HEALTHCAREHORIZONS
CONSULTING GROUP, INC.

November 20, 2018

HEALTHCARE CLAIMS AUDIT REPORT

City of Virginia Beach – Optima

AUDIT PERIOD: JANUARY – DECEMBER 2017

Healthcare Horizons Consulting Group, Inc.
2220 Sutherland Avenue, Knoxville, TN 37919

(800) 646-9987 or (865) 684-2917
HHAdmin@healthcarehorizons.com

HEALTHCAREHORIZONS.COM

HEALTHCAREHORIZONS
CONSULTING GROUP, INC.

Table of Contents

Executive Summary

The City of Virginia Beach engaged Healthcare Horizons to perform an audit of claims processed by Optima Health (Optima) for paid dates of January 2017 through December 2017. Healthcare Horizons received $94,937,069 in paid claims data from Optima and performed a full electronic review of claims processing. Of this total amount, $55,100,848 was paid for the school system and $39,836,221 for city employees. The purpose of the audit was to identify claim errors resulting in incorrect payments and to assess underlying conditions contributing to any errors identified. Healthcare Horizons delivered 200 targeted sample claims to Optima as potential errors (based on mining of the data) or higher-dollar items in need of review. A site visit was not necessary as Optima provided detailed feedback on all sample claim submissions with minimal follow-up questions required during the process.

Healthcare Horizons identified an agreed recovery amount of $56,865 from the sample claims, representing a minimal dollar percentage of errors given the overall size of the data set. The majority of sample findings are related to missed coordination of benefits, ambulatory surgical center pricing, and separate payment of pre-admission testing. The detailed results of all sample claims are presented in Appendix A. Based on the sample findings, Healthcare Horizons delivered out-of-sample claims with similar potential errors for coordination of benefits (detailed in Appendix B). The total estimated out-of-sample potential is $67,163 and per the Optima response, these dollars are recoverable. Finally, Healthcare Horizons is citing $57,549 in disputed findings from the sample claims with most of the dollars related to the administration of the Allowed Charge for emergency as defined in the Summary of Benefits.

The Optima responses to the draft report are incorporated into the report text by issue. Where appropriate, Healthcare Horizons has added a final audit comment to address the response.

Our findings for the audit are summarized as follows.

Issue	Site Visit Recovery Amount	Site Visit Disputed Amount	Out-of-Sample Recovery	Total Audit Potential (Excluding Disputed)
Other Insurance	$17,725.63	$0.00	$67,162.82	$84,888.45
Pricing - ASC	$14,282.93	$0.00	$0.00	$14,282.93
Pre-Admission Testing	$11,992.44	$0.00	$0.00	$11,992.44
Outpatient During Inpatient	$5,329.16	$0.00	$0.00	$5,329.16
Duplicates	$3,897.04	$0.00	$0.00	$3,897.04
Outpatient with Admission	$2,009.56	$0.00	$0.00	$2,009.56
Surgery Global	$990.21	$0.00	$0.00	$990.21
Benefit Exclusion - Foot Orthotics	$544.19	$0.00	$0.00	$544.19
Multiple Procedure Reductions	$94.05	$0.00	$0.00	$94.05
Allowable Charge - Out of Network	$0.00	$49,199.83	$0.00	$0.00
Benefit Maximum - Hearing Aid	$0.00	$8,349.65	$0.00	$0.00
Totals	**$56,865.21**	**$57,549.48**	**$67,162.82**	**$124,028.03**

CITY

Issue	Site Visit Recovery Amount	Site Visit Disputed Amount	Out-of-Sample Recovery	Total Audit Potential (Excluding Disputed)
Other Insurance	$7,204.47	$0.00	$67,162.82	$74,367.29
Pricing - ASC	$3,025.79	$0.00	$0.00	$3,025.79
Pre-Admission Testing	$6,389.96	$0.00	$0.00	$6,389.96
Outpatient with Admission	$708.00	$0.00	$0.00	$708.00
Surgery Global	$126.39	$0.00	$0.00	$126.39
Benefit Exclusion - Foot Orthotics	$47.00	$0.00	$0.00	$47.00
Allowable Charge - Out of Network	$0.00	$29,266.59	$0.00	$0.00
Benefit Maximum - Hearing Aid	$0.00	$5,470.91	$0.00	$0.00
Totals	**$17,501.61**	**$34,737.50**	**$67,162.82**	**$84,664.43**

SCHOOLS

Issue	Site Visit Recovery Amount	Site Visit Disputed Amount	Out-of-Sample Recovery	Total Audit Potential (Excluding Disputed)
Other Insurance	$10,521.16	$0.00	$0.00	$10,521.16
Pricing - ASC	$11,257.14	$0.00	$0.00	$11,257.14
Pre-Admission Testing	$5,602.48	$0.00	$0.00	$5,602.48
Outpatient During Inpatient	$5,329.16	$0.00	$0.00	$5,329.16
Duplicates	$3,897.04	$0.00	$0.00	$3,897.04
Outpatient with Admission	$1,301.56	$0.00	$0.00	$1,301.56
Surgery Global	$863.82	$0.00	$0.00	$863.82
Benefit Exclusion - Foot Orthotics	$497.19	$0.00	$0.00	$497.19
Multiple Procedure Reductions	$94.05	$0.00	$0.00	$94.05
Allowable Charge - Out of Network	$0.00	$19,933.24	$0.00	$0.00
Benefit Maximum - Hearing Aid	$0.00	$2,878.74	$0.00	$0.00
Totals	**$39,363.60**	**$22,811.98**	**$0.00**	**$39,363.60**

Process Overview

Healthcare Horizons systematically reviews 100% of claims payments by the administrator on behalf of our clients via our proprietary electronic claims 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 sample claims selection as well as the errors identified during the sample review.

Issue	Audit Items	Recovery		Disputed	
		Items	Amount	Items	Amount
Duplicates	12	2	$3,897.04	0	$0.00
Eligibility	3	0	$0.00	0	$0.00
Other Insurance	10	3	$17,725.63	0	$0.00
Retirees with Other Insurance	10	0	$0.00	0	$0.00
COBRA with Other Insurance	5	0	$0.00	0	$0.00
ESRD	10	0	$0.00	0	$0.00
Readmissions	6	0	$0.00	0	$0.00
Outpatient During Inpatient	2	1	$5,329.16	0	$0.00
ER with Admission	1	0	$0.00	0	$0.00
Pre-Admission Testing	25	13	$11,992.44	0	$0.00
Outpatient with Admission	6	3	$2,009.56	0	$0.00
Surgery Global	14	7	$990.21	0	$0.00
Multiple Procedure Reductions	4	1	$94.05	0	$0.00
Pricing - ASC	6	5	$14,282.93	0	$0.00
Pricing - Transfer	7	0	$0.00	0	$0.00
Pricing - PHCS	4	0	$0.00	0	$0.00
Pricing - PHCS - No Discount	19	0	$0.00	0	$0.00
Pricing - Optima	7	0	$0.00	0	$0.00
Allowable Charge - In Network	10	0	$0.00	0	$0.00
Allowable Charge - Out of Network	10	0	$0.00	10	$49,199.83
Benefit Maximum - Hearing Aid	16	0	$0.00	16	$8,349.65
Benefit Exclusion - Foot Orthotics	9	7	$544.19	0	$0.00
Benefit Exclusion - Non Emergency ER	4	0	$0.00	0	$0.00
Totals	**200**	**42**	**$56,865.21**	**26**	**$57,549.48**

Recoverable Findings

Optima has effective system edits in place to prevent duplicate payment errors. Healthcare Horizons performs several queries to identify potential duplicate payments, and our initial analysis yielded a small volume of potential duplicates that were all submitted in the sample selection. Optima agreed with two duplicate payment errors totaling $3,897 (audit items 5 and 11) with a root cause of manual processor error.

> ***Optima's Response: Duplicate Claim Errors***
>
> *Agreed, for the two duplicate claims identified, education was provided to the claims processor. Optima has recently incorporated additional training as it relates to Duplicate claims to enhance their knowledge on how to effectively process these claims.*
>
> **Healthcare Horizons Final Comment**: Healthcare Horizons will work with Optima to track recovery of the overpayments on behalf of the City.

Retroactive notification of other primary insurance (Medicare) resulted in the identification of recoverable claims. Healthcare Horizons utilizes the claims data to identify members with other primary insurance based on a coordination of benefits (COB) savings amount present on certain claims. We then test claims for the same members with no COB savings to determine if coordination with the primary carrier was missed. For audit items 22, 24, and 25 Optima agreed with missed coordination of benefits due to retroactive notification of Medicare primary coverage ($17,726 paid). Based on the other insurance primary dates noted, Healthcare Horizons has delivered 28 additional out-of-sample claims for review and recovery with an estimated potential of $67,163. We request claim-level feedback on these claims from Optima along with the written audit response. Finally, Optima should speak to processes in place to identify and adjust claims impacted by the receipt of retroactive other primary insurance information.

> ***Optima's Response: COB***
>
> *Optima agrees with the assigning of the errors; the Recovery Department is responsible for the verification of the eligibility date of Medicare or other primary insurances. Claims that have processed as primary after the members effective date of other insurance are reprocessed to coordinate correctly. An education was conducted with the Recovery Department based upon the findings of the audit. Optima will work with the Recovery Department to analyze areas of improvement and streamline current processes.*
>
> **Healthcare Horizons Final Comment**: Optima should ensure that the out-of-sample claims are in the recovery process as well. We request notification of any claims cited by Healthcare Horizons that are not in recovery by Optima.

A single overpayment was identified for outpatient services billed during a concurrent inpatient stay. Healthcare Horizons examines the full claims population for outpatient claims billed separately in error during an inpatient stay. If the services were correctly billed with the inpatient claim, no additional reimbursement would occur as the inpatient case rate covers all services rendered during the stay. For audit item 57 paid at $5,329, Optima agreed that separate charges for blood were paid in error. Optima may choose to use this example for additional education for this particular provider.

> ***Optima's Response: Outpatient during IP***
> *Agreed, for the one error received; feedback and refresher training has been reviewed with the responsible claims processor.*
>
> **Healthcare Horizons Final Comment**: Healthcare Horizons will work with Optima to track recovery of the overpayment on behalf of the City.

A material number of pre-admission testing claims were paid in error as the provider contract prohibits separate payment of this testing prior to a planned inpatient admission. It is common for hospital contracts to state that pre-admission testing services (such as lab, X-ray, or EKG) are not to be paid separately from the subsequent inpatient reimbursement. Healthcare Horizons identified thirteen claims paid in error for this issue for a total of $11,992 (audit items 60, 62, 63, 65, 67, 69, 71, 73, 75, 77, 79, 81, and 83). Note that all potential errors were submitted in the sample selection. Optima should speak to root cause and any planned correction action to prevent these overpayments moving forward.

> ***Optima's Response: Pre-Admission Testing***
> *Optima agrees with the assigning of these errors as pre-op was within the 10 day window of the facility charges. Optima will be working with System Administration on potential system edits to identify opportunities in the improvement of Optima's auto adjudication of inpatient claims. In the interim, an audit will be developed to capture any potential errors pre and post auto adjudication.*
>
> **Healthcare Horizons Final Comment**: Healthcare Horizons will test the system edits in future audits to ensure the corrective action is successful. In addition, Healthcare Horizons will work with Optima to track recovery of the overpayments on behalf of the City.

A limited number of outpatient claims were billed and paid in error due to a subsequent inpatient admission. Similar to the pre-admission testing issue described above, providers should generally not submit separate outpatient bills when a patient is subsequently admitted on the same day. The subsequent inpatient reimbursement covers all services for the day. Audit items 85, 87, and 89 were agreed as overpaid by Optima for a total of $2,010. Optima should speak to root cause and any planned correction action to prevent these overpayments moving forward.

Optima's Response: Inpatient

Optima agrees with the assigning of these errors, Optima will be working with System Administration on potential system edits to identify opportunities in the improvement of Optima's auto adjudication of inpatient claims. In the interim, an audit will be developed to capture any potential errors pre and post auto adjudication.

Healthcare Horizons Final Comment: Healthcare Horizons will test the system edits in future audits to ensure the corrective action is successful. In addition, Healthcare Horizons will work with Optima to track recovery of the overpayments on behalf of the City.

Healthcare Horizons identified incorrect separate payments for physician evaluations that should be inclusive of the global surgery rate. For many surgical procedures the fee for the professional surgery claim is inclusive of any visits that occur one day prior to the surgery or up to 90 days after the surgery for follow-ups. Optima agreed with seven overpayments for this issue totaling $990 on the sample claims selection (audit items 92, 94, 96, 98, 100, 102, and 104). All potential overpayments for this issue were submitted in the sample selection; therefore, no additional follow-up is required.

Optima's Response: Surgical Global

Optima disagrees with the assigning of errors 92,94,96,98,100,102, and 104. At the time of the audit no surgical claims were on file identifying services were global. After additional review, these sample claims are now recoverable. Once we receive approval from Virginia Beach we will forward the recommended claims for review and recovery.

Healthcare Horizons Final Comment: While Optima disagrees with the errors, it is agreed that the claims are recoverable. Our position is that Optima should have system edits in place to identify evaluations that are part of a global rate once a surgery claim is received. As recovery will not create adverse member impact, we suggest that the City direct Optima to recover the overpayments.

Healthcare Horizons identified a single overpayment due to a missed multiple procedure reduction caused by fragmented billing. When multiple surgical procedures are performed in the same operative session, it is industry standard to allow the primary procedure at the full fee schedule rate and secondary procedures at a reduced rate (usually 50% of the full fee). These reductions are taken since the primary procedure payment accounts for patient preparation and other services. Healthcare Horizons often finds that payers fail to implement systems to combine procedures across claims when payments are processed on different claims for the same surgical case. Only a single error was identified in the data set for this issue resulting in an overpayment of $94 (audit item 107).

Optima's Response: MPR

Optima agrees with the assigning of this error, this claim was processed prior to the update on our claims editing software. A module in the upgrade has the ability to read historical claims and identify split billing for potential multiple reductions.

Healthcare Horizons Final Comment: Healthcare Horizons will work with Optima to track recovery of the overpayment on behalf of the City.

Similar to prior audits, overpayments were identified for ambulatory surgical centers due to the incorrect payment of secondary surgical procedures. For certain facilities, the Optima contract only allows payment for the primary surgical procedure with all other lines denied for payment. Healthcare Horizons identified five overpayments totaling $14,283 for this issue (audit items 109, 111, 112, 113, and 114). While the number of claims has been minimal, this particular error has been identified in prior Optima audits.

Optima's Response: ASC Pricing

Optima Health agrees with the assigning of this error. This was a processing error and the responsible claims processors will receive education and additional training. Policy will be reviewed to identify areas where policy can be better defined. Optima is committed to excellence and will continue to investigate ways to better support accurate claims processing practices.

Healthcare Horizons Final Comment: Healthcare Horizons will continue to monitor this issue in future audits. In addition, Healthcare Horizons will work with Optima to track recovery of the overpayments on behalf of the City.

Healthcare identified claims paid in error for non-covered foot orthotics. As part of the comprehensive benefits testing, Healthcare Horizons identified claims paid in error for non-covered foot orthotics for a total of $544 (audit items 189, 191, 192, 193, 194, 195, and 196). The plan document specifically excludes these items unless approved as medically necessary. Optima should ensure system setup to deny these claims on behalf of the group. As all likely overpayments were submitted in the sample, no additional follow-up is required.

Optima's Response: Foot Orthotics

Optima Health agrees with the assigning of this error. This was a manual error and the responsible claims processors will receive education and additional training. Shared Services is working with System Administration to implement system edits to aid in minimizing the claims processors margin of error in processing of this specific benefit. Optima Health is committed to researching and implementing ways to better improve processing of claims.

Healthcare Horizons Final Comment: Healthcare Horizons will work with Optima to track recovery of the overpayments on behalf of the City.

Disputed Findings

Optima does not currently limit participating provider payments to the lesser of the contracted rate or billed charges defined in the summary of benefits. The summary of benefits defines Allowable Charge as follows:

> ***Allowable Charge*** *is the amount Optima determines should be paid to a Provider for a Covered Service. When You use In-Network benefits from Plan Providers Allowable Charge is the Provider's contracted rate with Optima or the Provider's actual charge for the service, whichever is less. Plan Providers accept this amount as payment in full.*

Based on this language, Healthcare Horizons submitted claims for participating providers with a payment greater than the provider's actual charges. In each instance, Optima simply responded that the claims were paid correctly at the contracted rate. While it is common in the industry to pay at the contracted rate even if it exceeds billed charges, this contradicts the language in the Summary of Benefits. Healthcare Horizons recommends that Optima and the group engage in discussions to clarify plan intent for this issue. Pending further direction, Healthcare Horizons is citing the sample claims as disputed for $169,929 (audit items 152-161). If a determination is made to enforce the allowable charge language, Healthcare Horizons will deliver a full impact report to Optima.

> ***Optima's Response: Allowable Charge Language***
> *As mentioned in previous audits by Horizon when industry standards are applicable, the group's intent is not required. The administration of allowable charges has been the policy and practice of Optima Health Plan since Optima became the TPA for Virginia Beach 18+ years ago. Acceptance of these policies and practices are supported by the PSA section2.1 Administrative Services. Optima will present updated language as it relates to allowable charges to Virginia Beach for approval. Upon approval, the appropriate verbiage updates will be made to better support Optima's current policies and practices.*
>
> **Healthcare Horizons Final Comment**: Healthcare Horizons agrees that plan language needs correction to reflect plan intent and Optima administration. Based on the Optima response, we will remove this disputed dollar finding from all applicable charts.

Optima is not administering the Allowable Charge language present in the Summary of Benefits for out-of-network emergency claims. Regarding the Allowable Charge limit for out-of-network claims, the Summary of Benefits states the following:

> *When You use Out-of Network benefits from Non-Plan Providers Allowable Charge may be a negotiated rate; or if there is no negotiated rate Allowable Charge is Optima's In-Network contracted rate for the same service performed by the same type of Provider or the Provider's actual*

charge for the service, whichever is less. Non-Plan Providers may not accept this amount as payment in full. If You use a Non-Plan Provider who charges more than our allowable amount the Provider may balance bill You for the difference. You will have to pay the difference to the Provider in addition to Your Copayment or Coinsurance amount. Charges from Non-Plan Providers will be higher than the Plan's Allowable Charge so You will usually pay more out of pocket when You use Out of Network benefits.

In addition, the Summary of Benefits specifically addresses emergency cases:

Members who receive Emergency Services from Non-Plan Providers may be responsible for charges in excess of what would have been paid had the Emergency Services been received from Plan Providers.

In testing claims for this issue, Healthcare Horizons selected a number of out-of-network claims allowed at full billed charges and requested that Optima address the Allowable Charge limitation described above. For the majority of claims submitted in this category, Optima responded as follows: "paid at charges so that member is not balance billed." Given the plan language, our position is that these claims should have only paid an amount equivalent to Optima's in-network contracted rate. We again suggest discussions between Optima and the group to verify plan intent. Pending these discussions, Healthcare Horizons has cited the entire paid amount of $49,200 as disputed for this category (audit items 162-171). Based on the final determination, Healthcare Horizons will produce a full impact report if warranted.

Optima Response: Allowable Charges

Optima complies with the ACA provision for OON ER reimbursement (the greater of the plans allowable, UCR (56% of billed charges) or Medicare). Optima's policy and practice is OON claims are paid under HMO rules for POS plans which ensures that members are not balanced billed by OON providers performing emergency services. Optima will receive approval from the group to update the language to reflect industry standards, which are currently in line with Optima's policies and practice.

Healthcare Horizons Final Comment: The plan language seems clear in that the intent is to limit out-of-network emergency room payments. Our recommendation is for the City to require Optima to administer the policy as written in the plan document. Any balance billing that occurs can be addressed on a case-by-case basis. This policy will protect the City from potential abusive billing practices by out-of-network providers.

Optima does not currently include dispensing fees or molds as part of the $1,250 benefit maximum (per ear) for hearing aids. Based on the 1/1/2013 and 1/1/2018 Plan Documents, Healthcare Horizons notes the following language from the Hearing Aid Rider:

> ***Pre-Authorization for all covered services is required.*** Covered services include the following up to the annual maximum benefit amount of $1,250 and as specified on the Plan's Summary of Benefits:
> • Hearing aid(s);
> • Audiometric specialist office visit(s) for fitting, including molds, and dispensing;
> • Repair or refurbishment of the hearing aid(s) up to the annual maximum benefit amount.

Based on this language, Healthcare Horizons presented sixteen claims (audit items 172-187) for members that exceeded a total benefit of $2,500 for both ears with an estimated overpayment of $8,350. In each instance, Optima responded as follows: "per the member's SOB, $2500 maximum is for hearing aid only. Does not include dispensing and/or mold fee." We request that the City and Optima work to clarify plan intent given the discrepancy between the plan document and current administration. Note that all potential overpayments were included in the sample selection.

> ***Optima Response: Hearing Aid***
> *Optima Health agrees that further discussion on this benefit would be needed.*

> **Healthcare Horizons Final Comment**: We will continue to cite this issue as disputed; however, the Hearing Aid Rider seems clear in that dispensing fees or molds should be included in the maximum. As recovery will create adverse member impact, the City may choose to request a direct settlement for this issue.

Conclusion

Healthcare Horizons appreciates the opportunity to perform this claims audit on behalf of The City of Virginia Beach. The overall results continue to represent above average performance by Optima in the administration of healthcare claims. We would also like to recognize the cooperation exhibited by the entire Optima team during this process.

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

- Optima should initiate recovery on all agreed overpayments and report any negative potential member impact to both Healthcare Horizons and the group prior to any collections activity. We request that a monthly collections report be delivered to Healthcare Horizons until collections are complete.
- Optima should engage in discussions with the group to clarify plan intent for Allowable Charge (emergency) and the hearing aid benefit limitation.

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 Detail

Audit Item	Issue	Recovery	Disputed	Comment	City/Schools
1	Duplicates	$0.00	$0.00	Patient seen in ER twice on the same day	Schools
2	Duplicates	$0.00	$0.00	Patient seen in ER twice on the same day	Schools
3	Duplicates	$0.00	$0.00	Claim reversed and denied prior to audit	Schools
4	Duplicates	$0.00	$0.00	Correct claim for 3/4 combo	Schools
5	Duplicates	$693.22	$0.00	Agreed duplicate error	Schools
6	Duplicates	$0.00	$0.00	Correct claim for 5/6 combo	Schools
7	Duplicates	$0.00	$0.00	Multiple MRIs on the same day	Schools
8	Duplicates	$0.00	$0.00	Multiple MRIs on the same day	Schools
9	Duplicates	$0.00	$0.00	Claim reversed and denied prior to audit	Schools
10	Duplicates	$0.00	$0.00	Correct claim for 9/10 combo	Schools
11	Duplicates	$3,203.82	$0.00	Agreed duplicate error	Schools
12	Duplicates	$0.00	$0.00	Correct claim for 11/12 combo	Schools
13	Eligibility	$0.00	$0.00	Claim reversed and denied prior to audit	Schools
14	Eligibility	$0.00	$0.00	Claim reversed and denied prior to audit	Schools
15	Eligibility	$0.00	$0.00	Claim reversed and denied prior to audit	Schools
16	Other Insurance	$0.00	$0.00	Claim reversed and coordinated prior to audit	Schools
17	Other Insurance	$0.00	$0.00	Claim reversed and coordinated prior to audit	Schools
18	Other Insurance	$0.00	$0.00	No other insurance on DOS	City
19	Other Insurance	$0.00	$0.00	Medicare primary 9/1/17 - DOS prior	Schools
20	Other Insurance	$0.00	$0.00	No other insurance on DOS	Schools
21	Other Insurance	$0.00	$0.00	No other insurance on DOS	City
22	Other Insurance	$7,204.47	$0.00	Retroactive notification of other insurance (Medicare primary 3/1/15)	City
23	Other Insurance	$0.00	$0.00	Coordinated correctly - primary paid $0.00 (all to deductible)	Schools
24	Other Insurance	$7,758.66	$0.00	Retroactive notification of other insurance (Medicare primary 7/1/17)	Schools
25	Other Insurance	$2,762.50	$0.00	Retroactive notification of other insurance (Medicare primary 12/1/10)	Schools
26	Retirees with Other Insurance	$0.00	$0.00	Member under 65 - Optima primary (DOB not in data)	Schools
27	Retirees with Other Insurance	$0.00	$0.00	Member under 65 - Optima primary (DOB not in data)	Schools
28	Retirees with Other Insurance	$0.00	$0.00	Member under 65 - Optima primary (DOB not in data)	City
29	Retirees with Other Insurance	$0.00	$0.00	Member under 65 - Optima primary (DOB not in data)	City
30	Retirees with Other Insurance	$0.00	$0.00	Member under 65 - Optima primary (DOB not in data)	Schools
31	Retirees with Other Insurance	$0.00	$0.00	Member under 65 - Optima primary (DOB not in data)	City
32	Retirees with Other Insurance	$0.00	$0.00	Member under 65 - Optima primary (DOB not in data)	Schools
33	Retirees with Other Insurance	$0.00	$0.00	Member under 65 - Optima primary (DOB not in data)	City
34	Retirees with Other Insurance	$0.00	$0.00	Member under 65 - Optima primary (DOB not in data)	City
35	Retirees with Other Insurance	$0.00	$0.00	Member under 65 - Optima primary (DOB not in data)	City
36	COBRA with Other Insurance	$0.00	$0.00	Member under 65 - Optima primary (DOB not in data)	City
37	COBRA with Other Insurance	$0.00	$0.00	Member under 65 - Optima primary (DOB not in data)	Schools
38	COBRA with Other Insurance	$0.00	$0.00	Member under 65 - Optima primary (DOB not in data)	Schools
39	COBRA with Other Insurance	$0.00	$0.00	Member under 65 - Optima primary (DOB not in data)	Schools
40	COBRA with Other Insurance	$0.00	$0.00	Member under 65 - Optima primary (DOB not in data)	Schools
41	ESRD	$0.00	$0.00	Medicare Part A only 6/1/14 to 1/16/18	City
42	ESRD	$0.00	$0.00	Medicare primary 9/1/18 (DOS prior)	Schools
43	ESRD	$0.00	$0.00	Optima does not have Medicare primary effective date on file for ESRD	Schools
44	ESRD	$0.00	$0.00	Medicare primary 5/1/18 (DOS prior)	City
45	ESRD	$0.00	$0.00	Medicare primary 9/1/17 (DOS prior)	Schools
46	ESRD	$0.00	$0.00	Medicare primary 3/1/18 (DOS prior)	City
47	ESRD	$0.00	$0.00	Optima does not have Medicare primary effective date on file for ESRD	City
48	ESRD	$0.00	$0.00	Optima does not have Medicare primary effective date on file for ESRD	Schools
49	ESRD	$0.00	$0.00	Optima does not have Medicare primary effective date on file for ESRD	Schools
50	ESRD	$0.00	$0.00	Optima does not have Medicare primary effective date on file for ESRD	City
51	Readmissions	$0.00	$0.00	Unrelated readmission per Optima	City
52	Readmissions	$0.00	$0.00	Unrelated readmission per Optima	City
53	Readmissions	$0.00	$0.00	Unrelated readmission per Optima	Schools
54	Readmissions	$0.00	$0.00	Unrelated readmission per Optima	Schools
55	Readmissions	$0.00	$0.00	Unrelated readmission per Optima	City
56	Readmissions	$0.00	$0.00	Unrelated readmission per Optima	City
57	Outpatient During Inpatient	$5,329.16	$0.00	Agreed error	Schools
58	Outpatient During Inpatient	$0.00	$0.00	Informational inpatient claim	Schools
59	ER with Admission	$0.00	$0.00	Member not directly admitted from ER	Schools
60	Pre-Admission Testing	$159.11	$0.00	PAT allowed separately in error	Schools
61	Pre-Admission Testing	$0.00	$0.00	Informational inpatient claim	Schools
62	Pre-Admission Testing	$2,003.21	$0.00	PAT allowed separately in error	Schools
63	Pre-Admission Testing	$159.11	$0.00	PAT allowed separately in error	Schools
64	Pre-Admission Testing	$0.00	$0.00	Informational inpatient claim	Schools
65	Pre-Admission Testing	$139.40	$0.00	PAT allowed separately in error	Schools
66	Pre-Admission Testing	$0.00	$0.00	Informational inpatient claim	Schools
67	Pre-Admission Testing	$4,149.20	$0.00	PAT allowed separately in error	City
68	Pre-Admission Testing	$0.00	$0.00	Informational inpatient claim	City

Audit Item	Issue	Recovery	Disputed	Comment	City/Schools
69	Pre-Admission Testing	$249.17	$0.00	PAT allowed separately in error	Schools
70	Pre-Admission Testing	$0.00	$0.00	Informational inpatient claim	Schools
71	Pre-Admission Testing	$695.30	$0.00	PAT allowed separately in error	Schools
72	Pre-Admission Testing	$0.00	$0.00	Informational inpatient claim	Schools
73	Pre-Admission Testing	$131.20	$0.00	PAT allowed separately in error	Schools
74	Pre-Admission Testing	$0.00	$0.00	Informational inpatient claim	Schools
75	Pre-Admission Testing	$1,885.38	$0.00	PAT allowed separately in error	City
76	Pre-Admission Testing	$0.00	$0.00	Informational inpatient claim	City
77	Pre-Admission Testing	$215.98	$0.00	PAT allowed separately in error	City
78	Pre-Admission Testing	$0.00	$0.00	Informational inpatient claim	City
79	Pre-Admission Testing	$164.00	$0.00	PAT allowed separately in error	Schools
80	Pre-Admission Testing	$0.00	$0.00	Informational inpatient claim	Schools
81	Pre-Admission Testing	$139.40	$0.00	PAT allowed separately in error	City
82	Pre-Admission Testing	$0.00	$0.00	Informational inpatient claim	City
83	Pre-Admission Testing	$1,901.98	$0.00	PAT allowed separately in error	Schools
84	Pre-Admission Testing	$0.00	$0.00	Informational inpatient claim	Schools
85	Outpatient with Admission	$241.06	$0.00	Outpatient allowed separately in error	Schools
86	Outpatient with Admission	$0.00	$0.00	Informational inpatient claim	Schools
87	Outpatient with Admission	$1,060.50	$0.00	Outpatient allowed separately in error	Schools
88	Outpatient with Admission	$0.00	$0.00	Informational inpatient claim	Schools
89	Outpatient with Admission	$708.00	$0.00	Outpatient allowed separately in error	City
90	Outpatient with Admission	$0.00	$0.00	Informational inpatient claim	City
91	Surgery Global	$0.00	$0.00	Informational surgery claim	Schools
92	Surgery Global	$86.39	$0.00	Evaluation allowed separately in error	Schools
93	Surgery Global	$0.00	$0.00	Informational surgery claim	Schools
94	Surgery Global	$79.23	$0.00	Evaluation allowed separately in error	Schools
95	Surgery Global	$0.00	$0.00	Informational surgery claim	City
96	Surgery Global	$126.39	$0.00	Evaluation allowed separately in error	City
97	Surgery Global	$0.00	$0.00	Informational surgery claim	Schools
98	Surgery Global	$232.00	$0.00	Evaluation allowed separately in error	Schools
99	Surgery Global	$0.00	$0.00	Informational surgery claim	Schools
100	Surgery Global	$151.46	$0.00	Evaluation allowed separately in error	Schools
101	Surgery Global	$0.00	$0.00	Informational surgery claim	Schools
102	Surgery Global	$186.45	$0.00	Evaluation allowed separately in error	Schools
103	Surgery Global	$0.00	$0.00	Informational surgery claim	Schools
104	Surgery Global	$128.29	$0.00	Evaluation allowed separately in error	Schools
105	Multiple Procedure Reductions	$0.00	$0.00	Informational primary procedure	Schools
106	Multiple Procedure Reductions	$0.00	$0.00	Claim reversed and corrected prior to audit	Schools
107	Multiple Procedure Reductions	$94.05	$0.00	Agreed error - missed reduction	Schools
108	Multiple Procedure Reductions	$0.00	$0.00	Informational primary procedure	Schools
109	Pricing - ASC	$1,766.39	$0.00	Agreed error - should only allow highest RVU procedure	Schools
110	Pricing - ASC	$0.00	$0.00	Claim reversed and corrected prior to audit	Schools
111	Pricing - ASC	$3,320.95	$0.00	Agreed error - should only allow highest RVU procedure	Schools
112	Pricing - ASC	$2,859.40	$0.00	Agreed error - should only allow highest RVU procedure	Schools
113	Pricing - ASC	$3,025.79	$0.00	Agreed error - should only allow highest RVU procedure	City
114	Pricing - ASC	$3,310.40	$0.00	Agreed error - should only allow highest RVU procedure	Schools
115	Pricing - Transfer	$0.00	$0.00	Claim correctly paid at transfer per diem	Schools
116	Pricing - Transfer	$0.00	$0.00	Claim correctly paid at transfer per diem	Schools
117	Pricing - Transfer	$0.00	$0.00	Claim correctly paid at transfer per diem (lesser of)	Schools
118	Pricing - Transfer	$0.00	$0.00	Claim correctly paid at transfer per diem (lesser of)	Schools
119	Pricing - Transfer	$0.00	$0.00	Claim correctly paid at full DRG	Schools
120	Pricing - Transfer	$0.00	$0.00	Claim correctly paid at transfer per diem	City
121	Pricing - Transfer	$0.00	$0.00	Claim correctly paid at transfer per diem	Schools
122	Pricing - PHCS	$0.00	$0.00	PHCS pricing correct per Optima	Schools
123	Pricing - PHCS	$0.00	$0.00	PHCS pricing correct per Optima	City
124	Pricing - PHCS	$0.00	$0.00	PHCS pricing correct per Optima	Schools
125	Pricing - PHCS	$0.00	$0.00	PHCS pricing correct per Optima	City
126	Pricing - PHCS - No Discount	$0.00	$0.00	PHCS pricing returned at 100%	Schools
127	Pricing - PHCS - No Discount	$0.00	$0.00	PHCS pricing returned at 100%	Schools
128	Pricing - PHCS - No Discount	$0.00	$0.00	PHCS pricing returned at 100%	Schools
129	Pricing - PHCS - No Discount	$0.00	$0.00	iSight pricing returned at 100%	Schools
130	Pricing - PHCS - No Discount	$0.00	$0.00	PHCS pricing returned at 100%	City
131	Pricing - PHCS - No Discount	$0.00	$0.00	MultiPlan pricing returned at 100%	Schools
132	Pricing - PHCS - No Discount	$0.00	$0.00	iSight pricing returned at 100%	Schools
133	Pricing - PHCS - No Discount	$0.00	$0.00	PHCS pricing returned at 100%	Schools
134	Pricing - PHCS - No Discount	$0.00	$0.00	PHCS pricing returned at 100%	City
135	Pricing - PHCS - No Discount	$0.00	$0.00	MultiPlan pricing returned at 100%	City
136	Pricing - PHCS - No Discount	$0.00	$0.00	MultiPlan pricing returned at 100%	City
137	Pricing - PHCS - No Discount	$0.00	$0.00	PHCS pricing returned at 100%	Schools
138	Pricing - PHCS - No Discount	$0.00	$0.00	PHCS pricing returned at 100%	City
139	Pricing - PHCS - No Discount	$0.00	$0.00	PHCS pricing returned at 100%	City
140	Pricing - PHCS - No Discount	$0.00	$0.00	MultiPlan pricing returned at 100%	City
141	Pricing - PHCS - No Discount	$0.00	$0.00	MultiPlan pricing returned at 100%	City
142	Pricing - PHCS - No Discount	$0.00	$0.00	Secondary payment	City
143	Pricing - PHCS - No Discount	$0.00	$0.00	PHCS pricing returned at 100%	City
144	Pricing - PHCS - No Discount	$0.00	$0.00	PHCS pricing returned at 100%	City

Audit Item	Issue	Recovery	Disputed	Comment	City/Schools
145	Pricing - Optima	$0.00	$0.00	Pricing correct - stop loss	Schools
146	Pricing - Optima	$0.00	$0.00	Pricing correct - stop loss	Schools
147	Pricing - Optima	$0.00	$0.00	Pricing correct - flat rate	Schools
148	Pricing - Optima	$0.00	$0.00	Pricing correct - stop loss	Schools
149	Pricing - Optima	$0.00	$0.00	Pricing correct - percent of charges	City
150	Pricing - Optima	$0.00	$0.00	Informational - need name of drug, physician order, NDC code, and invoice	City
151	Pricing - Optima	$0.00	$0.00	Pricing correct - stop loss	Schools
152	Allowable Charge - In Network	$0.00	$0.00	Optima and the City to correct plan document to match intent	Schools
153	Allowable Charge - In Network	$0.00	$0.00	Optima and the City to correct plan document to match intent	Schools
154	Allowable Charge - In Network	$0.00	$0.00	Optima and the City to correct plan document to match intent	Schools
155	Allowable Charge - In Network	$0.00	$0.00	Optima and the City to correct plan document to match intent	City
156	Allowable Charge - In Network	$0.00	$0.00	Optima and the City to correct plan document to match intent	Schools
157	Allowable Charge - In Network	$0.00	$0.00	Optima and the City to correct plan document to match intent	City
158	Allowable Charge - In Network	$0.00	$0.00	Optima and the City to correct plan document to match intent	Schools
159	Allowable Charge - In Network	$0.00	$0.00	Optima and the City to correct plan document to match intent	Schools
160	Allowable Charge - In Network	$0.00	$0.00	Optima and the City to correct plan document to match intent	Schools
161	Allowable Charge - In Network	$0.00	$0.00	Optima and the City to correct plan document to match intent	City
162	Allowable Charge - Out of Network	$0.00	$12,014.99	Per plan design, non-par providers are limited to par rate for similar services (emergent)	City
163	Allowable Charge - Out of Network	$0.00	$11,784.06	Per plan design, non-par providers are limited to par rate for similar services (emergent)	Schools
164	Allowable Charge - Out of Network	$0.00	$4,270.78	Per plan design, non-par providers are limited to par rate for similar services (emergent)	City
165	Allowable Charge - Out of Network	$0.00	$3,910.00	Per plan design, non-par providers are limited to par rate for similar services (anesthesia)	City
166	Allowable Charge - Out of Network	$0.00	$3,469.05	Per plan design, non-par providers are limited to par rate for similar services (emergent)	Schools
167	Allowable Charge - Out of Network	$0.00	$3,446.75	Per plan design, non-par providers are limited to par rate for similar services (emergent)	City
168	Allowable Charge - Out of Network	$0.00	$2,870.07	Per plan design, non-par providers are limited to par rate for similar services (emergent)	City
169	Allowable Charge - Out of Network	$0.00	$2,754.00	Per plan design, non-par providers are limited to par rate for similar services (surgeon)	City
170	Allowable Charge - Out of Network	$0.00	$2,520.13	Per plan design, non-par providers are limited to par rate for similar services (emergent)	Schools
171	Allowable Charge - Out of Network	$0.00	$2,160.00	Per plan design, non-par providers are limited to par rate for similar services (facility eye surgery)	Schools
172	Benefit Maximum - Hearing Aid	$0.00	$674.09	Dispensing and mold fees should be included in maximum per rider	City
173	Benefit Maximum - Hearing Aid	$0.00	$592.92	Dispensing and mold fees should be included in maximum per rider	Schools
174	Benefit Maximum - Hearing Aid	$0.00	$710.38	Dispensing and mold fees should be included in maximum per rider	Schools
175	Benefit Maximum - Hearing Aid	$0.00	$706.20	Dispensing and mold fees should be included in maximum per rider	City
176	Benefit Maximum - Hearing Aid	$0.00	$482.22	Dispensing and mold fees should be included in maximum per rider	City
177	Benefit Maximum - Hearing Aid	$0.00	$708.72	Dispensing and mold fees should be included in maximum per rider	City
178	Benefit Maximum - Hearing Aid	$0.00	$552.22	Dispensing and mold fees should be included in maximum per rider	City
179	Benefit Maximum - Hearing Aid	$0.00	$758.72	Dispensing and mold fees should be included in maximum per rider	City
180	Benefit Maximum - Hearing Aid	$0.00	$248.30	Dispensing and mold fees should be included in maximum per rider	Schools
181	Benefit Maximum - Hearing Aid	$0.00	$723.84	Dispensing and mold fees should be included in maximum per rider	City
182	Benefit Maximum - Hearing Aid	$0.00	$308.30	Dispensing and mold fees should be included in maximum per rider	Schools
183	Benefit Maximum - Hearing Aid	$0.00	$300.00	Dispensing and mold fees should be included in maximum per rider	Schools
184	Benefit Maximum - Hearing Aid	$0.00	$248.30	Dispensing and mold fees should be included in maximum per rider	City
185	Benefit Maximum - Hearing Aid	$0.00	$308.30	Dispensing and mold fees should be included in maximum per rider	City
186	Benefit Maximum - Hearing Aid	$0.00	$308.30	Dispensing and mold fees should be included in maximum per rider	City
187	Benefit Maximum - Hearing Aid	$0.00	$718.84	Dispensing and mold fees should be included in maximum per rider	Schools
188	Benefit Exclusion - Foot Orthotics	$0.00	$0.00	Covered for diabetics	City
189	Benefit Exclusion - Foot Orthotics	$42.50	$0.00	Agreed error	Schools
190	Benefit Exclusion - Foot Orthotics	$0.00	$0.00	Covered for diabetics	City
191	Benefit Exclusion - Foot Orthotics	$47.00	$0.00	Agreed error	Schools
192	Benefit Exclusion - Foot Orthotics	$317.24	$0.00	Agreed error	Schools
193	Benefit Exclusion - Foot Orthotics	$47.00	$0.00	Agreed error	City
194	Benefit Exclusion - Foot Orthotics	$50.00	$0.00	Agreed error	Schools
195	Benefit Exclusion - Foot Orthotics	$23.80	$0.00	Agreed error	Schools
196	Benefit Exclusion - Foot Orthotics	$16.65	$0.00	Agreed error	Schools
197	Benefit Exclusion - Non Emergency ER	$0.00	$0.00	Optima states retro-review not mandated by the group	City
198	Benefit Exclusion - Non Emergency ER	$0.00	$0.00	Optima states retro-review not mandated by the group	City
199	Benefit Exclusion - Non Emergency ER	$0.00	$0.00	Optima states retro-review not mandated by the group	Schools
200	Benefit Exclusion - Non Emergency ER	$0.00	$0.00	Optima states retro-review not mandated by the group	Schools
		$56,865.21	**$57,549.48**		

Appendix B – Out-of-Sample Claims

Audit Item	Issue	Recovery	Comment	City/Schools
201	Other Insurance	$1,575.90	Per sample item 22 - Medicare primary 3/1/15	City
202	Other Insurance	$1,575.90	Per sample item 22 - Medicare primary 3/1/15	City
203	Other Insurance	$1,575.90	Per sample item 22 - Medicare primary 3/1/15	City
204	Other Insurance	$1,575.90	Per sample item 22 - Medicare primary 3/1/15	City
205	Other Insurance	$2,101.20	Per sample item 22 - Medicare primary 3/1/15	City
206	Other Insurance	$1,413.18	Per sample item 22 - Medicare primary 3/1/15	City
207	Other Insurance	$1,413.18	Per sample item 22 - Medicare primary 3/1/15	City
208	Other Insurance	$1,884.25	Per sample item 22 - Medicare primary 3/1/15	City
209	Other Insurance	$1,413.18	Per sample item 22 - Medicare primary 3/1/15	City
210	Other Insurance	$1,413.18	Per sample item 22 - Medicare primary 3/1/15	City
211	Other Insurance	$1,413.18	Per sample item 22 - Medicare primary 3/1/15	City
212	Other Insurance	$1,551.03	Per sample item 22 - Medicare primary 3/1/15	City
213	Other Insurance	$1,662.57	Per sample item 22 - Medicare primary 3/1/15	City
214	Other Insurance	$1,380.38	Per sample item 22 - Medicare primary 3/1/15	City
215	Other Insurance	$1,662.57	Per sample item 22 - Medicare primary 3/1/15	City
216	Other Insurance	$1,662.57	Per sample item 22 - Medicare primary 3/1/15	City
217	Other Insurance	$2,770.95	Per sample item 22 - Medicare primary 3/1/15	City
218	Other Insurance	$1,662.57	Per sample item 22 - Medicare primary 3/1/15	City
219	Other Insurance	$1,662.57	Per sample item 22 - Medicare primary 3/1/15	City
220	Other Insurance	$1,662.57	Per sample item 22 - Medicare primary 3/1/15	City
221	Other Insurance	$1,662.57	Per sample item 22 - Medicare primary 3/1/15	City
222	Other Insurance	$1,108.38	Per sample item 22 - Medicare primary 3/1/15	City
223	Other Insurance	$4,987.71	Per sample item 22 - Medicare primary 3/1/15	City
224	Other Insurance	$7,204.47	Per sample item 22 - Medicare primary 3/1/15	City
225	Other Insurance	$1,440.38	Per sample item 22 - Medicare primary 3/1/15	City
226	Other Insurance	$6,650.28	Per sample item 22 - Medicare primary 3/1/15	City
227	Other Insurance	$9,385.83	Per sample item 22 - Medicare primary 3/1/15	City
228	Other Insurance	$1,690.47	Per sample item 22 - Medicare primary 3/1/15	City
	Totals	**$67,162.82**		