Final Federal Targeted Market Conduct Examination of
Blue Cross Blue Shield of Texas, HIOS ID # TX- 33602
State of Texas as of June18, 2024

Examination Report: 33602– 2021– FED – 1

In accordance with Title 45 of the Code of Federal Regulations (C.F.R.), Section 150.313, the Center for Consumer Information and Insurance Oversight (CCIIO) has completed a targeted Market Conduct Examination (Examination) of Blue Cross Blue Shield of Texas, HIOS ID #33602, (Issuer) in the State of Texas. The Examination review period was January 1, 2021 through September 30, 2021, and was called to assess the Issuer's compliance with section 2713 of the Public Health Service Act (PHS Act) and implementing regulation:

- Coverage of preventive health services – 45 C.F.R. § 147.130.

CCIIO also reviewed the Issuer's compliance with the following:

- Coverage of COVID-19 diagnostic testing – Families First Coronavirus Response Act, Pub. L. 116-127, div. F § 6001(a)(1) and (2).[1]

[1] References in this document to § 6001 of the Families First Coronavirus Response Act refer to that statute, as amended by § 3201 of division A of the Coronavirus Aid, Relief, and Economic Security Act, Pub. L. 116-136.

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I. Executive Summary

The Center for Consumer Information and Insurance Oversight (CCIIO) conducted a targeted Market Conduct Examination (Examination) of Blue Cross Blue Shield of Texas (Issuer) to assess the Issuer's compliance with the federal market reform requirements mandating coverage of certain preventive health services – section 2713 of the PHS Act and implementing regulation 45 C.F.R. § 147.130, and coverage of COVID-19 diagnostic testing – Families First Coronavirus Response Act, Pub. L. 116-127, Div. F § 6001(a)(1) and (2). The period covered by the Examination was January 1, 2021 through September 30, 2021 (Examination Period).

A random sample of 1,690 Issuer-generated claims was selected and reviewed. An additional sample of 406 claims was selected (2,096 claims samples in total) to evaluate the Issuer's exceptions process for coverage of contraceptive services. This additional sample was selected by analyzing contraceptive pharmacy claims that were associated with medical management techniques such as prior authorization and step therapy. In addition to the selected claim samples, 82 Issuer documents were reviewed (2,178 total claim files and documents).

CCIIO discovered one violation by the Issuer, affecting four individuals, for failing to provide coverage of preventive health services without cost sharing. Consistent with the finding detailed in this Examination report, within 60 calendar days from the date of this final report, the Issuer is directed to take corrective measures such as modifying policies and procedures to ensure future compliance, notifying members of the policy revisions, conducting a self-audit to identify any inappropriately denied claims, re-adjudicating those identified claims, and providing CCIIO with a list of claims identified and re-adjudicated.

This report is by exception; the Examination Results section only indicates areas where findings were noted and includes responses from the Issuer to criticisms noted in this report (when provided). In summary, findings were identified for the following Federal requirements:

a. Coverage of preventive health services – section 2713(a) of the PHS Act and 45 C.F.R. § 147.130(a)(1).

The Examination identified practices that do not comply with applicable Federal requirements, some of which may also violate State insurance laws and regulations.

The Issuer is directed, within 60 calendar days from the date of this final report, to take immediate corrective action with respect to the finding identified in this report to demonstrate its ability and intention to conduct business in accordance with Federal requirements. When applicable, corrective actions for other jurisdictions and/or affiliates should also be addressed.

II. Scope of Examination

CCIIO conducted this Examination pursuant to 45 C.F.R. § 150.313. The Examination Period was January 1, 2021 through September 30, 2021. The purpose of the Examination was to assess the Issuer's compliance with select applicable Federal requirements.

This report identifies findings that have been discovered based on the review and sampling procedures identified in this report but does not constitute an exhaustive list of violations that may require correction. Some non-compliant practices may not have been discovered or noted in this report. Failure to identify or address business practices that do not comply with Federal requirements does not constitute acceptance of such practices.

The examination and testing methodologies followed standards established by the National Association of Insurance Commissioners and procedures developed by CCIIO. All samples were selected by using a computer-generated, random sample program unless otherwise stated herein.

CCIIO organized the Examination's sample population by selecting preventive services recommended guidelines by the following: United States Preventive Services Task Force (USPSTF); Health Resources and Services Administration (HRSA), Women's Preventive Services Guidelines; and Pediatric Bright Futures and Immunizations. CCIIO then organized samples by the Issuer's insurance markets, as well as paid claims and denied claims. The methodology was designed so that claims included in one sample area would not be duplicated in other review areas.

Area Reviewed	Population	Sample Size
45 CFR 147.130(a)(1)(i)-USPSTF A & B Recommendations individual market, paid medical claims[2]	522,478	59
USPSTF A & B Recommendations individual market, denied medical claims	45,959	90
USPSTF A & B Recommendations group market, paid medical claims	1,105,140	125
USPSTF A & B Recommendations group market, denied medical claims	48,398	94
45 CFR 147.130(a)(1)(iv) HRSA Women's Preventive Services Guidelines[3] individual market, paid medical claims	83,039	123
HRSA Women's Preventive Services Guidelines individual market, denied medical claims	12,215	212
HRSA Women's Preventive Services Guidelines group market, paid medical claims	164,699	245
HRSA Women's Preventive and Contraceptive group market, denied medical claims	9,013	156
45 CFR 147.130(a)(1)(ii) and (iii)- Pediatric Bright Futures and Immunizations individual market, paid medical claims	520,030	65
Pediatric Bright Futures and Immunizations individual market, denied medical claims	65,541	98
Pediatric Bright Futures and Immunizations group market, paid medical claims	963,066	119

[2] We acknowledge that, since the completion of CMS's audit of BCBSTX, the United States District Court for the Northern District of Texas issued a final judgment in Braidwood Management Inc. v. Becerra, No. 4:20-cv-00283-O (N.D. Tex. Mar. 30, 2023), which held, among other things, that the USPSTF's recommendations operating in conjunction with PHS Act section 2713(a)(1) violate the Appointments Clause. The government has appealed the final judgment, and in the meantime, the Fifth Circuit has granted the government's motion for a partial stay of the district court's order. See No. 23-10326 (5th Cir. May 15, 2023).

[3]The HRSA Women's Preventive Services Guidelines contains samples of contraceptive claims for services that are performed by a medical professional such as IUDs and implantable rods.

Area Reviewed	Population	Sample Size
Pediatric Bright Futures and Immunizations group market, denied medical claims	57,486	86
Pharmacy individual market, paid claims	110,630	37
Pharmacy individual market, denied claims	31,886	40
Pharmacy group market, paid claims	211,836	72
Pharmacy group market, denied claims	54,276	69
Pharmacy Women's Contraceptive[4] individual market, denied claims*	117,918	247
Pharmacy Women's Contraceptive small group market, denied claims*	145,651	152
Pharmacy Women's Contraceptive large group market, denied claims*	3,348	7
Policy and procedure documents, claim processing documents, provider manuals, and other miscellaneous documents provided by the Issuer	N/A	82

*Note: CCIIO selected an additional sample from existing data to further analyze contraceptive pharmacy claims that were rejected for reason codes associated with medical management techniques, such as prior authorization and step therapy. The Pharmacy Women's Contraceptive individual, small group, and large group markets denied claims were sampled from the revised pharmacy claim data set, with an emphasis on denied claims to focus on exceptions processes.

To test the effectiveness of the contraceptive formulary exception process, denied claims data was analyzed for denials related to Prior Authorization, Plan Limitations Exceeded, and Refill Too Soon reasons. Members with denials or claim handling with the following attributes were targeted for sampling:

1. Multiple rejected attempts to fill a contraceptive Rx, followed by a paid claim for a different contraceptive
2. Non-formulary contraceptive approved with no previous rejections

[4] Pharmacy Women's Contraceptive samples contains contraceptive claims for self-administered contraceptive drugs.

3. Multiple rejected attempts to fill a contraceptive Rx, followed by a paid claim for the same contraceptive
4. Multiple rejected attempts to fill a contraceptive Rx – not filled, no other contraceptives filled during the exam period.

The Issuer's responses to criticisms issued during the Examination process appear after the findings in the Examination Results section of this report.

III. Issuer Profile

Blue Cross and Blue Shield of Texas is a division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

Blue Cross and Blue Shield of Texas, headquartered in Richardson, Texas, has 22 customer service centers, and serves over 6 million members in 254 counties.

IV. Summary of Findings

Finding 1	
Summary	Failing to cover preventive health services without cost sharing for evidence-based items or services, immunization, and contraception. This occurred because of the Issuer's internal policy requiring that preventive diagnosis codes be paired with preventive service codes in order for a service to be processed as preventive without member cost sharing. The provider submitted claims for service codes 58300, 58301, 87624, and 96372, for contraceptive items and related services. For service code 96372, the Issuer alleged that the provider used an outdated service code combination but was unable to provide CCIIO with evidence that guidance regarding the updated diagnosis code had been made available at the time of the claim.
Citations	Section 2713(a) of the PHS Act and 45 C.F.R. § 147.130(a)(1)
Corrective Action	**Corrective Actions:** Conduct a self-audit to identify all claims from January 1, 2021 through the date of this final report for service codes 58300, 58301, 87624, and 96372 for which coverage was denied or cost sharing imposed because of the outdated service code combination, where the Issuer did not make guidance on the updated codes available timely to providers. Within 60 calendar days from the date of this final report, provide documentation containing the results from the self-audit, re-adjudicate all such claims and provide a list of the claims identified and re-adjudicated to CCIIO. Include the claim number, date of service, date of original denial or imposition of cost sharing, date of re-adjudication, amount paid to provider, provider reimbursement check number issued, amount refunded to member, and member refund check number issued on the date of re-adjudication. Review and update claim policies to ensure compliance with Federal preventive health services statutes and rules. Provide the updated claim policies to CCIIO within 60 calendar days from the date of this final report.

V. Examination Results

A. Preventive Health Services Findings –

Finding 1 –Violation of section 2713(a) of the PHS Act and 45 C.F.R. § 147.130(a)(1).

Section 2713(a) of the PHS Act states in pertinent part:

> (a) In General. —A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost-sharing requirements for—
>
> (1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
>
> (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
>
> (3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
>
> (4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.
>
> (5) for the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

> Nothing in this subsection shall be construed to prohibit a plan or issuer from providing coverage for services in addition to those recommended by United States Preventive Services Task Force or to deny coverage for services that are not recommended by such Task Force.

45 C.F.R. § 147.130(a)(1) Coverage of preventive health services states in pertinent part:

> (a) Services— (1) In general. Beginning at the time described in paragraph (b) of this section and subject to §§ 147.131, 147.132, and 147.133, a group health plan, or a health insurance issuer offering group or individual health insurance coverage, must provide coverage for and must not impose any cost-sharing requirements (such as a copayment, coinsurance, or a deductible) for—
>
> > (i) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved (except as otherwise provided in paragraph (c) of this section);
> >
> > (ii) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);
> >
> > (iii) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration;
> >
> > (iv) With respect to women, such additional preventive care and screenings not described in paragraph (a)(1)(i) of this section as

provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of section 2713(a)(4) of the Public Health Service Act, subject to §§ 147.131, 147.132, and 147.133; and

(v) Any qualifying coronavirus preventive service, which means an item, service, or immunization that is intended to prevent or mitigate coronavirus disease 2019 (COVID-19) and that is, with respect to the individual involved—

(A) An evidence-based item or service that has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; or

(B) An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (regardless of whether the immunization is recommended for routine use). For purposes of this paragraph (a)(1)(v)(B), a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention.

Plans and issuers subject to section 2713 of the PHS Act must cover, without cost sharing, items and services that are integral to the furnishing of the recommended preventive service, regardless of whether the item or service is billed separately. Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency, 85 FR 71142, 71174 (Nov. 2, 2020).

The Issuer failed to comply with the above requirements in the circumstances detailed in the findings below.

Preventive Health Services Finding

CCIIO requested the Issuer's claims data, focusing on those claims with ICD-10 diagnosis and/or CPT procedure codes that indicated the member received preventive services. CCIIO analyzed the Issuer's claims data and identified claims for which the Issuer denied coverage or applied cost sharing to the

member. CCIIO then requested those claim files to review whether the Issuer improperly denied coverage or applied cost sharing. CCIIO received and reviewed these claim files for compliance with the regulations.

CCIIO identified claims indicating that the Issuer inappropriately denied coverage of preventive health services or applied cost sharing to preventive health services in four instances, affecting four individuals. Claim files that contained violations for this finding are listed in the table below:

Area Reviewed	Population	Sample Size	Total Violations	% Of Error
HRSA Women's Preventive Services Guidelines group market, denied medical claims	9,013	156	2	1.3%
HRSA Women's Preventive Services Guidelines group market, paid medical claims	164,699	245	2	0.8%

CCIIO identified potential violations and provided these to the Issuer in the form of criticisms. Criticisms #1, #2, #3, #4, #5 and #6 identified those claims that indicated a service was preventive and for which the Issuer denied payment or applied cost sharing. This impacted the following preventive health services:

- Criticism #1 – USPSTF: Two claims for preeclampsia screening and depression screening;
- Criticism #2 – HRSA: Two claims for intrauterine devices and HPV testing;
- Criticism #3 – HRSA: Two claims for injectable contraceptives and intrauterine devices with progestin;
- Criticism #4 – USPSTF: Three claims for depression screening and STI testing;
- Criticism #5 – Bright Futures Preventive Services: One claim for body mass index: weight assessment and counseling; and

- Criticism #6 – HRSA: 19 claims related to anxiety disorder.

The Issuer agreed with all items for Criticism #2 and one item for Criticism #3. Because the Issuer agreed, these items are not addressed in the table below.

The Issuer disagreed with all items for Criticisms #1, #4, #5, #6, and one item for Criticism #3. For these items, the Issuer stated the following:

Criticism 1	
Subject	Applying cost sharing to USPSTF A&B Recommended health services: Two claims for preeclampsia screening and depression screening. USPSTF A&B recommendations include screening for depression in the general adult population, including pregnant and postpartum women, and recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy. These claims were billed with the following diagnosis and procedure codes: 1. ICD-10 code Z00.00 (Encounter for general adult medical examination without abnormal findings) and CPT code 84550 (Uric acid); and 2. ICD-10 code Z13.89 (Encounter for screening for other disorder) and CPT code 96160 (Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument).
Citation	Section 2713(a) of the PHS Act and 45 C.F.R. § 147.130(a)(1)
General Issuer Response	We disagree that the Issuer is in violation of 45 C.F.R. § 147.130(a)(1)(i) - Coverage of preventive health services. In order for the Company to process claims at the preventive level with no member cost share, the claim must include a preventive diagnosis code, a preventive procedure code, meet medical policy review criteria, and fall within the guidelines issued by the United States Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and the Health Resources

	and Service Administration (HRSA) (Bright Futures recommendations). See Preventive Services Policy at 4, CMS_BCBSTX_0012689_RFI 1.3 CPCP006 Preventive Services Policy 10-01-21_FINAL.pdf, produced March 1, 2022.
Specific Issuer Response Item 1	Per the Company's Preventive Services Policy, CPT code 84550 is not classified as a "preventive procedure code." See id.
Specific Issuer Response Item 2	Per the Company's Preventive Services Policy, CPT code 96160 is only "Payable with a diagnosis code in Diagnosis List 1." See Preventive Services Policy at 8 & 14. The diagnosis code billed, Z13.89, does not appear on Diagnosis List 1. Id. at 30.
CCIIO Response	CCIIO finds the Issuer's response sufficient to remove the findings for all items in Criticism #1. 45 C.F.R. § 147.130(a)(1) defines the requirement for certain recommended preventive health services to be covered by health plans without imposing cost sharing. The CPT code for item 1 (84550) is for Uric Acid and does not appear to be a preventive procedure code. The CPT code for item 2 (96160) is for the administration of a patient-focused health risk assessment instrument and does not appear to be a preventive procedure code. The CPT code is not specific only to screening for depression. The diagnosis codes used by the provider do not explicitly identify a billed procedure as a preventive service and are not included on the list of codes required to be used to indicate a service is a preventive service.

Issuer Response: Concur, subject to the following proposed modification/clarification: "CCIIO finds the Issuer's response sufficient to remove the findings for ~~two~~ all items in Criticism #1."

Only two items were at issue in Criticism #1. BCBSTX requests this clarification, which is also consistent with other language in the Draft Report, see, e.g., Criticism #4, Criticism #6.

CCIIO concurs with the Issuer's position and incorporated the recommended edits above.

Criticism 3	
Subject	Applying cost sharing to HRSA Women's Preventive Services Guidelines health services: Two claims for injectable contraceptives and intrauterine devices with progestin. HRSA Contraception recommendations include that adolescent and adult women have access to the full range of contraceptives and contraceptive care to prevent unintended pregnancies and improve birth outcomes. The claim billed with the following diagnosis and procedure codes: 1. ICD-10 code Z30.42 (Encounter for surveillance of injectable contraceptive) and CPT code 96372 (injection of drug or substance under skin or into muscle)
Citation	Section 2713(a) of the PHS Act and 45 C.F.R. § 147.130(a)(1)
Specific Issuer Response Item 1	We disagree that the Issuer is in violation of 45 C.F.R. § 147.130(a)(iv) - Coverage of preventive health services. In order for the Company to process claims at the preventive level with no member cost share, the claim must include a preventive diagnosis code, a preventive procedure code, meet medical policy review criteria, and fall within the guidelines issued by the United States Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and the Health Resources and Service Administration (HRSA) (Bright Futures recommendations). See Preventive Services Policy at 4, CMS_BCBSTX_0012689_RFI 1.3 CPCP006 Preventive Services Policy 10-01-21_FINAL.pdf, produced March 1, 2022. Prior to 01/10/2020, CPT code 96372 ("Injection of drug/substance under ski[n] or into muscle") was coded as ACA "Contraceptive Drug Administration." See BCBSTX PREMIER 96372.pdf [CMS_BCBSTX_0028838]. However, code 96372 ceased to be classified as ACA "Contraceptive Drug Administration" on 01/10/2020. See id. "End Date." The date of service for this claim was 01/29/2021, over a year after the relevant code was no longer classified as preventive. Code 96372 was classified as a Medical Therapeutic procedure code which pulled medical benefits. Because this claim did not "include a preventive procedure code," it

Criticism 3	
	was not processed at the preventive level with no member cost share. The claim correctly applied medical benefits for injection administration based on code used at time of service.
CCIIO Response	CCIIO does not find the Issuer's response sufficient to remove the findings for item 1 in Criticism #3. 45 C.F.R. § 147.130(a)(1) defines the requirement for certain recommended preventive health services to be covered by health plans without imposing cost sharing, including preventive care and screenings provided for in comprehensive guidelines supported by the HRSA with respect to Women. HRSA Contraception recommendations s state: "The Women's Preventive Services Initiative (WPSI) recommends that adolescent and adult women have access to the full range of female-controlled contraceptives to prevent unintended pregnancy and improve birth outcomes. Contraceptive care should include contraceptive counseling, initiation of contraceptive use, and follow-up care (e.g., management, and evaluation as well as changes to and removal or discontinuation of the contraceptive method)." (HRSA Women's Preventive Services Guidelines, 2019) According to the WPSI 2021 Coding Guide, both the diagnosis code, Z30.42, and procedure code, 96372, used for this claim are listed for contraceptive shots or injections. In addition, the Issuer's Preventive Services Policy in effect during the Examination Period lists procedure code 96372 under "Contraceptive Methods and Counseling." While the policy does make clear throughout that *"In order for preventive claims to process at the preventive level with no member cost share, the claim must include a preventive diagnosis code, meet medical policy review criteria, and fall within the guidelines issued by the USPSTF, ACIP, HRSA, OR Bright Futures*." (CMS_BCBSTX_0012689_RFI 1.3 CPCP006 Preventive Services Policy 10-01-21_FINAL.pdf, pg. 4), the policy does not state that a

Criticism 3	
	specific diagnosis code is required in order for this procedure code to be reimbursable at the preventive level (*id*. pg. 20)

Issuer Response: Concur, subject to the following proposed modifications on page 20:

In addition, the Issuer's Preventive Services Policy in effect during the Examination Period lists procedure code 96372 under "Contraceptive Methods and Counseling." While the policy does make clear throughout that "In order for preventive claims to process at the preventive level with no member cost share, the claim must include a preventive diagnosis code, (CMS_BCBSTX_0012689_RFI 1.3 CPCP006 Preventive Services Policy 10-01-21_FINAL.pdf, pg. 4), ~~T~~the policy does not state later under under "Contraceptive Methods and Counseling" that a specific diagnosis code is required in order for this procedure code to be reimbursable at the preventive level ~~(CMS_BCBSTX_0012689_RFI 1.3 CPCP006 Preventive Services Policy 10-01-21_FINAL.pdf~~, id. pg. 20; see also page 29 ("Many of the services listed above may be performed for indications other than preventive care. In these situations, services may be covered by another provision of the individual's benefit plan and subject to applicable cost sharing.").

CCIIO concurs with the Issuer's position for most of the recommended edits. CCIIO incorporated the recommended edits and added the remaining language included in the Issuer's policy referenced above. However, CCIIO does not concur with including recommended edit in the last sentence of the Issuer's response. Therefore, this recommended edit was not incorporated above.

Criticism 4	
Subject	Applying cost sharing to USPSTF A&B Recommended Services: Three claims for depression screening and STI testing. USPSTF A&B recommendations include screening for depression in the general adult population, including pregnant and postpartum women. In addition, USPSTF A&B recommendations include screening for chlamydia and gonorrhea in sexually active women

Criticism 4	
	age 24 years and younger and in older women who are at increased risk for infection. Three claims were billed with the following diagnosis and procedure codes: 1. ICD-10 code Z13.89 (Encounter for screening for other disorder) and CPT code 96127 (Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument); 2. ICD-10 code Z20. 2 (Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission) and CPT code 84791 (infectious agent detection by nucleic acid (DNA or RNA); chlamydia trachomatis, amplified probe technique); and 3. ICD-10 code Z20. 2 (Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission) and CPT code 84791 (infectious agent detection by nucleic acid (DNA or RNA); neisseria gonorrhoeae, amplified probe technique).
Citation	Section 2713(a) of the PHS Act and 45 C.F.R. § 147.130(a)(1)
General Issuer Response	We disagree that the Issuer is in violation of 45 C.F.R. § 147.130 (a)(1)(i) - Coverage of preventive health services. In order for the Company to process claims at the preventive level with no member cost share, the claim must include a preventive diagnosis code, a preventive procedure code, meet medical policy review criteria, and fall within the guidelines issued by the United States Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and the Health Resources and Service Administration (HRSA) (Bright Futures recommendations). See Preventive Services Policy at 4, CMS_BCBSTX_0012689_RFI 1.3 CPCP006 Preventive Services Policy 10-01-21_FINAL.pdf, produced March 1, 2022.
Specific Issuer Response Item 1	Per the Company's Preventive Services Policy, CPT "code 96127 is only reimbursable at the preventive level when billed with a diagnosis of Z00.129, Z13.31, Z13.32, Z13.39, Z13.41, or Z13.42."

Criticism 4	
	See Preventive Services Policy at 8. Here, provider billed diagnosis code Z13.89.
Specific Issuer Response Items 2-3	Per the Company's Preventive Services Policy, the diagnosis code billed on both items, code Z20.2, does not appear on Diagnosis List 1 and is not considered a "preventive diagnosis code." Id. at 30. Diagnosis code Z20.2 is a medical diagnosis code. Because this claim did not "include a preventive diagnosis code," it is not processed at the preventive level with no member cost share. The benefits under this policy are subject to a coinsurance of 30% as patient responsibility.
CCIIO Response	CCIIO finds the Issuer's response sufficient to remove the findings for all items in Criticism #4. 45 C.F.R. § 147.130(a)(1) defines the requirement for certain recommended preventive health services to be covered by health plans without imposing cost sharing. For item 1 in Criticism #4, CPT code (96127) is for a brief emotional/behavioral assessment and does not appear to be a preventive procedure code. This may include an assessment for depression, but the CPT code is not specific only to screening for depression. The diagnosis code used by the provider does not explicitly identify a billed procedure as a preventive service and is not included on the list of codes required to be used to indicate a service is a preventive service. For items 2 and 3 in Criticism #4, while the CPT codes (87491 and 87591) indicate STI testing was performed, the diagnosis code used by the provider does not explicitly identify a billed procedure as a preventive service and is not included on the list of codes required to be used to indicate a service is a preventive service.

Issuer Response: Concur

CCIIO concurs with the Issuer's position.

Criticism 5	
Subject	Applying cost sharing to Bright Futures Preventive Services: One claim for body mass index: weight assessment and counseling. Pediatric Bright Futures & Immunization recommendations include anticipatory guidance and counseling for children and adolescents based on recommended measurements to be taken within preventive visits during a child's development, including body mass index. This claim was billed with the following diagnosis and procedure codes: 1. ICD-10 code Z68.54 (Body mass index [BMI] pediatric, greater than or equal to 95th percentile for age) and CPT code 99204 (New patient office visit, 45-59 minutes).
Citation	Section 2713(a) of the PHS Act and 45 C.F.R. § 147.130(a)(1)
Issuer Response	We disagree that the Issuer is in violation of 45 C.F.R. § 147.130(a)(1)(iii) - Coverage of preventive health services. In order for the Company to process claims at the preventive level with no member cost share, the claim must include a preventive diagnosis code, a preventive procedure code, meet medical policy review criteria, and fall within the guidelines issued by the United States Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and the Health Resources and Service Administration (HRSA) (Bright Futures recommendations). See Preventive Services Policy at 4, CMS_BCBSTX_0012689_RFI 1.3 CPCP006 Preventive Services Policy 10-01-21_FINAL.pdf, produced March 1, 2022. Per the Company's Preventive Services Policy, the diagnosis code billed Z68.54, does not appear on Diagnosis List 1 and is not considered a "preventive diagnosis code." Id. at 30. Because this claim did not "include a preventive diagnosis code," it is not processed at the preventive level with no member cost share.
CCIIO Response	CCIIO finds the Issuer's response sufficient to remove the finding for Criticism #5.

Criticism 5	
	45 C.F.R. § 147.130(a)(1) defines the requirement for certain recommended preventive health services to be covered by health plans without imposing cost sharing. The CPT code (99204) is for a general office visit and is not a preventive procedure code. The diagnosis code used by the provider does not explicitly identify a billed procedure as a preventive service and is not included on the list of codes required to be used to indicate a service is a preventive service.

Issuer Response: Concur

CCIIO concurs with the Issuer's position.

Criticism 6	
Subject	Applying cost sharing to HRSA Women's Preventive Services Guidelines health services: 19 claims related to anxiety disorder. HRSA Women's Preventive Services recommendations include screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum. These claims were billed with the following diagnosis and procedure codes: 1. ICD-10 codes F11 (Generalized anxiety disorder), F413 (Other mixed anxiety disorders), F418 (Other specified anxiety disorders), or F419 (Anxiety disorder, unspecified); and 2. CPT codes 99203 (New patient office visit, 30-44 minutes), 99204 (New patient office visit, 45-59 minutes), 83036 (Hemoglobin; glycosylated (A1C)), 82947 (blood glucose testing), 99213 (established patient office visit, 20-29 minutes), 99214 (Established patient office or other outpatient visit, 30-39 minutes), or 99215 (Office or other outpatient visit for an established patient).

Criticism 6	
Citation	Section 2713(a) of the PHS Act and 45 C.F.R. § 147.130(a)(1)
Issuer Response	We disagree that the Issuer is in violation of 45 C.F.R. § 147.130(a)(1)(iv) - Coverage of preventive health services. In order for the Company to process claims at the preventive level with no member cost share, the claim must include a preventive diagnosis code, a preventive procedure code, meet medical policy review criteria, and fall within the guidelines issued by the United States Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and the Health Resources and Service Administration (HRSA) (Bright Futures recommendations). See Preventive Services Policy at 4, CMS_BCBSTX_0012689_RFI 1.3 CPCP006 Preventive Services Policy 10-01-21_FINAL.pdf, produced March 1, 2022. The diagnosis codes billed, codes F411 (Generalized anxiety disorder), F413 (Other mixed anxiety disorders), F418 (Other specified anxiety disorders), and F419 (Anxiety disorder, unspecified), are medical codes related to diagnosing anxiety disorders and are not related to preventive care. Furthermore, per the Company's Preventive Services Policy, any "Anxiety Screening" must be billed with a procedure code of 96127 (Brief Behavioral Assessment), 99384, 99385, 99386, 99387, 99394, 99395, 99396, or 99397 (Preventive Medicine Services), or G0444 (Screening for Depression). See Preventive Services Policy at 19. Because these claims did not include a preventive procedure code or a preventive diagnosis code, they were not processed at the preventive level with no member cost share. The claims processed correctly applying medical benefit level coverage.
CCIIO Response	CCIIO finds the Issuer's response sufficient to remove the finding for all items in Criticism #6. 45 C.F.R. § 147.130(a)(1) defines the requirement for certain recommended preventive health services to be covered by health plans without imposing cost sharing.

Criticism 6	
	The CPT codes does not indicate an anxiety screening was performed and are not preventive procedure codes. The diagnosis codes used by the provider do not explicitly identify a billed procedure as a preventive service and are not included on the list of codes required to be used to indicate a service is a preventive service.

Issuer Response: Concur

CCIIO concurs with the Issuer's position.

Corrective Actions:

Conduct a self-audit to identify all claims from January 1, 2021 through the date of this final report for service codes 58300, 58301, 87624, and 96372 for which coverage was denied or cost sharing imposed because of the outdated service code combination, where the Issuer did not make guidance on the updated codes available timely to providers.

Within 60 calendar days from the date of this final report, provide documentation containing the results from the self-audit, re-adjudicate all such claims and provide a list of the claims identified and the results of any re-adjudications to CCIIO. Include the claim number, date of service, date of original denial or imposition of cost sharing, date of re-adjudication, amount paid to provider, provider reimbursement check number issued, amount refunded to member, and member refund check number issued on the date of re-adjudication. In addition, review and update claim policies to ensure compliance with all Federal preventive health services statutes and rules.

Issuer Response: Concurs with the position as outlined in Finding 1 of the Draft Report, subject to the below proposed modification(s) to the Corrective Actions.[1] Initial investigation into the remedial measures requested indicates that additional time will be needed to complete the self-audit and readjudications, as well as the review and updates to policies:

Conduct a self-audit to identify all claims from January 1, 2021 through the date of this final report for service codes 58300, 58301, 87624, and 96372 for which coverage was denied or cost sharing imposed because of the outdated service code combination, where the Issuer did not make guidance on the updated codes available timely to providers.

Within ~~45~~ 90 calendar days from the date of this final report, provide documentation containing the results from the self-audit, re-adjudicate all such claims and provide a list of the claims identified and re-adjudicated to CCIIO. Include the claim number, date of service, date of original denial or imposition of cost sharing, date of readjudication, amount paid to provider, provider reimbursement check number issued, amount refunded to member, and member refund check number issued on the date of readjudication.

Review and update claim policies to ensure compliance with Federal preventive health services statutes and rules. Provide the updated claim policies to CCIIO within ~~45~~ 90 calendar days from the date of this final report.

CCIIO conditionally concurs with the Issuer's position. CCIIO approved extending the due date from 45 days to 60 days from the date of this final report. The partial recommended edits are incorporated above.

VI. Closing

A total of 2,096 claims and documents were reviewed as part of this Examination. Of the selected samples, CCIIO found one violation that affected four individuals related to coverage of preventive health services.

VII. Examination Report Submission

The courtesy and cooperation extended by the officers and employees of the Issuer during the course of the Examination are hereby acknowledged.

Jeffrey C. Wu -S

Digitally signed by Jeffrey C. Wu -S
Date: 2024.06.19 23:00:28 -04'00'

Jeff Wu
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Centers for Medicare & Medicaid Services
US Department of Health & Human Services

In addition, the following individuals participated in this Examination and in the preparation of this report:

Center for Consumer Information and Insurance Oversight

- Mary Nugent- Director, Division of Plan and Issuer Enforcement
- Darshell Shepphard, MCM
- Judah Katz, Esq., MCM
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