HEALTHCAREHORIZONS
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Healthcare
Claims Audit Report
The City of Virginia Beach
Optima Health

December 7, 2015

Audit Period April 2014 – December 2014

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Executive Summary

The City of Virginia Beach engaged Healthcare Horizons to perform an audit of claims processed by Optima Health (Optima) for paid dates of April 2014 through December 2014. Healthcare Horizons received $78,126,256 in paid claims data from Optima and performed a full electronic review of claims processing. Of this total amount, $43,687,806 was paid for school membership and $34,438,450 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 160 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 for the audit as Optima provided detailed responses to all of our inquiries.

Healthcare Horizons identified an agreed recovery amount of $32,835 from the sample claims, representing an extremely low volume of errors given the overall size of the data set. The majority of sample findings are related to coordination of benefits and facility pricing. 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 in the categories of coordination of benefits (ESRD), facility pricing, and post-operative physician evaluations. Upon review of these out-of-sample claims, Optima agreed to an additional recovery amount of $995. The majority of the out-of-sample potential was dismissed due to updated Medicare primary information related to sample item 41.

The Optima audit response is included as Appendix C. Where applicable, Healthcare Horizons has inserted text from the response into this report including any necessary final comments.

Our findings for the audit are summarized as follows.

Issue	Sample Recovery Amount	Out-of-Sample Recovery Amount	Total Audit Finding
Multiple Procedure Reductions - Facility	$15,645.00	$810.00	$16,455.00
Other Insurance	$7,768.64	$0.00	$7,768.64
Pricing - Transfers	$6,117.72	$0.00	$6,117.72
Pre/Post Operative Period	$238.13	$184.72	$422.85
Multiple Procedure Reductions - Professional	$1,185.16	$0.00	$1,185.16
Pre-Admission Testing	$1,008.30	$0.00	$1,008.30
Pricing - Par	$561.88	$0.00	$561.88
Duplicates	$169.38	$0.00	$169.38
Eligibility - After Termination	$101.25	$0.00	$101.25
Copayments - Outpatient MH	$40.00	$0.00	$40.00
Totals	**$32,835.46**	**$994.72**	**$33,830.18**

CITY

Issue	Sample Recovery Amount	Out-of-Sample Recovery Amount	Total Audit Finding
Multiple Procedure Reductions - Facility	$10,863.00	$810.00	$11,673.00
Pricing - Transfers	$6,117.72	$0.00	$6,117.72
Multiple Procedure Reductions - Professional	$737.57	$0.00	$737.57
Pre-Admission Testing	$620.98	$0.00	$620.98
Pre/Post Operative Period	$87.50	$65.00	$152.50
Duplicates	$169.38	$0.00	$169.38
Eligibility - After Termination	$101.25	$0.00	$101.25
Copayments - Outpatient MH	$40.00	$0.00	$40.00
Totals	**$18,737.40**	**$875.00**	**$19,612.40**

SCHOOLS

Issue	Sample Recovery Amount	Out-of-Sample Recovery Amount	Total Audit Finding
Other Insurance	$7,768.64	$0.00	$7,768.64
Multiple Procedure Reductions - Facility	$4,782.00	$0.00	$4,782.00
Pre/Post Operative Period	$150.63	$119.72	$270.35
Pricing - Par	$561.88	$0.00	$561.88
Multiple Procedure Reductions - Professional	$447.59	$0.00	$447.59
Pre-Admission Testing	$387.32	$0.00	$387.32
Totals	**$14,098.06**	**$119.72**	**$14,217.78**

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.

The following section describes the general areas of testing by Healthcare Horizons.

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 actually 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 in order 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.

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Sample Selection

The following chart details the composition of the sample claims selection as well as the errors identified in reviewing the sample.

Issue	Audit Items	Recovery	
		Items	Amount
Pricing - Par	9	1	$561.88
Pricing - PHCS	3	0	$0.00
Pricing - Transfers	4	1	$6,117.72
Other Insurance	15	1	$7,768.64
Secondary Payments	9	0	$0.00
ESRD	6	0	$0.00
Duplicates	18	1	$169.38
Multiple Procedure Reductions - Facility	7	7	$15,645.00
Multiple Procedure Reductions - Professional	12	3	$1,185.16
Multiple Procedure Reductions - Radiology	4	0	$0.00
Pre-Admission Testing	14	5	$1,008.30
Pre/Post Operative Period	10	4	$238.13
Eligibility - After Termination	1	1	$101.25
Eligibility - Not on File	6	0	$0.00
DRG Readmissions	8	0	$0.00
Benefit Exclusions - Dental	2	0	$0.00
Copayments - Diagnostic	3	0	$0.00
Copayments - Emergency Room	10	0	$0.00
Copayments - Hearing	2	0	$0.00
Copayments - Inpatient MH	2	0	$0.00
Copayments - Office Visit	6	0	$0.00
Copayments - Outpatient MH	4	1	$40.00
Copayments - Outpatient Surgery	5	0	$0.00
Totals	**160**	**25**	**$32,835.46**

Recoverable Findings

Healthcare Horizons identified a single pricing error in which Optima failed to apply lesser of billed charges logic. For Audit Item 7, Optima agreed that the payment should have been limited to billed charges per the provider contact, resulting in an overpayment of $562. Based on this finding, Healthcare Horizons examined all claims in the data set for this particular provider and no additional claims were identified with payment in excess of billed charges. This appears to be an isolated manual error.

> ***Optima Response: Single Pricing Error***
> *A single claim was identified in the audit sample (item 7) that should have been limited to billed charges per the provider contract. We will continue our internal audit practice to achieve the highest level of accuracy possible.*

A single transfer claim was found to be paid incorrectly at the full inpatient case rate. For cases when a patient is transferred to another acute care facility, contracts often contain special terms for pricing the transfer claim as the facility did not provide treatment for the entire case. For Audit Item 13, Optima agreed that the transfer claim was priced incorrectly at the full rate resulting in an overpayment of $6,118. Healthcare Horizons reviewed all additional transfer claims for this particular facility and did not identify any additional likely errors. Given the amount of this pricing error, we request that Optima address root cause in its response to this report.

> ***Optima Response: Single Transfer Rate***
> *A single claim was identified in the audit sample (item 13) that involved a transfer from one acute care facility to another that was incorrectly priced at the full rate resulting in an overpayment of $6,118. This was a processor oversight. We are committed to achieving the highest level of accuracy possible through our internal audit process. We will continue to educate our claims processors to be diligent in identifying this scenario.*

Optima correctly identified historical claims in need of coordination; however, a single claim was omitted for adjustment in error. For Audit Item 30, Healthcare Horizons questioned the presence of other primary insurance that should pay as primary. Optima agreed that that the sample claim was overpaid at $7,769 due to missed coordination; however, all other claims for the member had been identified and corrected prior. This appears to be a manual oversight as Optima reviewed all claims for this particular member with a retroactive change in other insurance.

> ***Optima Response: Secondary Payment***
> *A single claim was identified in the audit sample (item 30) that was calculated as primary when Optima should have paid as secondary. Reviewing claims for retroactive change in coverage is a manual process and we are committed to achieving the highest level of accuracy possible through our internal audit process.*

Retroactive notification of Medicare primary coverage due to ESRD resulted in the identification of recoverable claims. For audit item 41, Optima confirmed retroactive Medicare primary coverage due to ESRD. At the time of processing, the claim was processed correctly as primary; however, the claim is now recoverable ($6,211) and

requires coordination with Medicare. In addition to the sample claim, Healthcare Horizons has delivered 75 out-of-sample claims processed as primary after the Medicare effective date provided to us by Optima. In total, we estimate a recovery amount of $79,276 for this issue including the out-of-sample claims provided.

Optima Response: Retroactive notification of Medicare primary coverage due to ESRD resulted in the identification of recoverable claims

Optima disagrees that the claims are now recoverable. Medicare is the secondary payer to group health plans (GHP) for individuals entitled to Medicare based on ESRD for a coordination period of 30 months. A member becomes eligible for Medicare ESRD on the fourth month after beginning dialysis and then is subject to coordination of benefits for 30 months. Members may become eligible for Medicare prior to becoming eligible for ESRD coverage; however they are considered under the Medicare Working aged guidelines. These guidelines state: If the individual is age 65 or older, is covered by a GHP through current employment or spouse's current employment AND the employer has 20 or more employees (or at least one employer is a multi-employer group that employs 20 or more individuals) GHP pays Primary, Medicare pays secondary. In the audit example and those selected for the out-of-sample audit, in most cases Medicare was active prior to the member beginning ESRD and the working aged guidelines apply. In the remaining cases, ESRD coordination of benefits was begun after the appropriate 30 month coordination period. A detailed list of eligibility dates can be provided.

Healthcare Horizons' Final Comment: Based on the updated Medicare primary effective date provided by Optima, we are in agreement that all claims (including out-of-sample) were processed correctly as primary. All applicable charts have been updated to reflect no dollar error for this issue.

Several facility claims were identified for incorrect payment of secondary surgical procedures. The Optima contract for certain facilities only allows a payment for the primary surgical procedure with all other lines paid at zero. Healthcare Horizons submitted seven facility claims with multiple surgical procedures allowed and Optima agreed to overpayments on all claims totaling $15,645. Based on a review of the entire data set for the facilities tested, a single out-of-sample claim was identified with a recovery potential of $810. While the number of claims has been minimal, this particular error has been identified in prior Optima audits. We request that Optima address any root cause correction opportunities in its response to this report.

Optima Response: Incorrect payment of secondary surgical procedures

Seven claims were identified in the audit sample with an incorrect payment of the second surgical procedures. Optima Health Plan has contracts with certain facilities that reimburse the procedure with the highest reimbursement amount. The employee who adjudicated these claims incorrectly is no longer with Optima. We have also submitted this manual process to our Business and Systems Integration team for further evaluation of an automated process.

Healthcare Horizons' Final Comment: Optima also agreed to the single out-of-sample claim with a recovery amount of $810.

Healthcare Horizons identified a small number of missed multiple procedure reductions caused by fragmented billing by professional providers. 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. A total of three errors were identified for this issue resulting in an overpayment of $1,185. Upon review of the entire dataset, no other likely errors were identified beyond the sample selection.

Optima Response: Missed multiple procedure reductions

Three claims were identified in the audit that resulted from the provider billing practice to split the claim for payment. This continues to be a manual process and we are currently evaluating an upgrade to our claims editing software that will identify claims fitting this scenario.

A small 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. Many provider contracts 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 five claims paid in error for this issue for a total of $1,008. All potential errors were submitted in the sample selection.

Optima Response: Incorrect payment of pre-admission testing

Five claims were identified in the audit that processed and paid separately from the subsequent inpatient reimbursement. We will continue to educate our claims processors on identifying and applying the pre-admission testing to the inpatient reimbursement.

Healthcare Horizons identified incorrect payments for post-operative physician visits. For many surgical procedures the fee for the surgery is inclusive of any follow-up visits that occur within 90 days of the surgery. Optima agreed to four overpayments for this issue totaling $238 on the sample claims selection. Based on these findings, Healthcare Horizons has submitted seventeen additional out-of-sample claims with a recovery potential of $1,490. Optima should speak to any processes in place to deny inappropriate billing of follow-up visits after surgery.

Optima Response: Incorrect payments of post-operative physician visits

Four claims were identified in the audit that resulted from payment of post-operative physician visits. Optima Health Plan has contacted our claims editing software vendor to evaluate the incorrect payments. Our editing rules require a direct match of all positions in the diagnosis code before and after the decimal period in order to trigger the denial. In addition, our editing software requires the diagnosis billed to be pointed to the procedure billed. Optima disagrees with fourteen of the additional out-of-sample selection as the criteria did not meet the rule criteria for denial. The remaining samples are currently under review by the software vendor.

Healthcare Horizons' Final Comment: Based on the out-of-sample review, Optima has agreed to $185 in additional recovery for this issue.

All additional agreed findings on sample claims were manual in nature with no underlying systemic root cause findings or out-of-sample review required. Additional details regarding these agreed items can be found in Appendix A:

Audit Item	Issue	Overpayment
63	Duplicate Payment	$169.38
112	Eligibility	$101.25
153	Missed copayment	$40.00

Informational Findings

While not considered an audit finding, an original pricing error resulted in the recovery of $69,673 for Audit Item 3. Based on our pricing analysis, Healthcare Horizons submitted Audit Item 3 to confirm pricing at the correct percent-of-charges reimbursement since the allowable was not consistent with other claims for the same provider in the data set. While Optima agreed with our assertion that the claim was originally priced incorrectly, they indicated the claim was already identified for adjustment outside of the Healthcare Horizons audit. As the claim was corrected five months after initial processing, we request that Optima detail root cause of the original error as well as the procedures in place for identification of this type of overpayment.

> **Healthcare Horizons' Final Comment**: Optima did not address this claim in the response to the audit. The City should request a more detailed response regarding the root cause of the overpayment as well as the processes in place to identify this type of error retrospectively.

Optima is waiving the emergency room copayment for claims billed with IV therapy. Healthcare Horizons submitted a number of POS emergency room claims with no $100 copayment applied and in each case Optima indicated that the 100% IV therapy benefit prevailed. Based on our experience, it is normal in the industry to apply an emergency room copayment even if IV therapy services are billed as well on the claim. Optima and the City should engage in discussions to clarify plan intent for this issue. Note that the overall financial impact is relatively immaterial as Healthcare Horizons only estimates a total of $1,300 in missed copayments for this issue for the audit period.

> ***Optima Response: Claims for IV therapy in ER***
> *There were several claims that were submitted as part of the audit for Emergency Room services where IV therapy services prevailed. These claims did not pull a $100 copayment because of a policy specific to IV therapy and Virginia Beach City and Schools that allowed the IV therapy benefit to be paid at 100%. With the change to coinsurance plans in 2015, this policy is no longer in place and the IV therapy in the Emergency Room is covered at the applicable ER benefit level.*

> **Healthcare Horizons' Final Comment**: The 2015 change is consistent with the industry to cover IV therapy performed in the emergency room at the emergency room benefit level.

Conclusion

Healthcare Horizons appreciates the opportunity to perform this claims audit on behalf of The City of Virginia Beach. The overall results represent exceptional 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 action 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 City prior to any collections activity. We request that a monthly collections report be delivered to Healthcare Horizons until collections are complete.

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Appendix A – Sample Detail

Audit Item	Issue	Recovery	Comment	City/Schools
1	Pricing - Par	$0.00	Priced correctly at percent of charges	City
2	Pricing - Par	$0.00	Priced correctly at percent of charges	Schools
3	Pricing - Par	$0.00	Adjusted to recover $69,672.90 on 5/28/15 - Optima states recovery not due to audit	City
4	Pricing - Par	$0.00	Priced correctly at percent of charges	City
5	Pricing - Par	$0.00	Priced correctly at stop loss rate	Schools
6	Pricing - Par	$0.00	Priced correctly at fee schedule rate	Schools
7	Pricing - Par	$561.88	Lesser of should have applied	Schools
8	Pricing - Par	$0.00	Priced correctly	City
9	Pricing - Par	$0.00	Priced correctly	Schools
10	Pricing - PHCS	$0.00	PHCS percent of charges pricing correct	Schools
11	Pricing - PHCS	$0.00	PHCS percent of charges pricing correct	City
12	Pricing - PHCS	$0.00	PHCS percent of charges pricing correct	City
13	Pricing - Transfers	$6,117.72	Transfer pricing not applied in error	City
14	Pricing - Transfers	$0.00	Priced correctly	City
15	Pricing - Transfers	$0.00	Priced correctly	City
16	Pricing - Transfers	$0.00	Priced correctly	City
17	Other Insurance	$0.00	Other insurance termed 11/30/13	Schools
18	Other Insurance	$0.00	Coordinated correctly - primary allowance to deductible	City
19	Other Insurance	$0.00	Opitma is primary over other plan	City
20	Other Insurance	$0.00	Coordinated correctly - primary denied as non-covered	Schools
21	Other Insurance	$0.00	Other insurance termed 3/21/14	City
22	Other Insurance	$0.00	Coordinated correctly - primary denied as non-covered	Schools
23	Other Insurance	$0.00	Coordinated correctly - primary denied as non-covered	City
24	Other Insurance	$0.00	Coordinated correctly - primary denied as non-covered	City
25	Other Insurance	$0.00	Optima states claim adjusted prior to pay as secondary	City
26	Other Insurance	$0.00	Coordinated correctly - primary allowance to deductible	Schools
27	Other Insurance	$0.00	Member has Medicare Part A only	Schools
28	Other Insurance	$0.00	Other insurance termed 12/31/13	Schools
29	Other Insurance	$0.00	Other insurance primary as of 4/17/15	City
30	Other Insurance	$7,768.64	Claim incorrectly processed as primary and not identified for recovery	Schools
31	Other Insurance	$0.00	Coordinated correctly - primary allowance to deductible	Schools
32	Secondary Payments	$0.00	Payment limited to patient portion on primary EOB	City
33	Secondary Payments	$0.00	Payment limited to patient portion on primary EOB	Schools
34	Secondary Payments	$0.00	Payment limited to patient portion on primary EOB	Schools
35	Secondary Payments	$0.00	Payment limited to patient portion on primary EOB	Schools
36	Secondary Payments	$0.00	Payment limited to patient portion on primary EOB	City
37	Secondary Payments	$0.00	Payment limited to patient portion on primary EOB	City
38	Secondary Payments	$0.00	Payment limited to patient portion on primary EOB	Schools
39	Secondary Payments	$0.00	Payment limited to patient portion on primary EOB	Schools
40	Secondary Payments	$0.00	Payment limited to patient portion on primary EOB	City
41	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
42	ESRD	$0.00	Medicare primary 8/1/16	Schools
43	ESRD	$0.00	Medicare primary 7/1/15	Schools
44	ESRD	$0.00	Medicare coverage termed prior	City
45	ESRD	$0.00	Medicare primary 8/1/16	City
46	ESRD	$0.00	Medicare primary 9/1/15	Schools
47	Duplicates	$0.00	Two separate ambulance transports	Schools
48	Duplicates	$0.00	Two separate ambulance transports	Schools
49	Duplicates	$0.00	Member seen twice in the ER	City
50	Duplicates	$0.00	Member seen twice in the ER	City
51	Duplicates	$0.00	Two separate ambulance transports	Schools
52	Duplicates	$0.00	Two separate ambulance transports	Schools
53	Duplicates	$0.00	Charges paid based on appeal	City
54	Duplicates	$0.00	Charges paid based on appeal	City
55	Duplicates	$0.00	Member seen twice in the ER	City
56	Duplicates	$0.00	Member seen twice in the ER	City
57	Duplicates	$0.00	Correct claim for 57/58 combo	Schools
58	Duplicates	$0.00	Optima states claim was denied correctly	Schools
59	Duplicates	$0.00	Dual coverage - primary/secondary payments	City

Audit Item	Issue	Recovery	Comment	City/Schools
60	Duplicates	$0.00	Dual coverage - primary/secondary payments	City
61	Duplicates	$0.00	Member seen twice in the ER	Schools
62	Duplicates	$0.00	Member seen twice in the ER	Schools
63	Duplicates	$169.38	Agreed duplicate error	City
64	Duplicates	$0.00	Correct claim for 63/64 combo	City
65	Multiple Procedure Reductions - Facility	$3,588.00	Agreed pricing error (only top procedure should be paid)	City
66	Multiple Procedure Reductions - Facility	$2,272.00	Agreed pricing error (only top procedure should be paid)	City
67	Multiple Procedure Reductions - Facility	$2,522.00	Agreed pricing error (only top procedure should be paid)	Schools
68	Multiple Procedure Reductions - Facility	$2,522.00	Agreed pricing error (only top procedure should be paid)	City
69	Multiple Procedure Reductions - Facility	$2,481.00	Agreed pricing error (only top procedure should be paid)	City
70	Multiple Procedure Reductions - Facility	$1,255.00	Agreed pricing error (only top procedure should be paid)	Schools
71	Multiple Procedure Reductions - Facility	$1,005.00	Agreed pricing error (only top procedure should be paid)	Schools
72	Multiple Procedure Reductions - Professional	$548.50	Agreed error - missed 50% reduction	City
73	Multiple Procedure Reductions - Professional	$189.07	Agreed error - missed 50% reduction	City
74	Multiple Procedure Reductions - Professional	$447.59	Agreed error - missed 50% reduction	Schools
75	Multiple Procedure Reductions - Professional	$0.00	Reduced correctly	City
76	Multiple Procedure Reductions - Professional	$0.00	Reduced correctly due to modifier 79	City
77	Multiple Procedure Reductions - Professional	$0.00	Reduced correctly	City
78	Multiple Procedure Reductions - Professional	$0.00	Reduced correctly	City
79	Multiple Procedure Reductions - Professional	$0.00	Reduced correctly	City
80	Multiple Procedure Reductions - Professional	$0.00	Reduced correctly	Schools
81	Multiple Procedure Reductions - Professional	$0.00	Reduced correctly	City
82	Multiple Procedure Reductions - Professional	$0.00	Reduced correctly	Schools
83	Multiple Procedure Reductions - Professional	$0.00	Reduced correctly	Schools
84	Multiple Procedure Reductions - Radiology	$0.00	Primary procedure - informational only	Schools
85	Multiple Procedure Reductions - Radiology	$0.00	No radiology reductions per contract for facility	Schools
86	Multiple Procedure Reductions - Radiology	$0.00	Primary procedure - informational only	Schools
87	Multiple Procedure Reductions - Radiology	$0.00	No radiology reductions per contract for facility	Schools
88	Pre-Admission Testing	$0.00	CT not considered as PAT by Optima	Schools
89	Pre-Admission Testing	$0.00	Inpatient claim - informational only	Schools
90	Pre-Admission Testing	$0.00	CT not considered as PAT by Optima	City
91	Pre-Admission Testing	$0.00	Inpatient claim - informational only	City
92	Pre-Admission Testing	$193.66	Agreed error to allow PAT (CXR,ECG)	City
93	Pre-Admission Testing	$0.00	Inpatient claim - informational only	City
94	Pre-Admission Testing	$193.66	Agreed error to allow PAT (CXR,ECG)	Schools
95	Pre-Admission Testing	$0.00	Inpatient claim - informational only	Schools
96	Pre-Admission Testing	$193.66	Agreed error to allow PAT (CXR,ECG)	Schools
97	Pre-Admission Testing	$0.00	Inpatient claim - informational only	Schools
98	Pre-Admission Testing	$193.66	Agreed error to allow PAT (CXR,ECG)	City
99	Pre-Admission Testing	$0.00	Inpatient claim - informational only	City
100	Pre-Admission Testing	$233.66	Agreed error to allow PAT (CXR,ECG)	City
101	Pre-Admission Testing	$0.00	Inpatient claim - informational only	City
102	Pre/Post Operative Period	$0.00	E/M allowed the day prior for minor procedure per Optima	City
103	Pre/Post Operative Period	$0.00	Surgical claim - informational only	City
104	Pre/Post Operative Period	$84.11	Agreed error - E/M should not be allowed	Schools
105	Pre/Post Operative Period	$0.00	Surgical claim - informational only	Schools
106	Pre/Post Operative Period	$0.00	Surgical claim - informational only	Schools
107	Pre/Post Operative Period	$26.38	Agreed error - E/M should not be allowed	Schools
108	Pre/Post Operative Period	$0.00	Surgical claim - informational only	City
109	Pre/Post Operative Period	$87.50	Agreed error - E/M should not be allowed	City
110	Pre/Post Operative Period	$0.00	Surgical claim - informational only	Schools
111	Pre/Post Operative Period	$40.14	Agreed error - E/M should not be allowed	Schools
112	Eligibility - After Termination	$101.25	Optima agrees claim needs recovery	City
113	Eligibility - Not on File	$0.00	Member is eligible on DOS	City
114	Eligibility - Not on File	$0.00	Member is eligible on DOS	Schools
115	Eligibility - Not on File	$0.00	Member is eligible on DOS	Schools
116	Eligibility - Not on File	$0.00	Member is eligible on DOS	City
117	Eligibility - Not on File	$0.00	Member is eligible on DOS	Schools
118	Eligibility - Not on File	$0.00	Member is eligible on DOS	Schools
119	DRG Readmissions	$0.00	Readmission policy is 72 hours	City
120	DRG Readmissions	$0.00	Readmission policy is 72 hours	City
121	DRG Readmissions	$0.00	Readmission policy is 72 hours	City
122	DRG Readmissions	$0.00	Readmission policy is 72 hours	City
123	DRG Readmissions	$0.00	Readmission policy is 72 hours	Schools
124	DRG Readmissions	$0.00	Readmission policy is 72 hours	Schools
125	DRG Readmissions	$0.00	Readmission allowed due to different diagnosis	Schools
126	DRG Readmissions	$0.00	Readmission allowed due to different diagnosis	Schools

Audit Item	Issue	Recovery	Comment	City/Schools
127	Benefit Exclusions - Dental	$0.00	Accidental coverage applies	City
128	Benefit Exclusions - Dental	$0.00	Accidental coverage applies	City
129	Copayments - Diagnostic	$0.00	Preventive benefit - no copay applicable	Schools
130	Copayments - Diagnostic	$0.00	Preventive benefit - no copay applicable	City
131	Copayments - Diagnostic	$0.00	Preventive benefit - no copay applicable	Schools
132	Copayments - Emergency Room	$0.00	Processed at 100% IV therapy benefit - informational finding	City
133	Copayments - Emergency Room	$0.00	Processed at 100% IV therapy benefit - informational finding	Schools
134	Copayments - Emergency Room	$0.00	Processed at 100% IV therapy benefit - informational finding	Schools
135	Copayments - Emergency Room	$0.00	Processed at 100% IV therapy benefit - informational finding	Schools
136	Copayments - Emergency Room	$0.00	Processed at 100% IV therapy benefit - informational finding	Schools
137	Copayments - Emergency Room	$0.00	False labor - no copay applicable	City
138	Copayments - Emergency Room	$0.00	Processed at 100% IV therapy benefit - informational finding	Schools
139	Copayments - Emergency Room	$0.00	Processed at 100% IV therapy benefit - informational finding	Schools
140	Copayments - Emergency Room	$0.00	Processed at 100% IV therapy benefit - informational finding	City
141	Copayments - Emergency Room	$0.00	Processed at 100% IV therapy benefit - informational finding	Schools
142	Copayments - Hearing	$0.00	Copay applied on another claim	Schools
143	Copayments - Hearing	$0.00	Copay applied on another claim	Schools
144	Copayments - Inpatient MH	$0.00	Member met OOP maximum	Schools
145	Copayments - Inpatient MH	$0.00	Member met OOP maximum	Schools
146	Copayments - Office Visit	$0.00	Copay applied on another claim	City
147	Copayments - Office Visit	$0.00	Office visit E/M denied	Schools
148	Copayments - Office Visit	$0.00	Copay applied on another claim	Schools
149	Copayments - Office Visit	$0.00	Copay applied on another claim	City
150	Copayments - Office Visit	$0.00	Copay applied on another claim	City
151	Copayments - Office Visit	$0.00	Copay applied on another claim	City
152	Copayments - Outpatient MH	$0.00	Member met OOP maximum	Schools
153	Copayments - Outpatient MH	$40.00	Agreed error	City
154	Copayments - Outpatient MH	$0.00	Member met OOP maximum	Schools
155	Copayments - Outpatient MH	$0.00	Copay applied on another claim	City
156	Copayments - Outpatient Surgery	$0.00	Preventive benefit - no copay applicable	Schools
157	Copayments - Outpatient Surgery	$0.00	Preventive benefit - no copay applicable	Schools
158	Copayments - Outpatient Surgery	$0.00	Preventive benefit - no copay applicable	City
159	Copayments - Outpatient Surgery	$0.00	Member met OOP maximum	City
160	Copayments - Outpatient Surgery	$0.00	Preventive benefit - no copay applicable	Schools
		$32,835.46		

Appendix B – Out-of-Sample Claims

Audit Item	Issue	Recovery	Comment	City / Schools
161	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
162	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
163	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
164	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
165	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
166	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
167	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
168	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
169	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
170	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
171	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
172	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
173	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
174	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
175	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
176	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
177	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
178	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
179	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
180	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
181	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
182	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
183	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
184	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
185	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
186	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
187	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
188	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
189	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
190	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
191	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
192	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
193	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
194	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
195	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
196	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
197	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
198	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
199	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
200	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
201	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
202	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
203	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
204	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
205	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
206	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
207	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
208	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
209	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
210	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
211	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools

Audit Item	Issue	Estimated Recovery		City / Schools
212	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
213	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
214	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
215	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
216	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
217	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
218	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
219	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
220	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
221	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
222	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
223	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
224	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
225	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
226	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
227	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
228	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
229	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
230	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
231	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
232	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
233	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
234	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
235	ESRD	$0.00	Optima revised Medicare primary date to 6/10/15	Schools
236	Multiple Procedure Reductions - Facility	$810.00	Agreed error	City
237	Pre/Post Operative Period	$54.72	Agreed error	Schools
238	Pre/Post Operative Period	$0.00	Optima requires exact match on diagnosis code	Schools
239	Pre/Post Operative Period	$65.00	Agreed error	City
240	Pre/Post Operative Period	$0.00	Optima requires exact match on diagnosis code	Schools
241	Pre/Post Operative Period	$65.00	Agreed error	Schools
242	Pre/Post Operative Period	$0.00	Optima requires exact match on diagnosis code	City
243	Pre/Post Operative Period	$0.00	Optima requires exact match on diagnosis code	Schools
244	Pre/Post Operative Period	$0.00	Optima requires exact match on diagnosis code	Schools
245	Pre/Post Operative Period	$0.00	Optima requires exact match on diagnosis code	Schools
246	Pre/Post Operative Period	$0.00	Optima requires exact match on diagnosis code	City
247	Pre/Post Operative Period	$0.00	Optima requires exact match on diagnosis code	Schools
248	Pre/Post Operative Period	$0.00	Optima requires exact match on diagnosis code	Schools
249	Pre/Post Operative Period	$0.00	Optima requires exact match on diagnosis code	Schools
250	Pre/Post Operative Period	$0.00	Optima requires exact match on diagnosis code	City
251	Pre/Post Operative Period	$0.00	Optima requires exact match on diagnosis code	City
252	Pre/Post Operative Period	$0.00	Optima requires exact match on diagnosis code	Schools
253	Pre/Post Operative Period	$0.00	Optima requires exact match on diagnosis code	Schools
		$994.72		

HEALTHCAREHORIZONS
CONSULTING GROUP, INC.

Appendix C – Optima Health Response

Dated November 19, 2015

Report attached in its entirety.

Optima Health
4417 Corporation Lane
Virginia Beach, Virginia 23462
Tel 757-687-6060
Fax 757-687-6031
www.optimahealth.com

November 19, 2015

Mr. Lyndon Remias
City Auditor
City of Virginia Beach
2401 Courthouse Drive
Virginia Beach, VA 23456

RE: **2014 Health Plan Audit**

Dear Lyndon,

Thank you for the opportunity to respond to the Draft Optima Health Claims Audit Report for The City of Virginia Beach and The School Board of the City of Virginia Beach dated October 8, 2015. For this audit period, over $78 million dollars in paid claims were audited. Optima Health's financial accuracy rate was once again over 99.9% for Virginia Beach City and Schools. This type of consistent result reconfirms our commitment to being good stewards of the City's health care dollars. As with prior audits, we welcome the feedback from this audit and continue to strive for excellence in all services provided to Virginia Beach City and Schools. Below please find our response to the Claims Audit Report.

1. ***Single Pricing Error***
   A single claim was identified in the audit sample (item 7) that should have been limited to billed charges per the provider contract. We will continue our internal audit practice to achieve the highest level of accuracy possible.

2. ***Single Transfer Rate***
   A single claim was identified in the audit sample (item 13) that involved a transfer from one acute care facility to another that was incorrectly priced at the full rate resulting in an overpayment of $6,118. This was a processor oversight. We are committed to achieving the highest level of accuracy possible through our internal audit process. We will continue to educate our claims processors to be diligent in identifying this scenario.

3. ***Secondary Payment***
   A single claim was identified in the audit sample (item 30) that was calculated as primary when Optima should have paid as secondary. Reviewing claims for retroactive change in coverage is a manual process and we are committed to achieving the highest level of accuracy possible through our internal audit process.

4. ***Retroactive notification of Medicare primary coverage due to ESRD resulted in the identification of recoverable claims***
   Optima disagrees that the claims are now recoverable. According to CMS.gov (https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/End-Stage-Renal-Disease-ESRD/ESRD.html) Medicare is the secondary payer to group health plans (GHP) for individuals entitled to Medicare based on ESRD for a

coordination period of 30 months. A member becomes eligible for Medicare ESRD on the fourth month after beginning dialysis and then is subject to coordination of benefits for 30 months. Members may become eligible for Medicare prior to becoming eligible for ESRD coverage; however they are considered under the Medicare Working aged guidelines. These guidelines state: If the individual is age 65 or older, is covered by a GHP through current employment or spouse's current employment AND the employer has 20 or more employees (or at least one employer is a multi-employer group that employs 20 or more individuals) GHP pays Primary, Medicare pays secondary. In the audit example and those selected for the out-of-sample audit, in most cases Medicare was active prior to the member beginning ESRD and the working aged guidelines apply. In the remaining cases, ESRD coordination of benefits was begun after the appropriate 30 month coordination period. A detailed list of eligibility dates can be provided.

5. ***Incorrect payment of secondary surgical procedures***
Seven claims were identified in the audit sample with an incorrect payment of the second surgical procedures. Optima Health Plan has contracts with certain facilities that reimburse the procedure with the highest reimbursement amount. The employee who adjudicated these claims incorrectly is no longer with Optima. We have also submitted this manual process to our Business and Systems Integration team for further evaluation of an automated process.

6. ***Missed multiple procedure reductions***
Three claims were identified in the audit that resulted from the provider billing practice to split the claim for payment. This continues to be a manual process and we are currently evaluating an upgrade to our claims editing software that will identify claims fitting this scenario.

7. ***Incorrect payment of pre-admission testing***
Five claims were identified in the audit that processed and paid separately from the subsequent inpatient reimbursement. We will continue to educate our claims processors on identifying and applying the pre-admission testing to the inpatient reimbursement.

8. ***Incorrect payments of post-operative physician visits***
Four claims were identified in the audit that resulted from payment of post-operative physician visits. Optima Health Plan has contacted our claims editing software vendor to evaluate the incorrect payments. Our editing rules require a direct match of all positions in the diagnosis code before and after the decimal period in order to trigger the denial. In addition, our editing software requires the diagnosis billed to be pointed to the procedure billed. Optima disagrees with fourteen of the additional out-of-sample selection as the criteria did not meet the rule criteria for denial. The remaining samples are currently under review by the software vendor.

9. ***Claims for IV therapy in ER***
There were several claims that were submitted as part of the audit for Emergency Room services where IV therapy services prevailed. These claims did not pull a $100 copayment because of a policy specific to IV therapy and Virginia Beach City and Schools that allowed the IV therapy benefit to be paid at 100%. With the change to coinsurance plans in 2015, this policy is no longer in place and the IV therapy in the Emergency Room is covered at the applicable ER benefit level.

Again, thank you for the opportunity to respond. We look forward to our continued partnership and providing a quality health plan for the Virginia Beach City and School employees and family members. If you have any questions or need anything further please let me know. I can be reached at 687-6060 or srfuqua@sentara.com.

Sincerely,

Stacy R. Fuqua

Stacy Fuqua
Sr. Client Executive