Final Report Federal Targeted Market Conduct Examination Report of
Christus Health Plan of Texas, HIOS ID # TX- 66252
State of Texas as of May 07, 2024

Examination Report: 66252 – 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 Christus Health Plan of Texas, HIOS ID #66252, (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) has conducted a targeted Market Conduct Examination (Examination) of Christus Health Plan 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 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 1,260 Issuer-generated claims was selected and reviewed. An additional sample of 107 claims was selected (1,367 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 with reason codes associated with medical management techniques. In addition to the selected claim samples, 142 Issuer documents were reviewed (1,509 total claim files and documents).

CCIIO discovered one violation by the Issuer, affecting 33 individuals, for failing to provide coverage of preventive health services without cost sharing or denying preventive health services claims, and one violation by the Issuer, affecting two individuals, for failing to provide coverage of COVID-19 diagnostic testing without cost sharing. Consistent with the findings detailed in this Examination report, within 45 days from the date of receipt of the 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 the identified claims, and providing CCIIO with a list of claims identified and re-adjudicated.

This report is by exception; the Examination Result 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 of the PHS Act and 45 C.F.R. § 147.130(a)(1); and,
b. Coverage of COVID-19 testing – Families First Coronavirus Response Act, Pub. L. 116-127, div. F § 6001(a)(1) and (2).

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, with 45 calendar days from the date of receipt of the 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 violations 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. The issuer only offered health insurance coverage in the individual market during the Examination Period. CCIIO then organized samples by 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 143.130(a)(1)(i) - (USPSTF) A & B Recommendations paid medical claims[2]	20,109	132
USPSTF A & B Recommendations denied medical claims	1,583	112
45 CFR 147.130(a)(1)(iv) HRSA Women's Preventive Services Guidelines paid medical claims	6,834	239

[2] We acknowledge that, since the completion of CMS's audit of Christus Health Plan of Texas, 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
HRSA Women's Preventive Services Guidelines denied medical claims	407	224
45 CFR 147.130(a)(1)(ii) and (iii) Pediatric Bright Futures and Immunizations paid medical claims	20,945	110
Pediatric Bright Futures and Immunizations denied medical claims	3,261	118
Pharmacy paid claims	175,890	109
Pharmacy denied claims	73,776	216
Pharmacy Women's Contraceptive rejected claims*	4,126	107
Policy and procedure documents, claim processing documents, provider manuals, and other miscellaneous documents provided by the Issuer	142	142

*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 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
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

Christus Health Plan is a Catholic, not-for-profit health care system made up of more than 600 centers, including long-term care facilities, community hospitals, walk-in clinics, and health ministries.

Christus Health Plan, headquartered in Irving, Texas, employs over 250 associates, and serves over 41,000 members. While most of the associates are located in the Irving, Texas office, provider relations representatives, and local marketing and sales agents reside in each individual market served.

IV. Summary of Findings

Finding 1	
Summary	Failing to cover preventive health services without cost sharing for evidence-based items and services, immunization, and contraception. This occurred because of the Issuer's systemic and operational claims processing configurations. Specifically, the Issuer stated that the "system was not appropriately configured" or there was a "configuration change" resulting in cost sharing being applied to preventive screenings and services. This impacted service codes for 00812, 36415, 45385, 77063, 77067, 80061, 82950, 83036, 85025, 86803, 87491, 87591, 87624, 87661, 88175, 88305, 99392, and 99396.
Citation	Section 2713(a) of the PHS Act and 45 C.F.R. § 147.130(a)(1)
Corrective Action	**<u>Corrective Actions:</u>** Within 45 calendar days from the date of receipt of the final report, perform a self-audit to identify all claims for service codes 00812, 36415, 45385, 77063, 77067, 80061, 82950, 83036, 85025, 86803, 87491, 87591, 87624, 87661, 88175, 88305, 99392, and 99396 that denied coverage or imposed cost sharing for preventive health services from January 1, 2021, forward. Conduct a self-audit to identify all claims from January 1, 2021 through the date of the final report is issued for service codes 00812, 36415, 45385, 77063, 77067, 80061, 82950, 83036, 85025, 86803, 87491, 87591, 87624, 87661, 88175, 88305, 99392, and 99396 for which coverage was denied or imposed cost sharing for preventive health services. Within 45 calendar days from the date of receipt of the 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

Finding 1	
	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 the final report.

Finding 2	
Summary	Failing to provide coverage of COVID-19 diagnostic testing without cost sharing. This occurred because of incorrect claim processing for service codes 87428 and 87635, imposing cost sharing for COVID-19 diagnostic testing, during the COVID-19 Public Health emergency period.
Citation	Families First Coronavirus Response Act, Pub. L. 116-127, div. F § 6001(a)(1) and (2)
Corrective Action	**Corrective Actions:** Conduct a self-audit to identify all claims from January 1, 2021, to May 11, 2023, for procedure codes 87428 and 87635 that denied coverage or imposed cost sharing for COVID-19 diagnostic testing. Within 45 calendar days from the date of receipt of the final report, perform a self-audit to identify all claims for service codes 87428 and 87635, that denied coverage or imposed cost sharing for COVID-19 diagnostic testing from January 1, 2021, through May 11, 2023. 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 2	

VI. 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 I 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.
>
> (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.

Issuer Response: We concur with the findings of the Preventive Services Report and our self-audit is in progress.

CCIIO concurs with the Issuer's position.

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 47 instances, affecting 33 individuals. Claim files that contained violations in this finding are listed in the table below:

Area Reviewed	Population	Sample Size	Total Violations	% Of Error
USPSTF A&B Recommendations, paid medical claims	20,086	109	39	35.8%
HRSA Women's Preventive Services Guidelines paid medical claims	6,834	239	8	3.5%

CCIIO identified potential violations and provided these to the Issuer in the form of criticisms. Criticisms #1 and #2 identified those claims that indicated a service was preventive and for which the Issuer denied payment or applied cost sharing.

- Criticism #1 – USPSTF: 44 claims for multiple preventive services screenings;
- Criticism #2 – HRSA: 18 claims for women's preventive services

The Issuer agreed with 39 items for Criticism #1, and ten items for Criticism #2. Because the Issuer agreed, these items are not addressed in the tables below.

The Issuer disagreed with five items for Criticism #1, and eight items for Criticism #2. For these items, the Issuer stated the following:

Criticism 1	
Subject	Applying cost sharing to USPSTF A&B Recommendations preventive health services: Four claims for lipid disorder screening and one claim for diabetes screening. USPSTF A&B recommendations include screenings for lipid disorders in the general adult population, as well as those who are at an increased risk for coronary heart disease. USPSTF A&B recommendations also include screenings for prediabetes and type 2 diabetes for asymptomatic adults who

Criticism 1	
	have overweight or obesity, and asymptomatic children and adolescents younger than 18 years. These claims were billed with the following diagnosis and procedure codes: 1. ICD-10 code E78.5 (Hyperlipidemia) and CPT code 84450 (Under Chemistry Procedures); and 2. ICD-10 code E11.9 (Type 2 diabetes mellitus without complications) and CPT code 83036 (hemoglobin; glycosylated [A1C])
Citation	42 U.S.C. § 300gg-13(a) and 45 C.F.R. § 147.130(a)(1)
General Issuer Response	After further review, CHRISTUS Health Plan does not agree with this finding. DX The diagnosis (DX) code associated with this claim is not indicative of a preventive service. Current Procedural Terminology (CPT) code can be used for medical and preventive health services, however, there is no indication that this was a preventive visit.
Specific Issuer Response Items 8, 9, 25, and 37	DX E78.5 indicates that the patient has a lipid disorder. This CPT in conjunction with the DX indicated treatment of the disorder and not prevention of it.
Specific Issuer Response Item 13	DX E11.9 indicates that the patient has type 2 diabetes. This CPT in conjunction with the DX indicates treatment of diabetes and not prevention of it.
CCIIO Response	CCIIO finds the Issuer's response sufficient to remove the findings for five 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 Issuer requirements for providers to submit claims for preventive services using specific criteria has demonstrated that these services were not submitted as preventive services

Criticism 2	
Subject	Applying cost sharing to USPSTF A&B Recommended preventive health services: two claims for supervision of pregnancy, one claim for bone density screening, one claim for diabetes screening, one claim for acute vaginitis, two claims for

Criticism 2	
	lipid disorder screening, and one claim for lipid disorder with a Hepatitis C screening. USPSTF A&B recommendations include screenings for common infections for pregnant persons in the general adult population, as well as those who are at an increased risk. USPSTF A&B recommendations include screenings for osteoporosis for men, women 65 years and older, and postmenopausal women under 65 years at increased risk. USPSTF A&B recommendations include screenings for prediabetes and type 2 diabetes for asymptomatic adults who have overweight or obesity, and asymptomatic children and adolescents younger than 18 years. USPSTF A&B recommendations include screenings for cervical cancer for women aged 21 to 65 years. USPSTF A&B recommendations include screenings for lipid disorders in the general adult population, as well as those who are at an increased risk for coronary heart disease. These claims were billed with the following diagnosis and procedure codes: 1. ICD-10 code Z34.81 (Encounter for Supervision of Normal Pregnancy) and CPT code 87624 (Infectious Agent Antigen Detection [HPV]); and 2. ICD-10 code M62.838 (Other specified disorders of bone density and structure, left thigh) and CPT code 77080 (Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites); and 3. ICD-10 code E11.3313 (Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral) and CPT code 83036 (hemoglobin; glycosylated [A1C]); and 4. ICD-10 code N76.0 (Acute vaginitis) and CPT code 87624 (Infectious Agent Antigen Detection [HPV]); and

Criticism 2	
	5. ICD-10 code O09.91 (Supervision of high risk pregnancy, unspecified, first trimester) and CPT code 87624 (Infectious Agent Antigen Detection [HPV]); and 6. ICD-10 code E78.5 (Hyperlipidemia) and CPT code 80061 (Lipid panel); and 7. ICD-10 code E78.2 (Mixed hyperlipidemia) and CPT code 80061 (Lipid panel); or CPT code 86803 (Hepatitis C antibody).
Citation	42 U.S.C. § 300gg-13(a) and 45 C.F.R. § 147.130(a)(1)
Specific Issuer Response Item 1	Dx code (Z34.81 - Encounter for Supervision of Normal Pregnancy) billed on claim is not sufficient billing in order to make CPT 87624 a preventive service for the member on this claim. An additional encounter screening Dx such as Z11.51 (Encounter for Screening for Humana Papillomavirus) is expected in order to make this a preventive service. According to the Office on Women's Health (OASH), HPV is not a common pregnancy screening. The following webpage supports this response: https://www.womenshealth.gov/pregnancy/youre-pregnant-now-what/prenatal-care-and-tests#5 -- Expand the "Prenatal Tests" section for more details. A copy of the webpage has been included with this response as "Crit 2 RFI 7R_Review Item CPT2.38_Prenatal care and tests"
Specific Issuer Response Item 7	The Dx codes associated to this claim are not indicative of a preventive service for CPT 77080. Dx Z12.31 is an Encounter for Screening Mammogram and Dx M62.838 is "Other specified disorders of bone density and structure, left thigh" which indicates this member already has a bone density disorder, therefore making CPT 77080 not a preventive service on this claim.
Specific Issuer Response Item 8	The Dx codes associated to this claim are not indicative of a preventive service for CPT 83036. Dx Z12.31 is an Encounter for Screening Mammogram and the Primary Dx E11.3313 is "Type 2 diabetes mellitus" which indicates this member already has Type 2 diabetes, therefore making CPT 83036 not a preventive service on this claim.
Specific Issuer Response Item 9	DX codes associated to this claim are not indicative of a preventive service. N76.0 "Acute vaginitis" indicates this

Criticism 2	
	member already has signs and symptoms of a vaginal disorder, therefore making CPT 87624 not a preventive service on this claim.
Specific Issuer Response Item 14	Dx code (O09.91 Supervision of High Risk Pregnancy, Unspecified, First Trimester) billed on claim is not sufficient billing in order to make CPT 87624 a preventive service for the member on this claim. An additional encounter screening Dx such as Z11.51 (Encounter for Screening for Humana Papillomavirus) is expected in order to make this a preventive service. According to the Office on Women's Health (OASH), HPV is not a common pregnancy screening. The following webpage supports this response: https://www.womenshealth.gov/pregnancy/youre-pregnant-now-what/prenatal-care-and-tests#5 -- Expand the "Prenatal Tests" section for more details. A copy of the webpage has been included with this response as "Crit 2 RFI 7R_Review Item CPT2.213_Prenatal care and tests"
Specific Issuer Response Item 15	DX code associated to this claim is not indicative of a preventive service. CPT code can be used for medical and preventive services, however there is no indication that this was a preventive visit. DX E78.5 indicates that the patient has a lipid disorder. This CPT in conjunction with the DX indicated treatment of the disorder and not prevention of it.
Specific Issuer Response Item 17	DX code associated with this claim is not indicative of a preventive service. CPT code can be used for medical and preventive services, however, there is no indication that this was a preventive visit. DX E78.2 indicates that the patient has a lipid disorder. This CPT in conjunction with the DX indicated treatment of the disorder and not prevention of it.
Specific Issuer Response Item 18	DX code associated with this claim is not indicative of a preventive service. CPT code can be used for medical and preventive services, however, there is no indication that this was a preventive visit. DX E78.2 indicates that the patient has a lipid disorder. This CPT in conjunction with the DX indicated treatment of the disorder and not prevention of it.
CCIIO Response	CCIIO finds the Issuer's response sufficient to remove the findings for eight items in Criticism #2.

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.

Corrective Actions:

Conduct a self-audit to identify all claims from January 1, 2021 through the date of the final report is issued for service codes 00812, 36415, 45385, 77063, 77067, 80061, 82950, 83036, 85025, 86803, 87491, 87591, 87624, 87661, 88175, 88305, 99392, and 99396 for which coverage was denied or imposed cost sharing for preventive health services.

Within 45 calendar days from the date of receipt of the final report, perform a self-audit to identify all claims for service codes 00812, 36415, 45385, 77063, 77067, 80061, 82950, 83036, 85025, 86803, 87491, 871591, 87624, 87661, 88175, 88305, 99392, and 99396, that, based on the applicable diagnosis codes or other information, reflect that Issuer denied coverage or imposed cost sharing for preventive health services from January 1, 2021 forward. Re-adjudicate all such claims and provide a list of the claims identified and the results of any re-adjudications to CCIIO. The results shall contain 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 the final report.

Issuer Response: We concur with the findings of the Preventive Services Report and our self-audit is in progress.

CCIIO concurs with the Issuer's position.

B. COVID-19 Diagnostic Testing Finding

Finding 2 – Families First Coronavirus Response Act, Pub. L. 116-127, div. F § 6001(a)(1) and (2), as amended, states in pertinent part:

> (a) In General.--A group health plan and a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan (as defined in section 1251(e) of the Patient Protection and Affordable Care Act)) shall provide coverage, and shall not impose any cost-sharing (including deductibles, copayments, and coinsurance) requirements or prior authorization or other medical management requirements, for the following items and services furnished during any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b-5(g)) beginning on or after the date of the enactment of this Act:
>
> > (1) An in vitro diagnostic test defined in section 809.3 of title 21, Code of Federal Regulations (or successor regulations) for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19, and the administration of such a test, that—
> >
> > > (A) is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and
> > >
> > > Cosmetic Act (21 U.S.C. 360(k), 360c, 360e, 360bbb–3);
> > >
> > > (B) the developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–3), unless and until the emergency use authorization request under such section 564 has been denied or the
> > >
> > > developer of such test does not submit a request under such section within a reasonable timeframe;
> > >
> > > (C) is developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID–19; or
> > >
> > > (D) other test that the Secretary determines appropriate in guidance.''
> >
> > (2) Items and services furnished to an individual during health care provider office visits (which term in this paragraph includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product described in paragraph (1), but only to

the extent such items and services relate to the furnishing or administration of such product or to the evaluation of such individual for purposes of determining the need of such individual for such product.

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

Issuer Response: We concur with the findings of the Preventive Services Report and our self-audit is in progress.

CCIIO concurs with the Issuer's position.

COVID-19 Diagnostic Testing Finding

The Issuer failed to provide coverage of items and services related to COVID-19 diagnostic testing without cost sharing for two procedures billed. COVID-19 diagnostic testing 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	Total Violations	% Of Error
HRSA Women's Preventive Services Initiative paid claims	6,834	239	1	0.42%
Pediatric Bright Futures and Immunizations paid claims	20,944	109	1	0.92%

CCIIO identified potential violations and provided these to the Issuer in the form of criticisms. Criticism 2 identified two claims for services related to COVID-19 diagnostic testing for which the Issuer denied payment or applied cost-sharing.

The Issuer disagreed with the criticisms for the services. For these items, the Issuer stated the following:

Criticism 2	
Subject	Applying cost sharing to two claims related to COVID-19 diagnostic tests furnished during the COVID-19

Criticism 2	
	Public Health Emergency on or after March 18, 2020 cost sharing emergency period. These claims were billed with the following diagnosis and procedure codes: 1. ICD-10 codes R53.83 (Other Fatigue) and R06.03 (Shortness of breath) with CPT code 87428 (Infectious agent antigen detection by immunoassay technique); and 2. ICD-10 code Z11.52 (Encounter for screening for COVID-19) and CPT code 87635 (Infectious agent detection by nucleic acid).
Citation	Families First Coronavirus Response Act, Pub. L. 116-127, div. F § 6001(a)(1) and (2)
Specific Issuer Response Item1	Encounters for COVID-19 testing, including preoperative testing, providers should code as exposure to COVID-19 (guideline I.C.1.g.1.e). Below are the two links related to this guidance. See attachment entitled; RFI 7R2_Review Item 51_ICD-10-CM Guidelines and RFI 7R2_Review Item 51_CMS Manual System Transmittal 10540 --- https://www.cms.gov/files/document/2021-coding-guidelines-updated-12162020.pdf --- https://www.cms.gov/files/document/r10540cp.pdf
Specific Issuer Response Item 2	For item #38 (CPT3), the Issuer stated “The 2021 ICD-10-CM Guidelines state that a screening code is not appropriate. The guidelines clearly state "Do not assign code Z11.– [5]2 - Encounter for screening for COVID-19. Encounters for COVID-19 testing, including preoperative testing, providers should code as exposure to COVID-19 (guideline I.C.1.g.1.e). Below are the two links related to this guidance. See attachment entitled; RFI 7R2_Review Item 51_ICD-10-CM Guidelines and RFI 7R2_Review Item 51_CMS Manual System Transmittal 10540. --- https://www.cms.gov/files/document/2021-coding-guidelines-updated-12162020.pdf

Criticism 2	
	--- https://www.cms.gov/files/document/r10540cp.pdf
CCIIO Response	CCIIO does not find the Issuer's response sufficient to remove the finding. The Families First Coronavirus Response Act, Pub. L. 116-127, div. F § 6001(a)(1) and (2)147.130(a)(1) defines the requirement for certain COVID-19 diagnostic tests and related items and services to be covered by health plans without imposing cost sharing. Although diagnosis codes can be used to explicitly identify a billed procedure as meeting the requirements under the law, the use of evaluation and management (EM) diagnosis codes do not specifically exclude a billed procedure from being a covered diagnostic COVID-19 service, particularly when a preventive diagnosis code is present as a non-primary diagnosis code on the claim.

Corrective Action:

Within 45 calendar days from the date of receipt of the final report, perform a self-audit to identify all claims for service codes 87428 and 87635, that denied coverage or imposed cost sharing for COVID-19 diagnostic testing from January 1, 2021, through May 11, 2023.

Re-adjudicate all such claims and provide a list of the claims identified and re-adjudicate the results of any to CCIIO. Include the results shall contain 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 Response: We concur with the findings of the Preventive Services Report and our self-audit is in progress.

CCIIO concurs with the Issuer's position.

VIII. Closing

A total of 1,509 claim files and documents were reviewed as part of this Examination. Of the claim files and documents reviewed, CCIIO found a total of two violations by the Issuer: one violation affecting 33 individuals for failing to provide coverage of preventive health services without cost sharing or denying preventive health services claims; and one violation affecting two individuals for failing to provide coverage of COVID-19 diagnostic testing without cost sharing.

IX. 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.

Mary M. Nugent -S

Digitally signed by Mary M. Nugent -S
Date: 2024.05.07 11:36:48 -04'00'

Mary Nugent Director
Division of Plan and Issuer Enforcement
Oversight Group
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
- Angela Veney

Examination Resources, LLC