for plan intent	Schools
223	Benefit Maximum - Hearing Aids	$0.00	$0.00	V5010 (assessment for hearing aid) not included in dollar maximum per Sentara - informational finding for plan intent	Schools
224	Benefit Maximum - Hearing Aids	$0.00	$0.00	V5010 (assessment for hearing aid) not included in dollar maximum per Sentara - informational finding for plan intent	City
225	Benefit Maximum - Hearing Aids	$0.00	$0.00	V5010 (assessment for hearing aid) not included in dollar maximum per Sentara - informational finding for plan intent	City
226	Benefit Maximum - Hearing Aids	$0.00	$0.00	V5010 (assessment for hearing aid) not included in dollar maximum per Sentara - informational finding for plan intent	Schools
227	Benefit Exclusion - Acupuncture	$41.65	$0.00	Agreed error	City
228	Benefit Exclusion - Acupuncture	$38.98	$0.00	Agreed error	City

Audit Item	Issue	Recovery Amount	Plan Intent / Disputed Amount	Comment	Group
229	Benefit Exclusion - Foot Orthotics	$0.00	$0.00	Member has diabetic flag - covered	Schools
230	Benefit Exclusion - Foot Orthotics	$42.50	$0.00	Agreed error	City
231	Benefit Exclusion - Foot Orthotics	$0.00	$0.00	Member has diabetic flag - covered	City
232	Benefit Exclusion - Foot Orthotics	$42.50	$0.00	Agreed error	Schools
233	Benefit Exclusion - Blood Pressure Monitor	$82.76	$0.00	Agreed error	Schools
234	Benefit Exclusion - Administrative Exams	$54.39	$0.00	Agreed error	Schools
235	Benefit Exclusion - Administrative Exams	$0.00	$0.00	Immunization is covered	City
236	Benefit Exclusion - Administrative Exams	$132.98	$0.00	Agreed error	City
237	Benefit Exclusion - Gastric Bypass	$2,129.16	$0.00	Agreed error	Schools
238	Benefit Exclusion - Gastric Bypass	$24,771.92	$0.00	Agreed error	Schools
239	Benefit Exclusion - Gastric Bypass	$1,512.00	$0.00	Agreed error	Schools
240	Benefit Exclusion - Gastric Bypass	$1,894.05	$0.00	Agreed error	Schools
241	Benefit Exclusion - Gastric Bypass	$0.00	$0.00	Recovered prior to audit	Schools
242	Benefit Exclusion - Gastric Bypass	$1,905.16	$0.00	Agreed error	Schools
243	Benefit Exclusion - Gastric Bypass	$1,911.89	$0.00	Agreed error	Schools
244	Benefit Exclusion - Gastric Bypass	$0.00	$0.00	Recovered prior to audit	Schools
245	Benefit Exclusion - Vision Training	$0.00	$0.00	Covered as medically necessary	Schools
246	Benefit Exclusion - Vision Training	$0.00	$0.00	Covered as medically necessary	Schools
247	Benefit Exclusion - Vision Training	$0.00	$0.00	Covered as medically necessary	Schools
248	Benefit Exclusion - Vision Training	$0.00	$0.00	Covered as medically necessary	Schools
249	Benefit Exclusion - Vision Training	$0.00	$0.00	Covered as medically necessary	Schools
250	Benefit Exclusion - Vision Training	$21.25	$0.00	Number of visits exceeded authorization	Schools
	Totals	**$205,503.19**	**$0.00**		

Appendix B – Out-of-Sample Claims Detail

Audit Item	Issue	Recovery Potential	Comment	Group
251	ESRD	$156.59	Medicare primary 12/1/2022 (retroactive) - needs coordination	City
252	ESRD	$112.69	Medicare primary 12/1/2022 (retroactive) - needs coordination	City
253	ESRD	$112.69	Medicare primary 12/1/2022 (retroactive) - needs coordination	City
254	ESRD	$293.03	Medicare primary 12/1/2022 (retroactive) - needs coordination	City
255	ESRD	$112.69	Medicare primary 12/1/2022 (retroactive) - needs coordination	City
256	ESRD	$112.69	Medicare primary 12/1/2022 (retroactive) - needs coordination	City
257	ESRD	$293.03	Medicare primary 12/1/2022 (retroactive) - needs coordination	City
258	ESRD	$1,225.70	Medicare primary 12/1/2022 (retroactive) - needs coordination	City
259	ESRD	$293.03	Medicare primary 12/1/2022 (retroactive) - needs coordination	City
260	ESRD	$344.74	Medicare primary 12/1/2022 (retroactive) - needs coordination	City
261	ESRD	$468.17	Medicare primary 12/1/2022 (retroactive) - needs coordination	City
262	ESRD	$3,553.92	Medicare primary 12/1/2022 (retroactive) - needs coordination	City
263	ESRD	$210.52	Medicare primary 12/1/2022 (retroactive) - needs coordination	City
264	Multiple Procedure Reductions	$144.65	CPT 11442 should be reduced by 50%	Schools
265	Multiple Procedure Reductions	$121.68	CPT 12042 should be reduced by 50%	Schools
266	Multiple Procedure Reductions	$128.29	CPT 36215 should be reduced by 50%	Schools
267	Multiple Procedure Reductions	$244.74	CPT 57282 should be reduced by 50%	Schools
268	Multiple Procedure Reductions	$292.95	CPT 36247 should be reduced by 50%	Schools
269	Multiple Procedure Reductions	$568.27	CPT 27829 should be reduced by 50%	Schools
270	Multiple Procedure Reductions	$164.21	CPT 51784 should be reduced by 50%	Schools
		$8,954.28		