

***Health Claims
Agreed Upon Procedures***

***For years ended
March 31, 2021 and 2020***

NEEDLES & ASSOCIATES, LLC

Health Claims Agreed Upon Procedures

Table of Contents *March 31, 2021 and 2020*

	<u>Page</u>
Agreed Upon Procedures Report	1 – 46
<u>Following are the results of various tests and data extractions:</u>	
HEALTH SORTS	
CPT Codes – Most frequent	2
CPT Codes – Top paid	3-5
CPT Codes – Emergency room visits	5-6
CPT Codes – CPT codes not allowed	7
CPT Codes – Male and female only procedures	7
ICD Codes – Top paid	7-9
COVID-19 Information	9-10
Primary Social Security Number – Top paid	11-12
General Sorts	12-13
Materiality Sorts	14
Services with Limitations	14-15
Services not Allowed	15-16
PRESCRIPTION SORTS	
Prescriptions – Top paid	17-18
Prescriptions – Drugs with street value	18-21
Prescription Sorts for Sample Selections	21
ELIGIBILITY DATABASES	
Prescription Eligibility Sorts	22
RN HEALTH AND PRESCRIPTION AUDIT	
Appendix A – RN Health claims review	25
Appendix B – RN Prescription claims review	41
CONCLUSION	46

Independent Accountants' Report on Applying Agreed-Upon Procedures

Health Claims Client
City, State

We have performed the procedures enumerated below, with respect to the claims remitted by Health Claims Client (the Plan) for the years ended March 31, 2021 and 2020 in accordance with the applicable provisions in the Plan documents. This engagement to apply agreed-upon procedures was performed in accordance with standards established by the American Institute of Certified Public Accountants. The sufficiency of the procedures is solely the responsibility of the specified users of the report.

Health Claims Client has agreed to and acknowledged that the procedures performed are appropriate to meet the intended purpose of assisting management and Trustees in assessing the claims processed by the Plan as well as evaluating underlying participant data during the years ended March 31, 2021 and 2020. This report may not be suitable for any other purpose. The procedures performed may not address all the items of interest to a user of this report and may not meet the needs of all users of this report and, as such, users are responsible for determining whether the procedures performed are appropriate for their purposes.

The procedures and the associated findings are as follows:

We have reviewed for this claim examination the claims filed as prepared by the administrative office for the years ended March 31, 2021 and 2020.

Health Claims Database

We received a database from Preferred Provider Organization (PPO) covering the following population:

Year	Eligible Primary Members
2021	1,983
2020	1,996

Total Health claims paid are as follows:

Year	Records Paid	Amount Paid
2021	164,335	\$13,188,966
2020	170,005	\$15,936,107
Total	136,335	\$23,493,088

Various tests were performed on the whole database in order to ensure the claims were paid according to the Plan rules as well as provide Plan statistics.

HEALTH CLAIMS

*Agreed Upon Procedures
March 31, 2021 and 2020*

HEALTH SORTS

CPT Codes – Most frequent

CPT codes indicate the medical procedure performed. The most common CPT codes should be for frequent procedures.

Sort #	Sort Description	Comments/Notes	Conclusion
1	Performed a summarization of CPT codes to determine which were most repeated.	CPT codes labeled with an A likely indicate hospitals/medical centers with revenue codes. Will review CPT code specifically in sort #3.	Most repeated codes fall in line with what we see in other plans. Nothing further needed.

Results:

2021-2020 Most Repeated CPT (Procedure Codes)			
<i>Total Amount Paid:</i>		\$	29,125,073
The sample below equals 43% of all claims paid.			
CPT	# of Records	Amount Paid	Description
A	20,293	\$ 11,110,512	Hospitals and medical centers.
99214	13,938	\$ 732,866	Office or other outpatient visit for the evaluation and management of an established patient. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
99213	12,735	\$ 374,637	Office or other outpatient visit for the evaluation and management of an established patient. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
80053	6,847	\$ 94,865	Comprehensive metabolic panel (lab work)
85025	5,189	\$ 48,205	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
36415	4,913	\$ 4,073	Collection of venous blood by venipuncture
97110	4,850	\$ 71,532	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
80061	4,515	\$ 36,299	Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478)
83036	4,105	\$ 25,811	Hemoglobin; glycosylated (A1C)
85027	3,237	\$ 10,573	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)
		\$ 12,509,373	Total

HEALTH CLAIMS

Agreed Upon Procedures March 31, 2021 and 2020

CPT Codes – Top paid

CPT and revenue codes were arranged in order of top paid. Top paid CPT and revenue codes were analyzed for 2021 and 2020 together and individually in order to find the top procedures in the Plan.

Sort #	Sort Description	Comments/Notes	Conclusion
2	Performed a summarization of CPT codes to determine which were top paid.	Emergency room visits were top paid after hospitals and medical centers. Will extract emergency room visits for further review.	Emergency Room visits dropped significantly in 2021 which may indicate that the ER visits were due to COVID restrictions and limited access to regular doctors. Top paid individual claims are selected for thorough review by R.N.

Results:

2021-2020 Top Paid by CPT (Procedure Codes)			
<i>Total Amount Paid:</i>		\$	29,125,073
The sample below equals 54% of all claims paid.			
CPT	# of Records	Amount Paid	Description
A	20,293	\$ 11,110,512	Hospitals and medical centers.
99284	2,218	\$ 1,214,662	Emergency department visit. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.
99285	1,341	\$ 743,267	Emergency department visit. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
99214	13,938	\$ 732,866	Office or other outpatient visit for the evaluation and management of an established patient. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
99283	1,888	\$ 586,005	Emergency department visit. Usually, the presenting problem(s) are of moderate severity.
99213	12,735	\$ 374,637	Office or other outpatient visit for the evaluation and management of an established patient. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
74177	644	\$ 290,476	Computed tomography, abdomen and pelvis; with contrast material(s) (CT Scan)
90999	2,550	\$ 270,600	Unlisted dialysis procedure, inpatient or outpatient
J9145	40	\$ 242,564	Injection, daratumumab, 10 mg (to treat multiple myeloma)
93306	655	\$ 228,271	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography (ultrasound of the heart)
		\$ 15,793,860	Total

HEALTH CLAIMS

*Agreed Upon Procedures
March 31, 2021 and 2020*

CPT Codes – Top paid...continued

2021 Top Paid by CPT (Procedure Codes)			
<i>Total Amount Paid:</i>		\$	13,188,966
The sample below equals 53% of all claims paid.			
CPT	# of Records	Amount Paid	Description
A	10,109	\$ 4,751,181	Hospitals and medical centers.
99284	955	\$ 456,059	Emergency department visit. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.
99214	6,822	\$ 370,619	Office or other outpatient visit for the evaluation and management of an established patient. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
99285	669	\$ 311,532	Emergency department visit. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
90999	1,099	\$ 255,351	Unlisted dialysis procedure, inpatient or outpatient
J9145	36	\$ 223,364	Injection, daratumumab, 10 mg (to treat multiple myeloma)
99283	823	\$ 221,741	Emergency department visit. Usually, the presenting problem(s) are of moderate severity.
99213	6,317	\$ 196,933	Office or other outpatient visit for the evaluation and management of an established patient. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
U0003	1,781	\$ 122,690	Infectious agent detection by nucleic acid (DNA or RNA); Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R
74177	329	\$ 118,613	Computed tomography, abdomen and pelvis; with contrast material(s) (CT Scan)
		\$ 7,028,083	Total

HEALTH CLAIMS

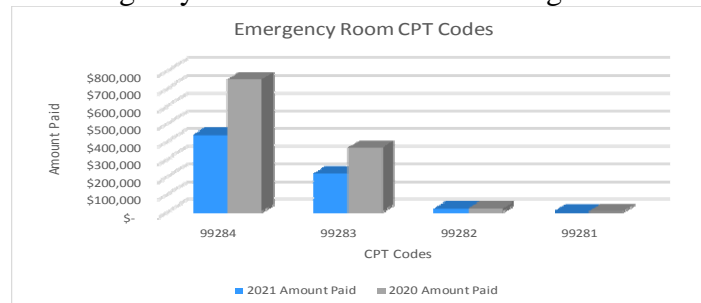
*Agreed Upon Procedures
March 31, 2021 and 2020*

CPT Codes – Top paid...continued

2020 Top Paid by CPT (Procedure Codes)				
<i>Total Amount Paid:</i>		\$	15,936,107	
The sample below equals 56% of all claims paid.				
CPT	# of Records	Amount Paid	Description	
A	10,184	\$ 6,359,331	Hospitals and medical centers.	
99284	1,263	\$ 758,603	Emergency department visit. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.	
99285	672	\$ 431,735	Emergency department visit. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	
99283	1,065	\$ 364,264	Emergency department visit. Usually, the presenting problem(s) are of moderate severity.	
99214	7,116	\$ 362,248	Office or other outpatient visit for the evaluation and management of an established patient. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.	
99213	6,418	\$ 177,704	Office or other outpatient visit for the evaluation and management of an established patient. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.	
74177	315	\$ 171,863	Computed tomography, abdomen and pelvis; with contrast material(s) (CT Scan)	
C1767	3	\$ 119,952	Generator, neurostimulator (implantable), nonrechargeable	
93306	326	\$ 110,068	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography (ultrasound of the heart)	
90945	203	\$ 104,851	Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single evaluation by a physician or other qualified health care professional	
		\$ 8,960,619	Total	

CPT Codes – Emergency room visits

Since emergency room visits were top paid CPT codes for the Plan, all emergency room CPT codes were extracted from the database. Emergency room visits in all CPT categories decrease from 2020 to 2021.



HEALTH CLAIMS

*Agreed Upon Procedures
March 31, 2021 and 2020*

CPT Codes – Emergency room visits...continued

Emergency Room Visits (in order of severity)			
CPT	2021 Amount Paid	2020 Amount Paid	Description
99285	\$ 292,271	\$ 428,527	Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
99284	\$ 431,957	\$ 745,731	Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.
99283	\$ 212,769	\$ 358,991	Usually, the presenting problem(s) are of moderate severity.
99282	\$ 15,821	\$ 17,126	Usually, the presenting problem(s) are of low to moderate severity.
99281	\$ 739	\$ 2,082	Usually, the presenting problem(s) are self-limited or minor.
	\$ 953,557	\$ 1,552,459	Total

Emergency Room Visits and Patients				
Year	Records Paid	Amount Paid	Total ER Visits	Total Patients
2021	2,139	\$ 953,557	922	619
2020	3,198	\$ 1,552,459	1,474	856
Total	5,337	\$ 2,506,016	2,396	-

CPT Codes – Line items with no CPT codes

Line items with no CPT codes are extracted and reviewed.

Sort #	Sort Description	Comments/Notes	Conclusion
3	Checked the claims without CPT codes.	These are line items with CPT Code A. Extracted those line items and reviewed providers to confirm that these were for hospitals/medical centers.	It is common practice to not include CPT codes for hospitals and medical centers since they use revenue codes for their billing. Based on our review of those with CPT code A, this is the case with this data as well. All paid claims had a revenue code in the database. Nothing further needed.

HEALTH CLAIMS

Agreed Upon Procedures March 31, 2021 and 2020

CPT Codes – CPT codes not allowed

These are CPT codes that are generally not allowed in Plans because they may be considered cosmetic or unnecessary procedures.

Sort #	Sort Description	Comments/Notes	Conclusion
4	CPT codes not allowed	CPT line items returned require additional review to determine if they are in fact not allowed based on ICD code description.	Final 6 records were selected based on supporting ICD codes indicating that the procedures may or may not be for cosmetic purposes. Sample will be selected and sent to R.N. for additional review. See RN Notes for thorough review.

CPT Codes – Male and female only procedures

Sort #	Sort Description	Comments/Notes	Conclusion
5	CPT codes - Male only	Male only CPT codes were extracted from database to determine if all line items paid under these codes were specific to the sex.	All results were male patients. Nothing further needed.
6	CPT codes - Female only	Female only CPT codes were extracted from database to determine if all line items paid under these codes were specific to the sex.	One record returned for a male with a female only CPT code. Sample will be selected and sent to R.N for additional review. See RN Notes for thorough review.

ICD Codes – Top paid

ICD (Internal Classification of Diseases) Codes are used by physicians and other health care providers to classify and code all diagnoses, symptoms and procedures.

ICD codes were arranged in order of top paid. Top paid ICD codes were analyzed for 2021 and 2020 together and individually in order to find the top procedures in the Plan.

Sort #	Sort Description	Comments/Notes	Conclusion
7	Performed a summarization of ICD codes to determine which were top paid.	COVID-19 was a top paid diagnosis in 2021. Will extract all COVID-19 information based on ICD and CPT codes.	The ICD codes fall within the parameters we see in plans. Top paid claims will be extracted for further review based on materiality claims sorts.

HEALTH CLAIMS

*Agreed Upon Procedures
March 31, 2021 and 2020*

ICD Codes – Top paid...continued

Results:

2021-2020 Top Paid by ICD (Diagnosis Codes)				
<i>Total Amount Paid:</i>		29,125,073		
The sample below equals 18% of all claims paid.				
ICD-10	# of Records	Amount Paid	Description	
U07.1	6,481	\$ 1,621,925	COVID-19	
Z38.01	436	\$ 833,422	Single liveborn infant, delivered by cesarean	
A41.9	2,555	\$ 573,535	Sepsis, unspecified organism	
N18.6	9,862	\$ 476,897	End stage renal disease	
C90.00	1,515	\$ 369,768	Multiple myeloma not having achieved remission	
A41.89	594	\$ 336,417	Other specified sepsis	
J95.01	511	\$ 321,717	Hemorrhage from tracheostomy stoma	
Z12.11	971	\$ 314,791	Encounter for screening for malignant neoplasm of colon	
I09.81	60	\$ 265,365	Rheumatic heart failure	
I47.1	231	\$ 254,748	Supraventricular tachycardia	
		\$ 5,368,585	Total	

2021 Top Paid by ICD (Diagnosis Codes)				
<i>Total Amount Paid:</i>		\$ 13,188,966		
The sample below equals 29% of all claims paid.				
ICD-10	# of Records	Amount Paid	Description	
U07.1	6,481	\$ 1,621,925	COVID-19	
A41.89	593	\$ 336,102	Other specified sepsis	
C90.00	1,250	\$ 332,417	Multiple myeloma not having achieved remission	
J95.01	511	\$ 321,717	Hemorrhage from tracheostomy stoma	
N18.6	4,710	\$ 310,457	End stage renal disease	
A41.9	913	\$ 244,122	Sepsis, unspecified organism	
Z20.828	3,235	\$ 207,609	Contact with and (suspected) exposure to other viral communicable diseases	
Z03.818	2,228	\$ 138,653	Encounter for observation for suspected exposure to other biological agents ruled out	
J96.01	866	\$ 136,135	Acute respiratory failure with hypoxia	
R07.9	782	\$ 124,560		
		\$ 3,773,697	Total	

HEALTH CLAIMS

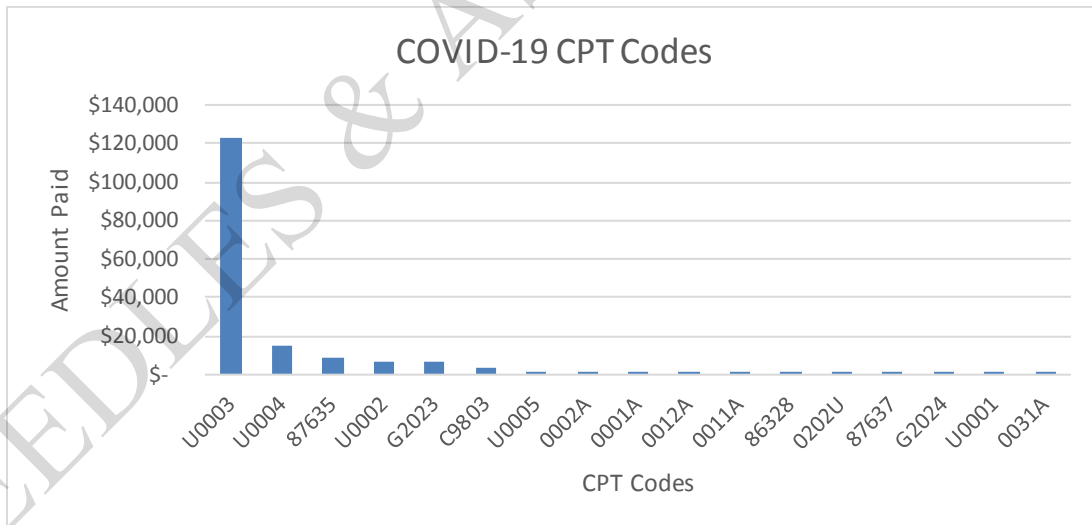
*Agreed Upon Procedures
March 31, 2021 and 2020*

ICD Codes – Top paid...continued

2020 Top Paid by ICD (Diagnosis Codes)			
<i>Total Amount Paid:</i>		\$	15,936,107
<i>The sample below equals 17% of all claims paid.</i>			
ICD-10	# of Records	Amount Paid	Description
Z38.01	296	\$ 716,307	Single liveborn infant, delivered by cesarean
A41.9	1,642	\$ 329,413	Sepsis, unspecified organism
I09.81	60	\$ 265,365	Rheumatic heart failure
I47.1	216	\$ 253,212	Supraventricular tachycardia
E11.69	656	\$ 213,081	Type 2 diabetes mellitus with other specified complication
G89.4	388	\$ 194,778	Chronic pain syndrome
K70.30	147	\$ 193,276	Alcoholic cirrhosis of liver without ascites
Z12.11	623	\$ 192,299	Encounter for screening for malignant neoplasm of colon
A40.9	194	\$ 172,666	Streptococcal sepsis, unspecified
I25.110	219	\$ 170,806	Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
		\$ 2,701,203	Total

COVID-19 Information

Covid-19 information was extracted based on CPT (procedure) and ICD (diagnosis) codes in the database. Top paid claims were extracted for further review by R.N.



HEALTH CLAIMS

*Agreed Upon Procedures
March 31, 2021 and 2020*

COVID-19 Information...continued

CPT	Amount Paid	Description
U0003	\$ 122,690	Virus detection test, amplified probe technique, making use of high throughput technologies
U0004	\$ 15,084	Virus detection test, any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies
87635	\$ 8,353	Virus detection test, amplified probe technique
U0002	\$ 6,907	Virus detection test, any technique, multiple types or subtypes (includes all targets), non-CDC
G2023	\$ 6,579	Specimen collection for Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source
C9803	\$ 3,914	Hospital outpatient clinic visit specimen collection for Severe Acute Respiratory Syndrome Coronavirus (COVID-19), any specimen source
U0005	\$ 1,200	Virus detection test. Amplified probe technique, CDC or non-CDC, making use of high throughput technologies, completed within 2 calendar days from date of specimen collection
0002A	\$ 1,050	Pfizer vaccine, second dose.
0001A	\$ 1,029	Pfizer vaccine, first dose.
0012A	\$ 758	Moderna vaccine, second dose.
0011A	\$ 677	Moderna vaccine, first dose.
86328	\$ 526	Antibody tests.
0202U	\$ 417	Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), nasopharyngeal swab, each pathogen reported as detected or not detected
87637	\$ 256	Infectious agent detection; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), influenza virus types A and B, and respiratory syncytial virus, multiplex amplified probe technique
G2024	\$ 159	Specimen collection for Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) from an individual in a SNF or by a laboratory on behalf of a HHA, any specimen source
U0001	\$ 136	Virus detection test. CDC 2019 Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel.
0031A	\$ 129	Janssen vaccine.
	\$ 169,863	Total

ICD	Amount Paid	Description
U07.1	\$ 1,621,925	COVID-19
Z20.822	\$ 20,978	Contact with and (suspected) exposure to COVID-19
Z11.52	\$ 4,144	Encounter for screening for COVID-19
J12.82	\$ 2,095	Pneumonia due to coronavirus disease 2019
Z86.16	\$ 130	Personal history of COVID-19
B97.29	\$ 100	Other coronavirus as the cause of diseases classified elsewhere
J12.81	\$ 97	Pneumonia due to SARS-associated coronavirus
	\$ 1,649,469	Total

HEALTH CLAIMS

*Agreed Upon Procedures
March 31, 2021 and 2020*

Primary Social Security Number – Top paid

Sort #	Sort Description	Comments/Notes	Conclusion
8	Checked SSN (family) for which members have the highest claims paid	Only extracted for SSNs with amounts paid by the plan. The top ten families with the highest paid amounts were extracted and the line items were summarized based on the ICD code. The ICD codes with the highest amount paid are deemed to be the primary diagnosis. Sorting by top paid primary member's social security number allowed us to see if the primary diagnosis were consistent with the top diagnosis codes in the Plan.	Top paid claims will be extracted for further review based on materiality claims sorts. Top paid SSNs along with an overview of the diagnosis are presented below.

Results:

2021 Top Paid by Social Security Number			
<i>Total Amount Paid:</i>		\$	13,188,966
The sample below equals 20% of all claims paid.			
ICD-10	# of Records	Amount Paid	Description
SSN1	757	\$ 581,486	COVID-19. Acute respiratory failure with hypoxia.
SSN2	586	\$ 323,174	Hemorrhage from tracheostomy stoma
SSN3	746	\$ 287,553	End stage renal disease
SSN4	1,100	\$ 285,975	Multiple myeloma not having achieved remission
SSN5	817	\$ 223,709	Encounter for antineoplastic chemotherapy
SSN6	174	\$ 199,078	Sepsis, unspecified organism. Pressure ulcer of sacral region, stage 4.
SSN7	515	\$ 189,294	COVID-19. Acute respiratory failure with hypoxia.
SSN8	881	\$ 184,451	Other specified sepsis.
SSN9	313	\$ 173,299	Other specified sepsis.
SSN10	474	\$ 167,959	Spinal stenosis, cervical region
		\$ 2,615,978	Total

HEALTH CLAIMS

*Agreed Upon Procedures
March 31, 2021 and 2020*

Primary Social Security Number – Top paid...continued

2020 Top Paid by Social Security Number			
<i>Total Amount Paid:</i>		\$	15,936,107
The sample below equals 21% of all claims paid.			
ICD-10	# of Records	Amount Paid	Description
SSN1	347	\$ 635,081	Single liveborn infant, delivered by cesarean
SSN2	1,106	\$ 524,616	Rheumatic heart failure
SSN3	1,684	\$ 417,672	Sepsis due to Escherichia coli [E. coli]. Kidney transplant failure.
SSN4	900	\$ 329,989	Benign neoplasm of cerebral meninges. Other nontraumatic intracerebral hemorrhage.
SSN5	669	\$ 301,967	Alcoholic cirrhosis of liver without ascites. Hepatic failure, unspecified without coma.
SSN6	686	\$ 244,449	Infection and inflammatory reaction due to nephrostomy catheter, initial encounter. Malignant neoplasm of stomach, unspecified
SSN7	1,169	\$ 238,838	Streptococcal sepsis, unspecified. Sepsis, unspecified organism.
SSN8	382	\$ 226,986	Supraventricular tachycardia. Non-ST elevation (NSTEMI) myocardial infarction
SSN9	398	\$ 205,075	Nontraumatic intracerebral hemorrhage in hemisphere, cortical.
SSN10	626	\$ 190,554	End stage renal disease. Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease.
		\$ 3,315,227	Total

General Sorts

The sorts below were performed in order to narrow down high-risk transactions that will require further review by R.N.

Results:

Sort #	Sort Description	Comments/Notes	Conclusion
9	Claims rounded to \$1,000	Sort is performed to flag transactions that may be fraudulent due to billed and paid amounts being rounded. Sample selected is based on claims billed and paid for rounded amounts.	Sample will be selected and sent to R.N for additional review.
10	Claims rounded to \$100	Sort is performed to flag transactions that may be fraudulent due to billed and paid amounts being rounded. Sample selected is based on claims billed and paid for rounded amounts.	Sample will be selected and sent to R.N for additional review.

HEALTH CLAIMS

Agreed Upon Procedures March 31, 2021 and 2020

General Sorts...continued

Sort #	Sort Description	Comments/Notes	Conclusion
11	Checked SSN (family) for which members have the highest claims paid	Only extracted for SSNs with amounts paid by the plan. The top ten families with the highest paid amounts were extracted and the line items were summarized based on the ICD code.	Top paid claims will be extracted for further review based on materiality claims sorts. Top paid SSNs along with an overview of the diagnosis will be presented in final report
12	Review void/denied/not paid claims to determine why these claims were not paid	A sample of claims will be selected in order to determine if processing procedures are accurate.	Sample will be selected and sent to R.N for additional review.
13	Checked that line amount paid is not greater than line amount billed.	A sample of claims will be selected in order to determine if processing procedures are accurate.	Sample will be selected and sent to R.N for additional review.
14	Duplicate Claims matched on: Line amount paid, Line amount billed, Incurred date, Provider, SSN, Patient DOB, CPT, and ICD10	Records returned will be manually reviewed to remove modifier codes that indicate separately identifiable services. This will narrow down the sample and eliminate false positives.	Sample will be selected and sent to R.N for additional review.
15	Claims processed before incurred	This will usually indicate that there is a processing error that needs to be corrected by the processor.	No records returned. Nothing further needed.
16	Claims received after 365 days	Plan indicates that members have 365 days to submit claims. Claims submitted after 365 days will be denied unless there are exceptions such as adjustments, additional information was requested, etc.	Sample will be selected and sent to R.N for additional review.

HEALTH CLAIMS

Agreed Upon Procedures March 31, 2021 and 2020

Materiality Sorts

Materiality was calculated based on total claims paid for 2021 and 2020. Three levels of materiality were considered: Planning Materiality, Tolerable Misstatement, and Individually Significant items. Individual claims that fell into these categories were selected for additional review by R.N. to ensure that payment for these claims were properly processed.

Results:

Sort #	Sort Description	Results 2020	Results 2021	Comments/Notes
17	Claims larger than Planning Materiality	Claims over: \$130,000 No records returned	Claims over: \$120,000 No records returned	No individual claims exceeded the planning materiality threshold. Nothing further needed.
18	Claims between Planning Materiality and Tolerable Misstatement	Claims between: \$97,000 and \$130,000 1 Record: \$97,314.69	Claims between: \$90,000 and \$120,000 7 Records: \$656,340	All claims between planning materiality and tolerable misstatement selected for additional review by R.N.
19	Claims between Tolerable Misstatement and Individually Significant Items	Claims between: \$65,000 and \$97,000 13 Records: \$1,009,571.91	Claims between: \$60,000 and \$90,000 6 Records: \$390,830.98	All claims between tolerable misstatement and individually significant category selected for additional review by R.N.

Services with Limitations

The Plan documents for Health Claims Client were thoroughly reviewed to determine the service limitations based on the different plan structures.

Results:

Sort #	Sort Description	Comments/Notes	Conclusion	Buy Up Plan	Retiree	Base Plan
20	Home health care limited to 60 visits per calendar year	Searched based on Benefit Codes in database.	No individuals exceeded the 60 visits per calendar year.	Coinsurance 20%/40%	Coinsurance 20%/40%	Coinsurance 20%/40%
21	Rehabilitation services limited to 60 visits per calendar year. For physical, occupational & speech therapy combined, including outpatient facility.	Searched based on Benefit Codes in database.	Nothing further needed.	Coinsurance 20%/40%	Coinsurance 20%/40%	\$50 copay per visit (deductible doesn't apply)/40%

HEALTH CLAIMS

***Agreed Upon Procedures
March 31, 2021 and 2020***

Services with Limitations...continued

Sort #	Sort Description	Comments/Notes	Conclusion	Buy Up Plan	Retiree	Base Plan
22	Skilled nursing care limited to 90 days per calendar year.	Searched based on Benefit Codes in database.	Nothing further needed.	Coinsurance 20%/Not Covered	Coinsurance 20%/Not Covered	Coinsurance 20%/Not Covered
23	Durable medical equipment limited to 1 DME for same/similar purpose. Repairs for misuse/abuse not covered.	Modifier NU: New Equipment Modifier RR: Rental Summarized by Patient and Modifier to see if there were more than one DME	No DME for same/similar purpose. Multiple DME for individuals was for disposable/replaceable items. Nothing further needed.	Coinsurance 20%/40%	Coinsurance 20%/40%	Coinsurance 20%/40%
24	Hospice services - pre-authorization required for out-of-network care.	Searched based on Benefit Codes in database.	Only individual out of network did not have claims paid by the plan.	Coinsurance 20%/40%	Coinsurance 20%/40%	Coinsurance 20%/40%

Services not Allowed

The Plan documents for Health Claims Client were thoroughly reviewed to determine the services that were not allowed based on the different plan structures.

Results:

Sort #	Sort Description	Comments/Notes	Conclusion	Buy Up Plan	Retiree	Base Plan
25	Acupuncture	A total of 6 records were returned; however, they were not paid by the plan.	Nothing further needed.	Not Covered	Not Covered	Not Covered
26	Bariatric surgery (see NHCAA notes)	One record returned. Amount paid \$1,484. Additional review of ICD code performed.	Bariatric surgery due to other health issues as indicated by ICD codes. Nothing further needed.	Not Covered	Not Covered	Not Covered

HEALTH CLAIMS

**Agreed Upon Procedures
March 31, 2021 and 2020**

Services not Allowed...continued

Sort #	Sort Description	Comments/Notes	Conclusion	Buy Up Plan	Retiree	Base Plan
27	Cometic surgery	A total of 16 claims were returned that could possibly fall into the cosmetic procedure category. Additional review was performed on ICD codes to narrow down purpose of procedure.	A total of 6 records were selected for additional review by R.N.	Not Covered	Not Covered	Not Covered
28	Non-emergency care when traveling outside of the U.S. Searched for providers with no U.S. address.	No providers had addresses outside of the U.S.	Nothing further needed.	Not Covered	Not Covered	Not Covered

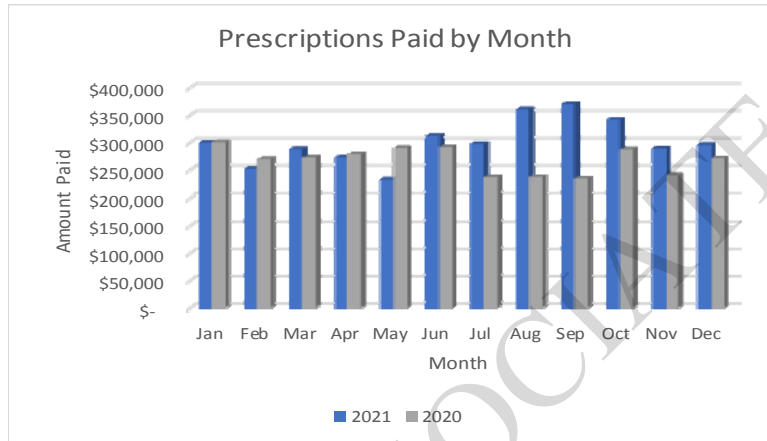
HEALTH CLAIMS

Agreed Upon Procedures March 31, 2021 and 2020

PRESCRIPTION SORTS

A prescription database for claims paid in 2021 was provided by PBM. Claims were paid as follows:

Year	Records Paid	Amount Paid by Client	Number of Drug Names	Number of Family IDs	Avg. paid per Family
2021	21,836	\$ 3,207,652	784	1,422	\$ 2,256



An analysis of the prescription database was performed in order to ensure that the prescription claims were paid according to the Plan description.

Prescriptions – Top paid

Prescriptions were sorted based on their name and total amount paid. These are customarily specialty drugs. The purpose of this sort is to determine the drug use and whether it is reasonable for these drugs to be top paid as well as insight to trends in the Plan.

Results:

Drug Name	# of Fills	Amount Paid	Average Per Fill	Drug Description	Comments	Conclusion
Humira	52	\$ 474,869	\$ 9,132	Used to treat many inflammatory conditions in adults, such as rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, plaque psoriasis, and a skin condition called hidradenitis suppurativa.	Will select for rx sample and health sample due to price ranges varying from one patient to another.	Sample will be selected and sent to R.N. for review.
Ozempic	371	\$ 390,087	\$ 1,051	A pre-filled, disposable, single-patient-use injection pen used along with diet and exercise to improve blood sugar control in adults with type 2 diabetes mellitus.	Use appears reasonable.	Nothing further needed.

HEALTH CLAIMS

*Agreed Upon Procedures
March 31, 2021 and 2020*

Prescriptions – Top paid...continued

Drug Name	# of Fills	Amount Paid	Average Per Fill	Drug Description	Comments	Conclusion
Trulicity	383	\$ 387,276	\$ 1,011	An injectable diabetes medicine that helps control blood sugar levels.	Use appears reasonable.	Nothing further needed.
Revlimid	22	\$ 350,618	\$ 15,937	Chemotherapy. It can treat myelodysplastic syndrome (MDS), multiple myeloma, and mantle cell lymphoma (MCL).	Use appears reasonable.	Nothing further needed.
Jardiance	339	\$ 293,247	\$ 865	To treat type 2 diabetes in adults.	Use appears reasonable.	Nothing further needed.
Oxervate	4	\$ 197,872	\$ 49,468	To treat neurotrophic keratitis (disease of the cornea of the eye).	Use appears reasonable.	Nothing further needed.
Xyrem	11	\$ 185,494	\$ 16,863	A central nervous system depressant. It is used to treat cataplexy (sudden loss of muscle strength) and reduce daytime sleepiness caused by narcolepsy.	Will select for rx sample and health sample since Xyrem is also known as GHB, a known street drug of abuse.	Sample will be selected and sent to R.N. for review.
Pomalyst	14	\$ 177,215	\$ 12,658	Used to treat multiple myeloma (cancer resulting from a progressive blood disease).	Use appears reasonable.	Nothing further needed.
Dupixent	49	\$ 142,736	\$ 2,913	Used for asthma or eczema in adults and children.	Use appears reasonable.	Nothing further needed.
Januvia	167	\$ 138,502	\$ 829	Oral medicine to control blood sugar levels for type 2 diabetes.	Use appears reasonable.	Nothing further needed.

Conclusion: We recommend that Health Claims Client discuss generic drug options for potential savings to the Plan with the prescription consultant.

Prescriptions – Drugs with street value

Drugs with a high risk of being abused or having street value are extracted from the prescription database. The list of drugs is updated regularly in order to include the most recent opioids on the market. Individuals who are prescribed drugs with street value are summarized to determine if there are multiple drugs being prescribed in this category. Individuals with high number of prescriptions or high dollar amounts are cross-referenced to the health database to determine if the use is warranted.

A total of \$231,529 was paid by the Plan for drugs with street value. This makes up 7% of all claims paid.

HEALTH CLAIMS

*Agreed Upon Procedures
March 31, 2021 and 2020*

Prescriptions – Drugs with street value...continued

Results:

Drug Name	# of Fills	Amount	# of Patients	Average per Patient	Drug Description	Comments	Conclusion
XYREM	11	\$ 185,494	1	\$ 185,494	A central nervous system depressant. It is used to treat cataplexy (sudden loss of muscle strength) and reduce daytime sleepiness caused by narcolepsy. Xyrem is also known as GHB, a known street drug of abuse.	Because of the potential for abuse and the serious side effects that may occur, Xyrem is available only from a certified pharmacy under a special program called Xyrem REMS Program. Will select for rx sample and health sample.	Sample will be selected and sent to R.N. for review.
VYVANSE	55	\$ 14,909	12	\$ 1,242	A central nervous system stimulant. It affects chemicals in the brain and nerves that contribute to hyperactivity and impulse control.	Will select sample based on Patient Only sort.	Sample will be selected and sent to R.N. for review.
HYDROCO/APAP	324	\$ 4,645	120	\$ 39	Narcotic. It can treat pain.	High number of patients but individual prescription amount is low.	Nothing further needed.
TRAMADOL	367	\$ 3,608	178	\$ 20	Narcotic. It can treat moderate to severe pain.	High number of patients but individual prescription amount is low.	Nothing further needed.

HEALTH CLAIMS

*Agreed Upon Procedures
March 31, 2021 and 2020*

Prescriptions – Drugs with street value...continued

Drug Name	# of Fills	Amount	# of Patients	Average per Patient	Drug Description	Comments	Conclusion
METHYLPHENID	40	\$ 3,458	11	\$ 314	Used to treat attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD), and narcolepsy.	Use appears reasonable.	Nothing further needed.
STRATTERA	9	\$ 3,202	1	\$ 3,202	Used to treat attention deficit hyperactivity disorder (ADHD).	Use appears reasonable.	Nothing further needed.
AMPHET/DEXTR	118	\$ 2,954	20	\$ 148	A combination medicine used to treat narcolepsy and attention deficit hyperactivity disorder (ADHD).	Use appears reasonable.	Nothing further needed.
BUT/APAP/CAF	61	\$ 2,434	22	\$ 111	Used to treat tension headaches. This medication may sometimes cause addiction.	Use appears reasonable.	Nothing further needed.
DEXMETHYLPHE	39	\$ 2,162	7	\$ 309	A stimulant that is used to treat attention deficit hyperactivity disorder (ADHD). High potential for abuse and dependence	Use appears reasonable.	Nothing further needed.
LYRICA	6	\$ 1,628	1	\$ 1,628	Used to treat pain caused by fibromyalgia, or nerve pain.	Use appears reasonable.	Nothing further needed.
ALPRAZOLAM	240	\$ 1,017	66	\$ 15	Sedative. Used to treat anxiety disorders, panic disorders, and anxiety caused by depression.	Use appears reasonable.	Nothing further needed.
Total		\$ 225,511					

HEALTH CLAIMS

***Agreed Upon Procedures
March 31, 2021 and 2020***

Prescriptions – Drugs with street value...continued

Remaining drugs with street value were less than \$1,000 per drug and no issues were noted.

Prescription Sorts for Sample Selection

The prescription database was reviewed and a sample was selected in each category for further review. Below is a listing of the sample selected and notes from the files reviewed.

Results:

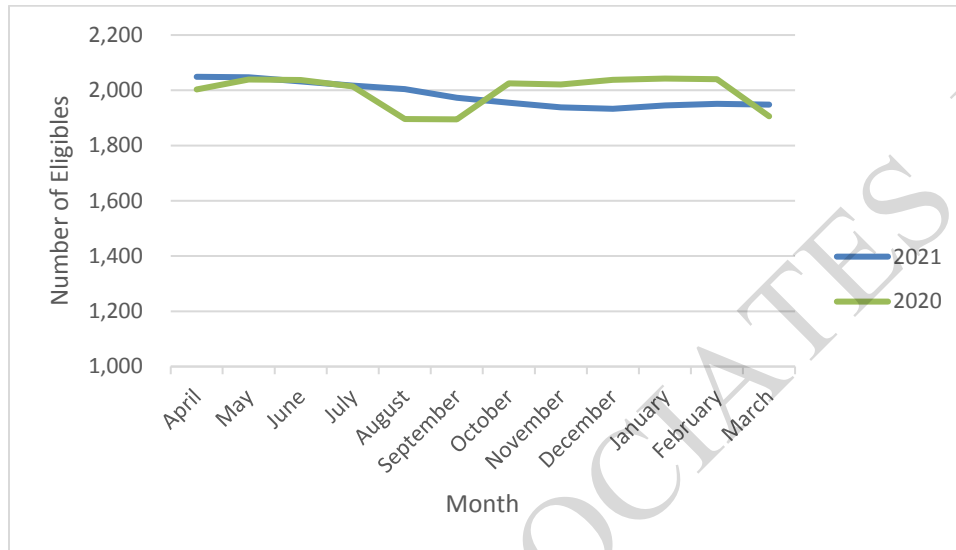
Sort #	Sort Description	Comments/Notes	Conclusion
Rx-1	Patient state does not match prescriber state	Patient was summarized by state and prescriber state. Matching states were excluded from review and top paid non-matching states were extracted for further review.	Sample of non-matches with high dollar or unusual prescriptions was selected for additional review by R.N.
Rx-2	Extracted top paid cardholders by SSN with state not matching prescriber state. Summarized to include drugs prescribed by patient.	These are patients who had prescriptions filled in different states and the provider showed up for different individuals or the drug was top paid.	Sample of non-matches with high dollar or unusual prescriptions was selected for additional review by R.N.
Rx-3	Patient state does not match pharmacy state	These are patients who had prescriptions paid in more than one state.	Sample of non-matches was selected for additional review by R.N.
Rx-4	Pharmacy does not match prescriber state	The majority of the non-matches were due to the Optum pharmacy providing specialty drugs.	Nothing further needed.
Rx-5	New prescriptions (refill number 00); Summarize by drug name.	Focused on initial prescriptions.	Sample of new prescriptions was selected for additional review by R.N.
Rx-6	Claims with no doctor visit.	Matched based on patient SSN on both databases. Most prescriptions require an annual visit to refill.	Sample of high dollar and high risk drugs was selected for additional review by R.N.
Rx-7	Top paid pharmacies (summarize by pharmacy and amount)	Removed chain pharmacies (Walgreens, CVS, etc.) since patient information is accessible by pharmacies in same chain.	Sample of small pharmacies was selected for additional review by R.N.
Rx-8	Top paid independent pharmacies (extract claims for review)	Removed chain pharmacies (Walgreens, CVS, etc.) since patient information is accessible by pharmacies in same chain.	Sample selected for additional review by R.N.
Rx-9	Prescribers with various patients	Focused on prescribers with unusual prescriptions.	Sample of prescribers was selected for additional review by R.N.

HEALTH CLAIMS

Agreed Upon Procedures March 31, 2021 and 2020

ELIGIBILITY DATABASES

An eligibility database was provided by Health Claims Client. The average number of eligible members was 1,983 in 2021 and 1,996 in 2020.



The entire Eligibility database was matched to the Prescription and Health databases on a monthly basis. For example, January claims were compared to January eligibility.

Prescription Eligibility Sorts

Prescription Eligibility Sorts					
Year	Incur Month	Total # of Claim Records per Rx Database	Total \$ of Records per Rx Database	# of Records NOT Eligible	\$ of Records NOT Eligible
2020	April	3,796	\$ 544,153	8	\$ 17
	May	3,505	\$ 638,957	5	\$ 157
	June	3,907	\$ 652,013	1	\$ 1,163
	July	3,899	\$ 634,803		\$ -
	August	3,841	\$ 633,382		\$ -
	September	3,901	\$ 620,942		\$ -
	October	4,070	\$ 695,893	2	\$ 135
	November	3,748	\$ 681,568	3	\$ 58
	December	4,123	\$ 702,185	1	\$ 1
	2021	January	3,245	\$ 441,159	9
February		2,840	\$ 590,425	4	\$ 892
March		2,323	\$ 344,514		\$ -
Total		43,198	\$ 7,179,994	33	\$ 3,148

HEALTH CLAIMS

*Agreed Upon Procedures
March 31, 2021 and 2020*

Health Eligibility Sorts

Health Eligibility Sorts							
Year	Incur Month	# of Eligibles per Eligibility Database	Total # of Claim Records per Health Database	Total \$ of Records per Health Database	# of Records NOT Eligible	\$ of Records NOT Eligible	
2018	April	1,951	422	\$ 30,843	2	\$ (128)	
	May	1,961	351	\$ 9,275	2	\$ (38)	
	June	1,969	390	\$ (9,571)	-	\$ -	
	July	1,993	417	\$ (9,039)	5	\$ (53)	
	August	1,996	575	\$ 5,012	12	\$ (51)	
	September	2,021	544	\$ 6,305		\$ -	
	October	2,032	997	\$ 30,211	3	\$ -	
	November	2,029	1,113	\$ 275	3	\$ (40)	
	December	2,039	1,062	\$ 53,914	12	\$ 1,398	
	2019	January	2,047	1,785	\$ 355,478	4	\$ -
		February	2,029	2,487	\$ 549,011	24	\$ (53)
		March	2,048	7,221	\$ 583,759	35	\$ (117)
April		2,003	13,587	\$ 1,333,801	228	\$ 3,603	
May		2,039	14,569	\$ 1,163,945	42	\$ 230	
June		2,037	12,909	\$ 1,368,120	76	\$ 427	
July		2,014	13,472	\$ 1,368,431	47	\$ 252	
August		1,896	13,754	\$ 1,469,513	192	\$ 799	
September		1,895	13,757	\$ 1,346,947	34	\$ -	
October		2,025	15,206	\$ 1,228,695	56	\$ -	
November		2,021	13,525	\$ 1,495,402	50	\$ -	
December		2,038	16,688	\$ 1,565,954	105	\$ 461	
2020	January	2,043	16,961	\$ 1,269,506	109	\$ 1,052	
	February	2,040	14,134	\$ 1,018,090	127	\$ -	
	March	1,906	12,971	\$ 969,380	66	\$ -	
	April	2,049	9,083	\$ 666,787	26	\$ 155	
	May	2,047	10,476	\$ 861,834	68	\$ 181	
	June	2,032	12,921	\$ 877,400	68	\$ -	
	July	2,017	14,862	\$ 1,571,440	49	\$ -	
	August	2,004	13,475	\$ 1,223,061	91	\$ -	
	September	1,973	12,652	\$ 1,103,386	74	\$ -	
	October	1,955	14,346	\$ 1,266,730	102	\$ -	
	November	1,938	13,192	\$ 1,031,637	131	\$ 1,050	
	December	1,933	14,592	\$ 1,200,131	199	\$ 914	
2021	January	1,945	12,754	\$ 1,133,477	69	\$ 420	
	February	1,951	8,004	\$ 464,839	61	\$ 345	
	March	1,948	6,623	\$ 401,833	37	\$ 175	
Total			331,877	\$ 29,005,815	2,209	\$ 10,982	

Conclusion: On the Prescription database, a total of \$3,148 was paid on ineligible members. On the Health database, a total of \$10,982 was paid on ineligible members. The total amount paid for ineligible claims was \$14,130. The ineligible claims paid were discussed with the Plan Administrator.

HEALTH CLAIMS

***Agreed Upon Procedures
March 31, 2021 and 2020***

RN HEALTH AND PRESCRIPTION AUDIT

A thorough review of claims provided by PPO and PBM was performed by Debbie Wilkins, RN, and Alma Vazquez, AHFI.

The complete database was reviewed and a sample was selected in each category for further review. Below is a listing of the sample selected and notes from the files reviewed.

NEEDLES & ASSOCIATES, LLC

Appendix A - RN Health Claims Review

#	Reason for Audit	RN Notes with new PPO sample #	To/From Dates	Total Billed Amount	Total Paid Amount	ICD-9/10	ICD-9/10	CPT
2	CPTNotAllowed **Was this procedure preauthorized to rule out a cosmetic procedure? --Yes	Sample #1--Provider is The University Hospital of Arkansas. Claim was received 2/1/2020. This is an output. Surgical claim for the reconstruction of an external ear canal. There is no preauthorization number for this procedure. PPO discount was applied and claim paid at 80% until all oop expenses were met. I will inquire if there was a pre-authorization for this procedure unless the diagnosis itself as "an acquired stenosis" is determined not cosmetic. **12/9/2021 response from processor--"Yes it was approved by UM as medically necessary." I requested an encrypted email copy of this authorization. **12/13/2021--received email of auth from processor: "The first attachment contains snippets from our Precertification/UM database that validates that the services in question were approved." I have attached to the file on w/drive. There is no special auth code provided. CPT code therefore allowable.	1/22/2020	\$ 13,684	\$ 8,415	Q27.39-Arteriovenous malformation, other site G51.0-Bell's palsy	H61.301-Acquired stenosis of right external ear canal, unspecified R13.10-Dysphagia, unspecified	96405-chemotherapy administration; intralesional, up to and including 7 lesions 69310-Reconstruction of external auditory canal (meatoplasty) (eg, for stenosis due to injury, infection) (separate procedure) 15839-Excise excessive skin/tissue
3	CPTNotAllowed	Sample #2--Provider is Methodist Specialty and Transplant Hospital. This is an output. Facility claim for bilateral breast reduction, claim has preauthorization approval number. Claim paid at 80% after ppo discount was applied. Claim fees/payment are reasonable.	9/24/2020	\$ 25,090	\$ 4,520	N62-Hypertrophy of breast	Z20.828-Contact with and (suspected) exposure to other viral communicable diseases	19318-Reduction of large breast 19318-Reduction of large breast
4	CPTNotAllowed	Sample #3--Provider is Advanced Aesthetics of State. This procedure was preauthorized and approved. Participant has met their deductible. The procedure was paid at 100% after the ppo discount was applied. The second procedure was considered and paid at 25% of the provider's negotiated rate for this procedure due to more than one surgical procedure performed on the same date of service. Fees/payment are reasonable.	11/18/2020	\$ 2,053	\$ 833	H02.831-Dermatochalasis of right upper eyelid H02.834-Dermatochalasis of left upper eyelid	D48.5-Neoplasm of uncertain behavior of skin	15823-Blepharoplasty, upper eyelid; with excessive skin weighting down lid 11313-Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm
5	CPTNotAllowed **Was this procedure preauthorized to rule out a cosmetic procedure? --Yes	Sample #4--Provider is Donald A. Hollsten at Methodist Ambulatory Surg Hospital. Deductible has not been met. This procedure appears not to have been preauthorized, there is no auth # listed on page 1 of the "electronic workflow management inquiry 3" screen print. The ppo discount was applied and paid at 80%. Will inquire with fund to see if this procedure for excision of eyelid tissue for drooping eyelid and irritated skin was preapproved. **12/9/2021 response from processor--"Yes it was approved by UM as medically necessary." I requested an encrypted email copy of this authorization. **12/13/2021--received email of auth from processor: "The first attachment contains snippets from our Precertification/UM database that validates that the services in question were approved." I have attached to the file on w/drive. There is no special auth code provided. CPT code therefore allowable.	5/20/2019	\$ 5,188	\$ 775	H02.831-Dermatochalasis of right upper eyelid H02.834-Dermatochalasis of left upper eyelid	H02.413-Mechanical ptosis of bilateral eyelids	67903 (50)- bilateral --Repair of blepharoptosis; (tarsus) levator resection or advancement, internal approach 15823-Blepharoplasty, upper eyelid; with excessive skin weighting down lid
6	CPTNotAllowed	Sample #5--Provider is San Antonio Plastic Surgery Center, P.A. This is the surgeon's claim for bilateral breast reduction, claim has a preauthorization approval number listed above on claim # E6Y1KZ46Y00 from the facility claim. The deductible has not been satisfied so claim paid at 80% after ppo discount was applied. Claim fees/payment are reasonable.	9/24/2020	\$ 2,000	\$ 766	N62-Hypertrophy of breast		19318-Breast reduction
7	CPTNotAllowed **Was this procedure preauthorized to rule out a cosmetic procedure?	Sample #6--Provider is Facial & Oculoplastic Surgery Center of State, PLL. This is an output. Procedure for eyelid surgery, there is no preauthorization number listed. Will inquire if this case was preapproved. Perhaps it was listed in the facility claim. The ppo discount was applied and the claim was paid at 80% of allowable. **12/9/2021 response from processor--"Yes it was approved by UM as medically necessary." I requested an encrypted email copy of this authorization. **12/13/2021--received email of auth from processor: "The first attachment contains snippets from our Precertification/UM database that validates that the services in question were approved." I have attached to the file on w/drive. There is no special auth code provided. CPT code therefore allowable.	4/12/2019	\$ 1,798	\$ 606	H02.413-Mechanical ptosis of bilateral eyelids	H53.453-Other localized visual field defect, bilateral	15823-Blepharoplasty, upper eyelid; with excessive skin weighting down lid

Appendix A - RN Health Claims Review

#	Reason for Audit	RN Notes with new PPO sample #	To/From Dates	Total Billed Amount	Total Paid Amount	ICD-9/10	ICD-9/10	CPT
8	CPTForFemale, but Male Match **claim requires reprocessing under correct female participant. PPO will reprocess this claim under the female spouse.	Sample #7--The provider is Hamilton Medical Center. This is an output. claim for complications during the third trimester of pregnancy. The claim was paid at 100% after ppo discount applied and copay applied. The ACAS Electronic Workflow Management Inquiry 1 screen show the patient as a female with date of birth 7/5/1996 with first name beginning with M, middle initial A, with relationship code as I. The PPO claim details screen shows member name as: M A and listed under member instead of spouse. The claim appears to have been under member who is male, first initial is M. This claim will require reprocessing under the correct participant, the female member with similar first name initials. **12/9/2021 response from processor--"Agree with your findings. The claim will be reprocessed under female spouse."	7/23/2020	\$ 834	\$ 307	O26.853-spotting complicating pregnancy, third trimester	Z3A.36-36 weeks gestation of pregnancy	G0463-Hospital outpatient clinic visit for assessment and management of a patient 59025-Fetal non-stress test
9	RoundedThousands	Sample 8--The provider is Windermere at Westover Hills. This is a split claim for the last 16 days of inpatient subacute rehab care for foot wound. The original claim is listed on the ACAS EWM Inq. 2 screen for dates 4/2-4/15/2019. The charges for 16 days for a subacute care setting are reasonable at \$375/day for a total payment of \$6,000 paid at 100% as all max out of pocket has been met. This rounded dollar billed/paid amount are reasonable.	4/15-4/30/2019	\$ 6,000	\$ 6,000	M86.671-Other chronic osteomyelitis, right ankle and foot	L97.519-Non-pressure chronic ulcer of other part of right foot with unspecified severity	Revenue Code--Subacute care-level 1
10	RoundedThousands	Sample #9-- The provider is Amoena USA Corp. This claim is for the purchase of 2 nonelastic extremity binders for leg swelling. It is usual and customary for these medical devices to be charged as a rounded dollar amount, \$1,500 each. The member's out of pocket max has been met, claim paid at 100%. Fees/payment are reasonable.	8/12/2020	\$ 3,000	\$ 3,000	R60.0-Localized edema		A4465 (lt)-Nonelastic binder for extremity A4465 (rt)-Nonelastic binder for extremity
11	RoundedThousands	Sample #10-- The provider is Amoena USA Corp. This claim is for the purchase of 2 nonelastic extremity binders for leg swelling. It is usual and customary for these medical devices to be charged as a rounded dollar amount, \$1,500 each. The member's out of pocket max has been met, claim paid at 100%. Fees/payment are reasonable.	12/15/2020	\$ 3,000	\$ 3,000	R60.0-Localized edema		A4465 (lt)-Nonelastic binder for extremity A4465 (rt)-Nonelastic binder for extremity
12	RoundedHundreds	Sample #47--The provider is Aegis Sciences Corporation. This output. COVID test billed at \$100 is usual and customary for a high throughput lab. Claim is paid at 100% per total coverage for all covid testing and care. Rounded dollar amount is reasonable.	6/27/2020	\$ 100	\$ 100	Z11.59-Encounter for screening for other viral diseases		U0003-Infectious agent detection by nucleic acid (DNA or RNA); Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R
13	RoundedHundreds	New Sample 48-- The provider is LabCorp. This output. COVID test billed at \$100 is usual and customary for a high throughput lab. Claim is paid at 100% per total coverage for all covid testing and care. Rounded dollar amount is reasonable.	11/25/2020	\$ 100	\$ 100	Z20.828-Contact with and (suspected) exposure to other viral communicable diseases		U0003-Infectious agent detection by nucleic acid (DNA or RNA); Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01

Appendix A - RN Health Claims Review

#	Reason for Audit	RN Notes with new PPO sample #	To/From Dates	Total Billed Amount	Total Paid Amount	ICD-9/10	ICD-9/10	CPT
14	Rounded Hundreds	Sample #49--The provider is LabCorp. This output. COVID test billed at \$100 is usual and customary for a high throughput lab. Claim is paid at 100% per total coverage for all covid testing and care. Rounded dollar amount is reasonable.	12/1/2020	\$ 100	\$ 100	Z11.59-Encounter for screening for other viral diseases		U0003-Infectious agent detection by nucleic acid (DNA or RNA); Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01
15	Void/Denied	Sample #30-- The provider is Baptist Medical Center. This amount was charged for implants (heart valve) and was not paid by the fund. Member is 85 years old. Claim remarks: The provider accepts the amount Medicare approved as payment in full. Denial/Void is reasonable.	10/4/2019	\$ 100,000	\$ -	I35.0-Nonrheumatic aortic (valve) stenosis I50.30-Unspecified diastolic (congestive) heart failure	I30.0-Acute nonspecific idiopathic pericarditis I42.9-Cardiomyopathy, unspecified	02RF38Z-Replacement of Aortic Valve with Zooplastic Tissue, Percutaneous Approach B3101ZZ-Fluoroscopy of Thoracic Aorta using Low Osmolar Contrast
16	Void/Denied	Sample #30-- The provider is Baptist Medical Center. This amount was charged for implants (heart valve) and was not paid by the fund. Member is 85 years old. Claim remarks: The provider accepts the amount Medicare approved as payment in full. Denial/Void is reasonable.	10/4/2019	\$ 100,000	\$ -	I35.0-Nonrheumatic aortic (valve) stenosis I50.30-Unspecified diastolic (congestive) heart failure	I30.0-Acute nonspecific idiopathic pericarditis I42.9-Cardiomyopathy, unspecified	02RF38Z-Replacement of Aortic Valve with Zooplastic Tissue, Percutaneous Approach B3101ZZ-Fluoroscopy of Thoracic Aorta using Low Osmolar Contrast
17	Void/Denied	Sample #13-- The provider is Fresenius Medical Care San Antonio. This claim shows only 5 of the 23 dialysis encounters during the month of January 2019. This participant is covered primary through Medicare for dialysis treatment. There is no payment on this claim as the adjusted claim - 02 include the other 18 dialysis charges (each encounter billed at \$5,719). The remarks on the claim: The provider accepts the amount Medicare approved as payment in full. Denial/Void is reasonable.	1/17/2019	\$ (5,719)	\$ -	N18.6-End stage renal disease E61.2-Magnesium deficiency	N25.81-Secondary hyperparathyroidism of renal origin	90999-unlisted dialysis procedure
18	Void/Denied	Sample #25: Provider is Alice Dialysis. This is a previously considered amount for only one day, one encounter of dialysis, and it's related charges. Claim was paid on adjustment, claim # ending in -C01 for 3 encounters. Denial is reasonable.	5/21/2018	\$ (6,789)	\$ (2,728)	N18.6-End stage renal disease D68.9-Coagulation defect, unspecified	N25.81-Secondary hyperparathyroidism of renal origin	90999-unlisted dialysis procedure
19	Void/Denied	Sample #12-- The Provider is Northeast Methodist Hospital. This is a claim for 8 days that was originally processed on was reconsidered on 8/10/2020 with an adjusted claimed amount of \$85,439.57. Denial is reasonable.	3/7-3/15/2019	\$ 85,440	\$ (23,473)	K52.9-Noninfective gastroenteritis and colitis, unspecified Z68.41-Body mass index [BMI] 40.0-44.9, adult	E87.1-Hypo-osmolality and hyponatremia I16.0-Hypertensive urgency	
20	Paid Gt Than Billed	Sample #31--Provider is Mission Trail Baptist Hospital. This claim is the first 12 intensive care days of the COVID hospitalization. Based on the information provided, this claim was billed at \$1,145,583.54. Although the set case rate for the room and board is allowed at a higher amount than it was billed, the total payment of this entire claim, split into several releases, was \$632,959.40. Fees/payment are reasonable.	7/3-7/14/2020	\$ 66,540	\$ 92,052	U07.1-COVID N39.0-Urinary tract infection, site not specified	T83.51A-Infection and inflammatory reaction due to indwelling urethral catheter, initial encounter J12.89-Other viral pneumonia	0B113F4-Bypass Trachea to Cutaneous with Tracheostomy Device, Percutaneous Approach 5A1955Z-Respiratory Ventilation, Greater than 96 Consecutive Hours 8E0ZXY6-Isolation ICU bed

Appendix A - RN Health Claims Review

#	Reason for Audit	RN Notes with new PPO sample #	To/From Dates	Total Billed Amount	Total Paid Amount	ICD-9/10	ICD-9/10	CPT
21	Paid Gt Than Billed	Sample #31--Provider is Mission Trail Baptist Hospital. This claim is the next subsequent intensive care days of the COVID hospitalization. Based on the information provided, this claim was billed at \$1,145,583.54. Although the set case rate for the room and board is allowed at a higher amount than it was billed, the total payment of this entire claim, split into several releases, was \$632,959.40. Fees/payment are reasonable.	7/15-7/26/2020	\$ 66,540	\$ 92,052	U07.1-COVID N39.0-Urinary tract infection, site not specified	T83.511A-Infection and inflammatory reaction due to indwelling urethral catheter, initial encounter J12.89-Other viral pneumonia	0B113F4-Bypass Trachea to Cutaneous with Tracheostomy Device, Percutaneous Approach 5A1955Z-Respiratory Ventilation, Greater than 96 Consecutive Hours
22	Paid Gt Than Billed	Sample #31--Provider is Mission Trail Baptist Hospital. This claim is the next subsequent intensive care days of the COVID hospitalization. Based on the information provided, this claim was billed at \$1,145,583.54. Although the set case rate for the room and board is allowed at a higher amount than it was billed, the total payment of this entire claim, split into several releases, was \$632,959.40. Fees/payment are reasonable.	7/27-8/7/2020	\$ 66,540	\$ 92,052	U07.1-COVID N39.0-Urinary tract infection, site not specified	T83.511A-Infection and inflammatory reaction due to indwelling urethral catheter, initial encounter J12.89-Other viral pneumonia	0B113F4-Bypass Trachea to Cutaneous with Tracheostomy Device, Percutaneous Approach 5A1955Z-Respiratory Ventilation, Greater than 96 Consecutive Hours 8E0ZXY6-Isolation ICU bed
23	Paid Gt Than Billed	Sample #45--The provider is Baptist Medical Center. This is a 22 day los for COVID (6/26-7/18/2020) with ventilation and 15 days of intensive care. The total billed amount of this hospitalization was \$328,093.72. This claim captures 4 days of ICU 7/6-7/10/20. The billed amount for just an ICU bed is \$27,725, however, the contract/case rate is \$38,355 which also bundles all of the services while in that ICU bed, eliminating other charges including IV solutions and bypass of cardiac artery. This was paid at 100%. Appears total payment to provider for entire hospitalization was \$180,855.50. Fees/payment are reasonable.	7/6-7/10/2020	\$ 27,725	\$ 38,355	U07.1-COVID J12.89-Other viral pneumonia	J96.01-Acute respiratory failure with hypoxia J15.9-Unspecified bacterial pneumonia	5A1955Z-Respiratory Ventilation, Greater than 96 Consecutive Hours 0BH17EZ-Insertion of Endotracheal Airway into Trachea, Via Natural or Artificial Opening 33774-Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass. 5A09557-Assistance with Respiratory Ventilation, Greater than 96 Consecutive Hours, Continuous Positive Airway Pressure 02HV33Z-Insertion of Infusion Device into Superior Vena Cava, Percutaneous Approach
24	Paid Gt Than Billed	Sample #31--The provider is Mission Trail Baptist Hospital. This claim is for the POST ICU (intermediate ICU a step down from intensive care) dates of service beginning 8/25/2020 nearing the end of the hospital stay. The post ICU days total 16 so 2 claims divided the dates into 2 groups of 8 POST ICU days. The amount is allowed at a higher contract/case rate that included bundled services while in ICU so other charges are disallowed. Total los is 69 days for COVID. Fees/payment are reasonable.	8/25-9/1/2020	\$ 32,840	\$ 61,368	U07.1-COVID N39.0-Urinary tract infection, site not specified	T83.511A-Infection and inflammatory reaction due to indwelling urethral catheter, initial encounter J12.89-Other viral pneumonia	0B113F4-Bypass Trachea to Cutaneous with Tracheostomy Device, Percutaneous Approach 5A1955Z-Respiratory Ventilation, Greater than 96 Consecutive Hours

Appendix A - RN Health Claims Review

#	Reason for Audit	RN Notes with new PPO sample #	To/From Dates	Total Billed Amount	Total Paid Amount	ICD-9/10	ICD-9/10	CPT
25	Duplicate	Sampled # 23--The provider is Methodist Stone Oak Hospital. This is a claim for the output. Procedure to implant 4 neurostimulator leads for chronic low back pain was precertified. It is not warranted to have 2 generators unless this was specifically detailed in the preauthorization. Otherwise, the claim amount of \$69,719 for one generator, CPT code C1820, would be covered. A second generator C1820 was also billed at \$69,719.00 and paid at \$31,512.99 would be considered a duplicate in claim #EFFCGQWMV02. **12/10/2021 update: this is not a duplicate claim, processor is only allowed to consider a maximum of \$99,999.99. Fees/payment are reasonable.	1/22/2020	\$ 69,719	\$ 31,513	M54.16-Radiculopathy, lumbar region G89.4-Chronic pain syndrome	M19.90-Unspecified osteoarthritis, unspecified site I10-Essential (primary) hypertension	C1820- Generator, neurostimulator (implantable), with rechargeable battery and charging system C1778-Lead, neurostimulator (implantable) 63650-Percutaneous implantation of neurostimulator electrode array, epidural
26	Duplicate	Sampled # 23--The provider is Methodist Stone Oak Hospital. This is a claim for the output. Procedure to implant 4 neurostimulator leads for chronic low back pain was precertified. It is not warranted to have 2 generators unless this was specifically detailed in the preauthorization. Otherwise, the claim #EFFCGQWMV01 billed amount for \$69,719 for one generator, CPT code C1820, would be covered. A second generator C1820 was also billed at \$69,719.00 and paid at \$31,512.99 would be considered a duplicate in claim #EFFCGQWMV02. **12/9/2021 response from processor--"The provider only billed for 1 unit of C1820 (generator, neurostimulator) however the billed charges exceed the \$\$ amount that we are able to enter on the processing screen (\$139,438.00) We can only enter \$99,999.99 on the processing screen; therefore, the claim line was split onto 2 claim lines/2 segments but is only considered 1 unit." Fees/payment are reasonable.	1/22/2020	\$ 69,719	\$ 31,513	M54.16-Radiculopathy, lumbar region G89.4-Chronic pain syndrome	M19.90-Unspecified osteoarthritis, unspecified site I10-Essential (primary) hypertension	C1820- Generator, neurostimulator (implantable), with rechargeable battery and charging system C1778-Lead, neurostimulator (implantable) 63650-Percutaneous implantation of neurostimulator electrode array, epidural
27	Duplicate	Sample #16--The provider is Methodist Stone Oak Hospital. This is for the implantation of a neurostimulator (an array) for chronic low back pain. This claim also considers the charge for one implantable neurostimulator generator, only one is typically required. However, the next claim #E6FB9CNS502 charges and pays for a second generator. This would be considered a duplicate payment for the same device. **12/10/2021 update: this is not a duplicate claim, processor is only allowed to consider a maximum of \$99,999.99. Fees/payment are reasonable.	4/19/2019	\$ 64,817	\$ 30,010	G89.4-Chronic pain syndrome M54.16-Radiculopathy, lumbar region		C1767-Generator, neurostimulator (implantable), nonrechargeable 63650-Percutaneous implantation of neurostimulator electrode array, epidural
28	Duplicate	Sample #16--The provider is Methodist Stone Oak Hospital. This is for the implantation of a neurostimulator (an array) for chronic low back pain. This claim also considers the charge for one implantable neurostimulator generator, only one is typically required. However, this claim #E6FB9CNS502 charges and pays for a second generator. This would be considered a duplicate payment for the same device. **12/9/2021 response from processor--"The provider only billed for 1 unit of C1767 (generator, neurostimulator) however the billed charges exceed the \$\$ amount that we are able to enter on the processing screen (\$129,634.00) We can only enter \$99,999.99 on the processing screen; therefore, the claim line was split onto 2 claim lines/2 segments but is only considered 1 unit." Fees/payment are reasonable.	4/19/2019	\$ 64,817	\$ 30,010	G89.4-Chronic pain syndrome M54.16-Radiculopathy, lumbar region		C1767-Generator, neurostimulator (implantable), nonrechargeable 63650-Percutaneous implantation of neurostimulator electrode array, epidural
29	Duplicate	Sample #27--The provider is Methodist Texan Hospital. This is a claim for the implantation of Autologous Tissue Substitute to replace the cervical vertebral joint. This was done twice for the fusion of 2 joints. This claim and EJY1M5JSX02 are not duplicates. The total charge for the implant was \$119,009, so this larger amount was considered in 2 claim releases. Fees/payment are reasonable.	10/8-10/12/2020	\$ 59,505	\$ 27,432	M48.02-Spinal stenosis, cervical region G95.9-Disease of spinal cord, unspecified	Z20.828-Contact with and (suspected) exposure to other viral communicable diseases	0RG2071-Fusion of 2 or more Cervical Vertebral Joints with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach 0PB30ZZ- Excision of Cervical Vertebra, Open Approach

Appendix A - RN Health Claims Review

#	Reason for Audit	RN Notes with new PPO sample #	To/From Dates	Total Billed Amount	Total Paid Amount	ICD-9/10	ICD-9/10	CPT
30	Duplicate	Sample #27--The provider is Methodist Texan Hospital. This is a claim for the implantation of Autologous Tissue Substitute to replace the cervical vertebral joint. This was done twice for the fusion of 2 joints. This claim and EJY1M5JSX01 are not duplicates. The total charge for the implant was \$119,009, so this larger amount was considered in 2 claim releases. Fees/payment are reasonable.	10/8-10/12/2020	\$ 59,505	\$ 27,432	M48.02-Spinal stenosis, cervical region G95.9-Disease of spinal cord, unspecified	Z20.828-Contact with and (suspected) exposure to other viral communicable diseases	0RG2071-Fusion of 2 or more Cervical Vertebral Joints with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach 0PB30ZZ- Excision of Cervical Vertebra, Open Approach
31	Duplicate	Sample #31--The provider is Mission Trail Baptist Hospital. This is the claim from the 69 day COVID hospitalization that breaks out the drugs from the hospitalization. The detail is listed in 2 separate claim numbers to represent the total cost of drugs during this hospitalization=\$154,778.70. This is not a duplicate. 1/2 of the total drug cost is considered and paid in this claim and the other ending in -08. Fees/payment are reasonable.	7/3-9/10/2020	\$ 77,389	\$ 11,608	U07.1-COVID N39.0-Urinary tract infection, site not specified	T83.511A-Infection and inflammatory reaction due to indwelling urethral catheter, initial encounter J12.89-Other viral pneumonia	0B113F4-Bypass Trachea to Cutaneous with Tracheostomy Device, Percutaneous Approach 5A1955Z-Respiratory Ventilation, Greater than 96 Consecutive Hours 8E0ZXY6-Isolation
32	Duplicate	Sample #31--The provider is Mission Trail Baptist Hospital. This is the claim from the 69 day COVID hospitalization that breaks out the drugs from the hospitalization. The detail is listed in 2 separate claim numbers to represent the total cost of drugs during this hospitalization=\$154,778.70. This is not a duplicate. 1/2 of the total drug cost is considered and paid in this claim and the other ending in -07. Fees/payment are reasonable.	7/3-9/10/2020	\$ 77,389	\$ 11,608	U07.1-COVID N39.0-Urinary tract infection, site not specified	T83.511A-Infection and inflammatory reaction due to indwelling urethral catheter, initial encounter J12.89-Other viral pneumonia	0B113F4-Bypass Trachea to Cutaneous with Tracheostomy Device, Percutaneous Approach 5A1955Z-Respiratory Ventilation, Greater than 96 Consecutive Hours 8E0ZXY6-Isolation
33	Duplicate - Why is max billing \$99k?	Sample #34--The provider is New San Antonio Specialty Hospital. This is a hospital claim for 60 days in ICU for respiratory and renal failure, prior to pandemic, on ventilator. Medicare is prime for this participant due to disability of quadriplegia. Total paid to this facility is \$37,509.99. This claim and the one below-BNK04 are one of 3 claims that broke out the total pharmacy (drug) charges for the entire hospitalization =\$212,946.37. It is usual and customary to max out a large claim to \$99,999.99. Medicare paid primary so the COB is only \$2,466.59 for each of these claims. The remaining amount of \$12,946.39 was paid at \$2,266.11. Fees/payment are reasonable.	9/27-11/25/2019	\$ 100,000	\$ 2,467	J95.822-Acute and chronic postprocedural respiratory failure R53.2-Functional quadriplegia	E43-Unspecified severe protein-calorie malnutrition N18.6-End stage renal disease	5A1955Z-Respiratory Ventilation, Greater than 96 Consecutive Hours 5A1D70Z-Performance of Urinary Filtration, Intermittent, Less than 6 Hours Per Day 0DH68UZ-Insertion of Feeding Device into Stomach, Via Natural or Artificial Opening Endoscopic 30243N1-Transfusion of Nonautologous Red Blood Cells into Central Vein, Percutaneous Approach
34	Duplicate - Why is max billing \$99k?	Sample #34--The provider is New San Antonio Specialty Hospital. This is a hospital claim for 60 days in ICU for respiratory and renal failure, prior to pandemic, on ventilator. Medicare is prime for this participant due to disability of quadriplegia. Total paid to this facility is \$37,509.99. This claim and the one above-BNK03 are one of 3 claims that broke out the total pharmacy (drug) charges for the entire hospitalization =\$212,946.37. It is usual and customary to max out a large claim to \$99,999.99. Medicare paid primary so the COB is only \$2,466.59 for each of these claims. The remaining amount of \$12,946.39 was paid at \$2,266.11. Fees/payment are reasonable.	9/27/2019	\$ 100,000	\$ 2,467	J95.822-Acute and chronic postprocedural respiratory failure R53.2-Functional quadriplegia	E43-Unspecified severe protein-calorie malnutrition N18.6-End stage renal disease	5A1955Z-Respiratory Ventilation, Greater than 96 Consecutive Hours 5A1D70Z-Performance of Urinary Filtration, Intermittent, Less than 6 Hours Per Day 0DH68UZ-Insertion of Feeding Device into Stomach, Via Natural or Artificial Opening Endoscopic 30243N1-Transfusion of Nonautologous Red Blood Cells into Central Vein, Percutaneous Approach

Appendix A - RN Health Claims Review

#	Reason for Audit	RN Notes with new PPO sample #	To/From Dates	Total Billed Amount	Total Paid Amount	ICD-9/10	ICD-9/10	CPT
35	PaidGt365	Sample #51--The provider is Baptist Medical Center. The original received date for this claim was 6/21/2016 and paid. This claim was received again on 8/30/2019 for an adjustment as "the provider's negotiated amount was reduced to reflect the reimbursement level authorized for the care provided." Filing is timely.	11/18-11/29/2015	\$ 92,894	\$ 26,669	E11.52-Type 2 diabetes N18.6-End stage renal disease	D61.818-Other pancytopenia D68.9- Coagulation defect, unspecified	0QBQ0ZZ-Excision of Right Toe Phalanx, Open Approach 047K3ZZ-Dilation of Right Femoral Artery, Percutaneous Approach
36	PaidGt365	Sample #32--The provider is St. Lukes Baptist Hospital. This is a 4 day pre-approved hospitalization for surgery. This claim was originally submitted 4/9/2016. Filing is timely.	3/29-4/1/2018	\$ 59,783	\$ 22,018	L02.31-Cutaneous abscess of buttock Z68.41-Body mass index [BMI] 40.0-44.9, adult		0J990ZZ-Drainage of Buttock Subcutaneous Tissue and Fascia, Open Approach
37	PaidGt365	Sample #17--The provider is North Central Baptist Hospital. Original claim was received 3/15/2018 for a 3 day hospitalization and paid. This claim was adjusted to correct the case rate paid to provider. Filing is timely.	3/4-3/6/2018	\$ 31,627	\$ 15,885	T42.4X2A- Poisoning by benzodiazepines, intentional self-harm, initial encounter E10.65-Type 1 diabetes mellitus with hyperglycemia	R45.851-Suicidal ideations Z91.5- Personal history of self-harm	
38	PaidGt365	Sample #19--The provider is Innovative Infusions. The original received date is 6/18/2019 and paid. This claim was received again on 8/20/2020 for claim adjustment of \$6.36. Filing is timely.	6/8/2019	\$ 24,746	\$ 6,928	M32.19-Other organ or system involvement in systemic lupus erythematosus		96415-Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure) J9312-Injection, rituximab, 10 mg (Rituximab is a monoclonal antibody)
39	PaidGt365	Sample #15--The provider is Innovative Infusions. The claim was originally received 7/24/2019 and paid. Claim received again on 8/18/2020 for an adjustment on the cost of the IV administration. Filing is timely.	7/20/2019	\$ 24,801	\$ 6,878	M32.19-Other organ or system involvement in systemic lupus erythematosus		96415-Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure) J9312-Injection, rituximab, 10 mg (Rituximab is a monoclonal antibody)
40	PaidGt365	Sample #24--The provider is Methodist Specialty Transplant Hospital. This claim for an output. diagnostic procedure was originally received on 6/29/2019 and paid. On 7/8/2020, this claim was resubmitted and adjusted. Filing is timely.	6/24/2019	\$ 22,515	\$ 4,513	N84.0- Polyp of corpus uteri	D50.0- Iron deficiency anemia secondary to blood loss (chronic)	58558-Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C
41	PaidGt365	Sample #38--The provider is Best Choice Anesthesia. The original claim was received 11/30/2018 and where only \$396.10 was paid. The claim was received again on 5/27/2020 and adjusted to cover the full amount for anesthesia for surgery of the spinal cord; all out of pocket was met. Filing is timely.	10/25/2018	\$ 3,855	\$ 3,855	M50.20- Other cervical disc displacement, unspecified cervical region	J44.9- Chronic obstructive pulmonary disease, unspecified	00630-Anesthesia for procedures in lumbar region; not otherwise specified

Appendix A - RN Health Claims Review

#	Reason for Audit	RN Notes with new PPO sample #	To/From Dates	Total Billed Amount	Total Paid Amount	ICD-9/10	ICD-9/10	CPT
42	PaidGt365 **Not filed timely, 836 days** Not filed timely, paid 836 days after the date of service. Please provide additional information why this claim was paid >365 days and if there was an earlier received date for this claim, please provide that document. **Confirmed--claim original submission was	Sample #39--The provider is Baptist Emergency Hospital. This is a one day claim for prophylactic IV infusion. The only claim and EOB submitted had a received date of 3/31/2020. This claim is not filed timely, 836 days from date of service, and appears as processed as primary. Will refer back to fund office to determine if this was received back in 2017 or 2018. **12/9/2021 response from processor--"This was a corrected claim to a previously submitted claim in history that had been received timely. Since the original claim was submitted timely, the new corrected claim is not subject to timely filing limits." I requested to receive an encrypted emailed copy of the originally submitted claim with date received. **12/13/2021--received email from processor on 12/10/21 stating, "The original received date for claim 42 is reflected on the first page of the documentation that I initially sent for this claim: 11/25/20. The related claim that had been submitted timely is under a different claim ID because it is a separate/unique claim for the same services, thus the sample selection is considered a replacement/corrected claim. The attached PDF is a printout of the original claim submission and the original received date is highlighted." We did not receive this page of the ACA electronic workflow management inquiry screen on their initial submission of documents, the received date is listed as 1/2/2018. This is within timely filing and is reasonable. This doc. is added to the file on w/drive.	12/15-12/16/2017	\$ 8,179	\$ 2,850	J18.1- Lobar pneumonia, unspecified organism		96365 (59)-Two line, Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour 96361 (59)-Two lines, Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)
43	PaidGt365	Sample #46--The provider is HB2, LLC. The original claim was received 4/9/2016 and paid. Claim was resubmitted 4/19/2019 for adjustment. Filing is timely.	2/17/2016	\$ 3,401	\$ 2,773	Z00.00- Encounter for general adult medical examination without abnormal findings		86141-C-reactive protein; high sensitivity (hsCRP)
44	PaidGt365	Sample #28--The provider is Methodist Stone Oak Hospital. Original claim was received 3/22/2018. The provider submitted the claim 2 years later with \$70.63 in pharmacy charges that were not payable due to timely filing. That charged put toward participant's out of pocket.	2/9/2018	\$ 11,223	\$ 2,684	F31.9-Bipolar disorder, unspecified	F41.9-Anxiety disorder, unspecified	36561-Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older C1788- Port, indwelling (implantable) J2704- Injection, propofol, 10 mg
45	2020Material	Sample #50--The provider is St. Anthony Hospital in Colorado and is considered In-Network. The total billed amount is \$290,786.48. This is a 10 day los for an intracerebral hemorrhage including 6 days of intensive care. The case rate is inclusive of all other charges outside of room/board. Claim is paid at 100%. Same process date. Fees/payment are reasonable.	2/18/2019	\$ 74,644	\$ 71,950	I61.1-Nontraumatic intracerebral hemorrhage in hemisphere, cortical Q28.2-Arteriovenous malformation of cerebral vessels	J95.821-Acute postprocedural respiratory failure R47.01-Aphasia	03BG0ZZ-Excision of Intracranial Artery, Open Approach 05BL0ZZ-Excision of Intracranial Vein, Open Approach 00970ZZ- Drainage of Cerebral Hemisphere, Open Approach B31F1ZZ-Fluoroscopy of Left Vertebral Artery using Low Osmolar Contrast

Appendix A - RN Health Claims Review

#	Reason for Audit	RN Notes with new PPO sample #	To/From Dates	Total Billed Amount	Total Paid Amount	ICD-9/10	ICD-9/10	CPT
46	2020Material - Same claim number but different process date	Sample #50--The provider is St. Anthony Hospital in Colorado and is considered In-Network. The total billed amount is \$290,786.48. This is a 10 day los for an intracerebral hemorrhage including 6 days of intensive care. The case rate is inclusive of the entire room and board including intensive care as well as specialty medications. Claim is paid at 100%. Same process date. Fees/payment are reasonable.	2/18-2/28/2019	\$ 9,177	\$ 71,950	I61.1-Nontraumatic intracerebral hemorrhage in hemisphere, cortical Q28.2-Arteriovenous malformation of cerebral vessels	J95.821-Acute postprocedural respiratory failure R47.01-Aphasia	03BG0ZZ-Excision of Intracranial Artery, Open Approach 05BL0ZZ-Excision of Intracranial Vein, Open Approach 00970ZZ- Drainage of Cerebral Hemisphere, Open Approach B31F1ZZ-Fluoroscopy of Left Vertebral Artery using Low Osmolar Contrast
47	2020Material - Same claim number but different process date	This claim # shows the amount that is not payable as it was part of the total case rate due to the provider. Same process date.	2/22/2019	\$ 39,758	\$ -	I61.1-Nontraumatic intracerebral hemorrhage in hemisphere, cortical Q28.2-Arteriovenous malformation of cerebral vessels	J95.821-Acute postprocedural respiratory failure R47.01-Aphasia	03BG0ZZ-Excision of Intracranial Artery, Open Approach 05BL0ZZ-Excision of Intracranial Vein, Open Approach 00970ZZ- Drainage of Cerebral Hemisphere, Open Approach B31F1ZZ-Fluoroscopy of Left Vertebral Artery using Low Osmolar Contrast
48	2020Material - Same claim number but different process date	Sample #40--The provider is University Health System. The total billed amount is \$217,671.17 for a liver transplant. There is a case rate for charges for a liver transplant by this provider. The charges for this claim are not payable as they are included in the total case rate. Processed on 10/8/2019.	8/22-8/28/2019	\$ 57,923	\$ -	K70.30-Alcoholic cirrhosis of liver without ascites K76.6-Portal hypertension	C22.0-Liver cell carcinoma 185.00-Esophageal varices without bleeding	0FY00Z0-Transplantation of Liver, Allogeneic, Open Approach 30243K1-Transfusion of Nonautologous Frozen Plasma into Central Vein, Percutaneous Approach 30243N1-Transfusion of Nonautologous Red Blood Cells into Central Vein, Percutaneous Approach
49	2020Material - Same claim number but different process date	Sample #40--The provider is University Health System. The total billed amount is \$217,671.17 for a liver transplant. There is a case rate for charges for a liver transplant by this provider. The case rate separates the room/board charges from all other charges during the hospitalization. Case paid at 100%. Processed on 10/8/2019. Fees/payment are reasonable.	8/26/2019	\$ 6,302	\$ 94,790	K70.30-Alcoholic cirrhosis of liver without ascites K76.6-Portal hypertension	C22.0-Liver cell carcinoma 185.00-Esophageal varices without bleeding	0FY00Z0-Transplantation of Liver, Allogeneic, Open Approach 30243K1-Transfusion of Nonautologous Frozen Plasma into Central Vein, Percutaneous Approach 30243N1-Transfusion of Nonautologous Red Blood Cells into Central Vein, Percutaneous Approach

Appendix A - RN Health Claims Review

#	Reason for Audit	RN Notes with new PPO sample #	To/From Dates	Total Billed Amount	Total Paid Amount	ICD-9/10	ICD-9/10	CPT
50	2020Material	Sample #40--The provider is University Health System. The total billed amount is \$217,671.17 for a liver transplant. There is a case rate for charges for a liver transplant by this provider. The case rate separates the room/board charges from all other charges during the hospitalization. Case paid at 100%. Processed on 10/8/2019. Fees/payment are reasonable.	8/22/2019	\$ 99,991	\$ 95,000	K70.30-Alcoholic cirrhosis of liver without ascites K76.6-Portal hypertension	C22.0-Liver cell carcinoma I85.00-Esophageal varices without bleeding	0FY00Z0-Transplantation of Liver, Allogeneic, Open Approach 30243K1-Transfusion of Nonautologous Frozen Plasma into Central Vein, Percutaneous Approach 30243N1-Transfusion of Nonautologous Red Blood Cells into Central Vein, Percutaneous Approach
51	2020Material - Same claim number but different process date	Sample #36--The provider is Baptist Medical Center. The total billed amount was \$282,165.90 for an 11 day los including intensive care days infection and leg amputation. There is a contract and/or case rate for this service to the provider. The total allowance for the hospitalization is \$85,327.40 which was initially paid at 80% until out of pocket max was met to pay remainder at 100%. Fees/payment are reasonable.	6/15-6/26/2019	\$ 36,590	\$ 85,327	A40.9-Streptococcal sepsis, unspecified E11.10-Type 2 diabetes mellitus with ketoacidosis without coma	A48.0- Gas gangrene I33.0- Acute and subacute infective endocarditis	0JBQ0ZZ- Excision of Right Foot Subcutaneous Tissue and Fascia, Open Approach 0Y6H0Z1-Detachment at Right Lower Leg, High, Open Approach
52	2020Material - Same claim number but different process date	Sample #36--The provider is Baptist Medical Center. There is no payment released for this portion of the claim as all of the charges are included in the case rate.	6/17/2019	\$ 26,226	\$ -	A40.9-Streptococcal sepsis, unspecified E11.10-Type 2 diabetes mellitus with ketoacidosis without coma	A48.0- Gas gangrene I33.0- Acute and subacute infective endocarditis	0JBQ0ZZ- Excision of Right Foot Subcutaneous Tissue and Fascia, Open Approach 0Y6H0Z1-Detachment at Right Lower Leg, High, Open Approach
53	2020Material	Sample #35--The provider is St. Lukes Baptist Hospital. The total billed amount for this inpatient rehab hospitalization was \$221,787.04. The contracted case rate is \$86,430.00. Claim paid at 100%. Fees/payment are reasonable.	5/30-7/12/2019	\$ 91,352	\$ 86,430	I61.8-Other nontraumatic intracerebral hemorrhage G93.6-Cerebral edema	I26.99- Other pulmonary embolism without acute cor pulmonale I50.23-Acute on chronic systolic (congestive) heart failure	3E0337Z-Introduction of Electrolytic and Water Balance Substance into Peripheral Vein, Percutaneous Approach
54	2020Material	Sample #33--The provider is Brooke Army Med Center. This 8 day hospitalization for serious wound care was billed as an all inclusive facility charge and paid in 2 releases to cover charges at 100% as all out of pocket was met. Each release was paid at \$40,647.92. Fees/payment are reasonable.	4/30-5/7/2018	\$ 81,296	\$ 81,296	T81.4XXA-Infection following a procedure, initial encounter M72.6-Necrotizing fasciitis	Z68.42-Body mass index [BMI] 45.0-49.9, adult B95.61-Methicillin susceptible Staphylococcus aureus infection as the cause of diseases classified elsewhere	0J9Q0ZZ-Drainage of Right Foot Subcutaneous Tissue and Fascia, Open Approach
55	2020Material	Sample #26--The provider is Brooke Army Med Center. This claim for a lumbar spinal fusion was billed as an all inclusive facility charge in 2 releases totaling \$68,007.13. Claims are paid at 80% until all out of pocket was met. Fees/payment are reasonable.	1/11-1/13/2018	\$ 70,586	\$ 68,007	M51.36-Other intervertebral disc degeneration, lumbar region	M54.4-Lumbago with sciatica	0SG03AJ- Fusion of Lumbar Vertebral Joint with Interbody Fusion Device, Posterior Approach, Anterior Column, Percutaneous Approach 0SH334Z-Insertion of Internal Fixation Device into Lumbosacral Joint, Percutaneous Approach

Appendix A - RN Health Claims Review

#	Reason for Audit	RN Notes with new PPO sample #	To/From Dates	Total Billed Amount	Total Paid Amount	ICD-9/10	ICD-9/10	CPT
56	2020Material - Same claim number but different process date	Sample #22--The provider is Methodist Specialty Transplant Hospital. This 13 day los for a kidney transplant failure including 10 days in intensive care. The remainder of this case rate was paid in the above claim # that is separated to show the remainder of the charges with a total payment of \$74,852.84. Claim paid 2/11/2020. Fees/payment are reasonable.	1/1/2020	\$ 58,065	\$ 25,983	T86.12-Kidney transplant failure L89.154-Pressure ulcer of sacral region, stage 4	Z51.5-Encounter for palliative care	
57	2020Material - Same claim number but different process date	Sample #22--The provider is Methodist Specialty Transplant Hospital. This 13 day los for a kidney transplant failure including 10 days in intensive care. This claim considered only the intensive care room/board. The remainder of this case rate was paid in the above claim # that is separated to show the remainder of the charges with a total payment of \$74,852.84. Claim paid 2/11/2020. Fees/pavment are reasonable.	1/4/2020	\$ 39,950	\$ 48,870	T86.12-Kidney transplant failure L89.154-Pressure ulcer of sacral region, stage 4	Z51.5-Encounter for palliative care	
58	2020Material - Same claim number but different process date	Sample #21--The provider is University Health System. The total billed amount is \$282,552.71. This is a 12 day los including 10 days of intensive care for mitral and tricuspid valve replacement. This claim pays the inclusive case rate for the ICU dates. Paid at 100%. (the charges for the new valves and implants are considered in a separate claim ending -01) Claim paid 8/5/2019. Fees/payment are reasonable.	7/8-7/10/2019	\$ 57,836	\$ 53,608	I08.1-Rheumatic disorders of both mitral and tricuspid valves N17.0-Acute kidney failure with tubular necrosis		02RG0JZ-Replacement of Mitral Valve with Synthetic Substitute, Open Approach 02UJ0JZ- Supplement Tricuspid Valve with Synthetic Substitute, Open Approach
59	2020Material - Same claim number but different process date	Sample #21--The provider is University Health System. The total billed amount is \$282,552.71. This is a 12 day los including 10 days of intensive care for mitral and tricuspid valve replacement. This claim pays the inclusive case rate for the room/board dates. Paid at 100%. (the charges for the new valves and implants are considered in a separate claim ending -01) Claim paid 8/5/2019. Fees/payment are reasonable.	7/8-7/10/2019	\$ 31,510	\$ 12,363	I08.1-Rheumatic disorders of both mitral and tricuspid valves N17.0-Acute kidney failure with tubular necrosis		02RG0JZ-Replacement of Mitral Valve with Synthetic Substitute, Open Approach 02UJ0JZ- Supplement Tricuspid Valve with Synthetic Substitute, Open Approach
60	2020Material - Same claim number but different process date	Sample #20--The provider is Baptist Medical Center. The total billed amount was \$308,236.58. This is a 6 day los for a heart attack with coronary artery procedures including intermediate intensive and coronary care. The provider has a contracted case rate where the intermediate icu days are both considered and include the implants used for the artery stents. The charges are paid at 80% until the out of pocket was met to pay claims at 100%. Claim was paid 8/27/2019. Fees/payment are reasonable.	8/6-8/12/2019	\$ 93,539	\$ 67,018	I21.4-Non-ST elevation (NSTEMI) myocardial infarction N17.9-Acute kidney failure, unspecified	I25.10-Atherosclerotic heart disease of native coronary artery without angina pectoris I25.84-Coronary atherosclerosis due to calcified coronary lesion	027137Z-Dilation of Coronary Artery, Two Arteries with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach B2111ZZ-Fluoroscopy of Multiple Coronary Arteries using Low Osmolar Contrast
61	2020Material - Same claim number but different process date	Sample #20--The provider is Baptist Medical Center. The total billed amount was \$308,236.58. These charges for intermediate coronary care were not allowed separate from the contracted paid amount.	8/6-8/12/2019	\$ 5,828	\$ -	I21.4-Non-ST elevation (NSTEMI) myocardial infarction N17.9-Acute kidney failure, unspecified	I25.10-Atherosclerotic heart disease of native coronary artery without angina pectoris I25.84-Coronary atherosclerosis due to calcified coronary lesion	027137Z-Dilation of Coronary Artery, Two Arteries with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach B2111ZZ-Fluoroscopy of Multiple Coronary Arteries using Low Osmolar Contrast
62	2020Material	Sample #18--The provider is Baptist Medical Center. The total billed amount was \$99,176.97. This is a 13 day hospitalization for the removal of a toe due to gangrene. The contracted rate for this provider is considered and paid at 100% as all out of pocket was previously met. Fees/payment are reasonable.	4/2-4/15/2019	\$ 99,177	\$ 97,315	E11.69-Type 2 diabetes mellitus with other specified complication M86.171-Other acute osteomyelitis, right ankle and foot	I96-Gangrene, not elsewhere classified	0QBNOZZ- Excision of Right Metatarsal, Open Approach 0QBQ0ZZ-Acute kidney failure, unspecified

Appendix A - RN Health Claims Review

#	Reason for Audit	RN Notes with new PPO sample #	To/From Dates	Total Billed Amount	Total Paid Amount	ICD-9/10	ICD-9/10	CPT
63	2020Material	Sample #14--The University Health System. This is a 28 day los for cancer and surgery. The total billed amount was \$153,650.46. The contracted case rate was considered and paid at 100%. Fees/payment are reasonable.	7/4-8/11/2019	\$ 44,222	\$ 80,948	C16.9-Malignant neoplasm of stomach, unspecified C77.2-Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes	C78.6-Secondary malignant neoplasm of retroperitoneum and peritoneum C79.82-Secondary malignant neoplasm of genital organs	07BD3ZX-Excision of Aortic Lymphatic, Percutaneous Approach, Diagnostic 00UB7ZX-Extraction of Endometrium, Via Natural or Artificial Opening, Diagnostic
64	2020Material - Same claim number but different process date	Sample 11-- The provider is Methodist Specialty Transplant Hospital. This is a 16 day los hospitalization for serious urethral and intestinal disorders. These charges exclude the intensive care r/b which is paid separately under same claim # below for only the ICU charges from 2/22/2019-2/26/2019. The allowable amount is paid at 100% per the contractual case rate. All out of pocket has previously been met. Fee/payment are reasonable.	2/11-2/27/2019	75661.46	42645.83	N32.1-Vesicointestinal fistula J96.01-Acute respiratory failure with hypoxia	K63.2-Fistula of intestine	0T788DZ-Dilation of Bilateral Ureters with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
65	2020Material - Same claim number but different process date	Sample 11-- The provider is Methodist Specialty Transplant Hospital. This is a 16 day los hospitalization for serious urethral and intestinal disorders. These claim line includes the intensive care r/b which is paid separately under same claim # above. Fees/payment are reasonable.	2/22/2019	\$ 19,025	\$ 23,385	N32.1-Vesicointestinal fistula J96.01-Acute respiratory failure with hypoxia	K63.2-Fistula of intestine	0T788DZ-Dilation of Bilateral Ureters with Intraluminal Device, Via Natural or Artificial Opening Endoscopic 52332-Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type) 0DJD8ZZ-Inspection of Lower Intestinal Tract, Via Natural or Artificial Opening Endoscopic
66	2021Material - Same claim number but different process date	Sample #45--The provider is Baptist Medical Center. This is a 22 day los for COVID (6/26-7/18/2020) with ventilation and 15 days of intensive care. The total billed amount of this hospitalization was \$328,093.72. This claim captures 4 days of ICU 7/6-7/10/20. The billed amount for just an ICU bed is \$27,725, however, the contract/case rate is \$38,355 which also bundles all of the services while in that ICU bed, eliminating other charges including IV solutions and bypass of cardiac artery. This was paid at 100%. Fees/payment are reasonable.	7/6-7/10/2020	\$ 37,671	\$ 38,355			
67	**SAME AS LINE 23 ABOVE**2021Material - Same claim number but different process date	Sample #45--The provider is Baptist Medical Center. This is a 22 day los for COVID (6/26-7/18/2020) with ventilation and 15 days of intensive care. The total billed amount of this hospitalization was \$328,093.72. This claim captures 7 days of Intermediate ICU 7/11-7/17/20. The billed amount for just an Intermediate ICU bed is \$28,735, however, the contract/case rate is \$53,697.00 which also bundles all of the services while in that Intermediate ICU bed, eliminating other charges including IV solutions and bypass of cardiac artery. This was paid at 100%. Fees/payment are reasonable.	7/11-7/17/2020	\$ 28,735	\$ 53,697			
68	2021 Material	Sample #44--The provider is Methodist Hospital. This is a 31 day hospitalization with intensive care and intermediate coronary critical care. The total billed amount is \$434,499.52. This is an in network provider and the charges listed on this -07 extension of the claim number represent all drug/pharmacy charges throughout the hospital stay (less \$1,857.27) and paid at 100% as out of pocket was met. This claim was paid 9/26/2020. Fees/payment are reasonable.	11/22-12/23/2019	\$ 98,000	\$ 98,000	A41.9-Sepsis L89.154-Pressure ulcer	J18.9-Pneumoia J96.01-Acute respiratory failure	02HV33Z-Insertion of Infusion Device into Superior Vena Cava, Percutaneous Approach 0JB70ZZ-Excision of Back Subcutaneous Tissue and Fascia, Open Approach 0BH17EZ-Insertion of Endotracheal Airway into Trachea, Via Natural or Artificial Opening

Appendix A - RN Health Claims Review

#	Reason for Audit	RN Notes with new PPO sample #	To/From Dates	Total Billed Amount	Total Paid Amount	ICD-9/10	ICD-9/10	CPT
69	2021Material - Same claim number but different process date	Sample #44--The provider is Methodist Hospital. This is a 31 day hospitalization with intensive care and intermediate coronary critical care. The total billed amount is \$434,499.52. This is an in network provider and the charges listed on this -06 extension of the claim number represent the first 6 days of ICU and paid at 100% as out of pocket was met. This claim was paid 9/26/2020. Fees/payment are reasonable.	11/22-11/27/2019	\$ 22,830	\$ 22,830	A41.9-Sepsis L89.154-Pressure ulcer	J18.9-Pneumoia J96.01-Acute respiratory failure	02HV33Z-Insertion of Infusion Device into Superior Vena Cava, Percutaneous Approach 0JB70ZZ-Excision of Back Subcutaneous Tissue and Fascia, Open Approach 0BH17EZ-Insertion of Endotracheal Airway into Trachea, Via Natural or Artificial Opening
70	2021Material - Same claim number but different process date	Sample #44--The provider is Methodist Hospital. This is a 31 day hospitalization with intensive care and intermediate coronary critical care. The total billed amount is \$434,499.52. This is an in network provider and the charges listed on this -06 extension of the claim number represent the next 8 days of Intermediate ICU and paid at 100% as out of pocket was met. This claim was paid 9/26/2020. Fees/payment are reasonable.	11/28-12/5/2019	\$ 24,080	\$ 24,080	A41.9-Sepsis L89.154-Pressure ulcer	J18.9-Pneumoia J96.01-Acute respiratory failure	02HV33Z-Insertion of Infusion Device into Superior Vena Cava, Percutaneous Approach 0JB70ZZ-Excision of Back Subcutaneous Tissue and Fascia, Open Approach 0BH17EZ-Insertion of Endotracheal Airway into Trachea, Via Natural or Artificial Opening
71	2021Material - Same claim number but different process date	Sample #44--The provider is Methodist Hospital. This is a 31 day hospitalization with intensive care and intermediate coronary critical care. The total billed amount is \$434,499.52. This is an in network provider and the charges listed on this -06 extension of the claim number represent the next 17 days of Intermediate CCU and paid at 100% as out of pocket was met. This claim was paid 9/26/2020. Fees/payment are reasonable.	12/6-12/22/2019	\$ 51,170	\$ 51,170	A41.9-Sepsis L89.154-Pressure ulcer	J18.9-Pneumoia J96.01-Acute respiratory failure	02HV33Z-Insertion of Infusion Device into Superior Vena Cava, Percutaneous Approach 0JB70ZZ-Excision of Back Subcutaneous Tissue and Fascia, Open Approach 0BH17EZ-Insertion of Endotracheal Airway into Trachea, Via Natural or Artificial Opening
72	2021Material - Same claim number but different process date	Sample #43--The provider is Mission Trail Baptist Hospital. The total billed amount is \$192,269.61. This portion of the claim represents the first 6 days of intermediate ICU and is a contracted rate to include all services as well as pharmacy charges during this time period. Claim was paid 3/16/2021 and paid at 100%. Fees/payment are reasonable.	1/23-1/28/2021	\$ 26,844	\$ 47,292	A41.89-Other specified sepsis U07.1- COVID-19	J12.82-Pneumonia due to coronavirus disease 2019 J96.01-Acute respiratory failure	3E0F7SF-Introduction of Other Gas into Respiratory Tract, Via Natural or Artificial Opening 8E0ZXY6-Isolation XW13325-Transfusion of Convalescent Plasma (Nonautologous) into Peripheral Vein, Percutaneous Approach, New Technology Group 5 XW033E5-Introduction of Remdesivir Anti-infective into Peripheral Vein, Percutaneous Approach, New Technology Group 5

Appendix A - RN Health Claims Review

#	Reason for Audit	RN Notes with new PPO sample #	To/From Dates	Total Billed Amount	Total Paid Amount	ICD-9/10	ICD-9/10	CPT
73	2021 Material - Same claim number but different process date	Sample #43--The provider is Mission Trail Baptist Hospital. The total billed amount is \$192,269.61. This portion of the claim considers the next 4 days of intermediate CCU and is a contracted rate to include all services as well as pharmacy charges during this time period. Claim was paid 3/16/2021 and paid at 100%. Fees/payment are reasonable.	1/29-2/1/2021	\$ 14,292	\$ 31,528	A41.89-Other specified sepsis U07.1-COVID-19	J12.82-Pneumonia due to coronavirus disease 2019 J96.01-Acute respiratory failure	3E0F75F-Introduction of Other Gas into Respiratory Tract, Via Natural or Artificial Opening 8E0ZXY6-Isolation XW13325-Transfusion of Convalescent Plasma (Nonautologous) into Peripheral Vein, Percutaneous Approach, New Technology Group 5 XW033E5-Introduction of Remdesivir Anti-infective into Peripheral Vein, Percutaneous Approach, New Technology Group 5
74	2021 Material	Sample #42--The provider is Baptist Medical Center. Total billed charges are \$308,079.01. This claim considers the next 8 days of intensive care room/board and paid on 12/22/2020 at 100%. Fees/payment are reasonable.	10/30-11/6/2020	\$ 48,352	\$ 61,368	U07.1-COVID-19 J96.01-Acute respiratory failure	J12.89-Other viral pneumonia J15.9-Unspecified bacterial pneumonia	5A1955Z-Respiratory Ventilation, Greater than 96 Consecutive Hours 0BH17EZ-Insertion of Endotracheal Airway into Trachea, Via Natural or Artificial Opening 8E0ZXY6- Isolation
75	2021 Material	Sample #42--The provider is Baptist Medical Center. Total billed charges are \$308,079.01. This claim considers the first 7 days of intensive care room/board and paid on 12/22/2020 at 100%. Fees/payment are reasonable.	10/23-10/29/2020	\$ 97,512	\$ 61,426	U07.1-COVID-19 J96.01-Acute respiratory failure	J12.89-Other viral pneumonia J15.9-Unspecified bacterial pneumonia	5A1955Z-Respiratory Ventilation, Greater than 96 Consecutive Hours 0BH17EZ-Insertion of Endotracheal Airway into Trachea, Via Natural or Artificial Opening 8E0ZXY6- Isolation
76	2021 Material	Sample #41--The provider is North Central Baptist Hospital. The total billed amount is \$151,187.00. This is a 12 day los for a newborn with respiratory distress syndrome. Member rate applied and paid at 80%. The out of pocket expenses were met w/ this payment so level of benefit payment was increased to 100%. Fees/payment are reasonable.	9/1-9/12/2020	\$ 92,232	\$ 66,481	Z38.01-Single liveborn infant, delivered by cesarean P22.0-Respiratory distress syndrome of newborn	P07.38-Preterm newborn, gestational age 35 completed weeks Z23-Encounter for immunization	5A09557- Assistance with Respiratory Ventilation, Greater than 96 Consecutive Hours, Continuous Positive Airway Pressure 3E0234Z-Introduction of Serum, Toxoid and Vaccine into Muscle, Percutaneous Approach 6A601ZZ-Phototherapy of Skin, Multiple
77	2021 Material	Sample #31--The provider is Mission Trail Baptist Hospital. This claim is for the POST ICU (intermediate ICU a step down from intensive care) dates of service beginning 8/25/2020 nearing the end of the hospital stay. The post ICU days total 16 so 2 claims divided the dates into 2 groups of 8 POST ICU days. The amount is allowed at a higher contract/case rate that included bundled services while in ICU so other charges are disallowed. Total los is 69 days for COVID. Fees/payment are reasonable. See claim line 88 explanation.	9/2-9/9/2020	\$ 26,224	\$ 61,368	U07.1-COVID N39.0-Urinary tract infection, site not specified	T83.511A-Infection and inflammatory reaction due to indwelling urethral catheter, initial encounter J12.89-Other viral pneumonia	0B113F4-Bypass Trachea to Cutaneous with Tracheostomy Device, Percutaneous Approach 5A1955Z-Respiratory Ventilation, Greater than 96 Consecutive Hours 8E0ZXY6-Isolation intermediate ICU bed

Appendix A - RN Health Claims Review

#	Reason for Audit	RN Notes with new PPO sample #	To/From Dates	Total Billed Amount	Total Paid Amount	ICD-9/10	ICD-9/10	CPT
78	2021 Material	Sample #31--The provider is Mission Trail Baptist Hospital. This claim is for the POST ICU (intermediate ICU a step down from intensive care) dates of service beginning 8/25/2020 nearing the end of the hospital stay. The post ICU days total 16 so 2 claims divided the dates into 2 groups of 8 POST ICU days. The amount is allowed at a higher contract/case rate that included bundled services while in ICU so other charges are disallowed. Total los is 69 days for COVID. Fees/payment are reasonable. See claim line 88 explanation.	8/25-9/1/2020	\$ 32,840	\$ 61,368	U07.1-COVID N39.0-Urinary tract infection, site not specified	T83.511A-Infection and inflammatory reaction due to indwelling urethral catheter, initial encounter J12.89- Other viral pneumonia	0B113F4-Bypass Trachea to Cutaneous with Tracheostomy Device, Percutaneous Approach 5A1955Z-Respiratory Ventilation, Greater than 96 Consecutive Hours 8E0ZXY6-Isolation intermediate ICU bed
79	2021Material - Looks like same claim but capped at billing for \$66,540. Why is billing capped?	Sample #31--The provider is Mission Trail Baptist Hospital. This claim is for the ICU dates of service that were divided into 12 days each for consideration of payment of such a large claim. Their system cannot accept an amount larger than \$99,999.99. The amount is allowed at a higher contract/case rate that included bundled services while in ICU so other charges are disallowed. Total los is 69 days for COVID. See claim line 88 explanation.	8/8-8/19/2020	\$ 66,540	\$ 92,052	U07.1-COVID N39.0-Urinary tract infection, site not specified	T83.511A-Infection and inflammatory reaction due to indwelling urethral catheter, initial encounter J12.89- Other viral pneumonia	0B113F4-Bypass Trachea to Cutaneous with Tracheostomy Device, Percutaneous Approach 5A1955Z-Respiratory Ventilation, Greater than 96 Consecutive Hours 8E0ZXY6-Isolation ICU bed
80	2021Material - Looks like same claim but capped at billing for \$66,540. Why is billing capped?	Sample #31--This claim is for the ICU dates of service that were divided into 12 days each for consideration of payment of such a large claim. Their system cannot accept an amount larger than \$99,999.99. The amount is allowed at a higher contract/case rate that included bundled services while in ICU so other charges are disallowed. Total los is 69 days for COVID. See claim line 88 explanation.	7/27-8/7/2020	\$ 66,540	\$ 92,052	U07.1-COVID N39.0-Urinary tract infection, site not specified	T83.511A-Infection and inflammatory reaction due to indwelling urethral catheter, initial encounter J12.89- Other viral pneumonia	0B113F4-Bypass Trachea to Cutaneous with Tracheostomy Device, Percutaneous Approach 5A1955Z-Respiratory Ventilation, Greater than 96 Consecutive Hours 8E0ZXY6-Isolation ICU bed
81	2021Material - Looks like same claim but capped at billing for \$66,540. Why is billing capped?	Sample #31--This claim is for the ICU dates of service that were divided into 12 days each for consideration of payment of such a large claim. Their system cannot accept an amount larger than \$99,999.99. The amount is allowed at a higher contract/case rate that included bundled services while in ICU so other charges are disallowed. Total los is 69 days for COVID. See claim line 88 explanation.	7/15-7/26/2020	\$ 66,540	\$ 92,052	U07.1-COVID N39.0-Urinary tract infection, site not specified	T83.511A-Infection and inflammatory reaction due to indwelling urethral catheter, initial encounter J12.89- Other viral pneumonia	0B113F4-Bypass Trachea to Cutaneous with Tracheostomy Device, Percutaneous Approach 5A1955Z-Respiratory Ventilation, Greater than 96 Consecutive Hours 8E0ZXY6-Isolation ICU bed

Appendix A - RN Health Claims Review

#	Reason for Audit	RN Notes with new PPO sample #	To/From Dates	Total Billed Amount	Total Paid Amount	ICD-9/10	ICD-9/10	CPT
82	2021Material - Looks like same claim but capped at billing for \$66,540. Why is billing capped? **Inquiry sent 12/14/21.	Sample #31--This claim is for the ICU dates of service that were divided into 12 days each for consideration of payment of such a large claim. The amount is allowed at a higher contract/case rate that included bundled services while in ICU so other charges are disallowed. Total los is 69 days for COVID. **12/14/2021 response from processor at PPO, "This was a very high dollar claim for billed charges exceeding \$1M. The patient was confined for 69 days. Our processing screen can only hold up \$99,999.99 in billed charges on each segment of the claim (i.e. -01, -02, -03, etc.). Therefore, the claim has be split up between multiple segments to account for the total billed amount. The per diem applicable to this claim is \$7671; thus, the room and board days were divided to determine the amount billed per day and then keyed on the claim by the appropriate number of units at the appropriate per diem per segment. For example: Revenue code 200 – total billed charges are \$293885.00 for 53 days293885 / 53 = \$5545 per day billed.....Contract per diem is \$7671.....Segment 00: The processor keyed 12 days of rev code 200....5545 (charge per day) x 12 days = \$66540. This equates to a negotiated rate of \$92,052 (7671 x 12)The system can only hold up to \$99,999.99 on a segment (billed or priced amount) The processor could have included 1 additional day but it still would have equated to 5 segments to account for all 53 days at the negotiated rate so the processor chose to keep it an even number. This method is applied throughout the entire claim." Fees/payment are reasonable.	7/3-7/14/2020	\$ 66,540	\$ 92,052	U07.1-COVID N39.0-Urinary tract infection, site not specified	T83.511A-Infection and inflammatory reaction due to indwelling urethral catheter, initial encounter J12.89-Other viral pneumonia	0B113F4-Bypass Trachea to Cutaneous with Tracheostomy Device, Percutaneous Approach 5A1955Z-Respiratory Ventilation, Greater than 96 Consecutive Hours 8E0ZZY6-Isolation ICU bed
83	RxClaimsHadXyremPrescribed	Sample #37--The provider is CEC Dezavala, LLC. Fees/payment for this claim are reasonable. Based on the medical claim database, this participant had narcolepsy diagnosed as early as 12/3/2019.	11/1/2020	\$ 18,562	\$ 981	N71.9-Inflammatory disease of uterus, unspecified	Z32.02-Encounter for pregnancy test, result negative	74177-Computed tomography, abdomen and pelvis; with contrast material(s)
84	RxClaimsHadXyremPrescribed	Sample #29--Provider is Tactile Systems Tech. Fees/payment for this claim are reasonable. Based on the medical claim database, this participant had narcolepsy diagnosed as early as 12/3/2019.	7/13/2020	\$ 2,365	\$ 680	I89.0-Lymphedema, not elsewhere classified		E0667-Segmental pneumatic appliance for use with pneumatic compressor, full leg

Appendix B - RN Prescription Claims Review

#	Reason for Audit	RN Notes	To/From Dates	Total Billed Amount	Total Paid Amount	ICD-9/10
1	Prescriber state does not match patient state: Sample - CVS Pharmacy. Her address is in TX. Prescriber in MO.	Durolane is the medication used to treat knee pain caused by osteoarthritis. This is an intra-articular injectable medication. The MD prescriber is Clayton Nuelle in Kansas City, MO. Drug is sourced from Briovarx in Minneapolis, MN by Specialty pharmacy. Patient lives in San Antonio, TX. Will need to verify the presence of a claim from Dr. Nuelle that this drug was injected in an office/output. facility around the date of 11/30/2020 in MO or in TX. The preauthorization date provided was 11/24/2020, Rx written 11/30/2020, claim paid 12/24/2020. Requesting review of medical database for this participant to determine if this injection procedure was performed by Dr. Nuelle. **11/3/2021--upon review of the medical claim database, the rt. knee was injected with this medication for a dx of primary osteoarthritis and was performed on 12/11/2020 in the md's secondary office location in San Antonio, that claim was paid. Rx sample is reasonable.	11/30/2020	\$ 1,219	\$ 882	M17.11-Unilateral primary osteoarthritis, right knee
2	Prescriber state does not match patient state: Sample - Prescriber is in KS, patient and pharmacy are in TX	Drug is Tacrolimus which weakens your immune system to prevent your body from "rejecting" the transplanted organ. This is an oral drug, a 30 day supply. Rx written 12/27/2019, claim submitted 5/1/2020, paid 5/29/2020. Claim submitted Patient lives in San Antonio, TX. Prescriber is listed in Kansas City, KS. This is a specialty antirejection drug for liver transplant provided by Specialty in MN. This provider matches up with a Texas Liver Consultant, INC. group (JOSHUA PINGLETON (NPI# 1609315845, PAC ID# 4981989266) is a physician enrolled in Centers for Medicare & Medicaid Services (CMS). The primary specialty is NURSE PRACTITIONER. Mailing address for prescriber is out of University of Kansas Medical Center, KS. Need to verify places of treatment, either at University of KS Med Ctr or telehealth. This practitioner appears to have a patient practice w/ the Liver group in San Antonio and billing out of U of KS Med Ctr. per the prescriber business practice location #9135885000. Will search med database for similar. **11/3/2021--the provider, Pingleton, appears later in the medical claim database on 2/5/2021, however, there is complete documentation of the liver transplant 8/22/2019 and hepatic failure following the transplant. This medication is a valid therapy and the prescribing provider, Joshua Pingleton, has privileges out of the U of K. It is highly likely that this was a prescription reorder as these medications are typically prescribed long term. Rx and ordering provider are reasonable.	12/27/2019	\$ 535	\$ 370	Z94.4-Liver transplant status
3	Prescriber state does not match patient state: Sample - Prescriber in MO has come up before in this database. All prescriptions written same day, filled different days.	Drug is Soolantra cream, 1%, Soolantra is a prescription cream used to treat rosacea. The prescription was written 8/14/2019. Claim submitted 7/20/2020, paid 7/29/2020. This provider (Christy Rainey) belongs to a large dermatology practice in Branson, MO and has hospital affiliations in TX. The medication is provided to participant via a local pharmacy in Grapevine, TX, 209 miles. Need to locate the office visit/telehealth visit for this participant on/around the order date of 8/14/2019. **11/3/2021--based on the information in the medical claim database for this participant, dr. Christy Rainey is in a full dermatology practice in San Antonio, TX whose NPI is still linked to her first practice in MO, over 5 years ago. The medical claims show an output. appt. on 8/14/2019 for rosacea by the physician assistant, Galvan. This Rx sample is reasonable.	8/14/2019	\$ 723	\$ 500	n/a
4	Prescriber state does not match patient state: Sample - Prescriber in PR has come up before in this database.	This is the automatic refill of Novolog insulin. Rx was written 5/26/2020 and filled 6/9/2020 as well as in next claim below on 10/9/2020 (#202715485132019). Both are prescribed by Dr. Enrique Maldonado Corchado of Puerto Rico and this one was filled at Walgreens Drug Store. Upon further internet NPI searches, this provider also has a practice in San Antonio, TX (7703 Floyd Curl Drive Division of Endocrinology, Diabetes, and Metabolism San Antonio, TX 78229..(787) 414-9722). This Rx sample is reasonable.	5/26/2020	\$ 1,042	\$ 816	

Appendix B - RN Prescription Claims Review

#	Reason for Audit	RN Notes	To/From Dates	Total Billed Amount	Total Paid Amount	ICD-9/10
5	Prescriber state does not match patient state: Sample - Prescriber in PR has come up before in this database.	This is the automatic refill of Novolog insulin. Rx was written 5/26/2020 and filled 10/9/2020 as well as in next claim above on 6/9/2020 (#201475898918023). Both are prescribed by Dr. Enrique Maldonado Corchado of Puerto Rico and this one was filled at Walgreens Drug Store. Upon further internet NPI searches, this provider also has a practice in San Antonio, TX (7703 Floyd Curl Drive Division of Endocrinology, Diabetes, and Metabolism San Antonio, TX 78229...(787) 414-9722). This Rx sample is reasonable.	5/26/2020	\$ 1,042	\$ 836	
6	Prescriber state does not match patient state: Why would Humira be the only drug from Florida? Pharmacy listed as Specialty.	Prescription is for Humira. This is prescribed as an injectable anti-inflammatory for obstruction of sweat gland disorder. Rx was written 10/1/2019, claim submitted 6/18/2020 and paid 7/15/2020. A year supply quantity was dispensed, 12. The prescribing provider has practices in TX, and 2 locations in Florida as a nurse practitioner. This drug was ordered from a specialty Specialty pharmacy #705 out of Alabama and shipped to the participant. A local pharmacy was likely not able to supply the quantity of 12 pre-filled Humira pens (about a 90 day supply). This Rx sample is reasonable.	10/1/2019	\$ 41,677	\$ 33,644	L73.2-Hidradenitis suppurativa
7	Sample - Prescriber in MO has come up before in this database. All prescriptions written same day, filled different days.	Prescription is for Dupixent for atopic dermatitis. Rx was written 6/29/2020, the fill date for this Rx was 7/14/2020 for a 28 day supply. The claim paid 8/7/2020. This MD provider belongs to a large dermatology practice in Branson, MO and has hospital affiliations in TX. In order for the quantity to meet the prescribed dosaging and frequency, it was necessary to source the medication from 2 Specialty specialty pharmacies (between the first prescription for this patient/drug on claim #201814999346012. This Rx sample is reasonable.	6/29/2020	\$ 3,888	\$ 3,234	L20.9-Atopic dermatitis, unspecified
8	Sample - Prescriber in MO has come up before in this database. All prescriptions written same day, filled different days.	Prescription is for Dupixent for atopic dermatitis. Rx was written 6/29/2020, the fill date for this Rx was 6/29/2020 for a 14 day supply. The claim paid 7/30/2020. This MD provider belongs to a large dermatology practice in Branson, MO and has hospital affiliations in TX. In order for the quantity to meet the prescribed dosaging and frequency, it was necessary to source the medication from 2 Specialty specialty pharmacies (between the first prescription for this patient/drug on claim #201965380625007. This Rx sample is reasonable.	6/29/2020	\$ 3,888	\$ 3,147	L20.9-Atopic dermatitis, unspecified
9	Small pharmacy	The prescription is for Trelegy (Trelegy Ellipta is used to improve symptoms and prevent bronchospasm in adults with COPD), written 8/20/2020, filled on 8/20/2020 and paid 8/28/2020. This pharmacy has 6 locations throughout Austin and San Antonio, Texas. Quantity dispensed is 60. This Rx sample is reasonable.	8/20/2020	\$ 942	\$ 398	
10	Small pharmacy	The prescription is for Leflunomide (used to treat rheumatoid arthritis), written 7/13/2020, filled on 7/13/2020 and paid 7/24/2020. This pharmacy has 6 locations throughout Austin and San Antonio, Texas. Quantity dispensed is 30. This Rx sample is reasonable.	7/13/2020	\$ 674	\$ 66	

Appendix B - RN Prescription Claims Review

#	Reason for Audit	RN Notes	To/From Dates	Total Billed Amount	Total Paid Amount	ICD-9/10
11	Drugs With Street Value - Xyrem	The prescribed medication is Xyrem for narcolepsy. This drug is closely monitored and a strict pre-authorization protocol must be met to receive approval. XYREM is considered a controlled substance regulated by the FDA because it carries certain risks. That's why it is available only through the XYWAV and XYREM REMS and dispensed only from the Certified Pharmacy. Will need to see if there is a documented medical claim for narcolepsy in the medical claims database. Prescription was written 10/25/2020, filled 11/23/2020 and paid 12/18/2020. The previous fill of Xyrem for this participant was 7/13/2020 on claim #201950822894005. So a medical dos will need to be located in the medical claims database at least Jan 2020-May 2020 or prior. The preauthorization date is valid 2/4/2020-2/4/2021. **11/3/2021--based on this participant's claims in the medical claim database, there is a documented claim on 1/3/2019 paid for the diagnosis of narcolepsy. This Rx sample is reasonable.	10/25/2020	\$ 18,394	\$ 16,591	
12	Drugs With Street Value - Xyrem	The prescribed medication is Xyrem for narcolepsy. This drug is closely monitored and a strict pre-authorization protocol must be met to receive approval. XYREM is considered a controlled substance regulated by the FDA because it carries certain risks. That's why it is available only through the XYWAV and XYREM REMS and dispensed only from the Certified Pharmacy. Will need to see if there is a documented medical claim for narcolepsy in the medical claims database on or prior to Jan 2020-May 2020. Prescription was written 5/2/2020, filled 7/13/2020 and paid 8/7/2020. The preauthorization date is valid 2/4/2020-2/4/2021. **11/3/2021--based on this participant's claims in the medical claim database, there is a documented claim on 1/3/2019 paid for the diagnosis of narcolepsy. This Rx sample is reasonable.	5/2/2020	\$ 18,394	\$ 16,591	
13	Drugs with street value - Vyvanse	Prescription is Vyvanse is FDA-approved to treat attention deficit hyperactivity disorder (ADHD). Patient is 35 years old member. This case was pre-authorized on 1/23/2020 and valid for one year. Prescription was written 8/11/2020, filled same day by SpecialtyRx and paid 9/9/2020. A 90 day supply was paid. There is no Dx provided. Due to the participant's age, we will search medical claim database to confirm a dx of ADHD. Otherwise, this drug, prescriber and pre-auth check out. **11/4/2021: based on the information provided in the participant's medical claim database, there are multiple claims with a diagnosis of ADHD, F90. The claim date more recent to the prescription date is 1/15/2020. This Rx sample is reasonable.	8/11/2020	\$ 1,196	\$ 773	F90.9-Attention-deficit hyperactivity disorder, unspecified type
14	Drugs with street value - Vyvanse	Vyvanse is FDA-approved to treat attention deficit hyperactivity disorder (ADHD). Participant is 13 years old. There is no preauthorization for this case, likely due to age. The prescription was written 3/17/2021, filled on 3/18/2021 by Walgreens for a 30 day supply and paid on 3/29/2021. This Rx sample is reasonable.	3/17/2021	\$ 402	\$ 293	F90.9-Attention-deficit hyperactivity disorder, unspecified type
15	Drugs with street value - Vyvanse	Prescription is Vyvanse is FDA-approved to treat attention deficit hyperactivity disorder (ADHD). Patient is 58 year old member. This case was pre-authorized on 1/16/2020 and valid for one year. The prescription was written 2/24/2021, filled 3/2/21 by CVS Pharmacy and paid 3/12/2021. Due to the participant's age, we will check the medical database for a dx of ADHD. **11/4/2021--based on the information in the participant's medical claim database, the diagnosis of Attention-deficit hyperactivity disorder, predominantly inattentive type" was located throughout the claims history also matching the date of the prescription. This Rx sample is reasonable.	2/24/2021	\$ 402	\$ 293	F90.1-Attention-deficit hyperactivity disorder, predominantly inattentive type
16	Drugs With Street Value - Strattera	The prescription is Strattera, a drug used to treat attention deficit hyperactivity disorder (ADHD). The patient is a 16 year old, no pre-authorization was done likely due to age. The prescription for a 30 day supply was ordered on 1/4/2021, filled by Walgreens on 1/5/2021 and paid on 1/14/2021. No diagnosis was provided. Therefore, we will search the medical database for this dx on or before 1/4/2021. **11/4/2021: based on the information provided in the participant's medical claim database, there are multiple claims with a diagnosis of ADHD, F90. The claim date more recent to the prescription date is 1/3/2021. This Rx sample is reasonable.	1/4/2021	\$ 474	\$ -	F90-Attention deficit hyperactivity disorder, unspecified type

Appendix B - RN Prescription Claims Review

#	Reason for Audit	RN Notes	To/From Dates	Total Billed Amount	Total Paid Amount	ICD-9/10
17	Drugs With Street Value - various drugs in this category	The prescription drug is Clonazepam used for seizure disorder and panic disorder. This was prescribed for a 30 day supply. Diagnosis is generalized anxiety disorder. This Rx sample is reasonable.	3/8/2021	\$ 45	\$ 11	F41.1-Generalized anxiety disorder
18	Drugs With Street Value - various drugs in this category	The prescription is hydroco/apap, aka Vicodin and was prescribed for one week. This is the same participant as above, and was prescribed 18 months sooner. This Rx sample is reasonable.	9/21/2020	\$ 11	\$ 4	G89.47-Chronic pain syndrome
19	Top paid sample - Humira cost is higher than other Humira	The prescription is Humira and is generally one of the highest cost specialty drugs on every healthcare plan. This participant does not have a dx listed. The cost is higher at \$14,920.45 as the quantity ordered/dispensed is 4 doses over a one month time frame, double than what is ordered for the participant in this rx sample below, claim #203163923335017. Will check the medical claim database for an appropriate diagnosis as Humira treats many inflammatory conditions. **11/4/2021--based on the information in the participant's medical claim database, there is clear documentation of a inflammatory disorder in which Humira is commonly prescribed: <u>Hidradenitis suppurativa</u> is inflammation of the apocrine sweat glands occurring in the axillae, anogenital regions, nipples, and under the female breast. The condition may produce chronic abscesses or sinus tract formation. This Rx sample is reasonable.	1/11/2021	\$ 14,920	\$ 11,144	L73.2-Hidradenitis suppurativa
20	Top paid sample - Humira cost is almost half of other Humira	The prescription is Humira and is generally one of the highest cost specialty drugs on every healthcare plan. The diagnosis listed on this sample does not fit the medication prescribed. Will check the medical claim database for an appropriate diagnosis as Humira treats many inflammatory conditions. **11/4/2021--based on the information provided in the participant's medical claim database, there is documentation of a diagnosis, by the md listed on the Rx spreadsheet, of M79.7-Fibromyalgia, a condition not commonly treated by Humira. Fibromyalgia is not considered an autoimmune disorder, it is a neurological disease. It is noted that this prescription and refills are preauthorized under PA-68868170 which means this drug was already reviewed for medical necessity. We would, however like to note, a diagnosis is not found on the medical claim database that fully supports the Humira prescription. The total 12 month cost of this drug is \$65,234. This Rx sample is, therefore, justified in the cost and coverage of Humira based solely on the preauthorization on 4/24/2020 which is valid for one year.	11/11/2020	\$ 6,946	\$ 5,304	M45.0-Ankylosing spondylitis of multiple sites in spine
21	Cosmetic - Possible cosmetic drug Finasteride	Finasteride is used to treat male pattern hair loss in me and is also used to treat symptoms of benign prostatic hyperplasia in men with an enlarged prostate. There is no diagnosis listed on this Rx sample so we will check the medical database for the presence of either diagnosis. This was ordered as a 90 day supply. **11/4/2021--this drug was not paid by the fund. Based on the medical claim database for this participant, the diagnosis is "other androgenic alopecia" or hair loss and is considered cosmetic. This Rx sample is not a coverable item.	6/9/2020	\$ 244	\$ -	L64.8-Other androgenic alopecia
22	Cosmetic - Possible cosmetic drug Lumigan	Prescription is Lumigan. This drug is used to lower the pressure in the eye to treat certain types of glaucoma. Lumigan may cause a gradual change in the color of your eyes or eyelids and lashes as well as increased growth or thickness of your eyelashes--a cosmetic procedure. There is no diagnosis provided in this sample and the patient is a female dependent of 18 years of age. We will check the medical database for a glaucoma or eye pressure diagnosis. In the absence of these diagnoses, this drug cost would require reimbursement. **11/4/2021--based on the information provided in the participant's medical claim database, there are claims indicating the diagnosis of primary open angle glaucoma, bilateral, in a moderate stage, for which this medication would be prescribed. This Rx sample is reasonable.	7/14/2020	\$ 496	\$ 289	H40.1132-Primary open-angle glaucoma, bilateral, moderate stage

Appendix B - RN Prescription Claims Review

#	Reason for Audit	RN Notes	To/From Dates	Total Billed Amount	Total Paid Amount	ICD-9/10
23	Sample - Top paid drug	The prescription is for Dupixent, an injectable drug. Dupixent (dupilumab) is used to treat moderate-to-severe eczema (atopic dermatitis) that cannot be controlled with topical medicines applied to the skin. Dupixent is used for eczema in adults and children at least 6 years old. The preauthorization for this drug was approved on 5/31/2020 and is valid for one year. The participant is 15 years old. This Rx sample is reasonable.	4/7/2020	\$ 3,888	\$ 3,234	L20.89-Other atopic dermatitis
24	Drugs With Street Value - various drugs in this category	The prescription drug is Narcan. Narcan nasal spray is used in an emergency situation to treat a possible opioid overdose in an adult or child. This medication is a standard of care for anyone who has been prescribed an opioid medication. This Rx sample is reasonable.	10/28/2020	\$ 150	\$ 90	

NEEDLES & ASSOCIATES, LLC

HEALTH CLAIMS

**Agreed Upon Procedures
March 31, 2021 and 2020**

CONCLUSION

The Plan has overpaid the following and is in the process of seeking reimbursement:

Ineligible health claims	\$10,982
Ineligible prescription claims	3,148
Total	\$14,130

Other Findings

In the health database, a total amount of \$306.90 was paid for a fetal non-stress test for a third trimester pregnancy which was processed under the wrong participant, a male, instead of a female. PPO agreed to reprocess claim under female spouse.

In the prescription database, there is one participant who has a preauthorization for Humira with 12 months of claims paid at \$65,234. Our audit of the participant's medical claim database does not appear to show a diagnosis that supports this biologic medication. We recommend that the Plan sustain a preauthorization program when a patient needs to start Humira drug therapy. It would be reasonable to require a preauthorization every 12 months.

We were engaged by Health Claims Client to perform this agreed-upon procedures engagement and conducted our engagement in accordance with attestation standards established by the AICPA. We were not engaged to and did not conduct an examination or review engagement, the objective of which would be the expression of an opinion or conclusion, respectively on the health claims review of Health Claims Client as of March 31, 2021 and 2020. Accordingly, we do not express such an opinion or conclusion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

We are required to be independent of Health Claims Client and to meet our ethical responsibilities, in accordance with the relevant ethical requirements related to our agreed-upon procedures engagement.

This report is intended solely for the information and use of the specified user listed above, and is not intended to be, and should not be, used by anyone other than these specified parties. This report relates only to the claims remitted to Plan and items specified in the above schedules and does not extend to any financial statements of Health Claims Client taken as a whole.

Broomfield, CO