THE CITY OF VIRGINIA BEACH AND THE SCHOOL BOARD OF THE CITY OF VIRGINIA BEACH

OPTIMA
CLAIMS AUDIT REPORT

November 7, 2013

Healthcare Horizons
Consulting Group, Inc.

TABLE OF CONTENTS

Executive Summary 1

Process Overview 4

Areas of Testing 5

Site Visit Selection 11

Agreed Findings 12

Disputed Findings 17

Informational Findings 18

Conclusion 20

Site Visit Detail ..... Appendix A

Out-of-Sample Claims ..... Appendix B

Optima Response ..... Appendix C

EXECUTIVE SUMMARY

The City of Virginia Beach engaged Healthcare Horizons to perform an audit of claims processed by Optima for paid dates of April 2012 through March 2013. Healthcare Horizons received $90,577,781 in paid claims data from Optima and performed a full electronic review of claims processing. Of this total amount, $55,345,029 was paid for school membership and $35,232,752 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 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 conducted the week of August 12, 2013 to review feedback from Optima on the sample claims. In addition, Healthcare Horizons reviewed the top ten facility contracts (based on paid amounts) and tested all claims for accuracy in pricing as well as any other relevant terms. The contract audit resulted in three additional write-ups for a total of 203 site visit claims.

Healthcare Horizons identified an agreed recovery amount of $30,416 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 outpatient surgery pricing for one facility, Medicare primary coverage due to ESRD, inpatient transfer pricing, and duplicate claims. 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 medical edits, ER copayments, outpatient surgery copayments, ESRD, and inpatient transfer pricing. Optima reviewed the out-of-sample claims and the resulting recovery amount is $14,801 as shown in ***Appendix B***.

The only disputed finding for the audit involves the coverage of botox injections for migraine headaches. Per the plan document, this service is non-covered; however, discussions with The City indicate that group intent may be to cover these services. Healthcare Horizons also presents an informational finding discussing the payment of claims for retirees eligible for Medicare. Per the plan document, retirees are to be terminated from the plan once they are eligible for Medicare. Review of claims with coordination of benefits can expose members who have Medicare coverage that has not been properly reported, and Healthcare Horizons continues to encourage Optima and The City to look for ways to utilize information held at Optima to better facilitate application of this plan limit.

The results of the 2013 claims audit are consistent with previous projects conducted for The City with no new systemic errors identified. The only new finding is related to special pricing for inpatient transfers.

The findings by category are as follows:

Issue	Site Visit Agreed Recovery Amount	Site Visit Agreed Clam Count	Site Visit Disputed Amount	Site Visit Disputed Claim Count	Out-of-Sample Recovery Amount	Agreed Out-of-Sample Claim Count
Duplicates	$4,247.38	11	$0.00	0	$0.00	0
Medical Edits	$80.44	2	$0.00	0	$198.38	3
ESRD	$7,713.81	3	$0.00	0	$7,779.98	8
Multiple Procedure Reductions - Surgery	$1,105.03	7	$0.00	0	$0.00	0
Pre-Admission Testing	$760.96	4	$0.00	0	$0.00	0
Transfers	$6,156.80	1	$0.00	0	$5,923.11	2
ER Copay	$400.00	4	$0.00	0	$900.00	9
Office Visit Copay	$80.00	3	$0.00	0	$0.00	0
Outpatient Surgery Copay	$500.00	5	$0.00	0	$0.00	0
Non-Covered Botox	$0.00	0	$7,613.12	6	$0.00	0
Facility MPR	$9,372.00	3	$0.00	0	$0.00	0
Totals	**$30,416.42**	**43**	**$7,613.12**	**6**	**$14,801.47**	**22**

The following tables detail the findings between City and Schools:

City

Issue	Site Visit Agreed Recovery Amount	Site Visit Agreed Clam Count	Site Visit Disputed Amount	Site Visit Disputed Claim Count	Out-of-Sample Recovery Amount	Agreed Out-of-Sample Claim Count
Duplicates	$302.80	3	$0.00	0	$0.00	0
Medical Edits	$0.00	0	$0.00	0	$134.20	2
ESRD	$6,035.39	1	$0.00	0	$6,417.15	7
Multiple Procedure Reductions - Surgery	$473.17	2	$0.00	0	$0.00	0
Pre-Admission Testing	$360.48	2	$0.00	0	$0.00	0
Transfers	$0.00	0	$0.00	0	$3,839.68	1
ER Copay	$200.00	2	$0.00	0	$600.00	6
Office Visit Copay	$60.00	2	$0.00	0	$0.00	0
Outpatient Surgery Copay	$400.00	4	$0.00	0	$0.00	0
Non-Covered Botox	$0.00	0	$4,783.25	4	$0.00	0
Facility MPR	$6,979.00	2	$0.00	0	$0.00	0
Totals	**$14,810.84**	**18**	**$4,783.25**	**4**	**$10,991.03**	**16**

Schools

Issue	Site Visit Agreed Recovery Amount	Site Visit Agreed Clam Count	Site Visit Disputed Amount	Site Visit Disputed Claim Count	Out-of-Sample Recovery Amount	Agreed Out-of-Sample Claim Count
Duplicates	$3,944.58	8	$0.00	0	$0.00	0
Medical Edits	$80.44	2	$0.00	0	$64.18	1
ESRD	$1,678.42	2	$0.00	0	$1,362.83	1
Multiple Procedure Reductions - Surgery	$631.86	5	$0.00	0	$0.00	0
Pre-Admission Testing	$400.48	2	$0.00	0	$0.00	0
Transfers	$6,156.80	1	$0.00	0	$2,083.43	1
ER Copay	$200.00	2	$0.00	0	$300.00	3
Office Visit Copay	$20.00	1	$0.00	0	$0.00	0
Outpatient Surgery Copay	$100.00	1	$0.00	0	$0.00	0
Non-Covered Botox	$0.00	0	$2,829.87	2	$0.00	0
Facility MPR	$2,393.00	1	$0.00	0	$0.00	0
Totals	**$15,605.58**	**25**	**$2,829.87**	**2**	**$3,810.44**	**6**

PROCESS OVERVIEW

Healthcare Horizons systematically reviews 100% of claim 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.

SITE VISIT SELECTION

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

Issue	Audit Items	Agreed Recovery		Disputed	
		Items	Amount	Items	Amount
Duplicates	39	11	$4,247.38	0	$0.00
Assistant Surgeon MPR	4	0	$0.00	0	$0.00
Assistant Surgeon Not Allowed	3	0	$0.00	0	$0.00
Medical Edits	10	2	$80.44	0	$0.00
Home Health During Inpatient	6	0	$0.00	0	$0.00
High Units	1	0	$0.00	0	$0.00
ESRD	10	3	$7,713.81	0	$0.00
Eligibility - Not on File	3	0	$0.00	0	$0.00
Multiple Procedure Reductions - Radiology	7	0	$0.00	0	$0.00
Multiple Procedure Reductions - Surgery	15	7	$1,105.03	0	$0.00
Other Insurance	10	0	$0.00	0	$0.00
Higher Secondary	10	0	$0.00	0	$0.00
High Secondary	4	0	$0.00	0	$0.00
Retiree with Medicare	15	0	$0.00	0	$0.00
ER with Admission	1	0	$0.00	0	$0.00
Outpatient with Admission	2	0	$0.00	0	$0.00
Pre-Admission Testing	4	4	$760.96	0	$0.00
Transfers	4	1	$6,156.80	0	$0.00
ER Copay	9	4	$400.00	0	$0.00
Office Visit Copay	16	3	$80.00	0	$0.00
Outpatient Surgery Copay	7	5	$500.00	0	$0.00
Outpatient Mental Health Copay	3	0	$0.00	0	$0.00
Non-Covered Virtual Colonoscopy	4	0	$0.00	0	$0.00
Non-Covered Botox	7	0	$0.00	6	$7,613.12
Facility MPR	3	3	$9,372.00	0	$0.00
Pricing	3	0	$0.00	0	$0.00
Contracts	3	0	$0.00	0	$0.00
Totals	**203**	**43**	**$30,416.42**	**6**	**$7,613.12**

AGREED FINDINGS

Optima paid multiple outpatient surgery case rates incorrectly for one particular facility tested by Healthcare Horizons. This is the same error for the same facility detected on previous audits. The Optima contract for this facility only allows a payment for the primary surgical procedure with all other lines paid at zero. Healthcare Horizons identified three claims paid in error for this provider due to the payment of secondary procedures. This issue represents the highest sample finding totaling $9,372. Optima indicated that these overpayments are routinely identified via a retroactive process. In its response to this report, Optima should provide any available details on why these claims were not previously identified for correction.

> ***Optima Response:*** *There were three claims in the audit sample where the secondary procedure was paid in error. Any overpayments in this area are routinely identified from a retrospective review process. We will continue to conduct internal audits on claims in this area to ensure claims are processed according to policy. We have also reeducated our claims processors on appropriate claims adjudication of outpatient surgery case rates.*

Three sample claims were adjusted by Optima after sample delivery to pay as secondary to Medicare based on ESRD entitlement. The claims for Audit Items 65, 67, and 72 were originally paid as primary; however, adjustments were made in July 2013 to process as secondary to Medicare resulting in a total recovery of $7,714. As the recoveries were performed after the sample delivery, Healthcare Horizons is citing the claims as audit findings. We request that Optima research these claims to determine if recoveries were automatically initiated based on a review of claims history after a retroactive notification of other primary insurance information. It is important for this type of process to be in place for The City. Based on the site visit findings, Healthcare Horizons has provided out-of-sample claims paid as primary for the three sample members with a recovery potential of $18,383.

> ***Optima Response:*** *There were three claims identified in the audit sample where the City paid as primary, however, adjustments were made to these claims in July 2013 to process the City as secondary to Medicare. As part of our normal business process we initiate recoveries once we are notified a member is eligible for Medicare. This is a*

standard business practice. Recoveries were not initiated because of the audit claims review.

Healthcare Horizons' Final Comment: Based on the feedback provided by Optima, Healthcare Horizons is citing an audit finding of $7,780 on eight of the out-of-sample claims as the recovery dates were after the sample delivery date. The remaining claims were recovered prior to the sample delivery date and are therefore not included as audit findings.

A single pricing error for an inpatient transfer claim was identified in the sample selection resulting in an overpayment of $6,157. For facility contracts that normally reimburse inpatient claims via a DRG case rate payment, it is common to include a special pricing provision for transfer claims (often a per diem or percent of charges). The rates are established to recognize that the facility is not entitled to payment for the entire case since it was necessary to transfer the patient to another acute care facility for treatment. Healthcare Horizons submitted two claims with transfer discharge status codes with Audit Item 147 paid in error at the full DRG rate. The correct claim was incorrectly coded with a transfer discharge status. Based on this finding, Healthcare Horizons has submitted ten additional out-of-sample transfer claims for review by Optima. Once these are reviewed by Optima, Healthcare Horizons will update any additional recovery amounts if applicable.

Optima Response: *One claim was identified in the claims sample for an overpayment of an inpatient transfer claim. Optima has a policy in place for our claim processors to review inpatient claims to ensure we are not paying both facilities when the member was transferred. We have reviewed this claim and the others identified in the out-of-sample claims. We have reeducated our claims processors to identify inpatient transfer claims and pay according to policy.*

Healthcare Horizons' Final Comment: Two out-of-sample claims were agreed as errors totaling $5,923. All charts have been updated to reflect this total.

The limited amount of errors identified in the sample indicates that Optima continues to have effective procedures in place to prevent duplicate payments. Healthcare Horizons identified $4,247 in duplicate payments in the sample, which is insignificant given the

volume of claims processed by Optima. All material potential overpayments were presented in the sample; therefore, no additional follow-up is required in this area.

A limited number of missed copayments were identified for emergency room, outpatient surgery, and office visit claims. A total of twelve sample claims were agreed to have missed applicable copayments for a total overpayment amount of $2,587. Some of these claims were found to have missed deductible requirements as well. Many of the false positives in the sample selection were due to secondary payments and ER services related to false labor (covered under maternity benefit – no copayment due). The overall volume of potential error in the dataset is minimal, and we are only recommending review of thirteen out-of-sample claims missing a copayment (ER and outpatient surgery) for a potential of $1,300. Our impression is that these overpayments are a result of manual error versus any systemic issue. As any recovery will create adverse member impact, The City will need to determine whether to request recovery on these claims.

> ***Optima Response:*** *A total of twelve claims were identified with missed copayments. As noted in the audit report, the missed copays were a result of manual errors versus any systemic issue. Please note, Optima health agreed to the 4 claims identified by Healthcare Horizons under "ER copay," however these claims are actually Outpatient claims. When these claims are reversed they will pull an outpatient copay due to the observation code billed on these particular claims. We will wait for direction from the City if we should recover these claims as the member would now be responsible for the applicable copay. We have reviewed the out-of-sample claims and have reeducated our claims processors to identify opportunities for copayments when the claim requires manual intervention.*
>
> **Healthcare Horizons' Final Comment:** Optima has presented new information regarding the errors on the emergency room copayments by stating that the outpatient copayment should apply given the observation coding. Healthcare Horizons agrees with this assessment and has updated all charts as such. Given the outpatient benefit, missed coinsurance is not applicable. The out-of-sample reports yielded $900 in overpayments.

A small volume 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 preadmission testing services (such as lab, X-ray, or EKG) are not to be paid separately from the subsequent inpatient reimbursement. Healthcare Horizons identified four claims paid in error for this issue for a total of $761. Optima should confirm whether it has a process in place to capture these claims retrospectively as the pre-admission testing claims are often submitted and paid prior to receipt of the inpatient claim. All potential errors were submitted in the site visit sample selection.

> ***Optima Response:*** *There were four claims identified as being paid in error as the provider contract prohibits separate payment of this testing prior to a planned inpatient admission. Optima has a process in place to prevent a separate payment for pre-admission testing. As the Inpatient claim is being processed for payment, the claims processor is trained to look for possible pre-admission services paid prior to the Inpatient claim being received. If there is a paid pre-admission claim, it would be reversed and denied. The claims processors have been reeducated.*

Optima failed to combine multiple claim submissions for the purpose of applying multiple procedure reductions on a limited number of cases for the audit period. 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 seven errors were identified for this issue resulting in an overpayment of $1,105 with six cases involving multiple claim submissions. Upon review of the entire dataset, no other likely errors were identified beyond the site visit selection. While the financial impact is fairly low, this error has been identified in previous audits as well. Optima should speak to any processes in place for combining claims for the purposes of applying multiple procedure reductions.

> ***Optima Response:*** *There were three claims in the sample identified for opportunity to combine multiple claims submissions for the purposes of applying multiple procedure reductions. Optima Health Plan has an internal audit process in place to identify*

multiple procedure claims reduction opportunities as a result of split billing from the provider. It is a manual process. We will continue our internal audit practice to achieve the highest level of accuracy as possible.

Optima has strong systemic edits in place to prevent payments for unbundled procedures, however, fragmented billing by providers may cause these edits to be bypassed. Healthcare Horizons tested the entire claims dataset against industry standard edits for unbundling and only identified five overpayments (including three out-of-sample claims). In each case, the provider submitted multiple bills for services performed on the same day, resulting in missed denials for unbundling. Similar to the multiple procedure reductions finding, the overall impact is minimal but Optima should describe procedures in place to account for fragmented billing.

DISPUTED FINDINGS

Healthcare Horizons disputes the coverage of botox injections for headaches and excessive sweating per the HMO plan document. The HMO plan document states the following:

> *Botox injections – are excluded from Coverage unless approved by the plan. Botox injections for the following are excluded from Coverage: headaches, cosmetic procedures, bone and joint conditions, writer's cramp.*

Optima responded in a similar fashion to last year by stating that the claims were approved as medically necessary. In discussions with The City, it appears that the plan intent moving forward is to cover these services. The summary plan document should be edited to reflect the final decision by The City. Healthcare Horizons estimates a total impact of $41,559 for botox payment in this audit period (including the sample claims).

We recommend that Optima notify the City of Virginia Beach, at the earliest possible time, of those instances where they will be paying medical claims that are specifically excluded by the City of Virginia Beach plan (i.e. botox). This will provide the City of Virginia Beach an opportunity to discuss these types of claims and determine whether they in fact wish to pay or continue to exclude this type of claim.

> ***Optima Response:*** *Optima uses the most updated evidence based medical criteria to make medically necessary determinations. We have a pre-authorization process in place today requiring physician notes in order for this service to be approved by the plan. Members who meet medical necessity based on strict criteria receive approval for Botox to treat conditions, such as, Chronic Migraine Headache Prophylaxis.*
>
> **Healthcare Horizons' Final Comment:** Optima has agreed to meet with the City to discuss the definition of medical necessity and to give the City an opportunity to make determinations regarding the impact to 2014 plan exclusions.

INFORMATIONAL FINDINGS

Healthcare Horizons believes that unnecessary payments are being made due to untimely termination of retirees entitled to Medicare. The benefits design states that members are covered on retiree segments until such time as they become eligible for Medicare. This rule applies except in cases where the member is in the 30-month coordination period due to ESRD prior to retirement. Healthcare Horizons sampled seven retiree members with Medicare primary coverage based on the secondary payment of the Medicare Part A deductible. The results are as follows:

Audit Items 123-125 – Group states that it is unable to reach member, therefore termination will occur on 8/31/2013. Healthcare Horizons has identified secondary payments (likely to Medicare) totaling $13,696 dating back to September 2011 service dates.

Audit Items 126-129 – Group states that the member was terminated on 6/30/2013. Healthcare Horizons has identified secondary payments (likely to Medicare) totaling $34,862 dating back to August 2011 service dates.

Audit Items 130-132 – Group states that the member was terminated on 11/30/2012. Healthcare Horizons has identified secondary payments (likely to Medicare) totaling $11,541 dating back to February 2011 service dates.

Audit Item 133 – Group states that the member was terminated on 4/30/2013. Healthcare Horizons has identified secondary payments (likely to Medicare) totaling $1,908 dating back to August 2011 service dates.

Audit Items 134-135 – Group states that the member was terminated on 6/30/2013. Healthcare Horizons has identified secondary payments (likely to Medicare) totaling $6,236 dating back to January 2012 service dates.

Audit Item 136 – Group states that the member will be terminated on 12/31/2013. Healthcare Horizons has identified secondary payments (likely to Medicare) totaling $12,578 dating back to January 2012 service dates.

Audit Item 137 – Group states that the member was terminated on 3/31/2013. Healthcare Horizons has identified secondary payments (likely to Medicare) totaling $2,446 dating back to January 2012 service dates.

As the dollar amounts reflected above are secondary payments, it is likely that the retirees had Medicare primary coverage prior to the ultimate termination date. Healthcare Horizons recommends that Optima notify the group immediately of any retiree members in which Medicare primary information is received so that the members may be reviewed for eligibility termination on a timely basis.

Healthcare Horizons audited the claims data against the top ten facility contracts and did not identify any pricing errors. Optima provided complete contracts for review which allowed us the opportunity to test all claims against fee schedules and other contractual terms. Three claims were submitted during the site visit but all proved to be processed correctly upon further review by Healthcare Horizons and Optima.

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 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 City prior to any collections activity. We request that a monthly collections report be delivered to Healthcare Horizons until a satisfactory percentage of collections have been achieved.
- Optima and The City should make a final determination on botox injections and correct the plan document as appropriate.

APPENDIX A
SITE VISIT DETAIL

CITY OF VIRGINIA BEACH
APPENDIX A
SITE VISIT DETAIL

Audit Item	Issue	Recovery	Disputed	Comment	City / Schools
1	Duplicates	$0.00	$0.00	Recovered $415.52 prior to sample delivery	Schools
2	Duplicates	$0.00	$0.00	Correct secondary payment for 1/2 combo	Schools
3	Duplicates	$0.00	$0.00	Correct primary payment for 3/4 combo	Schools
4	Duplicates	$40.00	$0.00	Duplicate paid in error as secondary	Schools
5	Duplicates	$95.66	$0.00	Duplicate paid in error as primary	City
6	Duplicates	$0.00	$0.00	Correct secondary payment for 5/6 combo	City
7	Duplicates	$75.00	$0.00	Duplicate paid in error as primary	City
8	Duplicates	$0.00	$0.00	Correct secondary payment for 7/8 combo	City
9	Duplicates	$0.00	$0.00	Correct payment for 9/10 combo	Schools
10	Duplicates	$0.00	$0.00	Optima states different referring physicians with multiple services	Schools
11	Duplicates	$0.00	$0.00	Two separate ambulance trips confirmed by Optima	City
12	Duplicates	$0.00	$0.00	Two separate ambulance trips confirmed by Optima	City
13	Duplicates	$0.00	$0.00	No duplicate - RT and LT parts	City
14	Duplicates	$0.00	$0.00	No duplicate - RT and LT parts	City
15	Duplicates	$0.00	$0.00	No duplicate - RT and LT parts	City
16	Duplicates	$0.00	$0.00	Correct payment for 16/17 combo	City
17	Duplicates	$132.14	$0.00	Error - duplicate	City
18	Duplicates	$1,989.62	$0.00	Duplicate paid in error as primary	Schools
19	Duplicates	$0.00	$0.00	Correct secondary payment for 18/19 combo	Schools
20	Duplicates	$53.39	$0.00	Error - duplicate	Schools
21	Duplicates	$0.00	$0.00	Correct payment for 20/21 combo	Schools
22	Duplicates	$0.00	$0.00	Correct payment for 22/23 combo	Schools
23	Duplicates	$0.00	$0.00	Recovered $2122.00 prior to sample delivery	Schools
24	Duplicates	$0.00	$0.00	Correct payment for 24/25 combo	Schools
25	Duplicates	$143.45	$0.00	Error - duplicate	Schools
26	Duplicates	$0.00	$0.00	Recovered $5221.91 prior to sample delivery	Schools
27	Duplicates	$0.00	$0.00	Correct payment for 26/27 combo	Schools
28	Duplicates	$0.00	$0.00	Correct payment for 28/29 combo	Schools
29	Duplicates	$198.40	$0.00	Error - duplicate	Schools
30	Duplicates	$0.00	$0.00	Correct payment for 30/31 combo	Schools
31	Duplicates	$217.36	$0.00	Error - duplicate	Schools
32	Duplicates	$0.00	$0.00	Correct payment for 32/33 combo	Schools
33	Duplicates	$217.36	$0.00	Error - duplicate	Schools
34	Duplicates	$0.00	$0.00	Correct payment for 34/35 combo	Schools
35	Duplicates	$1,085.00	$0.00	Error - duplicate	Schools
36	Duplicates	$0.00	$0.00	No duplicate - twins	City
37	Duplicates	$0.00	$0.00	No duplicate - twins	City
38	Duplicates	$0.00	$0.00	Both claims approved by medical review including total quantity	City
39	Duplicates	$0.00	$0.00	Both claims approved by medical review including total quantity	City
40	Assistant Surgeon MPR	$0.00	$0.00	Physician assistants not subject to reductions per Optima policy	Schools
41	Assistant Surgeon MPR	$0.00	$0.00	Physician assistants not subject to reductions per Optima policy	City
42	Assistant Surgeon MPR	$0.00	$0.00	Physician assistants not subject to reductions per Optima policy	Schools
43	Assistant Surgeon MPR	$0.00	$0.00	Physician assistants not subject to reductions per Optima policy	Schools
44	Assistant Surgeon Not Allowed	$0.00	$0.00	Physician assistants not subject to edits per Optima policy	City
45	Assistant Surgeon Not Allowed	$0.00	$0.00	Physician assistants not subject to edits per Optima policy	City
46	Assistant Surgeon Not Allowed	$0.00	$0.00	Physician assistants not subject to edits per Optima policy	City
47	Medical Edits	$0.00	$0.00	No edit per Optima policy	Schools
48	Medical Edits	$0.00	$0.00	Originally denied and paid after clinical review	City
49	Medical Edits	$0.00	$0.00	Primary procedure - informational only	Schools
50	Medical Edits	$55.44	$0.00	Error - unbundling (fragmented billing)	Schools
51	Medical Edits	$0.00	$0.00	Primary procedure - informational only	Schools
52	Medical Edits	$25.00	$0.00	Error - unbundling (fragmented billing)	Schools
53	Medical Edits	$0.00	$0.00	Allowed after clinical review	Schools
54	Medical Edits	$0.00	$0.00	Allowed after clinical review	City
55	Medical Edits	$0.00	$0.00	Primary procedure - informational only	Schools
56	Medical Edits	$0.00	$0.00	Originally denied and paid after clinical review	Schools
57	Home Health During Inpatient	$0.00	$0.00	Inpatient claim - informational only	Schools
58	Home Health During Inpatient	$0.00	$0.00	Injection order before admission	Schools
59	Home Health During Inpatient	$0.00	$0.00	Inpatient claim - informational only	Schools
60	Home Health During Inpatient	$0.00	$0.00	Patient was furloughed	Schools
61	Home Health During Inpatient	$0.00	$0.00	Inpatient claim - informational only	Schools
62	Home Health During Inpatient	$0.00	$0.00	Patient was furloughed	Schools
63	High Units	$0.00	$0.00	Originally denied and paid after clinical review	Schools
64	ESRD	$0.00	$0.00	Medicare primary 2/1/13	Schools
65	ESRD	$6,035.39	$0.00	Medicare primary 8/1/12 - adjusted on 7/16/13 (after sample delivery)	City
66	ESRD	$0.00	$0.00	Medicare Part A only	Schools
67	ESRD	$1,362.83	$0.00	Medicare primary 3/1/13 - adjusted on 7/24/13 (after sample delivery)	Schools
68	ESRD	$0.00	$0.00	Medicare secondary due to ESRD per group	Schools
69	ESRD	$0.00	$0.00	Medicare primary 4/1/12	Schools
70	ESRD	$0.00	$0.00	Medicare secondary due to ESRD per group	Schools
71	ESRD	$0.00	$0.00	Recovered $1117.23 prior to sample delivery	City
72	ESRD	$315.59	$0.00	Medicare primary 12/1/12 - adjusted on 7/18/13 (after sample delivery)	Schools
73	ESRD	$0.00	$0.00	Medicare secondary due to ESRD per group	Schools
74	Eligibility - Not on File	$0.00	$0.00	Member eligible	City
75	Eligibility - Not on File	$0.00	$0.00	Member eligible	City
76	Eligibility - Not on File	$0.00	$0.00	Member eligible	City
77	Multiple Procedure Reductions - Radiology	$0.00	$0.00	Primary procedure - informational only	City
78	Multiple Procedure Reductions - Radiology	$0.00	$0.00	Reductions not applicable to facility per Optima	City
79	Multiple Procedure Reductions - Radiology	$0.00	$0.00	Reductions not applicable to facility per Optima	City
80	Multiple Procedure Reductions - Radiology	$0.00	$0.00	Primary procedure - informational only	City

Audit Item	Issue	Recovery	Disputed	Comment	City / Schools
81	Multiple Procedure Reductions - Radiology	$0.00	$0.00	Reductions not applicable to facility per Optima	City
82	Multiple Procedure Reductions - Radiology	$0.00	$0.00	Primary procedure - informational only	City
83	Multiple Procedure Reductions - Radiology	$0.00	$0.00	Reductions not applicable to facility per Optima	City
84	Multiple Procedure Reductions - Surgery	$0.00	$0.00	Primary procedure - informational only	Schools
85	Multiple Procedure Reductions - Surgery	$224.36	$0.00	Error - missed reduction (fragmented billing)	Schools
86	Multiple Procedure Reductions - Surgery	$0.00	$0.00	Primary procedure - informational only	Schools
87	Multiple Procedure Reductions - Surgery	$73.95	$0.00	Error - missed reduction (fragmented billing)	Schools
88	Multiple Procedure Reductions - Surgery	$0.00	$0.00	Primary procedure - informational only	City
89	Multiple Procedure Reductions - Surgery	$79.90	$0.00	Error - missed reduction (fragmented billing)	City
90	Multiple Procedure Reductions - Surgery	$0.00	$0.00	Primary procedure - informational only	Schools
91	Multiple Procedure Reductions - Surgery	$80.43	$0.00	Error - missed reduction (fragmented billing)	Schools
92	Multiple Procedure Reductions - Surgery	$0.00	$0.00	Primary procedure - informational only	Schools
93	Multiple Procedure Reductions - Surgery	$137.63	$0.00	Error - missed reduction (fragmented billing)	Schools
94	Multiple Procedure Reductions - Surgery	$0.00	$0.00	Primary procedure - informational only	Schools
95	Multiple Procedure Reductions - Surgery	$0.00	$0.00	No reduction per Optima policy	Schools
96	Multiple Procedure Reductions - Surgery	$0.00	$0.00	Primary procedure - informational only	City
97	Multiple Procedure Reductions - Surgery	$393.27	$0.00	Error - missed reduction (fragmented billing)	City
98	Multiple Procedure Reductions - Surgery	$115.49	$0.00	Error - missed reduction	Schools
99	Other Insurance	$0.00	$0.00	Medicare coverage termed 9/30/12	City
100	Other Insurance	$0.00	$0.00	Medicare coverage termed 8/31/12	City
101	Other Insurance	$0.00	$0.00	Optima / Optima - coordinated correctly	Schools
102	Other Insurance	$0.00	$0.00	Optima / Optima - coordinated correctly	Schools
103	Other Insurance	$0.00	$0.00	Medicare primary 9/1/12 (retroactive notification)	City
104	Other Insurance	$0.00	$0.00	Medicare Part A only	City
105	Other Insurance	$0.00	$0.00	No other insurance	City
106	Other Insurance	$0.00	$0.00	No other insurance	Schools
107	Other Insurance	$0.00	$0.00	Medicare primary 1/1/12	Schools
108	Other Insurance	$0.00	$0.00	No other insurance	City
109	Higher Secondary	$0.00	$0.00	Paid correctly per COB policy (primary member responsibility amt)	Schools
110	Higher Secondary	$0.00	$0.00	Paid correctly per COB policy (primary member responsibility amt)	City
111	Higher Secondary	$0.00	$0.00	Paid correctly per COB policy (primary member responsibility amt)	City
112	Higher Secondary	$0.00	$0.00	Paid correctly per COB policy (primary member responsibility amt)	City
113	Higher Secondary	$0.00	$0.00	Paid correctly per COB policy (primary member responsibility amt)	City
114	Higher Secondary	$0.00	$0.00	Paid correctly per COB policy (primary member responsibility amt)	Schools
115	Higher Secondary	$0.00	$0.00	Paid correctly per COB policy (primary member responsibility amt)	City
116	Higher Secondary	$0.00	$0.00	Paid correctly per COB policy (primary member responsibility amt)	City
117	Higher Secondary	$0.00	$0.00	Paid correctly per COB policy (primary member responsibility amt)	Schools
118	Higher Secondary	$0.00	$0.00	Paid correctly per COB policy (primary member responsibility amt)	City
119	High Secondary	$0.00	$0.00	Paid correctly per COB policy (primary member responsibility amt)	City
120	High Secondary	$0.00	$0.00	Paid correctly per COB policy (primary member responsibility amt)	Schools
121	High Secondary	$0.00	$0.00	Paid correctly per COB policy (primary member responsibility amt)	Schools
122	High Secondary	$0.00	$0.00	Paid correctly per COB policy (primary member responsibility amt)	City
123	Retiree with Medicare	$0.00	$0.00	Group unable to reach retiree - will terminate 8/31/13	Schools
124	Retiree with Medicare	$0.00	$0.00	Group unable to reach retiree - will terminate 8/31/13 - Recovery prior to sample of $30,783.40 for Medicare primary	Schools
125	Retiree with Medicare	$0.00	$0.00	Group unable to reach retiree - will terminate 8/31/13	Schools
126	Retiree with Medicare	$0.00	$0.00	Group terminated 6/30/13	Schools
127	Retiree with Medicare	$0.00	$0.00	Group terminated 6/30/13	Schools
128	Retiree with Medicare	$0.00	$0.00	Group terminated 6/30/13	Schools
129	Retiree with Medicare	$0.00	$0.00	Group terminated 6/30/13	Schools
130	Retiree with Medicare	$0.00	$0.00	Group terminated 11/30/12	Schools
131	Retiree with Medicare	$0.00	$0.00	Group terminated 11/30/12	Schools
132	Retiree with Medicare	$0.00	$0.00	Group terminated 11/30/12	Schools
133	Retiree with Medicare	$0.00	$0.00	Group terminated 4/30/13	Schools
134	Retiree with Medicare	$0.00	$0.00	Group terminated 6/30/13	City
135	Retiree with Medicare	$0.00	$0.00	Group terminated 6/30/13	City
136	Retiree with Medicare	$0.00	$0.00	Group will terminate 12/31/13	Schools
137	Retiree with Medicare	$0.00	$0.00	Group terminated 3/31/13	City
138	ER with Admission	$0.00	$0.00	False labor charges allowed separately	Schools
139	Outpatient with Admission	$0.00	$0.00	IV therapy charges allowed separately	City
140	Outpatient with Admission	$0.00	$0.00	False labor charges allowed separately	City
141	Pre-Admission Testing	$180.24	$0.00	PAT allowed separately in error	Schools
142	Pre-Admission Testing	$180.24	$0.00	PAT allowed separately in error	City
143	Pre-Admission Testing	$220.24	$0.00	PAT allowed separately in error	Schools
144	Pre-Admission Testing	$180.24	$0.00	PAT allowed separately in error	City
145	Transfers	$0.00	$0.00	Newborn charges (incorrect revenue code billed)	Schools
146	Transfers	$0.00	$0.00	Mother charges	Schools
147	Transfers	$6,156.80	$0.00	Transfer rate not applied	Schools
148	Transfers	$0.00	$0.00	Transfer to hospital - informational	Schools
149	ER Copay	$100.00	$0.00	Error is actually missed $100 copayment for outpatient surgery (coinsurance does not apply)	Schools
150	ER Copay	$0.00	$0.00	False labor - no copay due (covered under global maternity benefit)	Schools
151	ER Copay	$100.00	$0.00	Error is actually missed $100 copayment for outpatient surgery (coinsurance does not apply)	City
152	ER Copay	$100.00	$0.00	Error is actually missed $100 copayment for outpatient surgery (coinsurance does not apply)	Schools
153	ER Copay	$0.00	$0.00	Secondary claim	Schools
154	ER Copay	$0.00	$0.00	False labor - no copay due (covered under global maternity benefit)	City
155	ER Copay	$0.00	$0.00	False labor - no copay due (covered under global maternity benefit)	Schools
156	ER Copay	$100.00	$0.00	Error is actually missed $100 copayment for outpatient surgery (coinsurance does not apply)	City
157	ER Copay	$0.00	$0.00	Member met OOP	City
158	Office Visit Copay	$0.00	$0.00	Secondary claim	Schools
159	Office Visit Copay	$0.00	$0.00	Secondary claim	Schools
160	Office Visit Copay	$0.00	$0.00	No copay due per adjustment	City

Audit Item	Issue	Recovery	Disputed	Comment	City / Schools
161	Office Visit Copay	$0.00	$0.00	Secondary claim	Schools
162	Office Visit Copay	$0.00	$0.00	Secondary claim	City
163	Office Visit Copay	$0.00	$0.00	Secondary claim	Schools
164	Office Visit Copay	$0.00	$0.00	Secondary claim	City
165	Office Visit Copay	$0.00	$0.00	Entire claim went to deductible - adjusted to pay $0.00 prior to sample delivery	Schools
166	Office Visit Copay	$0.00	$0.00	Secondary claim	Schools
167	Office Visit Copay	$0.00	$0.00	Secondary claim	City
168	Office Visit Copay	$0.00	$0.00	Secondary claim	Schools
169	Office Visit Copay	$20.00	$0.00	Error - copay missed	City
170	Office Visit Copay	$0.00	$0.00	Entire claim went to deductible - adjusted to pay $0.00 prior to sample delivery	City
171	Office Visit Copay	$0.00	$0.00	Secondary claim	Schools
172	Office Visit Copay	$40.00	$0.00	Error - copay missed	City
173	Office Visit Copay	$20.00	$0.00	Error - copay missed	Schools
174	Outpatient Surgery Copay	$100.00	$0.00	Error - copay missed	City
175	Outpatient Surgery Copay	$0.00	$0.00	OOP met	City
176	Outpatient Surgery Copay	$0.00	$0.00	No copay due	Schools
177	Outpatient Surgery Copay	$100.00	$0.00	Error - copay missed	City
178	Outpatient Surgery Copay	$100.00	$0.00	Error - copay missed	City
179	Outpatient Surgery Copay	$100.00	$0.00	Error - copay missed	City
180	Outpatient Surgery Copay	$100.00	$0.00	Error - copay missed	Schools
181	Outpatient Mental Health Copay	$0.00	$0.00	OOP met (verified that deductible applies to OOP maximum)	City
182	Outpatient Mental Health Copay	$0.00	$0.00	OOP met (verified that deductible applies to OOP maximum)	Schools
183	Outpatient Mental Health Copay	$0.00	$0.00	OOP met (verified that deductible applies to OOP maximum)	Schools
184	Non-Covered Virtual Colonoscopy	$0.00	$0.00	Authorized by Medical Review	Schools
185	Non-Covered Virtual Colonoscopy	$0.00	$0.00	Authorized by Medical Review	Schools
186	Non-Covered Virtual Colonoscopy	$0.00	$0.00	Authorized by Medical Review	City
187	Non-Covered Virtual Colonoscopy	$0.00	$0.00	Authorized by Medical Review	City
188	Non-Covered Botox	$0.00	$1,756.85	Non-covered per plan document - Optima did authorize	Schools
189	Non-Covered Botox	$0.00	$1,514.77	Non-covered per plan document - Optima did authorize	City
190	Non-Covered Botox	$0.00	$1,073.02	Non-covered per plan document - Optima did authorize	Schools
191	Non-Covered Botox	$0.00	$826.68	Non-covered per plan document - Optima did authorize	City
192	Non-Covered Botox	$0.00	$1,073.02	Non-covered per plan document - Optima did authorize	City
193	Non-Covered Botox	$0.00	$0.00	Covered in 2013 per client instruction	City
194	Non-Covered Botox	$0.00	$1,368.78	Non-covered per plan document - Optima did authorize	City
195	Facility MPR	$2,293.00	$0.00	Incorrect pricing per contract (should only allow the primary procedure for payment)	City
196	Facility MPR	$2,393.00	$0.00	Incorrect pricing per contract (should only allow the primary procedure for payment)	Schools
197	Facility MPR	$4,686.00	$0.00	Incorrect pricing per contract (should only allow the primary procedure for payment)	City
198	Pricing	$0.00	$0.00	PHCS pricing confirmed by Optima	City
199	Pricing	$0.00	$0.00	PHCS pricing confirmed by Optima	Schools
200	Pricing	$0.00	$0.00	Verified global transplant contractual rate	Schools
201	Contracts	$0.00	$0.00	Priced correctly at PPO rate	Schools
202	Contracts	$0.00	$0.00	Original admission - informational only	City
203	Contracts	$0.00	$0.00	Readmission not related per clinical review	City
		$30,416.42	**$7,613.12**		

APPENDIX B
OUT-OF-SAMPLE CLAIMS

CITY OF VIRGINIA BEACH
APPENDIX B
OUT-OF-SAMPLE CLAIMS

Audit Item	Issue	Recovery	Comment	City / Schools
204	Medical Edits	$0.00	Primary procedure - informational only	Schools
205	Medical Edits	$64.18	Error - unbundling (fragmented billing)	Schools
206	Medical Edits	$0.00	Primary procedure - informational only	City
207	Medical Edits	$55.44	Error - unbundling (fragmented billing)	City
208	Medical Edits	$0.00	Primary procedure - informational only	City
209	Medical Edits	$78.76	Error - unbundling (fragmented billing)	City
210	ER Copay	$100.00	Error is actually missed $100 copayment for outpatient surgery	City
211	ER Copay	$100.00	Error is actually missed $100 copayment for outpatient surgery	City
212	ER Copay	$100.00	Error is actually missed $100 copayment for outpatient surgery	City
213	ER Copay	$100.00	Error is actually missed $100 copayment for outpatient surgery	Schools
214	ER Copay	$100.00	Error is actually missed $100 copayment for outpatient surgery	City
215	ER Copay	$0.00	Secondary claim	Schools
216	ER Copay	$100.00	Error is actually missed $100 copayment for outpatient surgery	City
217	ER Copay	$100.00	Error is actually missed $100 copayment for outpatient surgery	Schools
218	ER Copay	$0.00	Copay taken	Schools
219	ER Copay	$100.00	Error is actually missed $100 copayment for outpatient surgery	City
220	ER Copay	$100.00	Error is actually missed $100 copayment for outpatient surgery	Schools
221	Outpatient Surgery Copay	$0.00	Claim denied prior to delivery	City
222	Outpatient Surgery Copay	$0.00	Preventive - no copay	City
223	ESRD	$300.00	Medicare primary 8/1/12 - needs recovery	City
224	ESRD	$5,061.94	Medicare primary 8/1/12 - adjusted on 9/12/13 (after sample delivery)	City
225	ESRD	$0.00	Medicare primary 8/1/12 - adjusted on 6/6/13 (prior to sample delivery)	City
226	ESRD	$0.00	Medicare primary 8/1/12 - adjusted on 5/17/13 (prior to sample delivery)	City
227	ESRD	$367.49	Medicare primary 8/1/12 - adjusted on 7/10/13 (after sample delivery)	City
228	ESRD	$318.96	Medicare primary 8/1/12 - adjusted on 7/10/13 (after sample delivery)	City
229	ESRD	$0.00	Medicare primary 8/1/12 - adjusted on 6/12/13 (prior to sample delivery)	City
230	ESRD	$0.00	Medicare primary 8/1/12 - adjusted on 6/12/13 (prior to sample delivery)	City
231	ESRD	$67.76	Medicare primary 8/1/12 - adjusted on 7/11/13 (after sample delivery)	City
232	ESRD	$138.19	Medicare primary 8/1/12 - needs recovery	City
233	ESRD	$162.81	Medicare primary 8/1/12 - needs recovery	City
234	ESRD	$0.00	Medicare primary 8/1/12 - adjusted on 5/23/13 (prior to sample delivery)	City
235	ESRD	$0.00	Medicare primary 8/1/12 - adjusted on 6/20/13 (prior to sample delivery)	City
236	ESRD	$1,362.83	Medicare primary 3/1/13 - adjusted on 7/24/13 (after sample delivery)	Schools
237	ESRD	$0.00	Medicare primary 12/1/12 - adjusted on 4/3/13 (prior to sample delivery)	Schools
238	ESRD	$0.00	Medicare primary 12/1/12 - adjusted on 4/3/13 (prior to sample delivery)	Schools
239	ESRD	$0.00	Claim was coordinated	Schools
240	Transfers	$2,083.43	Error - missed transfer pricing	Schools
241	Transfers	$3,839.68	Error - missed transfer pricing	City
242	Transfers	$0.00	Paid via per diem	Schools
243	Transfers	$0.00	Transfer pricing does not apply	City
244	Transfers	$0.00	Transfer pricing does not apply	Schools
245	Transfers	$0.00	Paid via percent of charges	City
246	Transfers	$0.00	Transfer pricing does not apply	Schools
247	Transfers	$0.00	Transfer pricing does not apply	Schools
248	Transfers	$0.00	Transfer pricing does not apply	City
249	Transfers	$0.00	Paid via per diem	City
		$14,801.47		

APPENDIX C
OPTIMA RESPONSE

OptimaHealth

October 17, 2013

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

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

RE: **2012 Health Plan Audit**

Dear Lyndon,

Thank you for the opportunity to respond to the Draft Optima Health Claims Audit Report for the The City of Virginia Beach and The School Board of the City of Virginia Beach dated September 27, 2013. Once again Optima Health demonstrated its commitment to the City of Virginia Beach through 'exceptional performance in the administration of health care claims' as noted in the audit report. With a full review of over $90 million in paid claims by Healthcare Horizons, Optima achieved a financial accuracy rate of 99.99%.

We have reviewed the Claims Audit Report as well as the Out-of-Sample claims provided. Below please find our response to the findings and recommendations included in the Healthcare Horizons report.

1. ***Outpatient Surgery Case Rates***
   There were three claims in the audit sample where the secondary procedure was paid in error. Any overpayments in this area are routinely identified from a retrospective review process. We will continue to conduct internal audits on claims in this area to ensure claims are processed according to policy. We have also reeducated our claims processors on appropriate claims adjudication of outpatient surgery case rates.

2. ***ESRD Entitlement***
   There were three claims identified in the audit sample where the City paid as primary, however, adjustments were made to these claims in July 2013 to process the City as secondary to Medicare. As part of our normal business process we initiate recoveries once we are notified a member is eligible for Medicare. This is a standard business practice. Recoveries were not initiated because of the audit claims review.

3. ***Inpatient Transfer Claim***
   One claim was identified in the claims sample for an overpayment of an inpatient transfer claim. Optima has a policy in place for our claim processors to review inpatient claims to ensure we are not paying both facilities when the member was transferred. We have reviewed this claim and the others identified in the out-of-sample claims. We have reeducated our claims processors to identify inpatient transfer claims and pay according to policy.

4. ***Missed copay***
   A total of twelve claims were identified with missed copayments. As noted in the audit report, the missed copays were a result of manual errors versus any systemic issue. Please note, Optima health agreed to the 4 claims identified by Healthcare Horizons under "ER copay," however these claims are actually Outpatient claims. When these claims are reversed they will pull an outpatient copay due to the observation code billed on these particular claims. We will wait for direction from the City if we should recover these claims as the member would now be responsible for the applicable copay. We have reviewed the out-of-sample claims and have reeducated our claims processors to identify opportunities for copayments when the claim requires manual intervention.

5. ***Pre-admission testing claims***
   There were four claims identified as being paid in error as the provider contract prohibits separate payment of this testing prior to a planned inpatient admission. Optima has a process in place to prevent a separate payment for pre-admission testing. As the Inpatient claim is being processed for payment, the claims processor is trained to look for possible pre-admission services paid prior to the Inpatient claim being received. If there is a paid pre-admission claim, it would be reversed and denied. The claims processors have been reeducated.

6. ***Multiple Procedure Reduction Opportunities***
   There were three claims in the sample identified for opportunity to combine multiple claims submissions for the purposes of applying multiple procedure reductions. Optima Health Plan has an internal audit process in place to identify multiple procedure claims reduction opportunities as a result of split billing from the provider. It is a manual process. We will continue our internal audit practice to achieve the highest level of accuracy as possible.

7. ***Botox Injections***
   Optima uses the most updated evidence based medical criteria to make medically necessary determinations. We have a pre-authorization process in place today requiring physician notes in order for this service to be approved by the plan. Members who meet medical necessity based on strict criteria receive approval for Botox to treat conditions, such as, Chronic Migraine Headache Prophylaxis.

With regard to the plan's Exclusions and Limitations, there are some services listed as not covered unless approved by the plan for medical necessity. In order to be certain the City of Virginia Beach agrees with the Optima Health definition of medical necessity, I will meet with representatives from the City of Virginia Beach, at the earliest possible time, to review Optima's policies and procedures for medical necessity. This will provide the City of Virginia Beach an opportunity to discuss these types of services and determine whether they in fact wish to pay or continue to exclude this type of service for the 2014 plan year.

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