The Frick Building
437 Grant Street, Suite 1020
Pittsburgh, PA 15219
412-281-2228
www.tfgpartners.com

San Joaquin Valley Insurance Authority

(SJVIA)

Audit Report

Review Medical Benefit Payments

Anthem

Audit Period:

January 1, 2021 through June 30, 2022

January 24, 2023

TABLE OF CONTENT

PROPRIETARY MATERIALS

This document and any related materials are for the exclusive use of San Joaquin Valley Insurance Authority ("SJVIA") in their evaluation of this health care claims review and may not be used for any other purpose.

All parties utilizing these materials recognize they are copyrighted products of TFG Partners, LLC and agree to protect the confidentiality and proprietary nature of this and any related documents.

REPORT CONTENT

Based on the audit, the sample was sent on October 28, 2022, the Audit Team produced this Audit Report, which consists of the following parts: 1) an executive overview of all findings; 2) detailed findings outlining the categories for SJVIA to review, i.e., the "Agree-to-Disagree" claims; and 3) supporting appendices.

The detailed findings section lists sample claims the Audit team reviewed during the on-site audit. To make SJVIA aware of the potential magnitude of the issues identified based on the reviews of the sample claims, the Audit Team also included in the overview tables the additional claims that are related to the selected sample claims and/or exhibit the same payment characteristics. Due to sample size limitations, these "additional" claims could not be reviewed during the on-site validation process.

Once Anthem has reviewed this report and provided the Audit Team and SJVIA with its comments, the Audit Team will create a final recommendation and closing summary, which will incorporate Anthem's responses and include a prioritized list of proposed action plans.

ADMINISTRATOR RESPONSE

The Audit Team requests that Anthem carefully review the Audit Report and provide the Audit Team and SJVIA with a timely response.

To assist SJVIA in the review of the audit report and response, Anthem is requested to address the following items in the response:

For agreed-upon audit findings:

- Root cause of the administrative error.
- If multiple claims are identified within a category, each claim should be itemized by claim number, and responded to separately.
- Address any remediation efforts that have been or will be put in place to eliminate future over/underpayments (with implementation dates).

For Review Categories or specific claims in disagreement:

- Provide a clear and detailed response to the claims at issue, together with any additional documentation in support of Anthem's position.
- Where clarification of issue with SJVIA is needed, provide a timetable for a discussion.

For additional claims that may be impacted by an administrative error:

- Provide the Audit Team and SJVIA with Anthem's plan for any impact analyses to identified additional claims effected by the error, the parameters of the analysis, and the timetable for implementation and completion.

INTRODUCTION

SJVIA engaged TFG Partners, LLC to perform a claims audit of all medical claims processed by Anthem on behalf of its Members. The audit period covered all paid claims from **January 1, 2021 through June 30, 2022**, consisting of a total of 230,852 paid claims with a total paid amount of $83,364,094.39.

The objective of the audit was to provide SJVIA with an overall assessment into the administrative performance of Anthem, using accurate and detailed audit data and insights and reduce unwarranted health benefit costs through:

1. Identification of any plan adjudication or plan intent inconsistencies, and
2. Restitution and/or Recovery of overpayments as directed by SJVIA.

For this audit, a claims history data file containing claims with paid dates from January 1, 2021 through June 30, 2022 was loaded into the auditor's proprietary electronic system.

The Audit Team developed a detailed benefit-auditing matrix, outlining benefit provisions for each SJVIA employee segment. The matrix was programmed into the auditor's system and the system processed a series of reviews based on proprietary algorithms for the following audit categories:

1. Coordination of Benefits (Medicare and Non-Medicare).
2. Technical and Medical Correct Coding.
3. Plan Benefit Compliance.
4. Member Liability.

From the detailed final listing of these reviews, the Audit Team selected an audit sample for further review. In many cases the Audit Team is simply requesting additional information not found on the claim file provided by the administrator, upon which to decide regarding the correctness of a claim.

All claims were electronically reviewed against SJVIA plan benefit requirements, and a sample of 150 claims was sent to Anthem.

The Audit Team provided the samples on October 28, 2022. The audit was conducted during the week of November 28, 2022. The Audit Team received the last responses back from Anthem on January 5, 2023. The Audit Team received the exception list confirmation from Anthem on January 11, 2023.

Anthem responded in writing with its comments and either agreed with the audit findings or stated its support for payment of the claim(s) in question (Agree-to-Disagree).

At the onset of the Audit, Anthem provided the "Control Totals", which contain the total number of claim lines and dollars that are on the claims data that was received (Table 1). The Audit Team was able to match to these totals.

Table 1. Control Totals

Claims	Totals
Total Claim Lines	741,434
Total Unique Claim Numbers	394,014
Charge/Billed Amount	$325,496,451.70
Allowed Amount	$88,190,311.66
Paid Amount	$81,788,352.62

Table 2. Claim Review "Filter"

Claims	Totals
Total Paid Claim Filtered	230,852
Total Paid Amount	$83,364,094.39
Potential Exceptions	22,012
Total Paid Amount	$20,784,390.07

Appendix B shows the complete overview of the potential exceptions that were further reviewed by the Audit Team.

Through the electronic audit and manual review process, a total of 22,012 claims were initially identified as potential exception items. The 22,012 claims were distributed in the review categories of Coordination of Benefits, Technical & Medical Correct Coding, Plan Benefit Implementation Compliance and Member Liability.

The number of 22,012 potential exception claims, with a paid amount of $20,784,390.07 does not reflect the potential overpaid or underpaid amounts, these amounts would need to be calculated.

The total is high because the Audit Team looks at categories to verify pricing and Medicare coverage of the claims for High Dollar/Individual Claim, Covered Greater Than Charged Facility, In-Network Allowed Equals Billed, Medicare & Non-Medicare Coordination as well as Inpatient Deductible/Copayment. These categories account for a total paid amount of $15,436,541.56 and 8,050 claims.

EXECUTIVE OVERVIEW

In summary, the great majority of claims processed by Anthem were adjudicated correctly based on our audit approach. However, approximately 9% of all filtered paid claims on the file, with a paid amount of $20.8 million, required further review and analysis (see Table 2).

Agreed Upon Error Categories

Anthem agreed to a total of 14 processing issues:

- Ten (10) claims with an overpaid amount of $1,731.35.
- Four (4) claims with an underpaid amount of $91.13.

The review categories that had agreed-to adjudication issues are:

Different Claim Duplicates – The Audit identified a claim in which Anthem had paid the service(s) twice. (1 manual errors out of 6 samples)

Covid – 19 – The Audit identified a claim in which Anthem had paid the service(s) at the incorrect allowance. (1 manual error out of 9 samples)

Dental Services – The Audit identified a paid claim that should have been denied as an exclusion under the plan. (1 manual error out of 2 samples)

Non-Covered Routine Diagnosis – The Audit identified a paid claim for non-covered routine services. Not covered - Routine Physicals and Immunizations. Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Preventive Care Services" provision of MEDICAL CARE THAT IS COVERED. (1 error out of 1 sample)

Office Visit Co-payment – The Audit identified a paid claim that did not apply the correct copayment. (1 error out of 4 samples)

Chiropractic Care Co-payment – The Audit identified paid claims that did not apply the correct copayment. (2 manual out of 3 samples)

Occupational Therapy Co-payment – The Audit identified paid claims that did not apply the correct copayment. (2 manual errors out of 2 samples)

Telemedicine Copayment – The Audit identified a paid claim that did not apply the correct copayment. (1 error out of 1 sample)

Emergency Room Consistency – The Audit identified In-Network facility paid claims for the Emergency Room and associated Out of Network paid claims that should have paid In-Network for the member. (3 underpayment errors out of 4 samples)

Individual Out of Pocket In-Network Exceeded – The Audit identified a member where their Individual Out of Pocket In-Network was exceeded. (1 manual underpayment error out of 3 samples)

Table 3. Agreed-to Sample & Additional Related Claims

Review Categories	Agreed-to Sample Claims				*Additional Claims*		
	#	Overpaid	#	Underpaid	#	Paid	Deductible
Technical & Medical Correct Coding							
Different Claim Duplicates	1	12.44					
Sub Totals	***1***	***12.44***					
Plan Benefit Compliance							
Covid-19	1	118.78			2,782	351,761.11	
Emergency Room Consistency Report			3	89.00	110	17,675.71	2,769.96
Dental Services	1	1,339.40			1	6,803.00	
Non-Covered Routine Diagnosis	1	104.73			5	68.04	
Sub Totals	***3***	***1,562.91***	***3***	***89.00***	***2,898***	***376,307.86***	***2,769.96***
Member Liability							
Copayments							
Telehealth Co-payment	1	35.00			290	40,560.62	
Office Visit Co-payment	1	21.00			2,487	177,697.32	807.27
Chiropractic Care Co-payment	2	60.00			94	1,624.50	67.23
Occupational Therapy Co-payment	2	40.00			13	1,442.12	
Out-of-Pocket							
Individual Out-of-Pocket In-Network Exceeded			1	2.13	67	35,043.83	2,477.91
Sub Totals	***6***	***156.00***	***1***	***2.13***	***2,951***	***256,368.39***	***3,352.41***
TOTALS	**10**	**$1,731.35**	**4**	**$91.13**	**5,849**	**$632,676.25**	**$6,122.37**

Note: The dollar values displayed for the additional claims are the total claim payment amount and not the potential overpayment/underpayment.

Table 3 shows a breakdown of the agreed to categories. The Table includes sample and out-of-sample claims Anthem agreed to were overpaid or underpaid, and additional claims that are related to agree to sample claims and remaining additional claims that are potentially overpaid or underpaid. The Audit Team includes the additional claims to make SJVIA and Anthem aware of the number of additional claims that have been identified through the 100% claims review process.

There are no additional claims for the following category: Different Claim Duplicates.

Agree-to Disagree Error Categories

There was a total of 14 claims where no agreement was determined, and these claims are described as *Agree-to-Disagree* claims (see overview below). These claims and categories should be discussed between SJVIA and Anthem to determine their outcome.

The review categories that had Agree-to-Disagree adjudication issues are:

- **Coordination of Benefits**:
  End Stage Renal Disease (ESRD)
- **Technical & Medical Correct Coding**
  Unclassified Drugs
  Medical Prescription Drug Pricing
- **Plan Benefit Compliance**:
  Inpatient Consistency
  Outpatient Surgery Consistency
  Emergency Room Consistency
  Colonoscopy Consistency

Detailed findings for each category begin on **page 14**.

Through a post-on-site assessment of the agreed to disagree claims, the Audit Team identified additional claims that are related to the sample claims or have general financial and processing implications beyond the audit sample. SJVIA may wish to address these additional claims with Anthem in the audit closing process. If it is decided these additional claims need to be reviewed, the actual overpayment will need to be determined.

Table 4. Agree-to Disagree to Sample Claims & Additional Related Claims

Review Categories	Agree-to-Disagree				*Additional Claims*		
	#	Overpaid	#	Underpaid	#	Paid	Deductible
Coordination of Benefits							
Medicare							
End Stage Renal Disease	8	5,057.55			210	329,338.97	1,219.16
Sub Totals	***8***	***5,057.55***			***210***	***329,338.97***	***1,219.16***
Technical & Medical Correct Coding							
Unclassified Drugs	2	5,080.05			45	25,555.81	184.03
Medical Prescription Drug Pricing	2	8,277.68			115	371,290.95	782.55
Sub Totals	***4***	***13,357.73***			***160***	***396,846.76***	***966.58***
Plan Benefit Compliance							
Inpatient Consistency			2	1,120.41	155	41,637.65	1,360.52
Outpatient Surgery Consistency			2	1,302.66	40	18,909.04	3,478.57
Emergency Room Consistency			1	49.50	110	17,675.71	2,769.96
Colonoscopy Consistency			1	150.28	64	42,957.42	602.60
Sub Totals			***6***	***2,622.85***	***369***	***121,179.82***	***8,211.65***
TOTALS	***12***	***$18,415.28***	***6***	***$2,622.85***	***739***	***$847,365.55***	***$10,397.39***

Note: The dollar values displayed for the additional claims are the total claim payment amount and not the potential overpayment/underpayment.

Table 4 shows a breakdown of the Agree-to-Disagree categories. The Table includes sample claims Anthem disagreed to were overpaid or underpaid, and any remaining additional claims tied to these disagreements that are potentially overpaid or underpaid. The Audit Team includes the additional claims to make SJVIA and Anthem aware of the number of additional claims that have been identified through the 100% claims review process.

Recommendations For Resolution of Sample Claims

The Audit Team proposes the following approach to resolve the issues concerning the sample claims:

Table 5. Audit Team Recommendations for Resolution

Audit Outcomes	Amount	Audit Team Recommendation
*The first priority for Anthem is to start the process of recovering the overpayments and reprocessing the underpayments on the **agreed-upon errors**. We recommend Anthem provide detailed recovery reports to SJVIA until all such recoveries are complete and documented.* *In addition, Anthem should review their claim adjudication process to ensure these types of overpayments do not recur. We recommend that any Anthem process improvements be reviewed with SJVIA prior to implementation.*		
Anthem agrees to overpayment (underpayment), Deductible – see totals Table 3.	**14 claims with an overpaid (underpaid) amount of $1,731.35 ($91.13)**	The Audit Team recommends that Anthem credit SJVIA the total agreed upon overpaid amount and remit the underpayments.
Additional Claims, not Part of the sample – see totals Table 3.	**5,849 claims with a paid amount of $632,676.25 and $6,122.37 Deductible**	These claims should be reviewed as part of Anthem's impact reporting and remediation. The Audit Team can provide Anthem with a listing of the additional claims.
*The second priority is for SJVIA and Anthem to reach agreement on the correct processing of **the Agree-to-Disagree claims**. Once the actual over/underpaid amounts are determined, Anthem should start the process of recovering/reprocessing the over/underpayments.*		
Agree-to-Disagree. Claims in which Anthem and TFG Partners did not agree, **or** the necessary information was not provided or available to determine if the claim was processed correctly – see totals Table 4.	**18 claims with a potential overpaid/(underpaid) amount of $18,415.28 and ($2,622.85)**	The Audit Team recommends that SJVIA discuss the issues with Anthem to determine the correct administration of these claims.
Additional Claims, not part of the sample – see totals Table 4.	**739 claims with a paid amount of $847,365.55 and $10,397.39 Deductible**	Based on SJVIA's determination of the correct administration of the Agree-to-Disagree claims, Anthem should review the additional claims and reimburse SJVIA the confirmed overpaid amounts.

DETAILED FINDINGS

This section outlines the categories for SJVIA to review, i.e., the "Agree-to-Disagree" claims and provide feedback regarding the processing of these claims.

The categories are in this section because the Audit Team:

1. disagrees with how the claims are being processed.
2. did not receive adequate information to determine if the clams were processed correctly.
3. believes there is a potential for process improvement.

COORDINATION OF BENEFITS

End Stage Renal Disease (ESRD)

This review category identifies paid claims that appear to have dialysis and or a kidney transplant.

The Audit Team requested the following information for each of the claims that was written up during the audit to determine if Medicare is the primary carrier.

This member file was identified by procedure code and/or diagnosis code as having Dialysis or a Kidney transplant. Please respond to the questions below so we can determine when Medicare will be the primary carrier.

1. What was the first date of Dialysis?
2. Did the member participate in self-dialysis training program that would allow the member to start.
3. It appears the member had a Kidney Transplant (dx V42.0, Z94.0). Please provide the date of transplant
4. If member had a Kidney Transplant did the member have dialysis prior to the transplant, if yes when did the dialysis begin?
5. Appears member already has Medicare prime. What date did Medicare become prime?

Electronic System and Manual Reviews

The system and subsequent manual review identified 223 claims, with a paid amount of $341,268.67 and $1219.16 applied to the deductible.

Sample Selection

The Audit Team selected 13 of the potential exceptions, with a paid amount of $11,929.73, for review on-site.

On-Site Audit Findings and Anthem Response
The Audit Team identified a processing error in 8 claims.

The details are as follows:

Item #	Date of Service	1st Date of Dialysis	First Date	Months – Self Dialysis Training	Medicare Primary Calculation		Date of Transplant		Transplant Date for Medicare to end
1-000030	7/7/2021	Unknown					06/30/19		**6/1/2022**
1-000037	6/15-20/2022	11/19/18	11/01/18	33	**08/01/21**		N/A		
1-000039	4/29/2022	02/01/14	02/01/14	33	**11/01/16**		N/A		
1-000046	1/25/2021				**01/00/00**		11/04/20		**11/1/2023**
1-000056	2/17/2022	09/01/16	09/01/16	33	**06/01/19**		10/31/20		**10/1/2023**
1-000087	1/14/2022	09/29/10	09/01/10	33	**06/01/13**		N/A		
1-000088	12/31/2021	Unknown	Unknown	Unknown	**Unknown**		Unknown		
1-000128	06/16-18/2022	Unknown	Unknown	Unknown	**Unknown**		Unknown		

Item # 1-000030
Diagnosis Z940 – (Kidney transplant status) was reported on the claim.

Anthem Response:
"Disagree - Please see below responses in bold:

What was the first date of Dialysis?
Elevance Health is primary over Medicare. Unable to determine first date of dialysis.

Did the member participate in self-dialysis training program that would allow the member to start Medicare coverage in the first month of dialysis?
Elevance Health is primary. Unable to determine member participation in self-dialysis training program.

It appears the member had a Kidney Transplant (dx V42.0, Z94.0). Please provide the date of transplant.
Date of Transplant: 6/30/19

If member had a Kidney Transplant did the member have dialysis prior to the transplant, if yes when did the dialysis begin?
Unable to determine if member had dialysis prior to dialysis.

Appears member already has Medicare prime. What date did Medicare become prime?
Disagree – per Limited Liability information, Elevance Health is prime.*"*

TFG Partners Comment: Based on the information received regarding the kidney transplant, it would appear Medicare would no longer be primary beginning on 06/01/2022.

Item # 1-000037
Procedure 90999 – (Dialysis procedure) was reported on the claim.

Anthem Response:
"Disagree - Please see below responses in bold:

What was the first date of Dialysis?
First date of dialysis is 11/19/2018

Did the member participate in self-dialysis training program that would allow the member to start Medicare coverage in the first month of dialysis?
Unable to determine member participation in self-dialysis training program.

It appears the member had a Kidney Transplant (dx V42.0, Z94.0). Please provide the date of transplant.
No transplant to date

If member had a Kidney Transplant did the member have dialysis prior to the transplant, if yes when did the dialysis begin?
Yes.

Appears member already has Medicare prime. What date did Medicare become prime?
Disagree – per Limited Liability information, Elevance Health is prime."

TFG Partners Comment: Based on the information received, it would appear Medicare would become primary on 08/01/2022.

Item # 1-000039
Diagnosis Z940 – (Kidney transplant status) was reported on the claim.

Anthem Response
"Disagree - Please see below responses in bold:
What was the first date of Dialysis?
First date of dialysis is 2/1/14

Did the member participate in self-dialysis training program that would allow the member to start Medicare coverage in the first month of dialysis?

Unable to determine member participation in self-dialysis training program.

It appears the member had a Kidney Transplant (dx V42.0, Z94.0). Please provide the date of transplant.
No transplant to date

If member had a Kidney Transplant did the member have dialysis prior to the transplant, if yes when did the dialysis begin?
Yes.

Appears member already has Medicare prime. What date did Medicare become prime?
Disagree – per Limited Liability information, Elevance Health is prime for part B. Medicare prime for Part A only effective 11/1/20"

TFG Partners Comment: Based on the information received, it would appear Medicare would become primary on 11/01/2016.

Item # 1-000046
Diagnosis Z940 – (Kidney transplant status) was reported on the claim.

Anthem Response:
"Disagree - Please see below responses in bold:

What was the first date of Dialysis?
No dialysis

Did the member participate in self-dialysis training program that would allow the member to start Medicare coverage in the first month of dialysis?
N/A

It appears the member had a Kidney Transplant (dx V42.0, Z94.0). Please provide the date of transplant.
11/4/20

If member had a Kidney Transplant did the member have dialysis prior to the transplant, if yes when did the dialysis begin?
No

Appears member already has Medicare prime. What date did Medicare become prime?
Disagree Per Limited Liability information, Elevance Health is prime."

TFG Partners Comment: Based on the information received regarding the kidney transplant, it would appear Medicare would no longer be primary as of 11/01/2023.

Item #1-000056
Diagnosis Z940 – (Kidney transplant status) was reported on the claim.

Anthem Response:
"Disagree - Please see below responses in bold:

What was the first date of Dialysis?
9/1/2016

Did the member participate in self-dialysis training program that would allow the member to start Medicare coverage in the first month of dialysis?
Unable to determine if member participated in self-dialysis training program

It appears the member had a Kidney Transplant (dx V42.0, Z94.0). Please provide the date of transplant.
10/31/20

If member had a Kidney Transplant did the member have dialysis prior to the transplant, if yes when did the dialysis begin?
Yes

Appears member already has Medicare prime. What date did Medicare become prime?
Per Limited Liability information, Medicare prime beginning 3/1/2019"

TFG Partners Comment: Based on the information received regarding the kidney transplant, it would appear Medicare would no longer be primary as of 10/01/2023.

Item # 1-000087
Diagnosis Z940 – (Kidney transplant status) was reported on the claim.

Anthem Response:
"Disagree - Please see below responses in bold:

What was the first date of Dialysis?
First date of dialysis is 9/29/2010

Did the member participate in self-dialysis training program that would allow the member to start Medicare coverage in the first month of dialysis?
Unable to determine member participation in self-dialysis training program.

It appears the member had a Kidney Transplant (dx V42.0, Z94.0). Please provide the date of transplant.
No transplant to date

If member had a Kidney Transplant did the member have dialysis prior to the transplant, if yes when did the dialysis begin?
N/A

Appears member already has Medicare prime. What date did Medicare become prime?
Per Limited Liability information, Elevance Health is prime effective 12/1/201"

TFG Partners Comment: Based on the information received, it would appear Medicare would become primary as of 06/01/2013.

Item # 1-000088
Diagnosis Z940 – (Kidney transplant status) was reported on the claim.

Anthem Response:
"Disagree - Please see below responses in bold:

What was the first date of Dialysis?
No recent dialysis. Unable to determine first date.

Did the member participate in self-dialysis training program that would allow the member to start Medicare coverage in the first month of dialysis?
Unable to determine member participation in self-dialysis training program.

It appears the member had a Kidney Transplant (dx V42.0, Z94.0). Please provide the date of transplant.
No transplant to date

If member had a Kidney Transplant did the member have dialysis prior to the transplant, if yes when did the dialysis begin?
N/A

Appears member already has Medicare prime. What date did Medicare become prime?

Per Limited Liability information, Elevance Health is secondary carrier. No Medicare"

TFG Partners Comment: Based on the information received, once a member has a claim for dialysis or a kidney transplant diagnosis, Anthem should investigate to determine when Medicare would become primary. We ask Anthem to confirm the dates to determine if there are claims that should be paid as secondary.

Item # 1-000128
Procedure 90999 – (Dialysis procedure) was reported on the claim.

Anthem Response:
"Disagree - Please see below responses in bold:

What was the first date of Dialysis?
First date of dialysis information not yet determined

Did the member participate in self-dialysis training program that would allow the member to start Medicare coverage in the first month of dialysis?
Unable to determine member participation in self-dialysis training program.

It appears the member had a Kidney Transplant (dx V42.0, Z94.0). Please provide the date of transplant.
No transplant to date

If member had a Kidney Transplant did the member have dialysis prior to the transplant, if yes when did the dialysis begin?
N/A

Appears member already has Medicare prime. What date did Medicare become prime?
Disagree Per Limited Liability information, member currently has no Medicare information on file. Please note that this member no longer has an active policy as of 12/12/22"

TFG Partners Comment: Based on the information received, once a member has a claim for dialysis, Anthem should investigate to determine when Medicare would become primary. We ask Anthem to confirm the dates to determine if there are claims that should be paid as secondary.

Audit Team Recommendation – Claims Reviewed On-site
– SJVIA and Anthem review the Agree-to-Disagree claims and determine if the claims were processed correctly. Depending on the outcome of the review process, Anthem credit SJVIA the agreed upon overpaid amount.

Additional Claims Not Reviewed On-site

There are a total of 210 additional claims with a paid amount of $329,338.97, which were not reviewed, see table below:

Item Number	Number of claims	Dollars Paid ($)	Applied to Deductible ($)
1-000030	37	111,356.17	0.00
1-000037	96	163,746.17	0.00
1-000039	20	2,599.62	0.00
1-000046	13	8,457.69	750.00
1-000056	17	1,711.70	469.16
1-000087	2	161.87	0.00
1-000088	3	70.99	0.00
1-000128	22	41,234.76	0.00
Total	**210**	**$329,338.97**	**$1,219.16**

Audit Team Recommendations – Claims Not Reviewed On-site

- Additional review would be necessary to determine if the other additional claims are underpaid. It is SJVIA's decision if they would like to have these claims reviewed.

- The Audit Team can provide Anthem with a list of the additional claims not reviewed during the on-site audit, so they can review these claims in a timely manner and make adjustments and start recoveries where appropriate or Anthem should conduct an Impact Analysis to determine the total claims and financial impact.

Anthem Audit Report Response and Proposed Action Plan

Medical Claims Prescription Drug Pricing - Unclassified Drugs

This review category identifies claims that are processed using the J3490 and J9999 CPT codes. J3490 is a code used for the billing of injectable drugs if no appropriate code or fee is available. J9999 is the procedure code used for billing chemotherapy drugs.

The purpose of the review is to quantify the frequency and amount of dollars paid under these codes. In addition, through a further on-site sample audit we verify drugs for which valid J-codes exist but are billed using J3490 or J9999. Therefore, the on-site review requests documentation regarding type of medication, number of units and price billed for drugs using the unclassified drug code. The review of medical necessity for which drugs with code J3490 or J9999 have been dispensed is not in the scope of this audit. The Audit Team reviews the claims to determine if the claims were priced based on the actual drug used.

Electronic System and Manual Reviews

The system and subsequent manual review identified 47 claims, with a paid amount of $31,324.43 and $184.03 applied to the deductible.

Sample Selection

The Audit Team selected 2 of the potential exceptions, with a paid amount of $5,768.62, for review.

On-Site Audit Findings and Anthem Response

The Audit Team identified potential processing error in both claims.

Anthem disagreed to the potential processing errors. The details are as follows:

Item #1-000099

Pricing information from Truven Redbook:
Drug Name: Medroxyprogesterone acetate 150 mg
NDC: 16714098101
AWP Unit: 1.1mg 150mg/ml
AWP 150mg: $83.65
Allowed: $300 → 300/83.65 = 3.6 times AWP
Over Paid: $216.35

TFG Partners Comment: The drug is priced 3.6 times over the AWP, which is not reasonable and customary pricing as required by ERISA.

Item #1-000155
Pricing information from Truven Redbook:
Drug Name: Darzalex Faspro 1800 – 3000 mg UT/15ML Solution
NDC: 57894050301
AWP Unit Price: $605.92
Allowed: $5,469.62 → 5,469.62 /605.92 = 9 times AWP
Over Paid: $4,863.70

TFG Partners Comment: The drug is priced 9 times over the AWP, which is not reasonable and customary pricing as required by ERISA.

Audit Team Recommendation – Claims Reviewed
– BKD and Anthem review the Agree-to-Disagree claims and determine if the claims were processed correctly. Depending on the outcome of the review process, Anthem credit BKD the agreed upon overpaid amounts.

Additional Claims Not Reviewed
There are 45 claims, with a total paid amount of $25,555.81 and $184.03 applied to the deductible, which were not reviewed.

Audit Team Recommendation – Claims Not Reviewed
– Additional review would be necessary to determine if the other additional claims are overpaid. It is BKD's decision if they would like to have these claims reviewed. The Audit Team can provide ANTHEM with a list of the additional claims not reviewed during the audit so they can review these claims in a timely manner and make adjustments and start recoveries where appropriate.

Anthem Audit Report Response and Proposed Action Plan

Medical Prescription Drug – without NDC

The review category identifies prescription drugs that appear to be priced over the AWP for the actual drug received.

Electronic System and Manual Reviews
The system and subsequent manual review identified 117 claims, with a paid amount of $382,766.31 and $782.55 applied to the deductible.

Sample Selection
The Audit Team selected 2 of the potential exceptions, with a paid amount of $11,475.36, for review.

On-Site Audit Findings and Anthem Response
The Audit Team identified potential processing errors in both claims.

Anthem disagreed to the potential processing errors. The details are as follows:

Item #1-000092
Pricing information from Truven Redbook:
Drug Name: Thyrogen
NDC: 58468003002
J3240: CMS Unit: 0.9mg
AWP Unit: 1.1mg →$2,130.06
1 CMS Unit: $2,130.04/1.1 * 0.9 = $1,742.76
Allowed: $4,750 → 4,750.24/1,1742.76 = 2.7 times AWP
Over Paid: $3,007.48

TFG Partners Comment: The drug is priced 2.7 times over the AWP, which is not reasonable and not customary as required by ERISA.

Item #1-000167
Pricing information from Truven Redbook:
Drug Name: Botox
NDC: 00023392102
J3240: CMS per unit
AWP Unit: 200u →$1,492.20
Units given: 195:
AWP 195 Units: $1,492.20/200 * 195 = $1,454.90
Allowed: $6,725.12 → 6,725.12/1,454.90 = 4.6 times AWP
Over Paid: $5,270.20

TFG Partners Comment: The drug is priced 4.6 times over the AWP, which is not reasonable and not customary as required by ERISA.

Audit Team Recommendation – Claims Reviewed
– BKD and Anthem review the Agree-to-Disagree claims and determine if the claims were processed correctly. Depending on the outcome of the review process, Anthem credit BKD the agreed upon overpaid amounts.

Additional Claims Not Reviewed
There are 115 claims, with a total paid amount of $371,290.95 and $782.55 applied to the deductible, which were not reviewed.

Audit Team Recommendation – Claims Not Reviewed
- Additional review would be necessary to determine if the other additional claims are overpaid. It is BKD's decision if they would like to have these claims reviewed. The Audit Team can provide Anthem with a list of the additional claims not reviewed during the audit so they can review these claims in a timely manner and make adjustments and start recoveries where appropriate.

Anthem Audit Report Response and Proposed Action Plan

PLAN BENEFIT COMPLIANCE

Inpatient Consistency

This review category identifies In-Network Inpatient facility claims and Out of Network associated paid claims. The member should be held harmless.

Electronic System and Manual Reviews
The system and subsequent manual review identified 157 claims, with a paid amount of $42,943.26 and $1,360.52 applied to the deductible.

Sample Selection
The Audit Team selected 2 of the potential exceptions, with a paid amount of $1,305.61, for review.

On-Site Audit Findings and Anthem Response
The Audit Team identified a processing error in both claims.

Anthem disagreed with the payment errors. The details are as follows:

Item # 1-000013
Anthem Response:
"Disagree – When the related professional claim was received, on 01/14/21; the facility claim was not yet on file. Therefore, the associated professional claim paid correctly at the out-of-network benefit level. Elevance can adjust to pay at the in-network benefit level on an appeal basis."

Item # 1-000017

Anthem Response:

"Disagree – When the related professional claim was received, on 06/18/21; the facility claim was not yet on file. Therefore, the associated professional claim paid correctly at the out-of-network benefit level. Elevance can adjust to pay at the in-network benefit level on an appeal basis."

TFG Partners Comment: The member was at an In-Network facility and has no control over the network for the associated services regardless of the provider specialty/type.

Audit Team Recommendation – Claims Reviewed On-site

– SJVIA and Anthem review the Agree-to-Disagree claims and determine if the claims were processed correctly. Depending on the outcome of the review process, Anthem credit SJVIA the agreed upon overpaid amount.

Additional Claims Not Reviewed On-site

There are a total of 155 additional claims with a paid amount of $41,637.65 and $1,360.61 applied to the deductible.

Audit Team Recommendations – Claims Not Reviewed On-site

– Additional review would be necessary to determine if the other additional claims are underpaid. It is SJVIA's decision if they would like to have these claims reviewed.

– The Audit Team can provide Anthem with a list of the additional claims not reviewed during the on-site audit, so they can review these claims in a timely manner and make adjustments and start recoveries where appropriate.

Anthem Audit Report Response and Proposed Action Plan

Outpatient Surgery Consistency

This review category identifies In-Network outpatient surgery facility claims and Out of Network associated paid claims. The member should be held harmless.

Electronic System and Manual Reviews

The system and subsequent manual review identified 42 claims, with a paid amount of $20,211.73 and $3,478.57 applied to the deductible.

Sample Selection

The Audit Team selected 2 of the potential exceptions, with a paid amount of $1,302.69 for review.

On-Site Audit Findings and Anthem Response
The Audit Team identified a processing error in both claims.

Anthem disagreed with the payment errors. The details are as follows:

Item # 1-000020
Anthem Response:
"Disagree – When the related professional claim was received, on 06/18/21; the facility claim was not yet on file. Therefore, the associated professional claim paid correctly at the out-of-network benefit level. Elevance can adjust to pay at the in-network benefit level on an appeal basis."

Item # 1-000040
Anthem Response:
"Disagree – When the related professional claim was received, on 12/20/21; the facility claim was not yet on file. Therefore, the associated professional claim paid correctly at the out-of-network benefit level. Elevance can adjust to pay at the in-network benefit level on an appeal basis."

TFG Partners Comment: The member was at an In-Network facility and has no control over the network for the associated services regardless of the provider specialty/type.

Audit Team Recommendation – Claims Reviewed On-site
– SJVIA and Anthem review the Agree-to-Disagree claim and determine if the claim was processed correctly. Depending on the outcome of the review process, Anthem credit SJVIA the agreed upon overpaid amount.

Additional Claims Not Reviewed On-site
There are a total of 40 additional claims with a paid amount of $18,909.04 and $3,478.57 applied to the deductible.

Anthem Audit Report Response and Proposed Action Plan

Emergency Room Consistency

This review category identifies In-Network Emergency Room facility claims and Out of Network associated paid claims. The member should be held harmless.

Electronic System and Manual Reviews
The system and subsequent manual review identified 114 claims, with a paid amount of $17,814.23 and $2,769.96 applied to the deductible.

Sample Selection
The Audit Team selected 4 of the potential exceptions, with a paid amount of $138.52, for review.

On-Site Audit Findings and Anthem Response
The Audit Team identified a processing error in one (1) claim.

Anthem disagreed with the payment error. The details are as follows:

Item # 1-000032
Anthem Response:
"Disagree – When the related professional claim was received, on 01/18/21; the facility claim was not yet on file. Therefore, the associated professional claim paid correctly at the out-of-network benefit level. Elevance can adjust to pay at the in-network benefit level on an appeal basis."

TFG Partners Comment: The member was at an In-Network facility and has no control over the network for the associated services regardless of the provider specialty/type.

Audit Team Recommendation – Claims Reviewed On-site
– SJVIA and Anthem review the Agree-to-Disagree claim and determine if the claim was processed correctly. Depending on the outcome of the review process, Anthem credit SJVIA the agreed upon overpaid amount.

Additional Claims Not Reviewed On-site
There are a total of 110 additional claims with a paid amount of $17,675.71 and $2,769.96 applied to the deductible.

Audit Team Recommendations – Claims Not Reviewed On-site
– Additional review would be necessary to determine if the other additional claims are underpaid. It is SJVIA's decision if they would like to have these claims reviewed.

– The Audit Team can provide Anthem with a list of the additional claims not reviewed during the on-site audit, so they can review these claims in a timely manner and make adjustments and start recoveries where appropriate.

Anthem Audit Report Response and Proposed Action Plan

Colonoscopy Consistency

This review category identifies In-Network colonoscopy facility claims and Out of Network associated paid claims. The member should be held harmless.

Electronic System and Manual Reviews

The system and subsequent manual review identified 65 claims, with a paid amount of $43,107.70 and $602.60 applied to the deductible.

Sample Selection

The Audit Team selected one (1) of the potential exceptions, with a paid amount of $150.28, for review.

On-Site Audit Findings and Anthem Response

The Audit Team identified a processing error in the claim.

Anthem disagreed with the payment error. The details are as follows:

Item # 1-000109

Anthem Response:

"Disagree – When the related professional claim was received, on 01/28/22; the facility claim was not yet on file. Therefore, the associated professional claim paid correctly at the out-of-network benefit level. Elevance can adjust to pay at the in-network benefit level on an appeal basis."

TFG Partners Comment: The member was at an In-Network facility and has no control over the network for the associated services regardless of the provider specialty/type.

Audit Team Recommendation – Claims Reviewed On-site

– SJVIA and Anthem review the Agree-to-Disagree claim and determine if the claim was processed correctly. Depending on the outcome of the review process, Anthem credit SJVIA the agreed upon overpaid amount.

Additional Claims Not Reviewed On-site

There are a total of 64 additional claims with a paid amount of $42,957.42 and $602.60 applied to the deductible.

Audit Team Recommendations – Claims Not Reviewed On-site

– Additional review would be necessary to determine if the other additional claims are underpaid. It is SJVIA's decision if they would like to have these claims reviewed.

– The Audit Team can provide Anthem with a list of the additional claims not reviewed during the on-site audit, so they can review these claims in a timely manner and make adjustments and start recoveries where appropriate.

Anthem Audit Report Response and Proposed Action Plan

ADDITIONAL FINDINGS

Policy/Processing Guidelines

The following samples are listed based on the Anthem response(s) regarding their internal policies and claim processing edits.

SJVIA should review the responses from Anthem to determine if they agree with how Anthem is processing the various items and determine if further action is warranted.

Speech Therapy

Per the SJVIA benefits – Speech therapy services. A specified number of additional visits may be authorized after your initial visit. While there is no limit on the number of covered visits for medically necessary speech therapy, visits must be authorized in advance.

Item # 1-000059
Anthem Response:
"The EOC for group number 275341Q400 does not have a pre auth requirement for Speech Therapy. Claim has been processed correctly."

Routine PAP Smears

This review category identifies paid claims for routine pap smears within the same calendar year.

Item # 1-000041
Anthem Response:
"The claims are for two different DOS with two different providers. There is no limitation in preventive services as long as medically necessary."

Outpatient Mental Health Copayment

This review category identifies claims that appear to have the incorrect or no copayment applied.

Item # 1-000005
SPD indicates $45 copay in office.

Group: 275341
Subgroup: 275341M250

Anthem Response:
"Disagree – Mental health visits are covered at 100% after a $25.00 copay when services are rendered by participating providers. Claim has been processed correctly."

High Dollar Individual Claim

High dollar paid claims reviewed for authorization and processing guidelines.

Item # 1-000077
Anthem Response:
"The claim has been allowed per the provider's contractual agreement NST (negotiated service type) V63, which is 90% of billed charges.
Total billed charges $723,750.89 x 90% = $651,375.81 allowance

Per Elevance Account Management, there is nothing contractually for high dollar claim prenotifications for this client. Elevance sends high dollar claim alerts for any claim over 50k as a courtesy."

COB – Not Coordinated Correctly

This review category identifies paid claims with other insurance to determine if the correct amount of patient responsibility was applied to the claim.

Item # 1-000006
Anthem Response:
"Per Medicare EOB, line 1 had deductible and coinsurance applied for a total member liability of $417.83. Per customized Medicare administration, any benefit deductible, copays, and coinsurance amounts are to be waived for members with Medicare as their primary insurance. Claim has been processed correctly."

Dental Services

This review category identifies paid claims for dental services with impacted teeth diagnosis.

Impacted Teeth not covered - Not covered - Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, or treatment to the teeth or gums, or treatment to or for any disorders for the jaw joint, except as specifically stated in the "Dental Care" or "Jaw Joint Disorders" provisions of MEDICAL CARE THAT IS COVERED. Cosmetic dental surgery or other dental services for beautification.

Item # 1-000144

Anthem Response:

"Services provided are related to an outpatient Operculectomy oral surgery that was performed under DCN ending in xx5461. The surgery was performed by an Oral Surgeon. Coverage would be under medical due to surgery and falls under outpatient benefits."

Chiropractic Care Over Plan Limit

This review category identifies paid claims for a member that appear to have exceeded the chiropractic care (12) visit limit.

Item # 1-000153

Anthem Response:

"Sample claim was processed with Medicare being the primary carrier. Although visit limitations have already been reached, there were available funds under the member's benefit reserve. Thus, payments were made to allow what was assigned by Medicare as patient responsibility."

Medicare Consistency (Active Under 65)

The review category identifies paid claims for a member with other insurance and all other claims that appear to not be coordinated.

Item # 1-000045

Anthem Response:

"The sample claim is for the subscriber and primacy is not an issue since Elevance will always be prime for the subscribers. Dependents are the only ones where we question for other medical insurance.

Regarding DCN ending in 2705, the claim was billed and processed as a Medicaid reclaimation claim."

Item # 1-000060

Anthem Response:

"Per Limited Liability Screen, COB is still under research. Since this is a pay and pursue plan, claims are processing as Elevance Health prime.

Out of sample claim in question claim xxxxxxxxxxx was processed as secondary at the time of process on 2/28/22, prior to the COB solicitation date of 6/12/22. This was submitted with EOB from the primary carrier. Thus, it was handled correctly as secondary."

Item # 1-000072
Anthem Response:
"The sample claim is for the subscriber and primacy is not an issue since Elevance will always be prime for the subscribers. Dependents are the only ones where we question for other medical insurance.

Regarding DCN ending in 2705, the claim was billed and processed as a Medicaid reclaimation claim."

Item # 1-000157
Anthem Response:
"The sample claim is for the subscriber and primacy is not an issue since Elevance will always be prime for the subscribers. Dependents are the only ones where we question for other medical insurance.

Regarding DCN ending in 7868, the claim was billed and processed as a Medicaid reclaimation claim."

Office Visit Copayment

This review category identifies office visit paid claims that appear to have applied the incorrect or no copayment.

Item #'s 1-000001 & 127
Anthem Response:
"Per customized Medicare administration, any benefit deductible, copays, and coinsurance amounts are to be waived for members with Medicare as their primary insurance. Claim has been processed correctly."

72 - Hour

This review category identifies outpatient services paid within 72 hours of an inpatient stay that should be covered within the DRG bundling. The 3-day rule, sometimes referred to as the 72-hour rule, requires all diagnostic or outpatient services rendered during the DRG payment window (the day of and three calendar days prior to the inpatient admission) to be bundled with the inpatient services.

Item # 1-000021

Anthem Response:

"When the outpatient claim was received, on 04/28/2022; the facility claim was not yet on file. Therefore, the outpatient claim was processed correctly based on the information that was on file at the time of process. "

Item # 1-000145

Anthem Response:

"When the outpatient claim was received, on 06/14/2021; the facility claim was not yet on file. Therefore, the outpatient claim was processed correctly based on the information that was on file at the time of process. "

Automobile Accident

This review category identifies claims with auto accident diagnosis codes with no other insurance paid. Ask the administrator if the claim was investigated for auto insurance and/or third-party liability insurance.

Item # 1-000034

Anthem Response:

"Per Anthem's TPL Department, the member responded to a questionnaire, on 11/14/2021, indicating that the claims are not related to injury/accident. The file has since been closed since there is no recovery available."

Medicare Coordination Excluded Over Age 65

This review category identifies coordinated claims with Medicare.

Item # 1-000141

Anthem Response:

"Claim ending in DCN xx1978 is for a third-party liability claim. The claim was adjusted to recover partial funds."

Individual Deductible INN Exceeded

This review category identifies members who appeared to have exceeded the Individual In-Network Deductible.

Item # 1-000049

Appears the $250 Individual INN deductible has been exceeded. (Embedded) (Excludes RX) Group: 275341M450

Anthem Response:
"The plan is based on benefit year and not calendar year.
Deductible claims for benefit year 12/14/21 – 12/13/22"

Chiropractic Care Co-payment

This review category identifies chiropractic care paid claims that appear to have applied the incorrect or no copayment.

Item # 1-000055
Anthem Response:
"Per customized Medicare administration, any benefit deductible, copays, and coinsurance amounts are to be waived for members with Medicare as their primary insurance. Claim has been processed correctly."

Speech Therapy Co-payment

This review category identifies speech therapy paid claims that appear to have applied the incorrect or no copayment.

Item # 1-000002
Anthem Response:
"Per customized Medicare administration, any benefit deductible, copays, and coinsurance amounts are to be waived for members with Medicare as their primary insurance. Claim has been processed correctly."

Family Deductible INN Exceeded

This review category identifies families that appear to have exceeded the Family In-Network Deductible.

Item # 1-000119
Appears the $500 Family Deductible has been exceeded. (Embedded) (Excluded RX) (No Cross Accumulation between INN & OON)
Group: 275341M450

Anthem Response:
"The plan is based on benefit year and not calendar year.
Deductible claims for benefit year 12/14/21 – 12/13/22"

Individual OOP INN Only Exceeded

This review category identifies members who appear to have exceeded the Individual In-Network Out of Pocket.

Item # 1-000104
Appears the $1000 Individual INN OOP has been exceeded. (Embedded) (Excludes RX)
Group: 275341Q400

Anthem Response:
"The plan is based on benefit year and not calendar year.
Individual par OOP claims for benefit year 12/14/21 – 12/13/22"

Individual OOP OON Only Exceeded

This review category identifies members who appear to have exceeded the Individual Out of Network Out of Pocket.

Item # 1-000102
Appears the $10000 Individual OON OOP has been exceeded. (Embedded) (Excludes RX) (Does Not cross accumulate) (Included Ded, Copay and Coins)
Group: 275341M150

Anthem Response:
"The system reflects a member OOP accum (highlighted in grey), which combines both in and out of network amounts. However, since the policy does not combine par and npar amounts, there are individual Accums for in network and out of network amounts.
The member's par OOP is at $3,000.00 and the npar OOP is at $8,382.40, which has not been over applied.
These two amounts total $11,382.40."

Family OOP INN Exceeded

This review category identifies families that appear to have exceeded the Family In-Network Out of Pocket.

Item # 1-000080
Appears the $2000 Family INN OOP has been exceeded. (Embedded) (Excluded RX) (Includes Ded, Copay and Coins)
Group: 275341Q400

Anthem Response:
"The plan is based on benefit year and not calendar year.
Family OOP claims for benefit year 12/14/21 – 12/13/22
Family OOP claims for benefit year 12/14/20 – 12/13/21"

Item # 1-000135
Appears the $7000 Family INN OOP has been exceeded. (Embedded) (Excluded RX) (Includes Ded, Copay and Coins)
Group: 275341M250

Anthem Response:
"Please note the OOP amounts do not cross apply. The par family OOP is at $5,797.57 and the npar family OOP is at $247.77 for a total combined amount of $6,045.34."

Diagnostic Tests in Office

This review category identifies claims applying deductible for diagnostic testing performed in the office. Per the plan SPD – The Benefit Year Deductible will not apply to diagnostic imaging and laboratory services provided by a participating provider.

Item # 1-000142
Procedure 76536 – Us exam of head and neck
Place of Service 11 – Office

Anthem Response:
"The plan is based on benefit year and not calendar year.
Deductible claims for benefit year 12/14/20 – 12/13/21"

Injection and Infusion Services with HCPCS Supplies

Consistent with CPT guidelines, HCPCS codes identified by code description as standard tubing, syringes, and supplies are considered included when reported with Injection and Infusion services, CPT codes 96360-96549, and will not be separately reimbursed.

Item # 1-000115
Procedures:

96413	Chemo iv infusion 1 hr
96415	Chemo iv infusion addl hr
E0776	
S1015	Iv tubing extension set

Anthem Response:
"The Host Plan is responsible for applying the pricing according to their editing logic, medical policies and contractual arrangements with the Host plan's provider contract. Elevance does not have access to these policies and provisions in place within the plan. Therefore, Elevance relies on the Host Plan to submit claims accurately based on those policies and procedures. Claim has been processed correctly."

Non-Covered Services

This review category identifies Procedure code G0378, these codes are for items and or services that CMS chose to exclude from the fee schedule payment by regulation. No RVU are shown, and no payment may be made under the fee schedule for these codes.

Item # 1-000022
Anthem Response:
"Elevance as a commercial carrier does not adopt every CMS policy. Claims submitted directly to Elevance for reimbursement go through ClaimsXten editing logic.
Per standalone pricing provided, allowance is based on units and conversion factor
99.42 units x 1.00 conversion factor = $99.42 fee schedule allowance."

Non-Covered Modifiers

This review category identifies State supplied vaccine – funded by the county, state or federal agency and therefore additional reimbursement for such services would not be appropriate. Modifier SE - State and/or federally funded programs/services; Ambulance transportation from Scene of accident or acute event to Residential, domiciliary, custodial facility (nursing home, not skilled nursing facility).

Item # 1-000035
Claim modifier "SE" with procedure code 99203.

Anthem Response:
"Services rendered were for a medical office visit and blood pressure readings. There were no vaccine administrations. Claim has been processed correctly."

Colorectal Cancer Screening

This review category identifies services that appear to be covered 100% under the Affordable Care Act.

Item # 1-000161

Anthem Response:

"SJVIA has elected to follow HCR Preventive logic, in which case preventive care is based on HCR criteria on standalone procedures, and procedure and diagnosis code matches to be considered under a Preventive classification, but not standalone diagnosis. Procedure code 45385 was handled as preventive since it was billed with a matching HCR preventive diagnosis code. Procedure code 45380 was billed with diagnosis code (D12.5), which is not considered preventive under HCR; thus, line two (2) was handled correctly at the surgical level. The allowance was applied to the member's medical deductible."

Provider Consistency

This review category identifies paid claims for providers who have both In and Out of Network claims on file.

Item # 1-000044

Anthem Response:

"The provider billed the claims under different tax ids. Claim ending in DCN 8431 is out-of-network and claim ending in DCN 2322 is in-network."

Item # 1-000083

Anthem Response:

"The provider became a PBP contracted provider as 06/15/21; thus, claim ending in DCN 7530 processed correctly as OON since DOS is 05/05/21 and claim ending in DCN 4265 processed correctly as INN since DOS is 06/15/21."

Item # 1-000118

Anthem Response:

"The provider became a PBP contracted provider as 02/01/21; thus, claim ending in DCN 5248 processed correctly as OON since DOS is 01/12/21 and claim ending in DCN 3785 processed correctly as INN since DOS is 02/01/21."

RETRACTIONS

While on site, the Audit Team discovered () claims that had been adjusted in 2022 after the audit sample date. The items listed below are some of the claims that caused a “false positive” in the claim sample.

Report	Item Number	Date of Refund	Refund Amount ($)
Different Claim Duplicates	1-000018	10/07/2022	98.27
Covid-19	1-000143	08/16/2022	614.20
In-Network Allowed Equals Billed Facility	1-000027	09/12/2022	40,920.00
In-Network Allowed Equals Billed Facility	1-000091	09/19/2022	376.22
		Total Amount	**$42,008.69**

REMAINING CATEGORIES

The Audit Team also reviewed claims in the following categories with no exception findings:

- Medicare Over Age 65 – Inpatient (Retired)
- Medicare Over Age 65 (Retired)
- Medicare Over Age 65 Active
- Medicare Coordination Inpatient – (Excludes Over Age 65 Retired Members)
- Medicare Coordination Outpatient (Excludes Over Age 65 and Retired Members)
- Coordination of Benefits Not Applied
- Unlisted Surgical Procedures
- Add- On Codes
- Multiple/Bilateral Surgeries
- Obstetrical Global Fee
- Covered Greater Than Charged – Professional
- Covered Greater Than Charged Facility
- Anesthesia – Surgery Denied/Not Billed
- Out-of-Network Allowed Equals Billed Facility
- Out-of-Network – Allowed Equals Billed Professional
- In-Network – Allowed Equals Billed Professional
- In-Network Allowed Equals Billed Facility
- Chemical Substance Abuse
- Inpatient Hospital
- Home Health Care Prior Authorization
- Foot Orthotics
- Morbid Obesity
- Inpatient In-Network Substance Abuse
- Outpatient Substance Abuse Co-payment
- Inpatient Deductible/Co-payment
- Emergency Room Co-payment
- Urgent Care Facility Co-payment
- Nutritional Co-payment

APPENDIX A – AUDIT APPROACH

TFG Partners performs a comprehensive series of electronic audits and manual reviews intended to identify various payment exception conditions for on-site analysis and validation, and to provide a complete due diligence review of Administrator performance. Overall objectives include the identification of systemic and non-systemic claims administrative weaknesses for corrective action and the identification of specific payment exceptions for potential recovery. The audit methodology is not focused on expected or targeted processing errors but is intended to review 100% of paid claims for the selected audit period through a comprehensive electronic and manual review process, utilizing a broad range of specialized exception reports.

TFG Partners' audit approach identifies a universe of potential payment exceptions, which is divided into two categories:

1. *Sample Claims*

The process encompasses both the selection of sample claims that, following a thorough review of SJVIA's Summary Plan Description ("SPD"), demonstrate potential as a payment exception, as well as sample claims for which there is insufficient claim file data available to the Audit Team to make a determination when it selects the sample. All sample claims require further investigation through review of the Administrator's claim documentation or access to the member history file, which is done on-site.

Once documentation and other critical information have been reviewed, determination as to the disposition of the sample claims in question can be made. Claims are either confirmed as payment errors or removed from the audit as correctly adjudicated. In cases where insufficient documentation is found, or where TFG Partners does not agree with the Administrator response, the claims will be categorized as "Agree-to-Disagree" and the report will reflect that status, including the cause of disagreement.

2. *Non-Sample Claims*

The process also identifies a universe of potential payment exceptions containing claims, which are related to the selected sample claims and/or exhibit the same payment characteristics as the sample claims (i.e., claims for the same patient with the same service/benefit issues). These claims cannot be reviewed during the on-site validation process due to sample size limitations, but we recommend they be submitted to Anthem for review and analysis. For purposes of this report, these claims are defined as non-sample claims.

The on-site documentation review, Administrator responses to claim payment issues, and Administrator system information related to the sample claims provide a basis for evaluating the non-sample claims. The report addresses each non-sample claim potential exception category and recommends the disposition of all claims within each category for (a) further review and resolution, or (b) no further review action required.

APPENDIX B – MANUAL REVIEW AND SAMPLE SELECTION

Review Categories	Manual Review			Audit Sample		
	#	$ Paid	$ Ded	#	$ Paid	$ Ded
1.Coordination of Benefits						
Medicare						
End Stage Renal Disease	223	341,268.67	1,219.16	13	11,929.73	
Medicare Over Age 65 - Inpatient (Retired)	158	9,103.42	1,355.35	1	22.89	
Medicare Over Age 65 (Retired)	247	17,946.32	1,763.18	1	32.44	
Medicare Consistency Report (Active Under 65)	479	193,957.89	7,866.11	5	1,968.21	607.16
Medicare Over Age 65 Active	742	67,295.83	161.03	1	553.38	
Medicare Coordination (Excludes Over Age 65 Retired Members)	806	355,588.54	9,996.20	1	259.05	
Medicare Coordination Inpatient - (Excludes Over Age 65 Retired Members)	175	203,353.85		1	1,556.00	
Medicare Coordination Outpatient (Excludes Over Age 65 and Retired Members)	675	300,581.96	9,996.20	1	100.33	
Non-Medicare						
Coordination of Benefits Not Applied	401	427,364.30	2,634.55	5	2,539.22	685.02
Coordination of Benefits Not Coordinated Correctly	1,401	261,881.71	4,958.99	1	468.95	
Automobile Accident	178	25,232.74	455.50	1	811.11	
Sub Totals	***5,485***	***2,203,575.23***	***40,406.27***	***31***	***20,241.31***	***1,292.18***
2.Technical & Medical Correct Coding						
Unlisted Surgical Procedures	174	163,111.77	6,650.60	1	4,900.00	
Different Claim Duplicates	6	788.25		6	788.25	
Add- On Codes	74	7,176.97		1	52.31	
Multiple/Bilateral Surgeries	225	259,615.77	3,972.03	1	2,014.10	706.98
Obstetrical Global Fee	8	314.28	155.24	1	73.27	
Different Claim Duplicates With Different Provider ID's	39	4,044.96	75.00	13	829.15	75.00
High Dollar/Individual Claim	24	6,246,165.06		1	651,375.81	
Covered Greater Than Charged	3	627.56	691.00	2	497.41	530.00
Covered Greater Than Charged Facility	20	1,084,301.31	1,134.50	2	118,470.53	
Unclassified Drugs	47	31,324.43	184.03	2	5,768.62	
Anesthesia - Surgery Denied/Not Billed	388	229,463.23	15,688.99	1	1,800.00	
72 - Hour Report	4	3,788.13		2	2,079.48	
Medical Prescription Drug Pricing	117	382,766.31	782.55	2	11,475.36	

Review Categories	Manual Review			Audit Sample		
	#	$ Paid	$ Ded	#	$ Paid	$ Ded
Injection and Infusion Services with HCPCS Supplies	12	166.56	8.98	1	18.00	
Non-Covered Services - E, M, Q, X	41	463.72		1	99.42	
Non-Covered Modifiers	15	353.28		1	80.77	
Out-of-Network Allowed Equals Billed Facility	7	57,577.22	1,000.00	4	3,910.64	1,000.00
Out-of-Network - Allowed Equals Billed	647	154,621.50	29,718.19	4	6,024.00	
In-Network - Allowed Equals Billed	3,891	873,857.56	46,543.38	4	4,059.03	
In-Network Allowed Equals Billed Facility	384	1,336,701.17	13,201.30	5	194,135.38	2,425.86
Provider Consistency	1,102	324,500.59	23,768.17	3	910.95	
Sub Totals	***7,228***	***11,161,729.63***	***143,573.96***	***58***	***1,009,362.48***	***4,737.84***
3.Plan Benefit Compliance						
Speech Therapy	375	42,035.73	1,785.00	1	60.00	
Routine PAP Smears	20	406.13		1	15.01	
Inpatient Consistency	157	42,943.26	1,360.52	2	1,305.61	
Outpatient Surgery Consistency	42	20,211.73	3,478.57	2	1,302.69	
Chemical Substance Abuse	63	500,797.11	4,161.38	1	9,100.00	
Covid-19	2,791	353,520.33		9	1,759.22	
Inpatient Hospital	279	590,137.28	1,939.69	1	5,311.06	
Home Health Care Prior Authorization	19	13,402.00		1	668.00	
Emergency Room Consistency Report	114	17,814.23	2,769.96	4	138.52	
Dental Services	3	8,612.05	500.00	2	1,809.05	500.00
Foot Orthotics	56	12,064.55	2,992.85	1	201.81	7.57
Chiropractic Care - Over Plan Limit	94	929.41		1	8.45	
Morbid Obesity	44	57,494.71	2,720.20	1	2,345.00	
Inpatient In-Network Substance Abuse	63	476,410.11	4,161.38	1	4,800.00	
Non-Covered Routine Diagnosis	6	172.77		1	104.73	
Diagnostic Tests in Office	6		1,302.05	1		115.47
Colonoscopy - Consistency Report	65	43,107.70	602.60	1	150.28	
ACA - Colorectal Cancer Screening	7		1,192.89	1		112.42
Sub Totals	***4,204***	***2,180,059.10***	***28,967.09***	***32***	***29,079.43***	***735.46***
4.Member Liability						
Copayments						
Outpatient Mental Health Care	988	76,776.10		1	61.90	
Outpatient Substance Abuse	140	9,007.93		1	20.55	
Telehealth	291	40,606.37		1	45.75	
Inpatient Deductible	273	4,346,746.10		1	5,583.20	
Emergency Room	568	548,347.90	139,666.78	2	2,585.80	750.00

Review Categories	Manual Review			Audit Sample		
	#	$ Paid	$ Ded	#	$ Paid	$ Ded
Urgent Care Facility	18	1,105.17		1	24.66	
Office Visit	2,491	145,066.55	807.27	4	369.23	
Nutritional	81	8,350.29	475.63	1	75.00	
Chiropractic Care	97	1,690.90	67.23	3	66.40	
Speech Therapy	19	5,298.12	1,785.00	2	102.25	285.00
Occupational Therapy	15	1,592.12		2	150.00	
Deductible						
Individual Deductible In-Network Exceeded	37	8,927.57	8,405.18	3	3,983.52	2,660.62
Family Deductible In-Network Exceeded	2		61.67	1		39.14
Out-of-Pocket						
Individual Out-of-Pocket In-Network Exceeded	70	35,184.86	2,477.91	3	141.03	
Individual Out-of-Pocket Out-of-Network Exceeded	3	316.80		1	79.20	
Family Out-of-Pocket In-Network Exceeded	2	10,009.33		2	10,009.33	
Sub Totals	***5,095***	***5,239,026.11***	***153,746.67***	***29***	***23,297.82***	***3,734.76***
Totals Exceptions	**22,012**	**$20,784,390.07**	**$366,693.99**	**150**	**$1,081,981.04**	**$10,500.24**

APPENDIX C – EXCEPTION LIST

- Separate spreadsheet - SJVIA_Anthem_Medical_Exception_List.xls