Final Federal Targeted Market Conduct Examination Report of
Celtic Insurance Company, HIOS ID # TX- 29418
State of Texas as of July 30, 2024

Examination Report: 29418 – 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 Celtic Insurance Company, HIOS ID #29418, (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(a) of the Public Health Service Act (PHS Act) and implementing regulations:

- 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.

Table of Contents

I. Executive Summary

The Center for Consumer Information and Insurance Oversight (CCIIO) has conducted a targeted Market Conduct Examination (Examination) of Celtic Insurance Company in the State 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 1,390 Issuer-generated claims was selected and reviewed. An additional sample of 596 claims was selected (1,986 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 rejected for reason codes associated with medical management techniques such as prior authorization, plan limitations exceeded, and refill too soon. In addition to the selected claim samples, 55 Issuer documents were reviewed (2,041 total claim files and documents).

CCIIO discovered one violation by the Issuer affecting 22 individuals for failing to provide coverage of recommended preventive health services, one violation by the Issuer, affecting one individual, for failing to provide coverage of COVID-19 immunization without cost sharing, and one violation by the Issuer, affecting nine individuals, for failing to make a claim determination in accordance with governing plan documents. Consistent with the findings detailed in this Examination report, within 45 calendar days from the date of receipt 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);

b. COVID-19 immunization - section 3203 of the CARES Act and 45 C.F.R. § 147.130(a)(1)(v); and,
c. Failure to make a claim determination in accordance with governing plan documents — 42 U.S.C. § 300gg–19(a)(2)(A), 45 C.F.R. § 147.136(b)(3)(i), and 29 U.S.C. § 1135, 29 C.F.R. § 2560.503-1(b)(5).

Additional details regarding these findings are in the Examination Results section of this report.

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 45 calendar days from the date of receipt of this final report, to take immediate corrective action with respect to the findings 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 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 State Preventive Services Task Force (USPSTF); Health Resources and Services Administration (HRSA), Women's Preventive Services Guidelines; and Pediatric Bright Futures and Immunizations. The Issuer only offered health insurance coverage in the individual insurance market during the Examination Period. CCIIO organized samples by the Issuer's individual insurance market, 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 paid medical claims[2]	320,255	184
USPSTF A & B Recommendations denied medical claims	24,145	109

[2] We acknowledge that, since the completion of CMS's audit of Celtic Insurance Company, 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).

Area Reviewed	Population	Sample Size
45 CFR 147.130(a)(1)(iv) – HRSA Women's Preventive Services Guidelines paid medical claims	261,059	368
HRSA Women's Preventive Services Guidelines denied medical claims	18,045	218
45 CFR 147.130(a)(1)(ii) and (iii) - Pediatric Bright Futures and Immunizations paid medical claims	520,997	184
Pediatric Bright Futures and Immunizations denied medical claims	45,737	109
Pharmacy paid claims	59,321	109
Pharmacy denied claims	10,473	109
Pharmacy Contraceptive claims - reject reason code 79 (refill too soon) *	5,977	135
Pharmacy Contraceptive claims - reject reason code 75 (prior authorization) *	233	233
Pharmacy Contraceptive claims - reject reason code 76 (plan limitations exceeded) *	796	228
Policy and procedure documents, claim processing documents, provider manuals, and other miscellaneous documents provided by the Issuer	N/A	55

*Note: CCIIO selected and requested an additional sample to further analyze contraceptive pharmacy claims that were rejected for reason codes associated with medical management techniques, such as prior authorization and step therapy.

To test the effectiveness of the contraceptive formulary exception process, denied claims data was analyzed for denials associated with reason codes Prior Authorization, Plan Limitations Exceeded, and Refill Too Soon. 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;
3. Multiple rejected attempts to fill a contraceptive Rx, followed by a paid claim for the same contraceptive; and,
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

Celtic Insurance Company is a Chicago-based health insurance company that specializes in individual health plans offered off the exchange for individuals, families, and self-employed workers.

Celtic Insurance Company is a subsidiary of Centene Corporation in the state of Texas, which offers coverage nationwide and serves over 27 million members.

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 for a service to be processed as preventive without cost sharing.

This also occurred because of manual processing errors due to incorrect patient demographics causing denial of preventive health services on the basis that the submitted claims coding was inconsistent with the member's gender.

The Issuer's practices impacted claims for services codes 45380, 45385, 77063, 77067, 80050, 87491, 86850, 96127, 96160, and
99391.

Citations

Section 2713(a) of the PHS Act and 45 C.F.R. § 147.130(a)(1)

Corrective Actions:
Conduct a self-audit to identify all claims from January 1, 2021, through the date this final Report is issued for service codes 45380, 45385, 77063, 77067, 80050, 87491, 86850, 96127, 96160, and
99391 for which coverage was denied or cost sharing imposed for preventive services for claims that did not have preventive diagnosis codes and preventive service codes and claims manually processed improperly.

Within 45 calendar days from the date of receipt 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 CMS within 45 calendar days from the date of receipt of this final report.

Finding 2
Summary
Failing to provide coverage of COVID-19 immunization without cost sharing.

This occurred because the Issuer failed to include a rate for such claims with service code 0013A in the claims processing system during the COVID-19 Public Health Emergency.

Citation
Section 3203 of the CARES Act and 45 C.F.R. § 147.130(a)(1)(v)

Corrective Actions:
Conduct a self-audit to identify all claims from January 1, 2021, through the date this final report is issued for all claims for service code 0013A that denied coverage or imposed cost sharing for COVID-19 immunization from January 1, 2021, to May 11, 2023.

Within 45 calendar days from the date of receipt 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.

Finding 3
Summary
Failing to process claims in accordance with governing plan documents.

This occurred because the Issuer did not follow governing plan processes to ensure that prior authorization determinations for non-formulary contraceptives were applied correctly. The Issuer required prior authorization without including a description of all claims procedures as part of the summary plan description.

Finding 3

Prior authorizations were denied as the provider was in the process of completing the Issuer requirement of prior authorization for 44 contraceptive prescriptions (Annovera), indicating the patient must try at least one preferred formulary drug before approval can be provided. These patients were prevented from fulfilling a contraceptive prescription (at no cost- sharing) for the contraceptive prescribed by the provider.

The Issuer incorrectly applied cost sharing to one contraceptive prescription (Nuvaring) that was submitted by the provider for exception, and then approved under a prior authorization determination.

Citations
Section 2719(a)(2)(B) of the PHS Act and 45 C.F.R. § 147.136(b)(3)(i)

Corrective Actions:
Within 45 calendar days from the date of receipt of this final report, provide supporting documentation to demonstrate that the Issuer has implemented administrative processes and safeguards to ensure and verify claim determinations for contraceptive prescriptions for Annovera and Nuvaring are made in accordance with governing plan documents to avoid the following:

1) Improper denial of prior authorization requests due to step therapy requirements; and
2) Improper application of cost sharing when processing exception requests as a prior authorization with a benefit determination letter.

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(a) 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 Findings

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 24 instances, affecting 22 individuals. Claim files that contained violations for this finding are listed in the table below:

Area Reviewed	Population	Sample Size	Violations	% of Error
USPSTF A&B Recommendations paid medical claims	320,255	184	9	4.9%

Area Reviewed	Population	Sample Size	Violations	% of Error
HRSA Women's Preventive Services Guidelines paid medical claims	261,059	368	6	1.6%
Pediatric Bright Futures and Immunizations paid medical claims	520,997	184	3	1.6%
USPSTF A&B Recommendations denied medical claims	24,145	109	2	1.83%
HRSA Women's Preventive Services Guidelines denied claims	18,045	218	2	0.91%
Pediatric Bright Futures and Immunizations denied claims	45,737	109	2	1.83%

CCIIO identified potential violations and provided these to the Issuer in the form of criticisms. Criticisms #1, #2, #3, #4, #5, #6, #7 and #9 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 and HRSA: Six claims for depression screening; one claim for HPV testing;
- Criticism #2 – USPSTF: Three claims for colonoscopies; one claim for hemoglobin testing; two claims for STIs; three claims for depression screening; and one claim for administration of patient-focused health risk assessment instrument;
- Criticism #3 – Bright Futures Preventive Services: One claim for depression screening;
- Criticism #4 – USPSTF: One claim for denied services inconsistent with member's gender due to a manual processing error;
- Criticism #5 – Bright Futures Preventive Services: One claim for transfusion; and two claims for behavioral assessment;
- Criticism #6 – HRSA: Two claims for denied services inconsistent with member's gender (member's gender was inaccurately reflected in member's eligibility file due to manual error);
- Criticism #7 – USPSTF: One claim for denied services inconsistent with member's gender due to a manual processing error; and,
- Criticism #9 - Bright Futures Preventive Services: One claim for denied services to newborn.

The Issuer agreed with six items in Criticism #1, six items in Criticism #2 and all items for Criticisms #3, #4, #5, #6, #7, and #9, totaling 21 claims. Because the Issuer agreed, these items are not addressed in the table below.

The Issuer disagreed with one item in Criticism #1 and three items in Criticism #2. For these items, the Issuer stated the following:

Criticism 1
Subject
Applying cost sharing to HRSA preventive health services: one claim for HPV testing.

The WPSI recommends cervical cancer screening for average-risk women aged 21 to 65 years. For women aged 21 to 29 years, the WPSI recommends cervical cancer screening using cervical cytology (Pap test) every 3 years. Co-testing with cytology and human papillomavirus testing is not recommended for women younger than 30 years. Women aged 30 to 65 years should be screened with cytology and human papillomavirus testing every 5 years or cytology alone every 3 years. Women who are at average risk should not be screened more than once every 3 years.

The claim was billed with the following diagnosis and procedure codes:
ICD-10 code Z01.419 (Encounter for gynecological examination (general) (routine) without abnormal findings) and CPT code 87624 (Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), high-risk types).
Citation
Section 2713(a) of the PHS Act and 45 C.F.R. § 147.130(a)(1)

Issuer Response Item 305
Disagree - per member claim history, a preventive HPV screening was processed on claim U124MPE36659 with a date of service of 02/12/2021. Per HRSA guidelines, the subsequent HPV test included in claim U236MPE55430 would not qualify as preventive.

CCIIO
Response
CCIIO finds the Issuer's response sufficient to remove the finding for the HPV screening claim.

HRSA Guidelines state:

> Women aged 30 to 65 years should be screened with cytology and human papillomavirus testing every 5 years or cytology alone every 3 years. Women who are at average risk should not be screened more than once every 3 years.

Criticism 1

As the member in this case had a previous HPV screening within the recommended timeframe, CCIIO agrees this claim is not required to be processed as preventive.

Criticism 2
Subject
Applying cost sharing to USPSTF A&B Recommendations preventive health services: three claims for a colonoscopy.

The USPSTF guidelines recommend screening for colorectal cancer starting at age 50 years and continuing until age 75 years.

The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese in order to screen for Type 2 Diabetes.

These claims were billed with the following diagnosis and procedure codes (Note: The procedures listed in #1 and #2 were billed on the same claim for the same patient.):

1. ICD-10 code Z12.11 (Encounter for screening for malignant neoplasm of colon) and CPT code 45380 (colonoscopy, flexible; with biopsy, single or multiple);
2. ICD-10 code Z12.11 (Encounter for screening for malignant neoplasm of colon) and CPT 45385 (colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique); and
3. ICD-10 code Z00.00 (Encounter for general adult medical examination without abnormal findings) and CPT code 83036
   (hemoglobin; glycosylated (A1C)).

Citation
Section 2713(a) of the PHS Act and 45 C.F.R. § 147.130(a)(1)

Issuer Response Item 66
(Note: 2 procedures billed on this claim)

A1., a & b) Review item #66 – CPT code 45380 and 45385. “Per review of the claim form, a screening procedure was not billed with CPT codes 45380 and 45385. Therefore, the colonoscopy service was billed as a diagnostic service, not a preventive service. Cost share was applied appropriately for a diagnostic colonoscopy.

Criticism 2
"We disagree that we are in violation of 45 C.F.R. § 147.130(a)(1)(i)
- Coverage of preventive health services."

CCIIO Response Item 66
CCIIO does not find the Issuer's response sufficient to remove the finding.

45 C.F.R. § 147.130(a)(1) defines the requirement for certain preventive health services to be covered without cost sharing. Criticism #2 regarding CPT codes 45380 and 45385 – 2 colonoscopy procedures with removal billed with a Primary ICD-10 code of Z12.11, Encounter for screening for malignant neoplasm of colon. Colonoscopy is an A recommendation by the USPSTF for a 52-year-old male. The Diagnosis Pointer (Claim form field E) for both CPT codes included the primary ICD-10 code. Therefore, both procedures are to be considered a preventive service, and no cost sharing is allowed.

The Issuer did not indicate that it has requirements for providers to use specific procedure and diagnosis codes to identify a colonoscopy as preventive.

Issuer Response Item 130
A1., c) Review Item #130 – CPT code 83036. "Per review of the claim form, the service was billed as a diagnostic service, not preventive. Cost share was applied appropriately for a diagnostic service.

"We disagree that we are in violation of 45 C.F.R. § 147.130(a)(1)(i)
- Coverage of preventive health services."

CCIIO Response Item 130
CCIIO finds the Issuer's response sufficient to remove the finding for the A1C testing in Criticism #2.

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 this item (83036) is for A1C testing. The accompanying diagnosis code (Z00.00) used by the provider is for a general adult medical examination and does not explicitly identify a billed procedure as a
preventive service.

Corrective Actions:

Conduct a self-audit to identify all claims from January 1, 2021, through the date

this final report is issued for service codes 45380, 45385, 77063, 77067, 80050, 87491, 86850, 96127, 96160, and 99391 for which coverage was denied or cost sharing imposed for preventive services for claims that did not have preventive diagnosis codes and preventive service codes and claims manually processed improperly.

Within 45 calendar days from the date of receipt 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 CMS within 45 calendar days from the date of receipt of this final report.

Issuer's Response: The Company concurs with CCIIO's position regarding codes 45380, 45385, 96127, 96160, 86850, 87491, 80050, 77063, 77067, and 99391.

Corrective Action Steps:

Codes added to the Preventive Care Code Set:

- Code 96127 was added to the Preventive Care Code Set effective November 1, 2019.
- Code 96160 was added to the Preventive Care Code Set effective January 1, 2019.
- Code 86850 was added to the Preventive Care Code Set effective April 1, 2021.
  Code 87491 configuration was updated removing one per year limit effective January 1, 2021.

For 2019-2021 claims with service codes 96127, 96160, 86850, and 87491, manual checks refunding cost share were issued directly to members with a letter explaining the issue in August 2022.

For 2022 claims with service code 96127, 96160, 86850, and 87491, a claims project was initiated to reprocess claims.

Claims denied due to Payment Integrity edit:

Claims denied as "x4 - Procedure code/diagnosis code inconsistent with members gender" (codes 80050, 77063, 77067) due to the member's enrollment file having the incorrect gender. The x4 denial was applied due to a Payment Integrity edit.

- Claim U023MPE24820 – Member's gender corrected in the system. Claim reprocessed and paid under claim U064MP534177 on April 4, 2022.
- Claim U277MPE31898 – Member's gender corrected in the system. Claim reprocessed and paid under claim U277MPE31898 on April 12, 2022.
- Claim U127MPE37098 – Member's gender corrected in the system. Claim reprocessed and paid under claim U127MPE37098 on April 12, 2022.
- Review of the Payment Integrity edit is currently under way.

Please note, procedure code 80050 is a laboratory panel which may or may not be performed as a preventative service. When this procedure code is billed in conjunction with a preventative visit or with a preventative diagnosis code, the system is configured to apply the preventative claims payment benefit.

Claim denied due to Member date of birth mismatch:
Claim denied as "MQ - Member name number date of birth do not match" (code 99391) due to newborn member's date of birth on the claim form not matching the date of birth on the enrollment system.

- Claim U183MPE42825- Member's date of birth was corrected in the system. Claim
  reprocessed and paid under claim U183MP890904 on April 12, 2022.

Colonoscopy Codes 45380 and 45385:
Claims processed as diagnostic colonoscopy with cost share.

The colonoscopy claims referenced in Criticism #2 and #3 do not include a preventive modifier on the claim form. We respectfully disagree these claims should have processed against the preventive care benefit.

The Company has taken Corrective Action Steps regarding preventive colonoscopy claims processing. The Company previously reported to the CMS Account Manager that a system limitation was identified that does not allow for preventive modifier positions outside of the Modifier 1 field to be adjudicated against preventive care benefits. Providers billing preventive modifiers in the Modifier 2 through 4 positions on the claim form caused claims to process as diagnostic and apply member cost share.

Corrective Action Steps

- A claims analysis was performed to identify impacted claims with dates of services of 2020-2023 billed with a preventative modifier in the modifier 2 through 4 positions. Manual checks will be issued to members for 2020 and 2021 dates of service.
- Claims projects were submitted to reprocess impacted claims for 2022 and 2023 dates of service.
- The Centene configuration team has developed functionality to identify claims with a preventative modifier outside of the modifier 1 position. If the claim is billed with the appropriate diagnosis code, CPT code, modifier, and the preventative service history meets the preventative care requirements, the claim will appropriately process against the preventative care benefits.

Per page 33 of the 2024 Provider Billing Manual:
Preventive benefits do not generally include services intended to treat an existing illness, injury, or condition. Benefits will be determined based on how the bill is submitted.
Claims must be submitted with the appropriate diagnosis and/or procedure code and modifier(s) when applicable to be paid at the 100% benefit level. If during a preventive care visit a member receives services to treat an existing illness, injury, or condition, he/she may be required to pay a copayment, deductible and/or coinsurance for those covered non-preventive services.

CCIIO concurs with the Issuer's position

B. COVID-19 Immunization Finding

Finding 2 - Violation of section 3203 of the CARES Act and 45 C.F.R. § 147.130(a)(1)(v).

Section 3203 of the CARES Act states in pertinent part:

(a) IN GENERAL. —Notwithstanding 2713(b) of the Public Health Service Act (42 U.S.C. 300gg-13), the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury shall require group health plans and health insurance issuers offering group or individual health insurance to cover (without cost-sharing) any qualifying coronavirus preventive service, pursuant to section 2713(a) of the Public Health Service Act (42 U.S.C. 300gg-13(a)) (including the regulations under sections 2590.715-2713 of title 29, Code of Federal Regulations, section 54.9815-2713 of title 26, Code of Federal Regulations, and section147.130 of title 45, Code of Federal

Regulations (or any successor regulations)). The requirement described in this subsection shall take effect with respect to a qualifying coronavirus preventive service on the specified date described in subsection (b)(2).
(b) DEFINITIONS. —For purposes of this section:

(1) QUALIFYING CORONAVIRUS PREVENTIVE SERVICE. —The term ‘‘qualifying coronavirus preventive service’’ means an item, service, or immunization that is intended to prevent or mitigate coronavirus disease 2019 and that is—

(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 with respect to the individual involved.

(2) SPECIFIED DATE. —The term ‘‘specified date’’ means the date that is 15 business days after the date on which a recommendation is made relating to the qualifying coronavirus preventive service as described in such paragraph.

(3) ADDITIONAL TERMS. —In this section, the terms ‘‘group health plan’’, ‘‘health insurance issuer’’, ‘‘group health insurance coverage’’, and ‘‘individual health insurance coverage’’ have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg-91), section 733 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b), and section 9832 of the Internal Revenue Code, as applicable.

45 C.F.R. §147.130(a)(1)(v) 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—

(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.

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

COVID-19 Immunization Finding

The Issuer failed to provide coverage of items and services related to COVID-19 immunization without cost sharing for one procedure billed. COVID-19 immunization services were reviewed as part of the claim population provided by the Issuer related to Pediatric Bright Futures and Immunizations claims. Claim files that contained violations for this finding are listed below.

Area Reviewed	Population	Sample Size	Violations	% of Error
Pediatric Bright Futures and Immunizations denied medical claims	45,737	109	1	0.92%

CCIIO identified potential violations and provided these to the Issuer in the form of criticisms. Criticisms #5 and #8 identified claims that indicated a service was related to COVID-19 diagnostic testing and COVID-19 immunization, and for which the Issuer denied coverage or applied cost sharing. This impacted the following services:

- Criticism #5 – Bright Futures Preventive Services: One claim for an emergency department visit; and
- Criticism #8 – Families First Coronavirus Response Act: One claim for which Issuer needed to provide the completed reprocessed claim.

The Issuer agreed with the item in Criticism #8 regarding service code 0013A (COVID-19 immunization). Because the Issuer agreed, this item is not addressed in the table below.

The Issuer disagreed with the item in Criticism #5. For this item, the Issuer stated the following:

Subject Criticism 5
Applying cost sharing to Bright Futures Preventive Services: One claim for an emergency department visit.

The Families First Coronavirus Response Act requires coverage of and prohibits cost-sharing for specific services furnished during any portion of the emergency period, including emergency room visits that result in an order for or administration of an in vitro diagnostic product for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19.

This claim was billed with the following diagnosis and procedure code:
1. ICD-10 code U07.1 (COVID-19, virus identified) and CPT code 99284 (Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and medical decision making of moderate complexity)
Citation
Families First Coronavirus Response Act, Pub. L. 116-127, div. F § 6001(a)(1) and (2); Section 2713(a) of the PHS Act and 45 C.F.R. § 147.130(a)(1)(v)

Issuer Response Item 170
CPT code 99284 is an emergency department visit. Per review of the claim form, the primary diagnosis on the claim is U071 – Pneumonia due to SARS-associated coronavirus. As noted in the initial response, effective 7/1/2021, the cost share for COVID treatment was no longer being waived. The claim was processed as an ER visit for treatment of a COVID diagnosis. The date of service on the claim is 9/10/2021, therefore, the cost share applied correctly on the claim. We disagree that we are in violation of Families First Coronavirus Response Act, Pub. L. 116–127, div. F, § 6001(a)(1) and (2), and 45 C.F.R. §
147.130 - Coverage of preventive health services.

CCIIO Response
CCIIO finds the Issuer’s response sufficient to remove the finding for treatment of COVID-19 of Criticism #5.
The claim was for treatment of COVID-19 and testing for pneumonia, not COVID-19

diagnostic testing. As this claim was not diagnostic, and the Issuer had ended its cost-share waiver for treatment of COVID-19 before the date of service, this claim is not noted as a violation in this report. Based on the date of service of this claim, CCIIO agrees that cost share was applied appropriately for this claim.

Corrective Actions:

Conduct a self-audit to identify all claims from January 1, 2021, through the date this final report is issued for all claims for service code 0013A that denied coverage or imposed cost sharing for COVID-19 immunization from January 1, 2021 to May 11, 2023.

Within 45 calendar days from the date of receipt 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.

Issuer's Response: The Company concurs with CCIIO's position as outlined in the Draft Report.

The Company would like to clarify that code 0013A is for the administration of a third dose of vaccine product when the initial immune response following a two-dose primary COVID-19 vaccine series is likely to be insufficient. It is not a COVID-19 diagnostic test.

The claim referenced in the finding was denied because the claim pricing configuration was not complete at the time the claim was received and processed on September 23, 2021. Code 0013A was a new code that became effective in mid-August 2021.

Corrective Action Steps

- Service code 0013A was configured in the claims processing system as of September 28, 2021.
- A review of code 0013A claims from January 1, 2021 through March 31, 2022 was completed. A total of 234 denied claims were identified and reprocessed.
- Subsequent to the identification of this issue, claims processes were updated to pend claims when a service code configuration is incomplete.

- A review of all claims for service code 0013A that denied coverage or imposed cost sharing for COVID-19 vaccine administration from January 1, 2021 to May 11, 2023 is underway.

CCIIO concurs with the Issuer regarding code 0013A. Initially, CCIIO noted that Celtic violated the Families First Coronavirus Response Act, Pub. L. 116-127, div. F § 6001(a)(1) and (2) for failing to provide coverage of COVID-19 diagnostic testing however, CCIIO clarified that code 0013A is for the administration of a third dose of vaccine product. CCIIO updated this finding to reflect Celtic's violation of Section 3203 of the CARES Act and 45 C.F.R. § 147.130(a)(1)(v) for failing to provide coverage of COVID-19 immunization without cost sharing.

C. Claims Process Findings

Finding 3 – Violation of Section 2719(a)(2)(B) and 45 C.F.R. § 147.136(b)(3)(i)

states in pertinent part:

> (a) Internal claims appeals
>
> * * * *
>
> (2) Established processes
>
> To comply with paragraph (1)—
>
> * * * *
>
> (B) a health insurance issuer offering individual health coverage, and any other issuer not subject to subparagraph (A), shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures set forth under applicable law (as in existence on March 23, 2010), and shall update such process in accordance with any standards established by the Secretary of Health and Human Services for such issuers.

45 C.F.R. § 147.136(b)(3)(i) states in pertinent part:

> (b) Internal claims and appeals process — (1) In general. A group health plan and a health insurance issuer offering group or individual health insurance coverage must implement an effective internal claims and appeals process, as

described in this paragraph (b).

* * * *

(3) Requirements for individual health insurance issuers. A health insurance issuer offering individual health insurance coverage must comply with all the requirements of this paragraph (b)(3).

(i) Minimum internal claims and appeals standards. A health insurance issuer offering individual health insurance coverage must comply with all the requirements of the ERISA internal claims and appeals procedures applicable to group health plans under 29 C.F.R. 2560.503-1 except for the requirements with respect to multiemployer plans, and except to the extent those requirements are modified by paragraph (b)(3)(ii) of this section. Accordingly, under this paragraph (b), with respect to individual health insurance coverage, the issuer is subject to the requirements in 29 C.F.R. 2560.503-1 as if the issuer were a group health plan.

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

Claim Process Findings

The Issuer's claim process was reviewed as part of the examination in all samples reviewed. In addition, in order 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 reason codes. 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
3. Multiple rejected attempts to fill a contraceptive Rx, followed by a paid claim for the same contraceptive; and,
4. Multiple rejected attempts to fill a contraceptive Rx – not filled, no other contraceptives filled during the exam period.

The Issuer failed to process claims in accordance with governing documents in 46 claim files reviewed. Claim files that contained violations for this finding are listed below.

Area Reviewed	Population	Sample Size	Violations	% of Error
Contraceptive pharmacy claims - reject reason code 75 (prior authorization)	233	233	45	19.31%
Contraceptive pharmacy claims - reject reason code	796	228	1	0.43%

Area Reviewed	Population	Sample Size	Violations	% of Error
76 (plan limitations exceeded)				

CCIIO organized its review, identifying potential violations, and provided these to the Issuer in the form of criticisms. Criticisms #2, #12 and #13 identified claims where the Issuer did not process the claim in accordance with governing documents. This impacted the following preventive health services:

- Criticism #2 – USPSTF: One claim for pediatric vision services and routine eye exam;
- Criticism #6 – HRSA: One claim for a preventive care visit denied as being a duplicate claim;
- Criticism #12 – HRSA Women's Preventive Services: 45 claims for denial of contraception for failure to complete step therapy, although the provider had submitted a prior authorization as required; and
- Criticism #13 – HRSA Women's Preventive Services: One claim for contraceptives where cost sharing was improperly applied, as a provider had submitted an exception request.

The Issuer agreed with all items for Criticisms #12 and 13, totaling 46 claims. Because the Issuer agreed, these items are not addressed in the table below.

The Issuer disagreed with one item for Criticism #2 and one item for Criticism #6. For these items, the Issuer stated the following:

Criticism 2
Subject
Failing to process claims in accordance with governing plan documents for USPSTF A&B Preventive health services: One claim for pediatric vision services and routine eye exam.

The USPSTF recommends vision screening at least once in all children aged 3 to 5 years to detect amblyopia or its risk factors. The Summary of Benefits states: "Vision Services – Pediatric (Children under the age of 19)
Routine eye exam (& Contact lens fitting) Limited to 1 visit per year. Covered at 100%." Cost-sharing was applied to the claim.

Criticism 2

This claim was billed with the following diagnosis and procedure codes:
1. ICD-10 code Z00.129 (Encounter for routine child health examination without abnormal findings) and CPT code 99174 (Instrument-based ocular screening (e.g., photoscreening,
   automated refraction), bilateral; with remote analysis and report).

Citation
Section 2719(a)(2)(B) and 45 C.F.R. § 147.136(b)(3)(i)

Issuer Response Item 147
Review Item #147 – CPT code 99174. Per review of the claim, the member is 12 years of age. Vision acuity screenings for children older than age five are a covered benefit, however, the appropriate procedure code for the age range must be present on the claim in order for the services to be processed under preventive care.
The following codes are covered and separately reimbursed for ages 0-5 and not separately reimbursed for ages greater that 5:

i. 99173 Screening Test of Visual Acuity, Quantitative, Bilateral
ii. 99174 Instrument-based ocular screening (e.g., photo screening, automated refraction), bilateral; with remote analysis and report
iii. 99177 Instrument-based ocular screening (e.g., photo screening, automated refraction), bilateral; with onsite analysis

This is not an internal claims processing or coverage issue, but rather a provider billing issue. In this instance, the member is older than five, as such, CPT code 99174 is not appropriate.
We disagree that we are in violation of 45 C.F.R. § 147.136(b)(3)(i) and 29 C.F.R. §2560.503-1(b)(5) Claims procedure.

CCIIO Response Item 147
CCIIO finds the Issuer's response sufficient to remove the finding for item #147 of Criticism #2.

The claim was billed with an improper CPT code due to the age of the patient on the date of service, who was over the age of five.

Criticism 6
Subject
Failing to process claims in accordance with governing plan documents for HRSA Preventive health services: one claim for a preventive care visit denied as being a duplicate claim.

WPSI recommends that women receive at least one preventive care visit per year beginning in adolescence and continuing across the lifespan to ensure the provision of all recommended preventive

Criticism 6

services, including preconception and many services necessary for prenatal and interconception care, are obtained.

This claim was 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 99386 (Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient).

Citation
Section 2719(a)(2)(B), 45 C.F.R. § 147.136(b)(3)(i)

Issuer Response Item 160
The provider did not submit the corrected claim in accordance with the corrected claim guidelines outlined on page 50 of the attached Provider Manual. Per the corrected claim guidelines listed in the Provider Manual, corrected claims must clearly indicate they are corrected in one of the following ways:

1. Submit a corrected claim via the Secure Provider Portal. Follow the instructions on the portal for submitting a correction.

2. Submit a corrected claim electronically via a clearinghouse.
• Institutional Claims (UB): Field CLM05-3=7 and Ref*8 = Original Claim Number
• Professional Claims (CMS): Field CLM05-3=7 and REF*8 = Original Claim Number

3. Submit a corrected paper claim to:
Ambetter
Attn: Corrected Claims PO Box 5010
Farmington, MO 63640-5010

Upon submission of a corrected paper claim, the original claim number must be typed in field 22 (CMS 1500) and in field 64 CMS 1450 (UB-04) with the corresponding frequency codes in field 22 of the CMS 1500 and in field 4 of the CMS 1450 (UB-04) form.

Criticism 6

Corrected claims must be submitted on standard red and white forms. Handwritten corrected claims will be upfront rejected.

The provider submitted claim # U245MPE45136 via a clearing house. The provider did not include the resubmission code or original claim number in the resubmitted claim.

Claim U245MPE45136 denied as a duplicate appropriately.

CCIIO Response
CCIIO finds the Issuer's response sufficient to remove the finding for item #160 of Criticism #6.

In this case, the corrected claim guidelines provided in the Issuer's Provider Manual were not followed in order for this claim to process appropriately as a corrected claim.

Corrective Actions:

Within 45 calendar days from the date of receipt of this final report, provide supporting documentation to demonstrate that the Issuer has implemented administrative processes and safeguards to ensure and verify claim determinations for contraceptive prescriptions for Annovera and Nuvaring are made in accordance with governing plan documents to avoid the following:

1) Improper denial of prior authorization requests due to step therapy requirements; and
2) Improper application of cost sharing when processing exception requests as a prior authorization with a benefit determination letter.

Issuer's Response: The Company concurs with CCIIO's position as outlined in the Draft Report.

The following Corrective Actions have been taken to address the finding.

- On June 16, 2022, Centene Pharmacy Services (CPS) Prior Authorization Operations added a reminder to policy HIM.PA.100 (Non-Formulary and Formulary Contraceptives) in Section I that once approval has been entered in the system the PA reviewer must enter an exception for copay code (drug needs to pay on Tier 0) and exception for subject to deductible code for the requested drug. Education also provided to PA reviewers regarding utilization of HIM.PA.100 for contraceptive PA reviews.

- CPS reviewed contraceptive denials from July 1, 2015, to May 20, 2022.
- On August 31, 2022, CPS Prior Authorization Operations implemented a decision tree to be used for contraceptive Prior Authorization reviews. The decision tree will auto-approve PA requests if criteria is met per HIM.PA.100.

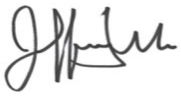
CCIIO concurs with Issuer's response

VI. Closing

A total of 2,041 claim files and documents were reviewed as part of this Examination. Of the files and documents reviewed, CCIIO found a total of three violations: one violation, affecting 22 individuals, related to coverage of preventive health services; one violation, affecting one individual, related to coverage of COVID-19 immunization; and one violation, affecting nine individuals, for failing to make a claim determination in accordance with governing plan documents.

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.



_____
Jeff Wu
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Center for Consumer Information and Insurance Oversight
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

- Darshell Shepphard, MCM
- Januwa Epps, MS, MSL

Examination Resources, LLC