



September 8, 2025

FINAL HEALTHCARE CLAIMS AUDIT REPORT City of Virginia Beach – Sentara

AUDIT PERIOD: JANUARY – DECEMBER 2024

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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 2024. Healthcare Horizons received \$131,457,176.30 in paid claims data from Sentara and performed a full electronic review of claims processing. Of this total amount, \$78,476,813.47 was paid for the school system and \$52,980,362.83 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 \$224,557.90 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 ASC pricing, duplicate payments, transfer pricing, out-of-network allowable charge, and non-covered gastric bypass surgery. Healthcare Horizons is also disputing a payment of \$27,327.62 related to non-covered gastric bypass surgery. It may be necessary for the City to clarify plan intent on this disputed item. 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 eleven additional out-of-sample claims related to coordination of benefits with other insurance and the benefit exclusion for administrative examinations (total agreed recovery amount of \$813.33). These additional out-of-sample claims are detailed in Appendix B.

The Sentara responses to the draft report are included within the report text along with final comments where applicable from Healthcare Horizons.

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

All

Issue	Sample Recovery Amount	Sample Disputed / Plan Intent Amount	Out-of-Sample Recovery Potential	Total Audit Potential (Excluding Disputed / Plan Intent)
ASC Pricing	\$56,386.70	\$0.00	\$0.00	\$56,386.70
Duplicates	\$45,642.52	\$0.00	\$0.00	\$45,642.52
Transfer Pricing	\$34,236.91	\$0.00	\$0.00	\$34,236.91
Out-of-Network Allowable Charge	\$26,709.61	\$0.00	\$0.00	\$26,709.61
Benefit Exclusion - Gastric Bypass Surgery	\$16,531.07	\$27,327.62	\$0.00	\$16,531.07
Assistant Surgeon Pricing	\$12,800.00	\$0.00	\$0.00	\$12,800.00
Surprise Bills	\$7,098.73	\$0.00	\$0.00	\$7,098.73
Benefit Exclusion - Genetic Testing	\$6,904.35	\$0.00	\$0.00	\$6,904.35
Other Insurance	\$5,766.25	\$0.00	\$621.31	\$6,387.56
Eligibility	\$4,694.37	\$0.00	\$0.00	\$4,694.37
Benefit Exclusion - Administrative Exams	\$3,255.84	\$0.00	\$192.02	\$3,447.86
Home Health During Inpatient	\$2,158.52	\$0.00	\$0.00	\$2,158.52
Pre-Admission Testing	\$1,579.43	\$0.00	\$0.00	\$1,579.43
Surgery Global	\$463.60	\$0.00	\$0.00	\$463.60
Benefit Exclusion - Wigs	\$237.50	\$0.00	\$0.00	\$237.50
Benefit Exclusion - Foot Orthotics	\$92.50	\$0.00	\$0.00	\$92.50
Totals	\$224,557.90	\$27,327.62	\$813.33	\$225,371.23

City

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	\$26,709.61	\$0.00	\$0.00	\$26,709.61
Duplicates	\$25,711.05	\$0.00	\$0.00	\$25,711.05
ASC Pricing	\$9,701.65	\$0.00	\$0.00	\$9,701.65
Eligibility	\$3,857.78	\$0.00	\$0.00	\$3,857.78
Benefit Exclusion - Gastric Bypass Surgery	\$3,846.30	\$0.00	\$0.00	\$3,846.30
Surprise Bills	\$2,150.28	\$0.00	\$0.00	\$2,150.28
Benefit Exclusion - Genetic Testing	\$1,563.34	\$0.00	\$0.00	\$1,563.34
Benefit Exclusion - Administrative Exams	\$1,071.29	\$0.00	\$30.00	\$1,101.29
Pre-Admission Testing	\$1,077.37	\$0.00	\$0.00	\$1,077.37
Surgery Global	\$231.80	\$0.00	\$0.00	\$231.80
Home Health During Inpatient	\$0.00	\$0.00	\$0.00	\$0.00
Totals	\$75,920.47	\$0.00	\$30.00	\$75,950.47

Schools

Issue	Sample Recovery Amount	Sample Disputed / Plan Intent Amount	Out-of-Sample Recovery Potential	Total Audit Potential (Excluding Disputed / Plan Intent)
ASC Pricing	\$46,685.05	\$0.00	\$0.00	\$46,685.05
Transfer Pricing	\$34,236.91	\$0.00	\$0.00	\$34,236.91
Duplicates	\$19,931.47	\$0.00	\$0.00	\$19,931.47
Assistant Surgeon Pricing	\$12,800.00	\$0.00	\$0.00	\$12,800.00
Benefit Exclusion - Gastric Bypass Surgery	\$12,684.77	\$27,327.62	\$0.00	\$12,684.77
Other Insurance	\$5,766.25	\$0.00	\$621.31	\$6,387.56
Benefit Exclusion - Genetic Testing	\$5,341.01	\$0.00	\$0.00	\$5,341.01
Surprise Bills	\$4,948.45	\$0.00	\$0.00	\$4,948.45
Benefit Exclusion - Administrative Exams	\$2,184.55	\$0.00	\$162.02	\$2,346.57
Home Health During Inpatient	\$2,158.52	\$0.00	\$0.00	\$2,158.52
Eligibility	\$836.59	\$0.00	\$0.00	\$836.59
Pre-Admission Testing	\$502.06	\$0.00	\$0.00	\$502.06
Benefit Exclusion - Wigs	\$237.50	\$0.00	\$0.00	\$237.50
Surgery Global	\$231.80	\$0.00	\$0.00	\$231.80
Benefit Exclusion - Foot Orthotics	\$92.50	\$0.00	\$0.00	\$92.50
Totals	\$148,637.43	\$27,327.62	\$783.33	\$149,420.76

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 claim 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 Verification	10	0	\$0.00	0	\$0.00
Transfer Pricing	3	2	\$34,236.91	0	\$0.00
Readmissions	2	0	\$0.00	0	\$0.00
Pre-Admission Testing	8	4	\$1,579.43	0	\$0.00
Out-of-Network Allowable Charge	5	3	\$26,709.61	0	\$0.00
Surprise Bills	4	4	\$7,098.73	0	\$0.00
Duplicates - Claim Level	24	0	\$0.00	0	\$0.00
Duplicates - Line Level	63	31	\$45,642.52	0	\$0.00
Eligibility	18	5	\$4,694.37	0	\$0.00
Other Insurance	7	1	\$5,766.25	0	\$0.00
ESRD	10	0	\$0.00	0	\$0.00
Home Health During Inpatient	4	2	\$2,158.52	0	\$0.00
Surgery Global	4	2	\$463.60	0	\$0.00
Assistant Surgeon Pricing	2	1	\$12,800.00	0	\$0.00
ASC Pricing	19	18	\$56,386.70	0	\$0.00
Benefit Maximum - Hearing Aids	4	0	\$0.00	0	\$0.00
Benefit Exclusion - Gastric Bypass Surgery	14	13	\$16,531.07	1	\$27,327.62
Benefit Exclusion - Foot Orthotics	4	2	\$92.50	0	\$0.00
Benefit Exclusion - Wigs	1	1	\$237.50	0	\$0.00
Benefit Exclusion - Massage Therapy	1	0	\$0.00	0	\$0.00
Benefit Exclusion - Genetic Testing	13	9	\$6,904.35	0	\$0.00
Benefit Exclusion - Administrative Exams	30	30	\$3,255.84	0	\$0.00
Totals	250	128	\$224,557.90	1	\$27,327.62

Recoverable Findings

1. Healthcare Horizons identified two pricing errors involving inpatient transfer claims. When inpatient facility claims are reimbursed via a DRG case rate, it is common for contracts to include special transfer pricing language. Specifically, if a patient is transferred to another acute care facility for care, the transferring facility has not fully treated the case. As such, reimbursement at the full DRG case rate is not warranted for the transferring hospital. This special transfer pricing is often based on a percent of charges or a per diem rate. For audit items 11 and 13, Sentara confirmed the transfer claims were priced in error at the full DRG case rates. The claims should have processed with transfer per diems resulting in a total overpayment amount of \$34,236.91 for this category of testing. As all questionable claims were submitted within the original targeted selection, no additional out-of-sample review is recommended.

Sentara's Response:

For the two errors identified, the health plan agrees that these were isolated manual processing errors and not indicative of a systemic issue. Appropriate corrective action has been taken, and no broader trends or configuration concerns were identified.

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

2. Several pre-admission testing claims are cited as recoverable as facility contracts typically prohibit separate payments for services 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. Sentara agreed to an overpayment in the amount of \$502.06 on audit item 16 as the provider billing error should have been denied. Healthcare Horizons also identified three other recoverable claims for this issue for a total of \$1,077.37 (audit items 18, 20, and 22). As the associated inpatient claims were not yet on file at the time of processing, Sentara disputes an error on these items (provider billing error). 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:

Sentara agrees the claims are recoverable. The root cause of these overpayments can be attributed to providers submitting claims prior to Sentara receiving the related facility claim.

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

3. Minimal overpayments were identified as part of the out-of-network Allowable Charge testing. 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. In order to test this pricing limitation, Healthcare Horizons submitted a number of out-of-network claims (based on a network indicator in the data) allowed at billed charges. For audit items 24 and 25 involving DME rental, Sentara responded that the provider was in-network, however, the pricing was incorrectly based on the units billed versus only one for the monthly rental. The adjustment of these claims will result in a total recovery amount of \$6,857.40. For audit item 26 involving an ambulatory surgical center, Sentara replied that an available PHCS discount was missed, resulting in an overpayment amount of \$19,852.21. The remaining items were closed as the providers were in-network with lesser of pricing (fee schedule amount higher than billed charges). We view these findings as isolated incidents with no cause for systemic concern.

Sentara’s Response:

For the errors identified, the health plan agrees that these were isolated manual processing errors and not indicative of a systemic issue. Appropriate corrective action has been taken, and no broader trends or configuration concerns were identified. Claims will be corrected accordingly.

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

4. Healthcare Horizons identified minimal surprise bills 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. Healthcare Horizons submitted four surprise bills allowed at charges (audit items 29, 30, 31, and 32) and Sentara agreed that all four were incorrectly allowed a billed charges resulting in a total overpayment amount of \$7,098.73. Given the minimal surprise bills in the data set allowed at billed charges, our impression is that Sentara has effective procedures in place to correctly price surprise bills.

Sentara’s Response:

For the errors identified, the health plan agrees that these were isolated manual processing errors and not indicative of a systemic issue. Appropriate corrective action has been taken, and no broader trends or configuration concerns were identified. Claims will be corrected accordingly.

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

5. Based on the size of the data set, Healthcare Horizons identified a minimal volume of duplicate payments.

Healthcare Horizons performs several 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. For the line-level duplicate payment submissions, Sentara agreed with 31 overpayments totaling \$45,642.52 (audit items 58, 60, 61, 63, 64, 65, 66, 67, 69, 70, 71, 73, 77, 78, 81, 83, 85, 87, 88, 90, 91, 94, 95, 97, 99, 100, 104, 110, 112, 113, and 115). The only trend identified within the duplicate payment findings involved claims with multiple service dates. As an example, the provider bills one claim with ten service dates and one claim with five service dates with only two service dates billed in duplicate. The absence of claim-level matching increases the difficulty in identifying these provider billing errors. Sentara may choose to use these examples as training opportunities.

Sentara's Response:

Sentara agrees with the findings. Sentara will use these examples as both training opportunities for staff and as a basis to partner with our System Configuration team to evaluate and enhance duplicate payment detection rules for scenarios involving line-level service date variations.

6. 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 data set and only five claims were identified with a service date after the eligibility termination date. For audit items 124, 130, 131, and 132, Sentara disputes an error as the claims were correct at the time of processing. However, the claims are recoverable (\$4,146.37) based on receipt of a retroactive eligibility termination. For audit item 129 with a paid amount of \$548.00, Sentara agreed to an error as the member was ineligible on the service date. As all questionable claims were presented in the initial claims selection, no additional out-of-sample review is required.

Sentara's Response:

We agree with the auditor that the claims are now recoverable.

7. Retroactive notification of other primary insurance resulted in the identification of recoverable claims.

Healthcare Horizons utilizes the claims data to identify members with other primary insurance based on a coordination of benefits (COB) savings amount present on certain claims. We then test claims for the same members with no COB savings to determine if coordination with the primary carrier was missed. While the claim was correct at the time of processing, audit item 143 is recoverable due to retroactive notification of other primary insurance. Pending coordination of benefits with the primary carrier, we are citing the entire paid amount of \$5,766.25 as recoverable. Based on the other insurance primary effective date noted for this member, we delivered eight additional out-of-sample claims for review and recovery by Sentara (\$2,120.57 paid).

Sentara's Response:

Sentara agrees that the claim was adjudicated correctly based on the information available at the time of processing; however, due to retroactive notification of other primary insurance, the claim is now deemed recoverable. We will initiate reprocessing of audit item 143, along with the eight additional out-of-sample claims to ensure proper coordination of benefits with the identified primary carrier.

Healthcare Horizons' Final Comment: Based on the detailed out-of-sample feedback from Sentara, only two claims are recoverable with a total paid amount of \$621.31. All charts have been updated to reflect this amount.

8. Two 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. While the surgery claims were not on file at the time of processing, our understanding is that audit items 160 and 162 are recoverable for \$463.60 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 the evaluation and management (E/M) services billed in audit items 160 and 162 fall within the global surgical period and should have been included in the global surgical reimbursement. As such, no separate payment should have been made for these services. We will initiate recovery accordingly.

Healthcare Horizons' Final Comment: The root cause of the overpayments is provider billing error. As such, there is no cause for systemic concern.

9. A single assistant surgeon claim was found to be priced at the full fee in error. It is industry standard for assistant surgeons to be reimbursed at a reduced percentage of the normal fee (such as \$20%). In reviewing all assistant surgeon claims, only a single item was found to be questionable (audit item 164). In this case, the assistant surgeon was paid much higher than the primary surgeon from the same practice (same TIN). Sentara agreed with a missed reduction opportunity resulting in an overpayment amount of \$12,800.00. We view this as a one-off or manual error with no cause for systemic concern.

Sentara's Response:

Sentara agrees that audit item 164 represents an isolated manual error in which the assistant surgeon was incorrectly reimbursed at the full fee. This was not indicative of a systemic issue. The claim will be reprocessed to reflect the appropriate assistant surgeon reduction, and the involved claims processor will receive targeted education to prevent recurrence.

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

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 eighteen overpayments totaling \$56,386.70 for this issue (audit items 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 182, and 183). Note that this finding is higher than the 2023 audit finding of \$12,433.77 (four claims). 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. We have taken steps to address this issue through refresher training and ongoing education for the Claims team. In addition, a key control has been implemented to support targeted quality monitoring specific to this scenario, ensuring that contract terms are applied correctly going forward.

11. Healthcare Horizons identified six members with gastric bypass services allowed in error. The plan document contains the following exclusion:

Morbid Obesity treatment including gastric bypass surgery, other surgeries, services or drugs are not Covered Services.

Based on this exclusion, Sentara agreed with a total overpayment amount of \$16,531.07 on audit items 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 199, 200, and 201. As all questionable claims were submitted in the initial 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:

We agree with the auditors findings. 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.

Healthcare Horizons' Final Comment: The City should direct Sentara on recovery for the overpayments as member balance billing will likely occur if the dollars are recouped from the providers.

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 with overpayments totaling \$92.50 for this issue (audit items 202 and 203). Note that the sample claims deemed as correct were for members with a history vascular disease or 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:

Sentara agrees these foot orthotic claims were paid in error based on plan exclusions. We are providing ongoing education and quality monitoring to prevent future occurrences.

Healthcare Horizons' Final Comment: The City should direct Sentara on recovery for the overpayments as member balance billing will likely occur if the dollars are recouped from the providers.

13. A single wig was found to be paid in error. Based on a review of the plan documents, wigs for hair loss for any reason are non-covered. Based on this exclusion, Sentara agreed to an overpayment of \$237.50 on audit item 206. Note that recovery of this claim will likely cause adverse member impact due to balance billing. Finally, Sentara should ensure appropriate system configuration to deny this item moving forward.

Sentara's Response:

We agree and will initiate reprocessing of this claim. We are actively working with our System Configuration team to review and enhance claim system edits to ensure that this exclusion is consistently enforced moving forward and to prevent future occurrences.

Healthcare Horizons' Final Comment: The City should direct Sentara on recovery for the overpayment as member balance billing will likely occur if the dollars are recouped from the providers.

14. Healthcare Horizons identified claims paid in error for genetic testing. The plan document contains the following exclusion:

Genetic Testing and Counseling are not Covered Services unless authorized by the Plan. Counseling is a Covered Service only when part of the approved genetic test unless considered preventive care.

Based on this exclusion, Sentara agreed with a total overpayment amount of \$6,904.35 on audit items 209, 210, 212, 214, 215, 216, 218, 219, and 220. The claims closed as correct were found to be authorized for medical necessity. As all questionable claims were submitted in the initial 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 this testing as applicable moving forward.

Sentara's Response:

We agree with the auditors findings. 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.

Healthcare Horizons' Final Comment: The City should direct Sentara on recovery for the overpayments as member balance billing will likely occur if the dollars are recouped from the providers.

15. 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 30 agreed overpayments totaling \$3,255.84 (audit items 221-250). The primary diagnosis codes included the following:

- Z02.1 – Encounter for pre-employment examination
- Z02.89 – Encounter for other administrative examinations
- Z02.9 – Encounter for administrative examinations, unspecified

Based on the initial findings, Healthcare Horizons submitted three additional out-of-sample claims to Sentara for review (\$192.02 in total). 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:

The health plan agrees per the plan documents, some administrative exams are not covered. We have worked with our System Configuration team on a system enhancement related to this excluded benefit.

Healthcare Horizons' Final Comment: Based on the detailed out-of-sample feedback from Sentara, all three additional claims were agreed to be recoverable. We recommend Sentara update the City when configuration changes are completed to administer this benefit exclusion. Finally, the City should direct Sentara on recovery for the overpayments as member balance billing will likely occur if the dollars are recouped from the providers.

Disputed / Plan Intent Findings

1. Healthcare Horizons requests a second pass review on two home infusion therapy claims with a service date during a concurrent inpatient stay. Healthcare Horizons queries the claims data set for home health services billed in error by the provider during a concurrent inpatient stay. As such, we presented audit items 155 and 157 as potential overpayments as the home infusion therapy services were performed during a concurrent inpatient stay (informational audit items 156 and 158). Sentara responded that the home infusion therapy services were authorized and therefore allowed for payment. We request a second review by Sentara to determine if these home health services are recoverable due to provider billing errors. Pending additional information, we have cited the total paid amount of \$2,158.52 as disputed.

Sentara's Response:

After further review, Sentara agrees the home health services were billed by the provider in error and are recoverable. However, the home health claims were received and processed prior to receiving the inpatient claim. They were initially processed correctly based on the information available at that time.

Healthcare Horizons' Final Comment: We appreciate the additional review by Sentara. We have updated all charts to reflect these claims as recoverable (\$2,158.52) on behalf of the City. We agree with a root cause of provider billing error.

2. Healthcare Horizons is disputing the payment of an inpatient facility claim related to gastric bypass surgery. Audit item 198 involves a two-day inpatient facility claim with a primary diagnosis of K95.09 (other complications of gastric band procedure). The surgery performed during the stay was for CPT 43774 (laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components). As the professional surgeon claim (audit item 199) and associated anesthesia claims (audit items 200 and 201) were agreed as non-covered, our position is that the inpatient facility claim should be denied as well. While Sentara agreed that the primary diagnosis of K95.09 is generally non-covered, they point to an admitting diagnosis of R10.12 (left upper quadrant pain) as a covered diagnosis for the inpatient facility claim. We request a second pass review to determine if the inpatient stay paid at \$27,327.62 should be denied as well.

Sentara's Response:

After further review, Sentara stands by its original decision. While we acknowledge that the primary diagnosis (K95.09) is generally considered non-covered, the admitting diagnosis of R10.12 (left upper quadrant pain) supported the medical necessity of the inpatient admission. Additionally, the inpatient stay was authorized and met criteria for coverage based on the presenting symptoms at the time of admission. Therefore, the claim was processed appropriately and payment of \$27,327.62 is considered valid.

Healthcare Horizons' Final Comment: We appreciate the additional review by Sentara. We recommend additional discussion between the City and Sentara on this claim. Note that the member did not present to the ER.

Informational Findings

1. Healthcare Horizons requests additional pricing details on a facility pricing audit item. Healthcare Horizons submitted ten in-network facility claims for pricing verification. These claims were selected based on high dollar, high utilization, no discount, and pricing variability. In each instance, Sentara verified accurate pricing and provided the applicable contract reimbursement methodology. For audit item 5, Sentara responded that the claim was priced correctly based on a DRG case rate. In reviewing the details of this claim, the total billed charge amount from the facility is \$11,023.30 and the resulting contractual allowed amount is \$241,313.24. While it is common for inpatient DRG reimbursement to exceed billed charges, this difference is noteworthy. In addition, the claim was for a one-day inpatient stay and the relative weight for the DRG is less than 1.0. As such, we request a second pass review of this claim by Sentara to ensure the pricing is accurate.

Sentara’s Response:

After further review, Sentara stands by its original determination. Audit item 5 was priced in accordance with the provider’s contracted DRG case rate. The claim in question was assigned DRG 690 with a severity level of 4, which justifies the contractual allowed amount despite the one-day length of stay and the relative weight being under 1.0. We acknowledge that the allowed amount exceeds the billed charges; however, this outcome is consistent with the negotiated reimbursement terms and not indicative of a pricing error.

Healthcare Horizons’ Final Comment: We recommend Sentara provide additional information to support this pricing including the determination of the severity level as well as the detailed calculations from the contract for DRG 690. Healthcare Horizons is glad to review this additional information on behalf of the City in a secure setting.

2. Healthcare Horizons recommends the City confirm cash collection on several high-dollar adjustments performed in late 2024 and early 2025 by Sentara. For several items presented as claim-level duplicates by Healthcare Horizons, Sentara responded that the dollars were already adjusted to recoup based on a duplicate or corrected claim submission by the provider. While these claims are not cited as audit findings, we recommend the City confirm recovery on these items via its group billing data. We are glad to provide additional details on these claims upon request. Note that the Healthcare Horizons claims audit data is only through 12/31/24 paid dates.

Audit Items	Issue	Amount	Adjustment Date
33/34	Duplicate	\$507.55	12/6/24
35/36	Duplicate (corrected claim)	\$9,303.00	11/29/24
37/38	Duplicate	\$27,242.00	12/2/24
39/40	Duplicate	\$1,084.67	12/2/24
41/42	Duplicate (corrected claim)	\$2,394.70	12/3/24

Audit Items	Issue	Amount	Adjustment Date
43/44	Duplicate (corrected claim)	\$2,417.60	2024
45/46	Duplicate	\$6,449.89	5/17/25
47/48	Duplicate	\$1,105.20	3/27/25
49/50	Duplicate (corrected claim)	\$2,530.71	2025
51/52	Duplicate	\$1,327.50	3/24/25
53/54	Duplicate (corrected claim)	\$1,938.22	12/24/24
55/56	Duplicate (corrected claim)	\$145,552.67	2025

3. Healthcare Horizons identified end stage renal disease (ESRD) patients with no record of Medicare coverage.

After 33 months of dialysis for end stage renal disease (ESRD), Medicare generally becomes primary for the patient over employer-sponsored plans. For audit items 146, 147, 148, 150, 152, and 153, Sentara does not show any other insurance coverage for the members including Medicare. The City and/or Sentara may choose to follow up on Medicare coverage for these members. We are glad to provide additional details upon request.

4. 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 for the City to clarify plan intent for this procedure code.

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 correct system configuration to deny non-covered services and supplies.
- The City and Sentara should discuss the disputed inpatient claim related to non-covered gastric bypass surgery. We also recommend additional follow-up on the informational finding related to pricing verification for DRG 690.

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 Verification	\$0.00	\$0.00	Priced correctly - secondary stop loss	Schools
2	Facility Pricing Verification	\$0.00	\$0.00	Priced correctly - DRG case rate	Schools
3	Facility Pricing Verification	\$0.00	\$0.00	Priced correctly - DRG case rate plus stop loss	Schools
4	Facility Pricing Verification	\$0.00	\$0.00	Priced correctly - DRG case rate	City
5	Facility Pricing Verification	\$0.00	\$0.00	Priced correctly - DRG case rate (allowed \$241,313.24 on billed charges of \$11,023.30?) Informational finding	City
6	Facility Pricing Verification	\$0.00	\$0.00	Priced correctly - DRG case rate	City
7	Facility Pricing Verification	\$0.00	\$0.00	Priced correctly - DRG case rate	Schools
8	Facility Pricing Verification	\$0.00	\$0.00	Priced correctly - percent of charges	City
9	Facility Pricing Verification	\$0.00	\$0.00	Priced correctly - secondary stop loss	Schools
10	Facility Pricing Verification	\$0.00	\$0.00	Priced correctly - DRG case rate (lesser of)	Schools
11	Transfer Pricing	\$23,489.77	\$0.00	Agreed error - missed transfer pricing	Schools
12	Transfer Pricing	\$0.00	\$0.00	Priced correctly at transfer rate	Schools
13	Transfer Pricing	\$10,747.14	\$0.00	Agreed error - missed transfer pricing	Schools
14	Readmissions	\$0.00	\$0.00	Readmission allowed correctly per Sentara documentation	City
15	Readmissions	\$0.00	\$0.00	Readmission allowed correctly per Sentara documentation	City
16	Pre-Admission Testing	\$502.06	\$0.00	Agreed processing error - should not allow separately	Schools
17	Pre-Admission Testing	\$0.00	\$0.00	Inpatient claim - informational only	Schools
18	Pre-Admission Testing	\$694.95	\$0.00	Agreed as recoverable - PAT claim received and processed prior to inpatient claim	City
19	Pre-Admission Testing	\$0.00	\$0.00	Inpatient claim - informational only	City
20	Pre-Admission Testing	\$186.13	\$0.00	Agreed as recoverable - PAT claim received and processed prior to inpatient claim	City
21	Pre-Admission Testing	\$0.00	\$0.00	Inpatient claim - informational only	City
22	Pre-Admission Testing	\$196.29	\$0.00	Agreed as recoverable - PAT claim received and processed prior to inpatient claim	City
23	Pre-Admission Testing	\$0.00	\$0.00	Inpatient claim - informational only	City
24	Out-of-Network Allowable Charge	\$3,428.70	\$0.00	INN claim priced incorrectly with units billed - should price with 1 unit for rental	City
25	Out-of-Network Allowable Charge	\$3,428.70	\$0.00	INN claim priced incorrectly with units billed - should price with 1 unit for rental	City
26	Out-of-Network Allowable Charge	\$19,852.21	\$0.00	Missed available PHCS discount	City
27	Out-of-Network Allowable Charge	\$0.00	\$0.00	INN claim priced via case rate (lesser of)	City
28	Out-of-Network Allowable Charge	\$0.00	\$0.00	INN claim priced via case rate (lesser of)	City
29	Surprise Bills	\$2,150.28	\$0.00	Claim processed at billed charges in error	City
30	Surprise Bills	\$1,361.45	\$0.00	Claim processed at billed charges in error	Schools
31	Surprise Bills	\$2,110.00	\$0.00	Claim processed at billed charges in error	Schools
32	Surprise Bills	\$1,477.00	\$0.00	Claim processed at billed charges in error	Schools
33	Duplicates - Claim Level	\$0.00	\$0.00	(33/34) - Overpayment of \$507.55 retracted 12/6/24 - need to confirm cash collection - informational finding	City
34	Duplicates - Claim Level	\$0.00	\$0.00	(33/34) - Overpayment of \$507.55 retracted 12/6/24 - need to confirm cash collection - informational finding	City
35	Duplicates - Claim Level	\$0.00	\$0.00	(35/36) - Due to corrected claim, \$9,303.00 retracted 11/29/24 - need to confirm cash collection - informational finding	City
36	Duplicates - Claim Level	\$0.00	\$0.00	(35/36) - Due to corrected claim, \$9,303.00 retracted 11/29/24 - need to confirm cash collection - informational finding	City
37	Duplicates - Claim Level	\$0.00	\$0.00	(37/38) - Overpayment of \$27,242.00 retracted 12/2/24 - need to confirm cash collection - informational finding	Schools
38	Duplicates - Claim Level	\$0.00	\$0.00	(37/38) - Overpayment of \$27,242.00 retracted 12/2/24 - need to confirm cash collection - informational finding	Schools
39	Duplicates - Claim Level	\$0.00	\$0.00	(39/40) - Overpayment of \$1,084.67 retracted 12/2/24 - need to confirm cash collection - informational finding	City
40	Duplicates - Claim Level	\$0.00	\$0.00	(39/40) - Overpayment of \$1,084.67 retracted 12/2/24 - need to confirm cash collection - informational finding	City
41	Duplicates - Claim Level	\$0.00	\$0.00	(41/42) - Due to corrected claim, \$2,394.70 retracted 12/3/24 - need to confirm cash collection - informational finding	City
42	Duplicates - Claim Level	\$0.00	\$0.00	(41/42) - Due to corrected claim, \$2,394.70 retracted 12/3/24 - need to confirm cash collection - informational finding	City
43	Duplicates - Claim Level	\$0.00	\$0.00	(43/44) - Due to corrected claim, \$2,417.60 retracted in 2024 - need to confirm cash collection - informational finding	Schools
44	Duplicates - Claim Level	\$0.00	\$0.00	(43/44) - Due to corrected claim, \$2,417.60 retracted in 2024 - need to confirm cash collection - informational finding	Schools
45	Duplicates - Claim Level	\$0.00	\$0.00	(45/46) - Overpayment of \$6,449.89 retracted 5/17/25 - need to confirm cash collection - informational finding	City

Audit Item	Issue	Recovery Amount	Plan Intent / Disputed Amount	Comment	Group
46	Duplicates - Claim Level	\$0.00	\$0.00	(45/46) - Overpayment of \$6,449.89 retracted 5/17/25 - need to confirm cash collection - informational finding	City
47	Duplicates - Claim Level	\$0.00	\$0.00	(47/48) - Overpayment of \$1,105.20 retracted 3/27/25 - need to confirm cash collection - informational finding	Schools
48	Duplicates - Claim Level	\$0.00	\$0.00	(47/48) - Overpayment of \$1,105.20 retracted 3/27/25 - need to confirm cash collection - informational finding	Schools
49	Duplicates - Claim Level	\$0.00	\$0.00	(49/50) - Due to corrected claim, \$2,530.71 retracted in 2025 - need to confirm cash collection - informational finding	Schools
50	Duplicates - Claim Level	\$0.00	\$0.00	(49/50) - Due to corrected claim, \$2,530.71 retracted in 2025 - need to confirm cash collection - informational finding	Schools
51	Duplicates - Claim Level	\$0.00	\$0.00	(51/52) - Overpayment of \$1,327.50 retracted 3/24/25 - need to confirm cash collection - informational finding	Schools
52	Duplicates - Claim Level	\$0.00	\$0.00	(51/52) - Overpayment of \$1,327.50 retracted 3/24/25 - need to confirm cash collection - informational finding	Schools
53	Duplicates - Claim Level	\$0.00	\$0.00	(53/54) - Due to corrected claim, \$1,938.22 retracted 12/24/24 - need to confirm cash collection - informational finding	Schools
54	Duplicates - Claim Level	\$0.00	\$0.00	(53/54) - Due to corrected claim, \$1,938.22 retracted 12/24/24 - need to confirm cash collection - informational finding	Schools
55	Duplicates - Claim Level	\$0.00	\$0.00	(49/50) - Due to corrected claim, \$145,552.67 retracted in 2025 - need to confirm cash collection - informational finding	Schools
56	Duplicates - Claim Level	\$0.00	\$0.00	(49/50) - Due to corrected claim, \$145,552.67 retracted in 2025 - need to confirm cash collection - informational finding	Schools
57	Duplicates - Line Level	\$0.00	\$0.00	Correct claim for 57/58 combo	City
58	Duplicates - Line Level	\$145.95	\$0.00	Agreed duplicate error	City
59	Duplicates - Line Level	\$0.00	\$0.00	Correct claim for 59/60/61 combo	Schools
60	Duplicates - Line Level	\$157.74	\$0.00	Agreed duplicate error	Schools
61	Duplicates - Line Level	\$132.68	\$0.00	Agreed duplicate error	Schools
62	Duplicates - Line Level	\$0.00	\$0.00	Correct claim for 62/63/64/65 combo	Schools
63	Duplicates - Line Level	\$100.00	\$0.00	Correct claim for 62/63/64/65 combo	Schools
64	Duplicates - Line Level	\$100.00	\$0.00	Correct claim for 62/63/64/65 combo	Schools
65	Duplicates - Line Level	\$100.00	\$0.00	Correct claim for 62/63/64/65 combo	Schools
66	Duplicates - Line Level	\$60.00	\$0.00	Agreed errors for missed copayments	Schools
67	Duplicates - Line Level	\$140.00	\$0.00	Agreed duplicate error	Schools
68	Duplicates - Line Level	\$0.00	\$0.00	Correct claim for 68/69 combo	Schools
69	Duplicates - Line Level	\$157.74	\$0.00	Agreed duplicate error	Schools
70	Duplicates - Line Level	\$60.00	\$0.00	Agreed errors for missed copayments	City
71	Duplicates - Line Level	\$656.10	\$0.00	Agreed duplicate error	City
72	Duplicates - Line Level	\$0.00	\$0.00	Correct claim for 72/73 combo	Schools
73	Duplicates - Line Level	\$198.44	\$0.00	Agreed duplicate error	Schools
74	Duplicates - Line Level	\$0.00	\$0.00	Correct claim for 74/75 combo	Schools
75	Duplicates - Line Level	\$0.00	\$0.00	Retracted prior to audit	Schools
76	Duplicates - Line Level	\$0.00	\$0.00	Correct claim for 76/77/78 combo	City
77	Duplicates - Line Level	\$157.74	\$0.00	Agreed duplicate error	City
78	Duplicates - Line Level	\$132.68	\$0.00	Agreed duplicate error	City
79	Duplicates - Line Level	\$0.00	\$0.00	Correct claim for 79/80/81 combo	Schools
80	Duplicates - Line Level	\$0.00	\$0.00	Correct claim for 79/80/81 combo	Schools
81	Duplicates - Line Level	\$265.36	\$0.00	Agreed duplicate error	Schools
82	Duplicates - Line Level	\$0.00	\$0.00	Correct claim for 82/83 combo	City
83	Duplicates - Line Level	\$526.49	\$0.00	Agreed duplicate error	City
84	Duplicates - Line Level	\$0.00	\$0.00	Correct claim for 84/85 combo	Schools
85	Duplicates - Line Level	\$16,324.89	\$0.00	Agreed duplicate error	Schools
86	Duplicates - Line Level	\$0.00	\$0.00	Correct claim for 86/87/88 combo	Schools
87	Duplicates - Line Level	\$132.68	\$0.00	Agreed duplicate error	Schools
88	Duplicates - Line Level	\$132.68	\$0.00	Agreed duplicate error	Schools
89	Duplicates - Line Level	\$0.00	\$0.00	Correct claim for 89/90/91 combo	Schools
90	Duplicates - Line Level	\$517.26	\$0.00	Agreed duplicate error	Schools
91	Duplicates - Line Level	\$377.48	\$0.00	Agreed duplicate error	Schools
92	Duplicates - Line Level	\$0.00	\$0.00	Retracted prior to audit	City
93	Duplicates - Line Level	\$0.00	\$0.00	Correct claim for 92/93 combo	City
94	Duplicates - Line Level	\$265.36	\$0.00	Agreed duplicate error	Schools
95	Duplicates - Line Level	\$265.36	\$0.00	Agreed duplicate error	Schools
96	Duplicates - Line Level	\$0.00	\$0.00	Correct claim for 96/97 combo	City
97	Duplicates - Line Level	\$791.05	\$0.00	Agreed duplicate error	City
98	Duplicates - Line Level	\$0.00	\$0.00	Correct claim for 98/99/100 combo	City
99	Duplicates - Line Level	\$132.68	\$0.00	Correct claim for 98/99/100 combo	City
100	Duplicates - Line Level	\$132.68	\$0.00	Correct claim for 98/99/100 combo	City

Audit Item	Issue	Recovery Amount	Plan Intent / Disputed Amount	Comment	Group
101	Duplicates - Line Level	\$0.00	\$0.00	Correct claim for 101/102/103/104 combo	City
102	Duplicates - Line Level	\$0.00	\$0.00	Correct claim for 101/102/103/104 combo	City
103	Duplicates - Line Level	\$0.00	\$0.00	Correct claim for 101/102/103/104 combo	City
104	Duplicates - Line Level	\$555.00	\$0.00	Agreed duplicate error	City
105	Duplicates - Line Level	\$0.00	\$0.00	Retracted prior to audit	City
106	Duplicates - Line Level	\$0.00	\$0.00	Correct claim for 105/106 combo	City
107	Duplicates - Line Level	\$0.00	\$0.00	Correct claim for 107/108/109/110	City
108	Duplicates - Line Level	\$0.00	\$0.00	Correct claim for 107/108/109/110	City
109	Duplicates - Line Level	\$0.00	\$0.00	Correct claim for 107/108/109/110	City
110	Duplicates - Line Level	\$22,308.00	\$0.00	Agreed duplicate error	City
111	Duplicates - Line Level	\$0.00	\$0.00	Correct claim for 111/112/113 combo	Schools
112	Duplicates - Line Level	\$251.90	\$0.00	Agreed duplicate error	Schools
113	Duplicates - Line Level	\$251.90	\$0.00	Agreed duplicate error	Schools
114	Duplicates - Line Level	\$0.00	\$0.00	Correct claim for 114/115 combo	City
115	Duplicates - Line Level	\$112.68	\$0.00	Agreed duplicate error	City
116	Duplicates - Line Level	\$0.00	\$0.00	Retracted prior to audit	City
117	Duplicates - Line Level	\$0.00	\$0.00	Correct claim for 116/117 combo	City
118	Duplicates - Line Level	\$0.00	\$0.00	Retracted prior to audit	City
119	Duplicates - Line Level	\$0.00	\$0.00	Correct claim for 118/119 combo	City
120	Eligibility	\$0.00	\$0.00	Retracted prior to audit	City
121	Eligibility	\$0.00	\$0.00	Retracted prior to audit	City
122	Eligibility	\$0.00	\$0.00	Retracted prior to audit	Schools
123	Eligibility	\$0.00	\$0.00	Retracted prior to audit	Schools
124	Eligibility	\$128.61	\$0.00	Recoverable retroactive termination	Schools
125	Eligibility	\$0.00	\$0.00	Retracted prior to audit	City
126	Eligibility	\$0.00	\$0.00	Retracted prior to audit	Schools
127	Eligibility	\$0.00	\$0.00	Retracted prior to audit	Schools
128	Eligibility	\$0.00	\$0.00	Retracted prior to audit	Schools
129	Eligibility	\$548.00	\$0.00	Agreed as recoverable	Schools
130	Eligibility	\$3,766.00	\$0.00	Recoverable retroactive termination	City
131	Eligibility	\$159.98	\$0.00	Recoverable retroactive termination	Schools
132	Eligibility	\$91.78	\$0.00	Recoverable retroactive termination	City
133	Eligibility	\$0.00	\$0.00	Retracted prior to audit	City
134	Eligibility	\$0.00	\$0.00	Retracted prior to audit	City
135	Eligibility	\$0.00	\$0.00	Retracted prior to audit	City
136	Eligibility	\$0.00	\$0.00	Member eligible	City
137	Eligibility	\$0.00	\$0.00	Retracted prior to audit	City
138	Other Insurance	\$0.00	\$0.00	No other insurance	City
139	Other Insurance	\$0.00	\$0.00	Anthem is secondary	City
140	Other Insurance	\$0.00	\$0.00	Anthem is secondary	City
141	Other Insurance	\$0.00	\$0.00	Anthem is secondary	City
142	Other Insurance	\$0.00	\$0.00	BCBS is secondary	Schools
143	Other Insurance	\$5,766.25	\$0.00	BCBS is primary	Schools
144	Other Insurance	\$0.00	\$0.00	No other insurance	City
145	ESRD	\$0.00	\$0.00	Medicare Part A only 3/1/11 (plan does not estimate)	City
146	ESRD	\$0.00	\$0.00	No record of Medicare	Schools
147	ESRD	\$0.00	\$0.00	No record of Medicare	City
148	ESRD	\$0.00	\$0.00	No record of Medicare	City
149	ESRD	\$0.00	\$0.00	Medicare secondary	Schools
150	ESRD	\$0.00	\$0.00	No record of Medicare	City
151	ESRD	\$0.00	\$0.00	Medicare secondary	Schools
152	ESRD	\$0.00	\$0.00	No record of Medicare	City
153	ESRD	\$0.00	\$0.00	No record of Medicare	Schools
154	ESRD	\$0.00	\$0.00	Medicare primary 11/1/24 - retracted prior to audit	City
155	Home Health During Inpatient	\$1,201.52	\$0.00	Agreed as recoverable	Schools
156	Home Health During Inpatient	\$0.00	\$0.00	Inpatient claim - informational only	Schools
157	Home Health During Inpatient	\$957.00	\$0.00	Agreed as recoverable	Schools
158	Home Health During Inpatient	\$0.00	\$0.00	Inpatient claim - informational only	Schools
159	Surgery Global	\$0.00	\$0.00	Surgery claim - informational only	City
160	Surgery Global	\$231.80	\$0.00	Received prior to surgery claim but recoverable	City
161	Surgery Global	\$0.00	\$0.00	Surgery claim - informational only	Schools
162	Surgery Global	\$231.80	\$0.00	Received prior to surgery claim but recoverable	Schools
163	Assistant Surgeon Pricing	\$0.00	\$0.00	Primary surgeon - informational only	Schools
164	Assistant Surgeon Pricing	\$12,800.00	\$0.00	Agreed error - missed assistant surgeon reduction	Schools
165	ASC Pricing	\$3,109.30	\$0.00	Per contract - only primary surgery is eligible for reimbursement	Schools
166	ASC Pricing	\$2,926.40	\$0.00	Per contract - only primary surgery is eligible for reimbursement	Schools

Audit Item	Issue	Recovery Amount	Plan Intent / Disputed Amount	Comment	Group
167	ASC Pricing	\$4,875.60	\$0.00	Per contract - only primary surgery is eligible for reimbursement	Schools
168	ASC Pricing	\$2,910.40	\$0.00	Per contract - only primary surgery is eligible for reimbursement	Schools
169	ASC Pricing	\$549.95	\$0.00	Per contract - only primary surgery is eligible for reimbursement	Schools
170	ASC Pricing	\$3,816.80	\$0.00	Per contract - only primary surgery is eligible for reimbursement	City
171	ASC Pricing	\$2,503.00	\$0.00	Per contract - only primary surgery is eligible for reimbursement	Schools
172	ASC Pricing	\$267.75	\$0.00	Per contract - only primary surgery is eligible for reimbursement	Schools
173	ASC Pricing	\$1,888.80	\$0.00	Per contract - only primary surgery is eligible for reimbursement	Schools
174	ASC Pricing	\$3,522.83	\$0.00	Per contract - only primary surgery is eligible for reimbursement	Schools
175	ASC Pricing	\$3,825.85	\$0.00	Per contract - only primary surgery is eligible for reimbursement	Schools
176	ASC Pricing	\$3,878.00	\$0.00	Per contract - only primary surgery is eligible for reimbursement	City
177	ASC Pricing	\$2,006.85	\$0.00	Per contract - only primary surgery is eligible for reimbursement	City
178	ASC Pricing	\$3,600.80	\$0.00	Per contract - only primary surgery is eligible for reimbursement	Schools
179	ASC Pricing	\$4,006.89	\$0.00	Per contract - only primary surgery is eligible for reimbursement	Schools
180	ASC Pricing	\$3,816.80	\$0.00	Per contract - only primary surgery is eligible for reimbursement	Schools
181	ASC Pricing	\$0.00	\$0.00	Retracted prior to audit	Schools
182	ASC Pricing	\$4,771.00	\$0.00	Per contract - only primary surgery is eligible for reimbursement	Schools
183	ASC Pricing	\$4,109.68	\$0.00	Per contract - only primary surgery is eligible for reimbursement	Schools
184	Benefit Maximum - Hearing Aids	\$0.00	\$0.00	Need plan intent on whether V5010 (assessment for hearing aid) is included in dollar maximum	Schools
185	Benefit Maximum - Hearing Aids	\$0.00	\$0.00	Need plan intent on whether V5010 (assessment for hearing aid) is included in dollar maximum	City
186	Benefit Maximum - Hearing Aids	\$0.00	\$0.00	Need plan intent on whether V5010 (assessment for hearing aid) is included in dollar maximum	City
187	Benefit Maximum - Hearing Aids	\$0.00	\$0.00	Need plan intent on whether V5010 (assessment for hearing aid) is included in dollar maximum	City
188	Benefit Exclusion - Gastric Bypass Surgery	\$2,457.18	\$0.00	Agreed error - non covered service	Schools
189	Benefit Exclusion - Gastric Bypass Surgery	\$1,966.90	\$0.00	Agreed error - non covered service	Schools
190	Benefit Exclusion - Gastric Bypass Surgery	\$1,477.69	\$0.00	Agreed error - non covered service	City
191	Benefit Exclusion - Gastric Bypass Surgery	\$694.44	\$0.00	Agreed error - non covered service	City
192	Benefit Exclusion - Gastric Bypass Surgery	\$694.44	\$0.00	Agreed error - non covered service	City
193	Benefit Exclusion - Gastric Bypass Surgery	\$208.13	\$0.00	Agreed error - non covered service	City
194	Benefit Exclusion - Gastric Bypass Surgery	\$771.60	\$0.00	Agreed error - non covered service	City
195	Benefit Exclusion - Gastric Bypass Surgery	\$1,965.74	\$0.00	Agreed error - non covered service	Schools
196	Benefit Exclusion - Gastric Bypass Surgery	\$2,791.11	\$0.00	Agreed error - non covered service	Schools
197	Benefit Exclusion - Gastric Bypass Surgery	\$189.40	\$0.00	Agreed error - non covered service	Schools
198	Benefit Exclusion - Gastric Bypass Surgery	\$0.00	\$27,327.62	Requesting second pass review as the professional surgery and anesthesia claims were agreed as errors - this is the inpatient facility claim	Schools
199	Benefit Exclusion - Gastric Bypass Surgery	\$1,281.58	\$0.00	Agreed error - non covered service	Schools
200	Benefit Exclusion - Gastric Bypass Surgery	\$1,377.00	\$0.00	Agreed error - non covered service	Schools
201	Benefit Exclusion - Gastric Bypass Surgery	\$655.86	\$0.00	Agreed error - non covered service	Schools
202	Benefit Exclusion - Foot Orthotics	\$50.00	\$0.00	Agreed error - non covered supply	Schools
203	Benefit Exclusion - Foot Orthotics	\$42.50	\$0.00	Agreed error - non covered supply	Schools
204	Benefit Exclusion - Foot Orthotics	\$0.00	\$0.00	Covered due to medical history	Schools
205	Benefit Exclusion - Foot Orthotics	\$0.00	\$0.00	Covered due to medical history	Schools
206	Benefit Exclusion - Wigs	\$237.50	\$0.00	Agreed error - non covered supply	Schools
207	Benefit Exclusion - Massage Therapy	\$0.00	\$0.00	Covered as part of approved therapy	Schools
208	Benefit Exclusion - Genetic Testing	\$0.00	\$0.00	Services were authorized as medically necessary	Schools
209	Benefit Exclusion - Genetic Testing	\$516.00	\$0.00	Agreed error - no authorization on file	Schools
210	Benefit Exclusion - Genetic Testing	\$531.34	\$0.00	Agreed error - no authorization on file	City
211	Benefit Exclusion - Genetic Testing	\$0.00	\$0.00	Services were authorized as medically necessary	Schools
212	Benefit Exclusion - Genetic Testing	\$516.00	\$0.00	Agreed error - no authorization on file	City
213	Benefit Exclusion - Genetic Testing	\$0.00	\$0.00	Services were authorized as medically necessary	Schools
214	Benefit Exclusion - Genetic Testing	\$930.34	\$0.00	Agreed error - no authorization on file	Schools
215	Benefit Exclusion - Genetic Testing	\$516.00	\$0.00	Agreed error - no authorization on file	City
216	Benefit Exclusion - Genetic Testing	\$516.00	\$0.00	Agreed error - no authorization on file	Schools
217	Benefit Exclusion - Genetic Testing	\$0.00	\$0.00	Services were authorized as medically necessary	Schools
218	Benefit Exclusion - Genetic Testing	\$516.00	\$0.00	Agreed error - no authorization on file	Schools
219	Benefit Exclusion - Genetic Testing	\$1,062.67	\$0.00	Agreed error - no authorization on file	Schools
220	Benefit Exclusion - Genetic Testing	\$1,800.00	\$0.00	Agreed error - authorization denied	Schools
221	Benefit Exclusion - Administrative Exams	\$107.99	\$0.00	Agreed error (pre-employment exam)	City
222	Benefit Exclusion - Administrative Exams	\$114.64	\$0.00	Agreed error (pre-employment exam)	City
223	Benefit Exclusion - Administrative Exams	\$106.34	\$0.00	Agreed error (administrative exam)	Schools
224	Benefit Exclusion - Administrative Exams	\$100.58	\$0.00	Agreed error (administrative exam)	Schools
225	Benefit Exclusion - Administrative Exams	\$151.10	\$0.00	Agreed error (administrative exam)	City
226	Benefit Exclusion - Administrative Exams	\$100.58	\$0.00	Agreed error (administrative exam)	City
227	Benefit Exclusion - Administrative Exams	\$100.58	\$0.00	Agreed error (administrative exam)	Schools

Audit Item	Issue	Recovery Amount	Plan Intent / Disputed Amount	Comment	Group
228	Benefit Exclusion - Administrative Exams	\$100.58	\$0.00	Agreed error (administrative exam)	Schools
229	Benefit Exclusion - Administrative Exams	\$105.07	\$0.00	Agreed error (administrative exam)	Schools
230	Benefit Exclusion - Administrative Exams	\$151.10	\$0.00	Agreed error (administrative exam)	Schools
231	Benefit Exclusion - Administrative Exams	\$114.64	\$0.00	Agreed error (administrative exam)	Schools
232	Benefit Exclusion - Administrative Exams	\$122.89	\$0.00	Agreed error (administrative exam)	City
233	Benefit Exclusion - Administrative Exams	\$114.64	\$0.00	Agreed error (administrative exam)	Schools
234	Benefit Exclusion - Administrative Exams	\$151.10	\$0.00	Agreed error (administrative exam)	Schools
235	Benefit Exclusion - Administrative Exams	\$85.79	\$0.00	Agreed error (administrative exam)	Schools
236	Benefit Exclusion - Administrative Exams	\$151.10	\$0.00	Agreed error (administrative exam)	Schools
237	Benefit Exclusion - Administrative Exams	\$100.58	\$0.00	Agreed error (administrative exam)	City
238	Benefit Exclusion - Administrative Exams	\$171.10	\$0.00	Agreed error (administrative exam)	City
239	Benefit Exclusion - Administrative Exams	\$100.58	\$0.00	Agreed error (administrative exam)	Schools
240	Benefit Exclusion - Administrative Exams	\$96.60	\$0.00	Agreed error (administrative exam)	Schools
241	Benefit Exclusion - Administrative Exams	\$131.10	\$0.00	Agreed error (administrative exam)	Schools
242	Benefit Exclusion - Administrative Exams	\$100.58	\$0.00	Agreed error (administrative exam)	Schools
243	Benefit Exclusion - Administrative Exams	\$151.10	\$0.00	Agreed error (administrative exam)	Schools
244	Benefit Exclusion - Administrative Exams	\$45.84	\$0.00	Agreed error (administrative exam)	Schools
245	Benefit Exclusion - Administrative Exams	\$46.03	\$0.00	Agreed error (administrative exam)	Schools
246	Benefit Exclusion - Administrative Exams	\$93.80	\$0.00	Agreed error (administrative exam)	City
247	Benefit Exclusion - Administrative Exams	\$96.60	\$0.00	Agreed error (administrative exam)	Schools
248	Benefit Exclusion - Administrative Exams	\$69.53	\$0.00	Agreed error (administrative exam)	Schools
249	Benefit Exclusion - Administrative Exams	\$108.61	\$0.00	Agreed error (administrative exam)	City
250	Benefit Exclusion - Administrative Exams	\$65.07	\$0.00	Agreed error (administrative exam)	Schools
Totals		\$224,557.90	\$27,327.62		

Appendix B – Out-of-Sample Claims Detail

Audit Item	Issue	Recovery Amount	Comment	Group
251	Other Insurance	\$0.00	BCBS primary 1.1.24 (DOS prior)	Schools
252	Other Insurance	\$0.00	BCBS primary 1.1.24 (DOS prior)	Schools
253	Other Insurance	\$0.00	BCBS primary 1.1.24 (DOS prior)	Schools
254	Other Insurance	\$0.00	BCBS primary 1.1.24 (DOS prior)	Schools
255	Other Insurance	\$0.00	BCBS primary 1.1.24 (DOS prior)	Schools
256	Other Insurance	\$0.00	BCBS primary 1.1.24 (DOS prior)	Schools
257	Other Insurance	\$362.59	BCBS primary 1.1.24 - Recoverable	Schools
258	Other Insurance	\$258.72	BCBS primary 1.1.24 - Recoverable	Schools
259	Benefit Exclusion - Administrative Exams	\$107.82	Administrative exams are non covered	Schools
260	Benefit Exclusion - Administrative Exams	\$30.00	Administrative exams are non covered	City
261	Benefit Exclusion - Administrative Exams	\$54.20	Administrative exams are non covered	Schools
		\$813.33		