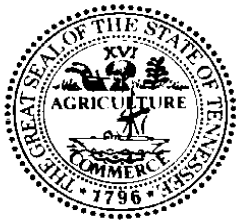

STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE DIVISION

and

THE OFFICE OF THE COMPTROLLER OF THE TREASURY

DIVISION OF STATE AUDIT

MARKET CONDUCT EXAMINATION

and

FINANCIAL AND COMPLIANCE EXAMINATION

OF

THE TENNCARE OPERATIONS

OF

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

d/b/a UnitedHealthCare Community Plan

NASHVILLE, TENNESSEE

FOR THE PERIOD JANUARY 1, 2011
THROUGH DECEMBER 31, 2011

TABLE OF CONTENTS

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DATE: October 24, 2013

The Market Conduct Examination and Financial and Compliance Examination of the TennCare Operations of UnitedHealthCare Plan of the River Valley, Inc., Nashville, Tennessee, was completed December 12, 2012. The report of this examination is herein respectfully submitted.

I. FOREWORD

On July 27, 2012, the TennCare Oversight Division of the Tennessee Department of Commerce and Insurance (TDCI) notified representatives of the TennCare operations of UnitedHealthcare Plan of the River Valley, Inc., (UPRV) d/b/a UnitedHealthcare Community Plan of its intention to perform a market conduct examination and a financial statement and compliance examination. Fieldwork began on October 1, 2012, and ended on October 12, 2012. All document requests were provided by December 12, 2012.

This report includes the results of the market conduct examination "by test" of the claims processing system for UPRV's TennCare operations. Further, this report reflects the results of an examination of financial statement account balances as reported for TennCare operations by UPRV. This report also reflects the results of a compliance examination for its TennCare operations of UPRV's policies and procedures regarding statutory and contractual requirements. A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein.

II. PURPOSE AND SCOPE

A. Authority

This examination of the TennCare operations of UPRV was conducted jointly by TDCI and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller) under the authority of Section 2.25 of the Contractor Risk Agreements (CRAs) for the East, Middle, and West Tennessee Grand Regions between the State of Tennessee and UPRV, Executive Order No. 1 dated January 26, 1995, and Tennessee Code Annotated (Tenn. Code Ann.) § 56-32-115 and § 56-32-132.

UPRV is licensed as a health maintenance organization (HMO) in the state and participates by contract with the state as a managed care organization (MCO) in the TennCare Program. The TennCare Program is administered by the TennCare Bureau within the Tennessee Department of Finance and Administration.

B. Areas Examined and Period Covered

As of financial statement date December 31, 2007, the Illinois Department of Insurance conducted a full scope financial examination of UPRV then known as John Deere Health Plan, Inc., because the company is domiciled in Illinois. The Tennessee Department of Commerce and Insurance received and accepted Illinois' Report of Examination dated June 22, 2009. As a result, this division focused on selected balance sheet accounts and the TennCare income statement as reported for UPRV's TennCare operations submitted with its National Association of Insurance Commissioners (NAIC) Annual Statement as of December 31, 2011, and the Medical Loss Ratio Reports for the East, Middle, and West Tennessee Grand Regions as of December 31, 2011.

The current market conduct examination by TDCI and the Comptroller focused on the claims processing functions and performance of UPRV's TennCare operations. The testing included an examination of internal controls surrounding claims adjudication, claims processing system data integrity, notification of claims disposition to providers and enrollees, and payments to providers.

The compliance examination focused on UPRV's TennCare provider appeals procedures, provider agreements, subcontracts, the demonstration of compliance with non-discrimination reporting requirements, and other relevant contract compliance requirements.

C. Purpose and Objective

The purpose of the examination was to obtain reasonable assurance that UPRV's TennCare operations were administered in accordance with the CRA and state statutes and regulations concerning HMO operations, thus reasonably assuring that UPRV's TennCare enrollees received uninterrupted delivery of health care services on an ongoing basis.

The objectives of the examination were to:

- Determine whether UPRV met certain contractual obligations under the CRAs and whether UPRV was in compliance with the regulatory requirements for HMOs set forth in Tenn. Code Ann. § 56-32-101 *et seq*.;

- Determine whether UPRV had sufficient financial capital and surplus to ensure the uninterrupted delivery of health care services for its TennCare members on an ongoing basis;

- Determine whether UPRV's TennCare operations properly adjudicated claims from service providers and made payments to providers in a timely manner;

- Determine whether UPRV's TennCare operations implemented an appeal system to reasonably resolve appeals from TennCare providers in a timely manner; and

- Determine whether UPRV corrected deficiencies outlined in prior TDCI examinations of UPRV's TennCare operations.

III. PROFILE

A. Administrative Organization

UPRV is a wholly owned subsidiary of UnitedHealthcare Service Company of the River Valley, Inc. (USCRV). USCRV performs all administrative functions of UPRV

through an administrative services agreement between UPRV and USCRV. USCRV is a wholly owned subsidiary of UnitedHealthcare, Inc. which in turn is a wholly owned subsidiary of UnitedHealth Care Services, Inc. (UHS). UHS is a wholly owned subsidiary of UnitedHealth Group Inc. which is a publicly held company trading on the New York Stock Exchange.

In addition to TennCare operations, UPRV has Medicare and commercial lines of business in Tennessee, as well as in other states.

The officers and directors or trustees for UPRV at December 31, 2011, were as follows:

Officers for UPRV

Daniel Roger Kueter, President, Commercial
Scott Andrew Bowers, President, Medicaid Division
Robert Worth Oberrender, Treasurer
Christina Regina Palme-Krizak, Secretary
Patrick Caser, Chief Financial Officer
Bruce Chase Steffens, M.D., Chief Medical Officer
Nyle Brent Cottington, Assistant Treasurer
Michelle Marie Huntley, Assistant Secretary

Directors or Trustees for UPRV

Daniel Roger Kueter
William Kenneth Appelgate, PhD.
Victoria Jean Kauzlarich
Steven Eugene Meeker
Scott Bowers
James Edward Hecker
Cathie Sue Whiteside
Bruce Chase Steffens, M.D.
James Wesley Waters

B. Brief Overview

UPRV has served TennCare enrollees in the East Tennessee Grand Region since the inception of the TennCare program in January 1994 under the CRA between UPRV, formerly John Deere Health Plan, and the TennCare Bureau.

For the Middle Tennessee Grand Region effective April 1, 2007, the West Tennessee Grand Region effective November 1, 2008, and the East Tennessee Grand Region effective January 1, 2009, UPRV is contracted through an at-risk agreement with the TennCare Bureau to receive monthly capitation payments based on the number of enrollees assigned to UPRV and each enrollee's eligibility classification.

For the period January 1, 2011, through December 31, 2011, UPRV received 65% of its nationwide revenue and 77% of its Tennessee revenue, from payments for providing medical and behavioral health benefits to TennCare members. As of December 31, 2011, UPRV had approximately 195,000 TennCare members in the East Tennessee Grand Region, 199,700 in the Middle Tennessee Grand Region, and 173,300 in the West Tennessee Grand Region.

C. Claims Processing Not Performed by UPRV

TennCare has contracted with other organizations for the administration and claims processing of these types of services:

- Dental
- Pharmacy

During the period under examination, UPRV subcontracted with the following vendors for the provision of specific TennCare benefits and/or the processing and payment of related claims submitted by providers:

- Vision – Spectera, Inc., a related party to UPRV
- Behavioral Health – United Behavioral Health, Inc. (UBH) a related party to UPRV

IV. PREVIOUS EXAMINATION FINDINGS

The previous examination findings are provided for informational purposes. The following is a summary of financial, claims processing and compliance deficiencies cited in the examination by TDCI for the period January 1, 2009 through December 31, 2009:

A. Financial Deficiency

1. Credit balances due to UPRV from medical providers were exchanged for the reduction of inter-company payables with USCRV. USCRV assumed responsibility for the collection of the provider credit balances. However, transfer of this asset in this manner was not defined in the management agreement between UPRV and USCRV.

   The finding has been repeated in the current examination report.

B. Claims Processing Deficiencies

1. UPRV was not in compliance with prompt pay claims processing requirements of Tenn. Code Ann. § 56-32-126(b)(1) for non-risk East Tennessee operations from February 2009 through June 2009 and separate testing for non-emergency transportation claims for March 2009 and May 2009.

2. The following deficiencies were noted when comparing the prompt pay data files submissions to the information recorded in UPRV's claims processing system:

   - For twelve of the 115 claims, total service lines reported in the prompt pay data file did not match the total service lines entered into the claims processing system. URPV should report all service lines as requested in order for TDCI to properly analyze the data file submissions.

   - For five of the 115 claims, UPRV incorrectly reported all service lines on the claim as capitated services. UPRV should correctly report each service line claim status in the prompt pay data file.

3. UPRV failed to achieve claims payment accuracy requirements of 97% for the East and West Tennessee Grand Regions in the first quarter 2009, West Tennessee Grand Region in the second quarter 2009, and the Middle Tennessee Grand Region in November 2009.

4. UPRV reported thirty-two claims as errors in the fourth quarter 2009 claims payment accuracy report. Two of the errors had not been corrected by UPRV as of June 16, 2010.

5. The following deficiencies were noted during the review of the procedures to prepare medical and NEMT claims payment accuracy reports:

   - In determining claims payment accuracy percentages reported to the TennCare Bureau, UPRV failed to include vision claims processed by the subcontractor, Spectera, Inc. When selecting claims for determining the claims payment accuracy percentages, the subcontractors' claims should be included and the test work should be performed by UPRV.

   - Section 2.22.6.2 of the CRAs for the East, Middle and West Tennessee Grand Regions require the claims payment accuracy reports be prepared by the plan's Internal Audit Department. The reports are not prepared by UPRV's Internal Audit Department but rather by a Quality Assurance Unit within UPRV's Claims Operations Department.

   - Section 2.22.6.5.1 of the CRAs for the East, Middle and West Tennessee Grand Regions list the minimum testing attributes and requires UPRV to maintain for audit and verification purposes the results for each attribute tested for each claim selected. UPRV does not retain the results for each attribute tested for audit and verification purposes.

   - Section 2.22.6.4.5 of the CRAs for the East, Middle and West Tennessee Grand Regions require UPRV to determine if the allowed payment agrees with the contracted rate. UPRV's claims payment accuracy testing

procedures do not confirm the allowed payment to the amount defined in the providers' contract for each claim tested.

6. For the 115 claims selected for testing, the following discrepancies related to adjudication accuracy were noted:

   - For one of the adjusted claims and one of the paid claims selected for testing, UPRV was unable to produce the provider contract agreements in effect for the date of service for the claims tested. TDCI was unable to determine the payment accuracy for these two claims. UPRV should maintain executed copies of all provider agreements.

   - For one paid and one adjusted claim selected for testing, the enrollees had other insurance; therefore, UPRV should not have paid as the primary carrier. For both these claims the enrollees had dual eligibility and the claims processor failed to process with the other insurance as primary.

   - For one paid and one adjusted claim selected for testing, the denial reason did not provide adequate information for the provider to properly correct and resubmit the claim for processing. UPRV should insure that all denial reasons adequately describe the reason for the claim denial so that the provider may correct the error and resubmit the claim for reprocessing.

   - For one adjusted claim selected for testing, the claim was denied on multiple submissions because UPRV did not specify to the provider all known reasons for denial on the first submission.

   - For one claim selected for testing, UPRV incorrectly denied the first submission for exceeding timely filing limits. The member was retro-actively eligible and therefore the timely filing denial was incorrect.

7. For the 115 claims selected for testing, the following pricing accuracy discrepancies were noted:

   - For one of the paid claims selected for testing, the claim was incorrectly paid at a discount off charges basis rather than the contracted per diem rate.

   - For one of the paid claims selected for testing, the claim was paid based on the wrong fee table loaded into the claims processing system for that particular provider. UPRV has reprocessed the incorrectly priced claim and loaded the correct fee table into the claims processing system. UPRV should review other payments to this provider made before the corrected fee table was loaded.

8. Initially, four unusual copayment amounts were judgmentally selected for testing.

- For one of the four copayments selected for testing, UPRV incorrectly applied a copayment on an enrollee not subject to copayment requirements.

An additional nine unusual copayment amounts were judgmentally selected for testing. For four of the nine additional copayments selected for testing, UPRV incorrectly applied a copayment amount.

- For three of the four errors, UPRV applied copayments on enrollees not subject to copayment requirements.

- For one of the four errors, a copayment was incorrectly applied to both physician and surgical services. The copayment should have only been applied to the physician services.

9. Electronic claims can be rejected by UPRV for accuracy and compliancy requirements. The review noted that certain rejection codes were not based on compliancy reasons (i.e. invalid data in the form of wrong format, invalid code, non-compliant usage, missing required data, etc.). Examples of rejection codes, not based on compliancy reasons, include "No Medical Coverage Effective for Date of Service" and "Duplicate Claim to Previously Submitted File or Duplicate Claim".

Findings similar to numbers 1 through 6 and number 8 have been repeated in this report.

C. Compliance Deficiencies

1. The following deficiencies were noted for seven of the thirteen provider complaints selected for testing:

   - For four provider complaints, UPRV sent an acknowledgment letter within 30 days but it did not resolve the complaint within the 60 days as stated in the letter.

   - For two provider complaints, UPRV did not send an acknowledgment letter and did not resolve the complaint within 60 days.

   - For one provider complaint, UPRV did not send an acknowledgment letter and the complaint was not resolved within 30 days.

2. The following is a summary of the significant claims processing issues and provider complaint procedures noted in the review of provider complaints submitted to TDCI:

- Prior denial decisions were upheld on appeal when submitted by the provider through UPRV's appeal process but the decisions were reversed upon submission to TDCI's provider complaint process.

- Individual anesthesia providers were not loaded into the claims processing system as part of the provider group causing incorrect denials.

- Error in the claims system provider file caused claims to be paid to wrong provider.

- Incorrect fee schedule was attached to the provider in the claims processing system causing claims to deny incorrectly.

- Procedure code incorrectly denied as invalid procedure on date of service because procedure code was not updated timely by UPRV in the claims processing system.

- Procedure code incorrectly denied as not covered as a result of a manual processing error.

- Denial and response by UPRV to a provider appeal incorrectly noted two anesthesia services would not be paid on the same day.

- An erroneous payment was incorrectly recouped by UPRV after the provider had already refunded the payment.

- Authorization incorrectly entered into UPRV claims processing system caused incorrect denial for no prior authorization obtained.

3. A subcontractor, Johnson & Rountree Premium, attempted to collect on behalf of UPRV alleged overpayments by UPRV to medical providers. The subcontract to Johnson & Rountree for the delegation of UPRV claims processing services was not submitted to TDCI or the TennCare Bureau for prior approval in violation of Section 2.26.3 of the CRAs for East, Middle, and West Tennessee Grand Regions and Tenn. Code Ann. § 56-32-103(c)(1).

4. The following is a summary of the significant claims processing issues and provider complaint procedures noted in the testing of independent reviews:

   - UPRV did not send payment in full to the provider within twenty calendar days upon receipt of the independent reviewer's decision pursuant to Tenn. Code Ann. § 56-32-126(b)(3)(C).

   - Prior denial decision was upheld on appeal when submitted by the provider through UPRV's appeal process. UPRV ultimately found the denial was incorrect during further investigation for independent review.

- Claims denied incorrectly for eligibility because the members were retroactively enrolled by TennCare to include the dates of service on the claims.

5. A subcontractor, Allied Interstate, Inc., attempted to collect on behalf of UPRV refund requests related to the coordination of benefits with other insurance plan. The subcontract with Allied Interstate, Inc., for the delegation of UPRV claims processing services was not submitted to TDCI or the TennCare Bureau for prior approval in violation of Section 2.26.3 of the CRAs for East, Middle, and West Tennessee Grand Regions and Tenn. Code Ann. § 56-32-103(c)(1).

6. For thirteen of the sixteen provider agreements selected for testing, the following deficiencies were noted.

   - For seven provider agreements, the executed contracts do not agree with provider agreement templates previously submitted by UPRV and approved by TDCI. These provider agreements included altered or missing language from the previously approved templates. For example Section 2.12.9.53 of the CRAs for the East, Middle, and West Tennessee Grand Regions require provider agreements to include specific conflict of interest language. For one provider agreement the required conflict of interest language was omitted.

   - For two provider agreements, the executed contracts include compensation exhibits which have never been submitted by UPRV and approved by TDCI.

   - For three provider agreements, the executed contracts were amended; however, the amendments were never submitted by UPRV to TDCI for approval.

   - For one provider agreement, the contract was effective November 1, 2008. On November 21, 2008, UPRV submitted the agreement to TDCI for approval. On December 19, 2008, TDCI disapproved the agreement for deficiencies with provider agreement language requirements and because all attachments were not provided. UPRV should not execute provider agreements without prior approval. The deficiencies noted on December 19, 2008 were never corrected by UPRV.

7. The following deficiencies were identified in the subcontracts tested:

   - For one medical management subcontract, the executed subcontract contains additional exhibits that were never submitted to TDCI for approval.

- For two medical management subcontracts, the executed subcontracts contain exhibits that do not agree to the exhibits prior approved by TDCI.

8. Section 2.22.6.2 of the CRAs for the East, Middle, and West Tennessee Grand Regions require the claims payment accuracy reports be prepared by the plan's Internal Audit Department. The reports are not prepared by UPRV's Internal Audit but rather by a Quality Assurance Unit within UPRV's Claims Operations Department.

9. TDCI noted no material instances of non-compliance with conflict of interest requirements during the examination test work; however, during the testing of provider agreements it was discovered that one agreement did not have the required conflict of interest language.

Findings similar to numbers 1, 2 and 4 have been repeated in this report.

V. SUMMARY OF CURRENT FINDINGS

The summary of current factual findings is set forth below. The details of testing as well as management's comments to each finding can be found in Sections VI, VII, and VIII of this examination report.

A. Financial Deficiency

1. Administrative costs are incorrectly reported as medical costs in the determination of medical loss percentages.

   (See Section VI.C. of this report)

2. Credit balances due to UPRV from medical providers were exchanged for the reduction of inter-company payables with USCRV. USCRV assumed responsibility for the collection of the provider credit balances. However, transfer of this asset in this manner was not defined in the management agreement between UPRV and USCRV.

   (See Section VI.D. of this report)

B. Claims Processing Deficiencies

1. UPRV was not in compliance with prompt pay claims processing requirements of Tenn. Code Ann. § 56-32-126(b)(1) for all claims processed and claims processed in each of the three Grand Regions for the month of January 2011. The processing of vision claims was not in compliance with prompt pay claims processing requirements of Tenn. Code Ann. § 56-32-126(b)(1) in the East Tennessee Grand Region for the month of November 2011. The processing of non-emergency medical transportation claims was not in compliance with

prompt pay claims processing requirements of Tenn. Code Ann. § 56-32-126(b)(1) in each of the three Grand Regions for the month of January 2011.

(See Section VII.A. of this report)

2. UPRV was not in compliance with the CHOICES prompt pay claims processing requirements of Section 2.22.4 of the CRAs for the months of January, June, and July 2011 in the Middle Tennessee Grand Region and January and July 2011 in the West Tennessee Grand Region.

   (See Section VII.A. of this report)

3. UPRV was not in compliance with Section 2.22.6 of the CRAs requirement that 97% of claims are paid accurately upon initial submission for the months of January, March, May and June 2011 for medical claims; February, March, April, May, and June 2011 for nursing facility claims; and March and April 2011 for Home Community-Based Community Services claims.

   (See Section VII.C. of this report)

4. Significant deficiencies were noted in UPRV's testing procedures and reporting for NEMT claims payment accuracy. UPRV's non-emergency medical transportation claim payment accuracy report testing was not performed in accordance with CRA requirements. UPRV did not select a sample from all processed and paid NEMT claims; however, UPRV incorrectly included only adjusted claims in the population when selecting the NEMT claims to be tested for NEMT claims payment accuracy reporting. Also, the error rate reported on the fourth quarter 2011 NEMT Claims Payment Accuracy Report was not calculated properly.

   (See Section VII.C. of this report)

5. Verification by TDCI of the claims payment accuracy report submitted by UPRV for December 2011 indicated the following deficiencies:

   - One claim determined as an error by UPRV in January 2012 was not adjusted by UPRV until October 2, 2012.

   - One claim did not pay according to the contracted rate noted in the agreement between the medical provider and UPRV. UPRV indicated that only a subsample of claims is verified against allowed payment rates in the

provider agreements. UPRV should update procedures to verify that the allowed payment rate agrees to the terms of the provider agreement for all claims selected for testing.

(See Section VII.C.1. of this report)

6. Comparison of the actual claim date with the claims processing system data indicated that for one of 75 claims selected for focused claims testing, the date of service was incorrectly entered by UPRV into the claims processing system.

   (See Section VII.E. of this report)

7. The following adjudication accuracy errors were noted by UPRV in the 75 claims selected for focused testing of claims processed in December 2011:

   - One medical claim was incorrectly denied with the explanation Medicaid identification and disclosure needed. The effective date of the Medicaid identification and disclosure was available to UPRV.

   - One non-emergency medical transportation (NEMT) claim was incorrectly denied for missing or invalid National Provider Identification (NPI) number. The reported NPI number by the provider was valid.

   - One NEMT claim was incorrectly denied with the explanation that the claim may be covered by coordination of benefits. Additionally, this error was identified by UPRV in February 2012 but the claim had not been adjusted by October 1, 2012.

   - One NEMT claim was incorrectly denied with the explanation that the claim was a duplicate of a previously submitted claim. The claim was not a duplicate since the provider billed an additional modifier to the procedure code.

   - One NEMT claim denied with the explanation “payment adjustment submission/billing error”. The denial reason communicated to the provider is vague and does not provide enough information for the provider to correct the claim.

   (See Section VII.F. of this report)

8. The following additional issues were noted by TDCI in the verification of adjudication accuracy in the 75 claims selected for focused testing of claims processed in December 2011:

   - For one CHOICES claim and one NEMT claim, UPRV denied service lines for ineligibility even though the enrollees were eligible on the dates of

service. Instead, the enrollees had been transferred to another Grand Region.

- One CHOICES claim billed by the provider through the electronic visit verification system was correctly denied by UPRV for absence of a prior authorization. A service was authorized by UPRV for the date of service; however, the provider billed a different service through the addition of a modifier to the procedure code. Other than the denial of the claim by UPRV's claims processing system, no evidence was noted by TDCI that the claims denials resulted in additional actions by care coordinators such as contacting the provider to discover why provider was performing services not authorized in the enrollee's plan of care.

- One CHOICES claim billed by the provider through the electronic visit verification system was correctly denied by UPRV for invalid bill type. The provider was able to perform a service not prior authorized by the enrollee in his/her plan of care. Other than the denial of the claim by UPRV's claims processing system, no evidence was noted by TDCI that the claims denials resulted in additional actions by care coordinators such as contacting the provider to discover why provider was performing services not authorized in the enrollee's plan of care.

- One CHOICES claim billed by the provider through the electronic visit verification system was correctly denied by UPRV for benefit maximum reached. A comparison of the number of authorizations loaded in UPRV's claims processing system was fewer than the number of authorizations loaded in the separate EVV system. As a result, the provider was able to perform services not authorized by UPRV or by the enrollee in his/her plan of care because of the incorrect authorization counts in the EVV system.

(See Section VII.F. of this report)

9. For two of the five enrollees selected for copayment testing, UPRV incorrectly applied copayments when the enrollee was not subject to copayment requirements.

   (See Section VII.H. of this report)

10. Review of mailroom inventory controls noted that the inventory reconciliation work sheets are not updated to reflect the disposition of all claims received daily in the mail including claims that are initially rejected but later rescanned and entered electronically.

    (See Section VII.L. of this report)

11. The following deficiencies were noted in the review of reimbursement changes

as the result of the State of Tennessee budget requirements effective July 1, 2011.

For emergency department professional fees to be capped at $50 for non-emergency claims:

- For eight of the 146 claims selected for testing, UPRV incorrectly paid over $50 when neither the first or second diagnosis was considered emergent.

- For one of the 146 claims selected for testing, UPRV incorrectly paid $50; however, the first and second diagnoses were considered emergent. The provider's contracted rate is greater than $50.

(See Section VII.M.1. of this report)

For the 50 normal delivery exception claims selected for testing for the 17% rate increase, TDCI noted the following:

- 19 claims remain incorrectly paid as of October 5, 2012,

- TDCI noted that 28 different providers represented the 50 normal delivery exception claims selected for testing by TDCI. The configuration on 10 of these providers has not been corrected to reflect the reimbursement changes for dates of service on or after July 1, 2011.

(See Section VII.M.3.a. of this report)

For the 56 Caesarean reimbursement exception claims selected for testing to be paid at the normal delivery rate, TDCI noted the following:

- 10 claims remain incorrectly paid as of October 5, 2012,

TDCI noted that 22 different providers represented the 56 Caesarean reimbursement exception claims selected for testing by TDCI. The configuration on 4 of these providers has not been corrected to reflect the reimbursement changes for Caesarean deliveries for dates of service on or after July 1, 2011.

(See Section VII.M.3.b of this report)

C. Compliance Deficiencies

1. For the test month of December 2011, the following deficiencies were noted in review of the provider appeal complaint log.

   - In violation of Tenn. Code Ann. § 56-32-126(b)(2)(A), there were 2,380 provider appeals that were not responded to within the 30 day deadline and

there was no acknowledgement communicated to the provider that a response would exceed 30 days.

- A total of 601 complaints exceeded 60 days. No agreement was made in writing with the provider noting that the response would exceed 60 days in violation of Tenn. Code Ann. § 56-32-126(b)(2)(A).

(See Section VIII.A. of this report)

2. A review of 11 complaints received by TDCI against UPRV noted the following areas where improvements should be made to UPRV's claims processing systems and the provider complaint procedures:

   - UPRV's claims processing procedures should include an active search for retroactive eligibility to prevent some claims being denied incorrectly for exceeding timely filing limits.

   - UPRV should ensure that first level responses to providers are accurate. Personnel responding to provider complaints should receive the proper training or relay the complaint to others in the organization if it is beyond their skill set.

   (See Section VIII.B. of this report)

3. A review of 5 independent review decisions made in favor of the provider noted the following area where improvements should be made to UPRV's processes for managing independent reviews:

   - UPRV did not send payment in full to the provider within twenty calendar days upon receipt of the reviewer's decision pursuant to Tenn. Code Ann. § 56-32-126(b)(3)(C). A decision was rendered by the independent review on December 7, 2011. The claim had not been adjusted for payment as of October 1, 2012.

   (See Section VIII.C. of this report)

4. UPRV's processes should be improved to promptly and accurately to correct all deficiencies noted by TDCI's review of UPRV's provider manual.

   (See Section VIII.D. of this report)

5. A subcontract for an emergency room diversion program was executed on April 1, 2011; however this subcontract was not approved by TDCI until June 9, 2011. Subcontracts should not be utilized until prior approved by TDCI.

   (See Section VIII.G. of this report)

6. UPRV's information systems policies and procedures did not include specific requirements for personnel to contact the TennCare privacy officer immediately upon becoming aware of any unauthorized use or disclosure of enrollee protected health information not otherwise permitted or required by HIPAA per Section 2.27.8 or the CRAs for the East, Middle and West Tennessee Grand Regions.

   (See Section VIII.K. of this report)

VI. DETAIL OF TESTS CONDUCTED – FINANCIAL ANALYSIS

A. Financial Analysis

As an HMO licensed in the State of Tennessee, UPRV is required to file annual and quarterly financial statements in accordance with NAIC guidelines with the Tennessee Department of Commerce and Insurance. The department uses the information filed on these reports to determine if UPRV meets the minimum requirement for statutory reserves. The statements are filed on a statutory basis of accounting. Statutory accounting differs from generally accepted accounting principles because "admitted" assets must be easily convertible to cash, if necessary, to pay outstanding claims. "Non-admitted" assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and should not be considered when calculating capital and surplus.

As of December 31, 2011, UPRV reported $1,010,036,179 in admitted assets, $557,260,161 in liabilities and $452,776,017 in capital and surplus on the 2011 Annual Statement submitted March 1, 2012. UPRV reported total net income of $211,900,766 on the statement of revenue and expenses. The 2011 Annual Statement and other financial reports submitted by UPRV can be found at www.tennessee.gov/commerce/tenncare/mcoreports.shtml .

1. Capital and Surplus

   Tenn. Code Ann. § 56-32-112(a)(2) requires UPRV to establish and maintain a minimum net worth equal to the greater of (1) $1,500,000 or (2) an amount totaling 4% of the first $150 million of annual premium revenue earned for the prior calendar year, plus 1.5% of the amount earned in excess of $150 million for the prior calendar year.

   Tenn. Code Ann. § 56-32-112(a)(2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health care services pursuant to any federal waiver received by the state that waives

any or all of the provisions of the federal Social Security Act (title XIX), and regulations promulgated pursuant thereto, or pursuant to any other federal law as adopted by amendment to the required title XIX state plan..." Based on this definition, all TennCare payments made to an HMO licensed in Tennessee for the provision of health care services to TennCare enrollees are to be included in the calculation of net worth and deposit requirements, regardless of the reporting requirements for the NAIC statements.

Section 2.21.6.1. of the CRAs for East, Middle, and West Tennessee Grand Regions require UPRV to establish and maintain the minimum net worth required by TDCI, including but not limited to Tenn. Code Ann. § 56-32-112.

TennCare Payments Received for the Examination Period

For the examination period January 1 through December 31, 2011, the following is a summary of TennCare payments received as defined by UPRV:

East Tennessee Grand Region – At-Risk Monthly Capitation Payments	$805,085,975
Middle Tennessee Grand Region Monthly Capitation Payments	851,801,140
West Tennessee Grand Region Monthly Capitation Payments	677,441,023
Total Payments Received from TennCare for the period January 1 through December 31, 2011	$2,334,328,138

Statutory Net Worth Calculation

UPRV's reported total company premium revenues of $3,926,752,259 on the 2011 NAIC Annual Statement; therefore, UPRV's current statutory net worth requirement is $62,651,284 ($150,000,000 x 4% + ($3,926,752,259-150,000,000) x 1.5%). UPRV's reported net worth at December 31, 2011, of $452,776,017 was $390,124,733 in excess of the minimum required.

2. Restricted Deposit

Tenn. Code Ann. § 56-32-112(b) requires HMOs to establish a restricted deposit and defines the calculation of the deposit based upon annual premium revenue. However, Section 2.21.6.4. of the CRAs for the East, Middle, and West Tennessee Grand Regions require MCOs to have on deposit an amount equal

to the calculated minimum net worth requirement. In addition the CRAs state:

> TDCI shall calculate the amount of the increased restricted deposits based on the CONTRACTOR's TennCare premium revenue only unless this calculation would result in restricted deposits below the statutory requirements set forth in Tenn. Code Ann. 56-32-112 related to restricted deposits; in which case the required amount would be equal to the statutory requirement as it is calculated by TDCI.

Utilizing only the 2011 TennCare premiums, the calculation based on Section 2.21.6.4 of the CRAs for the East, Middle, and West Tennessee Grand Regions does not result in a restricted deposit below the statutory requirements set forth in Tenn. Code Ann. § 56-32-112. UPRV's required restricted deposit as of January 1, 2012, is $42,049,692 based upon 2011 TennCare premiums of $2,553,312,802. UPRV had on file with TDCI as of April 13, 2012, safekeeping receipts totaling $42,100,000.

3. Claims Payable

As of December 31, 2011, UPRV reported $392,842,705 claims unpaid on the 2011 NAIC Annual Statement. Of the total claims unpaid reported, $242,968,241 represents an estimate for TennCare operations. This amount was certified by a separate statement of actuarial opinion. Review of the triangle lag payment reports after December 31, 2011, through August 31, 2012, for dates of services before January 1, 2012, determined that the reported claims payable for TennCare operations was adequate.

B. TennCare Operating Statements

Sections 2.30.14.3.3 and 2.30.14.3.4 of the CRAs for the East, Middle, and West Tennessee Grand Regions require each submission of NAIC financial statements to contain a separate income statement detailing the quarterly and year-to-date revenues earned and expenses incurred as a result of participation in the TennCare program.

No deficiencies were noted in the preparation of the TennCare Operating Statements.

C. Medical Loss Ratio Report

Section 2.30.16.2.1 of the CRAs for the East, Middle, and West Tennessee Grand Regions requires:

> The CONTRACTOR shall submit a *Medical Loss Ratio Report* monthly with cumulative year to date calculation using the forms in Attachment IX, Exhibit N. The CONTRACTOR shall report all medical expenses and complete the supporting claims lag tables. This report shall be accompanied by a letter

from an actuary, who may be an employee of the CONTRACTOR, indicating that the reports, including the estimate for incurred but not reported expenses, has been reviewed for accuracy. The CONTRACTOR shall also file this report with its NAIC filings due in March and September of each year using an accrual basis that includes incurred but not reported amounts by calendar service period that have been certified by an actuary. This report must reconcile to NAIC filings including the supplemental TennCare income statement.

The medical loss ratio (MLR) reports as submitted on January 21, 2012, for the period ending December 31, 2011 originally reported MLRs of 85.63% for the East Tennessee Grand Region, 84.75% for the Middle Tennessee Grand Region, and 83.05% for the West Tennessee Grand Region. TDCI reviewed the MLR reports for the same period ending December 31, 2011, but submitted a year later on January 21, 2013. UPRV reported adjusted MLRs of 82.78% for the East Tennessee Grand Region, 82.18% for the Middle Tennessee Grand Region, and 78.43% for the West Tennessee Grand Region. The reason for the noted decrease in MLR percentages is due to adjustments of incurred but not reported (IBNR) estimates. Over time the IBNR estimates are reduced with the submission and payment of actual claims.

The procedures and supporting documents to prepare the MLR were reviewed. TDCI selected November 2011 as a test month. The following deficiencies were noted during the review of documentation supporting the amounts reported on the MLR:

Administrative costs are incorrectly reported as medical costs in the determination of medical loss percentages. These administrative costs include:

- Subcontractor Monthly Fee for the Administration of the Electronic Visit Verification System
- Services related to detection of Audit Recovery Fee Payments to a Subcontractor
- Services related to detection of Fraud and Abuse Fee Payments to a Subcontractor

Although the effect is immaterial, UPRV should eliminate the inclusion of these administrative costs in the determination of the medical loss ratio percentages.

Management Comments

Management Concurs.

UPRV will modify on all subsequent filings.

D. Management Agreement

As previously stated, UPRV is a wholly-owned subsidiary of UnitedHealthcare Service Company of the River Valley (USCRV). UPRV has entered into a management agreement with USCRV to provide management services to UPRV for a fee based on a percentage of net premium income. Additionally, UPRV has entered into an administrative services agreement with United Behavioral Health (UBH) to provide mental health and substance abuse services paid on a per member per month rate. UBH is a related party to UPRV. The management agreements were previously approved by TDCI and the TennCare Bureau.

As previously noted in the prior examination of UPRV for the period January 1, 2009, through December 31, 2009, credit balances due to UPRV from medical providers were exchanged for the reduction of inter-company payables with USCRV. USCRV assumed responsibility for the collection of the provider credit balances. However, transfer of this asset in this manner was not defined in the management agreement between UPRV and USCRV. As of examination fieldwork in October 2012, UPRV had not corrected this deficiency. Subsequently with the filing of the 2012 NAIC Annual Statement, UPRV has corrected the issue by correctly reporting the credit balances due from medical providers.

Management Comments

Management Concurs.

E. Schedule of Examination Adjustments to Capital and Surplus

As result of the examination of TennCare operations, no adjustments are recommended to Capital and Surplus for the period ending December 31, 2011.

VII. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM

A. Time Study of Claims Processing

The purpose of conducting a time study of claims is to determine whether claims were adjudicated within the time frames set forth in Tenn. Code Ann. § 56-32-126(b)(1) and Section 2.22.4 of the CRAs for the East, Middle, and West Tennessee Grand Regions. The statute mandates the following prompt payment requirements:

> The health maintenance organization shall ensure that ninety percent (90%) of claims for payments for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the receipt of such claims. The health maintenance organization shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent

(99.5%) of all provider claims for services delivered to an enrollee in the TennCare program.

(A) "Pay" means that the health maintenance organization shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health maintenance organization.

(B) "Process" means the health maintenance organization must send the provider a written or electronic remittance advice or other appropriate written or electronic notice evidencing either that the claim had been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reasons for denial. If a claim is partially or totally denied on the basis that the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice must specifically identify all such information and documentation.

TDCI currently determines compliance with Tenn. Code Ann. § 56-32-126(b)(1) by testing monthly data file submissions from each of the TennCare MCOs. Each month is tested in its entirety for compliance with the prompt pay requirement of the statute. If a TennCare MCO fails to meet the prompt pay standards for any subsequent month after the month in which non-compliance was communicated by TDCI, the MCO will be penalized as allowed by the statute in an amount not to exceed ten thousand dollars ($10,000). The TennCare MCO is required to maintain compliance with prompt pay standards for 12 months after the month of failure to avoid the penalty.

Prompt Pay Results for All Claims Processed

The following table represents the results of prompt pay testing combined for all TennCare claims processed by UPRV and the vision claims subcontractor.

UPRV All TennCare Operations	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2011	97%	**99.2%**	**No**
February 2011	99%	99.8%	Yes
March 2011	99%	99.9%	Yes
April 2011	99%	99.9%	Yes
May 2011	100%	99.8%	Yes
June 2011	100%	100.0%	Yes
July 2011	99%	100.0%	Yes
August 2011	100%	100.0%	Yes
September 2011	99%	99.9%	Yes
October 2011	100%	99.9%	Yes
November 2011	99%	99.9%	Yes
December 2011	99%	99.9%	Yes

When combining the results for all claims processed, UPRV was in compliance with Tenn. Code Ann. § 56-32-126(b)(1) for all months in 2011 with the exception of January 2011. UPRV responded with a corrective action plan to TDCI's prompt pay results letter. The plan maintained compliance with prompt pay standards for 12 months after January 2011, thus avoiding the levy of an administrative penalty.

Management Comments

Management concurs.

UPRV has maintained compliance with prompt pay standards for more than 12 months following January 2011. In addition, UPRV has implemented controls to effectively manage compliance with Tenn. Code Ann.§ 56-32-126(b)(1), including enhanced inventory reporting, addition of work force management disciplines, implementation and certification status of Value Engineered Performance System (VEPS), which is a UPRV standard operations management model, implementation of inventory management tools such as OMEGA, daily inventory meetings with claims staff, and executive oversight of performance.

Finally, UPRV improved the claims auto adjudication rates and implemented additional levels of automation to improve and maintain compliance with the prompt pay requirements.

Prompt Pay Results by Grand Region

The results of prompt pay testing concluded that separate testing for the claims processed under the CRAs in each of the East, Middle, and West Tennessee Grand Regions were in compliance with Tenn. Code Ann. § 56-32-126(b)(1) except for the following instances of noncompliance during the 2011 calendar year:

Region - Month	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
East Tennessee			
January 2011	97%	**99.2%**	**No**
Middle Tennessee			
January 2011	97%	**99.3%**	**No**
West Tennessee			
January 2011	97%	**99.0%**	**No**

Management Comments

Management concurs.

UPRV has maintained compliance with prompt pay standards for more than 12 months following January 2011. In addition, UPRV has implemented controls to effectively manage compliance with Tenn. Code Ann.§ 56-32-126(b)(1), including enhanced inventory reporting, addition of work force management disciplines, implementation and certification status of Value Engineered Performance System (VEPS), which is a UPRV standard operations management model, implementation of inventory management tools such as OMEGA, daily inventory meetings with claims staff, and executive oversight of performance.

Finally, UPRV improved the claims auto adjudication rates and implemented additional levels of automation to improve and maintain compliance with the prompt pay requirements.

Prompt Pay Results for Vision Claims

The results of prompt pay testing concluded that separate testing for the claims processed by the vision subcontractor, Spectera, in each of the East, Middle, and West Tennessee Grand Regions were in compliance with Tenn. Code Ann. § 56-32-126(b)(1) except for the following instance of noncompliance during the 2011 calendar year:

Region - Month	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
East Tennessee			
November 2011	97%	**99.2%**	**No**

Management Comments

Management concurs.

UPRV subsequently initiated a subcontracted agreement with March Vision and since the initiation of that contract, UPRV has met Prompt Pay measures.

Prompt Pay Results for NEMT Claims

Pursuant to Section 2.22.4 of the CRAs for the East, Middle and West Tennessee Grand Regions, UPRV is required to comply with prompt pay claims processing requirements in accordance with Tenn. Code Ann.§ 56-32-126(b)(1). In addition, ATTACHMENT XI Sections A.15.3 and A.15.4 of the CRAs for the East, Middle, and West Tennessee Grand Regions require UPRV to comply with the following prompt pay claims processing requirements for non-emergency transportation claims (NEMT):

- The CONTRACTOR shall ensure that ninety percent (90%) of clean claims for payment for NEMT services delivered to a member are processed within thirty (30) calendar days of the receipt of such claims.

- The CONTRACTOR shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all NEMT provider claims for covered NEMT services delivered to a member.

The following instances of noncompliance were determined for NEMT claims for the period January 1 through December 31, 2011:

Region - Month	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
East Tennessee			
January 2011	**89%**	**97.1%**	**No**
Middle Tennessee			
January 2011	96%	**99.0%**	**No**
West Tennessee			
January 2011	97%	**99.4%**	**No**

Management Comments

Management concurs.

UPRV has maintained compliance with prompt pay standards for more than 12 months following January 2011. In addition, UPRV has implemented controls to effectively manage compliance with Tenn. Code Ann.§ 56-32-126(b)(1), including enhanced inventory reporting, addition of work force management disciplines, implementation and certification status of Value Engineered Performance System (VEPS), which is a UPRV standard operations management model, implementation of inventory management tools such as OMEGA, daily inventory meetings with claims staff, and executive oversight of performance.

Finally, UPRV improved the claims auto adjudication rates and implemented additional levels of automation to improve and maintain compliance with the prompt pay requirements.

Prompt Pay Results for CHOICES Claims

Pursuant to Section 2.22.4 of the CRAs for the East, Middle and West Tennessee Grand Regions, UPRV is required to comply with the following prompt pay claims processing requirements for nursing facility claims and for Home and Community-Based Services (HCBS) claims for services other than PERS, assistive technology, minor home modifications, and pest control submitted electronically in a HIPAA-compliant format (CHOICES claims):

- Ninety percent (90%) of clean claims for nursing facility services and HCBS excluding PERS, assistive technology, minor home modifications, and pest control shall be processed and paid within fourteen (14) calendar days of receipt.

- Ninety-nine point five percent (99.5%) of clean claims for nursing facility and HCBS other than PERS [personal emergency response system], assistive technology, minor home modifications, and pest control shall be processed and paid within twenty-one (21) calendar days of receipt.

For the East, Middle and West Tennessee Grand Regions, UPRV achieved monthly compliance with contractual prompt pay standards for the processing of CHOICES claims except for the following instances of noncompliance during the 2011 calendar year:

Region - Month	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
Middle Tennessee			
January 2011	95%	**98.9%**	**No**
June 2011	**89%**	99.8%	**No**
July 2011	**87%**	99.8%	**No**
West Tennessee			
January 2011	95%	**99.4%**	**No**
July 2011	**89%**	99.9%	**No**

Management Comments

Management concurs.

UPRV has maintained compliance with prompt pay standards for more than 12 months following July 2011. In addition, UPRV has implemented controls to effectively manage compliance with Tenn. Code Ann.§ 56-32-126(b)(1), including enhanced inventory reporting, addition of work force management disciplines, implementation and certification status of Value Engineered Performance System (VEPS), which is a UPRV standard operations management model, implementation of inventory management tools such as OMEGA, daily inventory meetings with claims staff, and executive oversight of performance.

Finally, UPRV improved the claims auto adjudication rates and implemented additional levels of automation to improve and maintain compliance with the prompt pay requirements.

The complete results of TDCI's prompt pay compliance testing can be found at http://www.tn.gov/commerce/tenncare/promptpaybpm.shtml.

B. Determination of the Extent of Test Work on the Claims Processing System

Several factors were considered in determining the extent of testing to be performed on UPRV's claims processing system.

The following items were reviewed to determine the risk that UPRV had not properly processed claims:

- Prior examination findings related to claims processing,
- Complaints or independent reviews on file with TDCI related to inaccurate claims processing,
- Results of prompt pay testing by TDCI,
- Results reported on the claims payment accuracy reports submitted to TDCI and the TennCare Bureau,
- Review of the preparation of the claims payment accuracy reports, and
- Review of internal controls related to claims processing.

As noted below, TDCI discovered deficiencies related to UPRV's procedures for preparing the claims payment accuracy reports. A discussion of the sample selection methodology can be found in Section VII.D. of this report.

C. Claims Payment Accuracy Reports

Section 2.22.6 of the CRAs for the East, Middle, and West Tennessee Grand Regions requires that 97% of claims are paid accurately upon initial submission. On a monthly basis, UPRV submits claims payment accuracy percentage reports to TennCare based upon audits conducted by UPRV. A minimum sample of one hundred and sixty (160) claims randomly selected from the entire population of electronic and paper claims processed or paid upon initial submission for the month tested is required. Additionally, each monthly sample of one hundred and sixty (160) claims shall contain a minimum of thirty (30) claims associated with nursing facility services provided to CHOICES members and thirty (30) claims associated with HCBS provided to CHOICES members. The testing attributes to be utilized by UPRV are defined in the CRAs between UPRV and the TennCare Bureau. Additionally, subcontractors responsible for processing claims shall submit a claims payment accuracy percentage report for the claims processed by the subcontractor. The following table represents claims payment accuracy percentages for medical claims reported by UPRV for the examination period January 1, 2011 through December 31, 2011.

Medical Claims Payment Accuracy Percentages

Month	East Region	Compliance	Middle Region	Compliance	West Region	Compliance
January 2011	**92.5%**	**No**	97.5%	Yes	99.4%	Yes
February 2011	98.8%	Yes	98.1%	Yes	98.8%	Yes
March 2011	**95.0%**	**No**	**94.5%**	**No**	98.8%	Yes
April 2011	97.5%	Yes	97.5%	Yes	**96.3%**	**No**
May 2011	**96.3%**	**No**	**96.9%**	**No**	**96.3%**	**No**
June 2011	**95.0%**	**No**	98.5%	Yes	98.0%	Yes
July 2011	99.4%	Yes	98.8%	Yes	98.8%	Yes
August 2011	98.8%	Yes	98.8%	Yes	100.0%	Yes
September 2011	99.2%	Yes	99.6%	Yes	100.0%	Yes
October 2011	99.0%	Yes	99.6%	Yes	100.0%	Yes
November 2011	98.5%	Yes	98.0%	Yes	98.0%	Yes
December 2011	99.2%	Yes	99.2%	Yes	99.2%	Yes

Nursing Facility Claims Payment Accuracy Percentages

Month	East Region	Compliance	Middle Region	Compliance	West Region	Compliance
January 2011	98.0%	Yes	100%	Yes	99.4%	Yes
February 2011	**96.0%**	**No**	93.0%	Yes	98.8%	Yes
March 2011	98.0%	Yes	**94.5%**	**No**	98.8%	Yes
April 2011	**96.0%**	**No**	97.5%	Yes	**96.3%**	**No**
May 2011	**95.0%**	**No**	**96.9%**	**No**	**96.3%**	**No**
June 2011	**95.0%**	**No**	98.5%	Yes	98.0%	Yes
July 2011	100%	Yes	98.8%	Yes	98.8%	Yes
August 2011	99.0%	Yes	98.8%	Yes	100.0%	Yes
September 2011	99.0%	Yes	99.6%	Yes	100.0%	Yes
October 2011	99.0%	Yes	99.6%	Yes	100.0%	Yes
November 2011	99.0%	Yes	98.0%	Yes	98.0%	Yes
December 2011	99.0%	Yes	99.2%	Yes	99.2%	Yes

Home and Community-Based Services Claims Payment Accuracy Percentages

Month	East Region	Compliance	Middle Region	Compliance	West Region	Compliance
January 2011	100.0%	Yes	97.0%	Yes	98.0%	Yes
February 2011	100.0%	Yes	98.0%	Yes	100.0%	Yes
March 2011	99.0%	Yes	**96.0%**	**No**	100.0%	Yes
April 2011	97.0%	Yes	99.0%	Yes	**96.0%**	**No**
May 2011	99.0%	Yes	100.0%	Yes	99.0%	Yes
June 2011	99.0%	Yes	100.0%	Yes	99.0%	Yes
July 2011	98.0%	Yes	99.0%	Yes	100.0%	Yes
August 2011	100.0%	Yes	100.0%	Yes	99.0%	Yes
September 2011	100.0%	Yes	100.0%	Yes	99.0%	Yes
October 2011	100.0%	Yes	100.0%	Yes	99.0%	Yes
November 2011	100.0%	Yes	99.0%	Yes	100.0%	Yes
December 2011	100.0%	Yes	100.0%	Yes	100.0%	Yes

As noted in the tables above, UPRV failed to achieve claims payment accuracy requirements of 97% for the East, Middle, and West for medical, nursing facility and HCBS claims for all months during calendar year 2011.

Management Comments

Management concurs.

UPRV has been in compliance with Section 2.22.6 of the CRA's requirement that 97% of claims are paid accurately upon initial submission for more than 12 consecutive months after the dates noted in the deficiency.

Subcontractor Claims Payment Accuracy Percentages

UPRV contracts with Spectera Vision for the provision of vision services. Spectera reported compliance for all months in 2011 for the claims payment accuracy percentage requirements of the CRAs.

Non-Emergency Medical Transportation (NEMT)

Additionally Section A.19.4.2 of the CRAs of the East, Middle, and West Tennessee Grand Regions requires UPRV to submit a quarterly NEMT claims payment accuracy report. The report shall be based on an audit conducted by the CONTRACTOR in accordance with Section 2.22.6 of the Agreement using a random sample of all “processed or paid” NEMT claims. The report shall include the number and percentage of NEMT claims that are paid accurately for each month in the

quarter. UPRV reported compliance with the claims payment accuracy requirement of 97% for all regions in every quarter during the calendar year 2011. However, TDCI has determined the reported percentages by UPRV are unreliable since significant deficiencies were noted in UPRV's testing procedures and reporting for NEMT claims payment accuracy. UPRV's NEMT claim payment accuracy report testing was not performed in accordance with CRA requirements. UPRV did not utilize a sample of all processed and paid NEMT claims; however, UPRV incorrectly included only adjusted claims in the population when selecting the NEMT claims to be tested for NEMT claims payment accuracy reporting. Also, the error rate reported on the fourth quarter 2011 NEMT claims payment accuracy percentage was not calculated properly. The claims payment error rate should be calculated by dividing the total number of claims with errors by the total number of claims tested for the quarter. UPRV incorrectly calculated the error rate by dividing the total number of claims with errors in the test population by the total number of NEMT claims processed by UPRV during the quarter.

Management Comments

Management concurs.

UPRV has transitioned NEMT CPA to the area that conducts the CPA testing for all claims, bringing consistency to its overall CPA process.

1. Procedures to Review the Claims Payment Accuracy Reports

   The review of the claims payment accuracy reports included an interview with responsible staff to determine the policies, procedures, and sampling methodologies surrounding the preparation of the claims payment accuracy reports. The review included verification that the number of claims selected by UPRV agreed with the requirements of Section 2.22.6.4 of the CRAs for the East, Middle, and West Tennessee Grand Regions. These interviews were followed by a review of the supporting documentation used to prepare the December 2011 claims payment accuracy reports for all regions. Six claims were reported as errors and ten claims reported as accurately processed by UPRV on the December 2011 claims payment accuracy report were selected for verification by TDCI. For claims that were considered errors, testing focused on the type of error (manual or system) and whether the claim was reprocessed. For claims that were reported as accurately processed by UPRV, TDCI tested these claims to the attributes required in Section 2.22.6.4 of the CRAs for the East, Middle, and West Tennessee Grand Regions. As previously noted, TDCI has determined that UPRV's reporting of the separate NEMT claims payments accuracy percentages is unreliable because of the significant deficiencies noted in the preparation of the NEMT claims payment accuracy reports by UPRV.

2. Results of the Review of the Claims Payment Accuracy Reporting

For the six claims reported as errors by UPRV in the December 2011 claims payment accuracy report and selected for verification by TDCI, the following deficiency was noted:

- One claim determined as an error by UPRV in January 2012 was not adjusted by UPRV until October 2, 2012.

Management Comments

Management Concurs.

Current procedures have been reviewed and updated to ensure that claims adjustments are correct the first time and issues are resolved. A process was initiated to help increase the quality of projects being submitted to the adjustment team. Additional education has been completed with staff to help increase overall productivity and quality.

For the ten claims reported as accurately processed by UPRV in the December 2011 claims payment accuracy report and selected for verification by TDCI, the following deficiency was noted:

- One claim did not pay according to the contracted rate noted in the agreement between the medical provider and UPRV. Section 2.22.6.4.5 of the CRAs for the East, Middle, and West Tennessee Grand Regions requires as a minimum audit procedure for claims payment accuracy testing and reporting the verification of allowed payment amount with contracted rate per the provider agreement. UPRV indicated that only a subsample of claims is verified against allowed payment rates in the provider agreements. UPRV should update procedures to verify that the allowed payment rate agrees to the terms of the provider agreement for all claims selected for testing.

Management Comments

Management concurs.

UPRV will review its procedures to ensure compliance with CRA Section 2.22.6.4.5.

D. Claims Selected For Testing

Medical and NEMT claims are processed by the parent of UPRV, UnitedHealthcare, Inc. Vision claims are processed by the subcontractor and related party, Spectera, Inc.

Effective January 1, 2012, the CRAs include additional monthly focused claims testing requirements that require UPRV to self-test the accuracy of claims processing based on claims selected by TDCI. For examination purposes, TDCI utilized the results of the focused claims testing to evaluate the accuracy of the claims processing system. The focused testing for January 2012 was based upon a total of 75 claims which were judgmentally selected from the December 2011 prompt pay data files submitted by UPRV to TDCI. The 75 claims selected for testing were comprised of the following:

- 20 denied medical claims
- 5 adjusted medical claims
- 20 denied CHOICES claims
- 5 adjusted CHOICES claims
- 10 vision claims
- 15 NEMT claims

An additional 25 paid claims were judgmentally selected from the November 2011 prompt pay data file previously submitted by UPRV to TDCI. The claims selected for testing were comprised of the following:

- 10 paid CHOICES claims
- 5 paid NEMT claims
- 10 paid medical claims

For each claim processed, the data files included the date received, date paid, the amount paid, and if applicable, an explanation for denial of payment. To ensure that the data files include all claims processed in the month, the total amount paid per the data files was reconciled to the triangle payment lags within an acceptable level.

In addition to the 75 focused claims tested by UPRV and the 25 paid claims testing performed during the examination, the TennCare Bureau requested that TDCI review specific reimbursement changes required by the state budget effective July 1, 2011. TDCI's testing results for reimbursement changes related to emergency department professional fees, professional delivery rates, and facility delivery rates are discussed in Section VII.M. of this report.

E. Comparison of Actual Claim with System Claim Data

The purpose of this test is to ensure that the information submitted on the claim was entered correctly in UPRV's claims processing system. The CRAs require minimum data elements to be recorded from medical claims and submitted to TennCare as encounter data. The data elements recorded on the claims were compared to the data elements entered into UPRV's claims processing system. No discrepancies

were noted in comparison of information submitted on claims to data in UPRV's claims processing system for the 25 claims selected for testing from the November 2011 prompt pay data files. The following error was noted by UPRV in response to the 75 claims selected from the January 2012 focused claims review:

- For one medical claim, the date of service was incorrectly entered by UPRV into the claims processing system for five lines on the medical claim. Even though the date of service was incorrect, the claim correctly denied for timely filing.

F. Adjudication Accuracy Testing

The purpose of adjudication accuracy testing is to determine if claims selected were properly paid, denied, or rejected.

For the 25 claims judgmentally selected from the November 2011 prompt pay data files, no adjudication errors were noted.

For the 75 claims selected for focused testing, UPRV reported the following errors to TDCI:

- One medical claim was incorrectly denied with reason code "Medicaid ID number/disclosure needed". UPRV stated "claim should not have been denied for missing Medicaid ID or TennCare Disclosure. The TennCare disclosure was effective on date of service and Medicaid ID is loaded."

  Additional comment provided by UPRV during examination fieldwork:

  Claim Auto Adjudicated Denied for No disclosure, the claim received on 12/2/2011. Processed on 12/5/2011. The disclosure that was on file was expired 08/28/2011. We received the new disclosure dated 11/16/2011. The disclosure was loaded on 01/19/2012.

  Opportunity- UPRV recognizes that the system has processed this claim as it is designed, and recognizes that UPRV Provider Operations has opportunity to improve in Disclosure management, including loading, managing the disclosure data within a timely manner.

- One non-emergency medical transportation (NEMT) claim was incorrectly denied with the reason code "NPI is missing/invalid". UPRV stated the provider did bill with the correct NPI number.

- One NEMT claim was incorrectly denied with the reason code "claim may be covered by COB (coordination of benefits)". UPRV stated that the Medicare denial EOB was attached and that Medicare does not cover NEMT. TDCI notes that this error was identified by UPRV in February 2012 but the claim had not been adjusted as of the start of fieldwork on October 1, 2012. UPRV should

timely adjust errors discovered in the focused testing reviews.

- One NEMT claim was incorrectly denied with reason code "duplicate claim/service". UPRV stated it was not a duplicate because the provider billed with a different modifier. In performing a check for duplicate claims, the claims processing system compares the five character procedure code and the first two character modifier code. Any additional modifier codes reported by the provider are not utilized in the duplicate check.

- UPRV indicated that one NEMT claim was correctly denied for the reason "payment adjustment submission/billing error." TDCI commented that this is a vague explanation and does not provide enough information for the provider to correct the claim. UPRV agreed and stated "it is the policy to provide on a claim the header denial, billing error and a claim level specific denial for the provider to know what needs to be corrected."

During fieldwork TDCI re-examined the results of UPRV self-reported focused claims testing for the month of January 2012. The following additional deficiencies were noted:

- UPRV indicated that one line of a CHOICES claim and two lines of a NEMT claim were correctly denied for non-eligibility; however, TDCI was able to verify that the enrollee was eligible on the date of service through the TennCare system. UPRV indicated that there were two "JD" numbers for this enrollee and the enrollee was in fact eligible on the date of service. UPRV assigns an internal "JD" number to all enrollees. Multiple JD numbers occur in UPRV's claims processing system when a member moves from one grand Tennessee region to another.

  UPRV Response

  UPRV believes the claims were denied correctly based on the information submitted by the provider. The provider submitted a claim [that] was received on 12/28/2011 using the member's incorrect member id, and the claim was subsequently denied. The provider also submitted a corrected claim on 1/24/2012 with the correct member identification and the claim was paid without incident.

  TDCI Rebuttal

  This unique situation creates confusion for the provider. The denial reason communicated to the provider was that the date of service was after subscriber's termination. The subscriber was not terminated from the TennCare program but moved to another grand Tennessee region. A search of eligibility sources

provided by TennCare would indicate the subscriber has not terminated.

- UPRV indicated one CHOICES claim billed through the EVV system was correctly denied for absence of authorization or precertification by UPRV's claims processing system. The claim billed from the EVV system included a modifier "UD". UPRV did authorize the service but did not authorize the procedure with the modifier "UD". UPRV indicated that the EVV system allows providers the flexibility in claim submission to submit with or without a modifier. Providers can change for billing purposes the service authorized and transmitted by UPRV to the EVV system. The service billed by the provider is different than the service authorized in the enrollee's plan of care.

  Section 2.9.6.9.3.3 of the CRA for East, Middle and West Grand Regions states:

  > The CONTRACTOR shall have systems in place to facilitate timely communication between internal departments and the care coordinator to ensure that each care coordinator receives all relevant information regarding his/her members, e.g., member services, disease management, utilization management, and claims processing. The care coordinator shall follow-up on this information as appropriate, e.g., documentation in the member's plan of care, monitoring of outcomes, and, as appropriate, needs reassessment and updating the plan of care.

  The billed service is correctly denied in the claims processing system however no follow-up by the care coordinator or other UPRV staff reconciles why the provider is billing services not authorized in the enrollee's plan of care.

  UPRV Response

  UPRV believes that we are meeting the requirements of 2.9.6.9.3.3. UPRV has systems in place to facilitate timely communication to care coordinators as it relates to his/her member. UPRV ensures that a member's care is consistent with the care that is documented in the member's plan of care (POC). UPRV's system communicates the authorized services to the provider via the Sandata Electronic Visit Verification vendor. Each visit is validated by telephonic verification at the beginning and end of the services rendered. Contracted providers are expected to adhere to Tennessee Department of Commerce and Insurance approved provider agreement-Tennessee Program Network Ancillary Provider Agreement, which defines the contracted provider responsibilities.

  Section F - Contracting Provider Agrees to perform and bill only for those services requested by the referring TPNPPs. If services are necessary beyond the original referral request, the referring TPNPP must pre-authorize such services. Should contracting provider render services to a Tennessee program Member without first receiving the appropriate authorization, River Valley Plan

has the right to deny any claim for the unauthorized visit and contracting Provider may not collect any reimbursement from the Tennessee Program Member pursuant to section 14.

Any deviation of authorized services will be denied by the health plan.

UPRV ensures that its care coordinators receive and have access to all information regarding his/her members care, including and not limited to claims processing.

TDCI Rebuttal

Other than the denial of the claim by UPRV's claims processing system, no evidence was noted by TDCI that the claims denials resulted in additional actions by care coordinators such as contacting the provider to discover why provider was performing services not authorized in the enrollee's plan of care.

Additional UPRV Comment:

The EVV system no longer allows providers to add or remove modifiers.

- UPRV indicated one CHOICES claim billed through the EVV system was correctly denied for having an invalid bill type by UPRV's claim processing system. UPRV notes that "provider has responsibility to select appropriate bill type for submission". The provider has the ability to change the authorized bill type in the EVV system.

  Section 2.9.6.9.3.3 of the CRA for East, Middle and West Grand Regions states:

  > The CONTRACTOR shall have systems in place to facilitate timely communication between internal departments and the care coordinator to ensure that each care coordinator receives all relevant information regarding his/her members, e.g., member services, disease management, utilization management, and claims processing. The care coordinator shall follow-up on this information as appropriate, e.g., documentation in the member's plan of care, monitoring of outcomes, and, as appropriate, needs reassessment and updating the plan of care.

  The billed service is correctly denied in the claims processing system, however, no follow-up by the care coordinator or other UPRV staff reconciles why the provider is billing services not authorized in the enrollee's plan of care.

UPRV Response

UPRV believes that we are meeting the requirements of 2.9.6.9.3.3. UPRV has systems in place to facilitate timely communication to care coordinators as it

relates to his/her member. UPRV ensures that a member's care is consistent with the care that is documented in the member's plan of care(POC). UPRV's system communicates the authorized services to the provider via the Sandata Electronic Visit Verification vendor. Each visit is validated by telephonic verification at the beginning and end of the services rendered. Contracted providers are expected to adhere to Tennessee Department of Commerce and Insurance approved provider agreement-Tennessee Program Network Ancillary Provider Agreement, which defines the contracted provider responsibilities.

Section F - Contracting Provider Agrees to perform and bill only for those services requested by the referring TPNPPs. If services are necessary beyond the original referral request, the referring TPNPP must pre-authorize such services. Should contracting provider render services to a Tennessee program Member without first receiving the appropriate authorization, River Valley Plan has the right to deny any claim for the unauthorized visit and contracting Provider may not collect any reimbursement from the Tennessee Program Member pursuant to section 14.

Any deviation of authorized services will be denied by the health plan.

UPRV ensures that its care coordinators receive and have access to all information regarding his/her members care, including and not limited to claims processing.

TDCI Rebuttal

Other than the denial of the claim by UPRV's claims processing system, no evidence was noted by TDCI that the claims denials resulted in additional actions by care coordinators such as contacting the provider to discover why provider was performing services not authorized in the enrollee's plan of care.

- UPRV indicated two CHOICES claims billed through the EVV system were correctly denied for the benefit maximum being reached. The provider was able to bill through the EVV system for services in excess of the benefit maximum established by UPRV's authorization system. The authorization granted by UPRV was for services for home visits to an enrollee in which the provider is granted a maximum visit limit for a specific time period (ex: a time period of a month). UPRV noted that the EVV system is not a claims adjudication system and does not have the capacity to determine if a claim has reached the member's benefit maximum. However, it was found that the number of the authorizations granted in UPRV's CareOne system was less than the authorization limits entered into the EVV system. UPRV noted that a problem was discovered in the manner in which authorizations were amended in the EVV system. Attempts by UPRV to delete authorizations on the EVV system were not successful. This resulted in a provider being allowed to bill from the EVV system services beyond the authorization limits granted by UPRV. UPRV indicated that this should not occur after January 1, 2012 because a stricter enforcement of

scheduling was implemented. Rather than the provider scheduling a set number of visits in a monthly time frame, the provider must perform the service based on an hourly or daily set schedule. Before this stricter enforcement of scheduling, a provider could perform the service beyond the schedule determined by enrollee's plan of care. Additionally, the billed service was correctly denied in the claims processing system; however, there was no follow-up by the care coordinator or other UPRV staff to determine why the provider was billing services not authorized in the enrollee's plan of care.

UPRV Response

UPRV believes that we are meeting the requirements of 2.9.6.9.3.3. UPRV has systems in place to facilitate timely communication to care coordinators as it relates to his/her member. UPRV ensures that a member's care is consistent with the care that is documented in the member's plan of care (POC). UPRV's system communicates the authorized services to the provider via the Sandata Electronic Visit Verification vendor. Each visit is validated by telephonic verification at the beginning and end of the services rendered. Contracted providers are expected to adhere to Tennessee Department of Commerce and Insurance approved provider agreement-Tennessee Program Network Ancillary Provider Agreement, which defines the contracted provider responsibilities.

Section F - Contracting Provider Agrees to perform and bill only for those services requested by the referring TPNPPs. If services are necessary beyond the original referral request, the referring TPNPP must pre-authorize such services. Should contracting provider render services to a Tennessee program Member without first receiving the appropriate authorization, River Valley Plan has the right to deny any claim for the unauthorized visit and contracting Provider may not collect any reimbursement from the Tennessee Program Member pursuant to section 14.

Any deviation of authorized services will be denied by the health plan.

UPRV ensures that its care coordinators receive and have access to all information regarding his/her members care, including and not limited to claims processing.

UPRV recognized an opportunity to improve authorization management. UPRV implemented a deletion/void process for authorization.

Previous Process:

1. *CMA's would end date and zero out all counts in a service line. This did not work because it would create an unlimited value in Sandata.*

2. *CMA would select the delete button and build a new service line within the same notification: This did not work because the new service line added to what was already there and the previous authorization would receive a "C"*

value of change verses a "V" value of void.

The current Process includes:

CMA now deletes the authorization and creates a new notification to build the new line. Sandata updated their system to receive the "V" and show authorizations are voided in their system.

The process is more streamlined for CMA, Sandata and providers. Claim has been adjusted (September 2012).

TDCI Rebuttal

Due to the errors noted in the authorization counts, the provider performed services not authorized by the enrollee in his/her plan of care.

- UPRV indicated two CHOICES claims billed through the EVV system were correctly denied for incorrect/missing date of service by UPRV's claims processing system. The claim billing period spanned more than one month of service. TennCare requires services to be billed in one month spans. A feature in the EVV system allows the provider to select for billing purposes the dates of services of claims to be invoiced to UPRV. UPRV utilizes this date to determine the span dates to be applied on all claims received with an invoice passed electronically from EVV to UPRV. UPRV and Sandata both indicate they have communicated to providers the requirements for one month span date billing. However, the steps performed by a provider in the EVV system do not clearly indicate the application of monthly span billing but rather an attempt by provider to bill all unpaid services. UPRV and Sandata noted that changes were made in the invoicing procedures that send monthly files for invoicing from the EVV to UPRV each time the provider bills from the EVV system.

  UPRV Response

  Contracted providers are expected to adhere to Tennessee Department of Commerce and Insurance approved provider agreement-Tennessee Program Network Ancillary Provider Agreement, which defines the contracted provider responsibilities. Long Term Care Contracted Provider Responsibilities, section 7- Contracting Providers Shall comply with all requirements including but not limited to those set forth in the provider manual.

  TDCI Rebuttal

  The changes to invoicing procedures to limit EVV invoicing to monthly files should prevent future denials for incorrect date spans.

G. Price Accuracy Testing

The purpose of price accuracy testing is to determine whether payments for specific procedures are in accordance with the system price rules assigned to providers, whether payments are in accordance with provider contracts, and whether amounts are calculated correctly. No discrepancies were noted during price accuracy testing for the 25 claims selected for testing from the November 2011 prompt pay data files or in the 75 claims selected for testing in the January 2012 focused claims review.

H. Copayment Testing

The purpose of copayment testing is to determine whether copayments have been properly applied for enrollees subject to out-of-pocket payments.

TDCI requested from UPRV a listing of all enrollees with copayments for the period January 1, 2011, through December 31, 2011. The listing was reviewed for unusual copayments applied to individual claims. A copayment amount was determined as unusual if it does not match the copayment amounts required in the CRAs. Five enrollees were judgmentally selected for testing.

- For two of the five enrollees selected for copayment testing, UPRV incorrectly applied copayments when the enrollee was not subject to copayment requirements. The effected claims were adjusted by UPRV.

Management Comments

Management concurs.

UPRV has addressed the issue by providing additional education to the claims processor regarding the standard operating procedure.

I. Remittance Advice Testing

The purpose of remittance advice testing is to determine whether remittance advices sent to providers accurately reflect the processed claim information in the system.

No discrepancies were noted between the claims payment per the claims processing system and the related information communicated to the providers.

J. Analysis of Cancelled Checks/Electronic Funds Transfer

The purpose of analyzing cancelled checks and electronic funds transfer is to: (1) verify the actual payment of claims by UPRV; and (2) determine whether a pattern of significant lag times exists between the issue date and the cleared date on the checks examined.

The examiners requested UPRV to provide ten cancelled checks or electronic funds transfers from the 25 claims selected for testing from the November 2011 prompt

pay data files. UPRV provided the cancelled checks or the proof of electronic funds transfer. The check or paid amounts agreed with the amounts paid per the remittance advice and no pattern of significant lag times between the issue date and the cleared date was noted.

K. Pended and Unpaid Claims Testing

The purpose of analyzing pended claims is to determine if a significant number of claims are unprocessed and as a result a material liability exists for the unprocessed claims.

The pended and unpaid data files submitted to TDCI during field work, as of October 31, 2012, were reviewed for claims which exceeded 60 days old. The pended and unpaid data files combined for East, Middle, and West Tennessee claims processed by UPRV and UPRV's subcontractors indicate a total of 10,958 claims were more than 60 days old. UPRV, including subcontractors, processed 865,709 initial submission claims for the month of October 2012, thus, it does not appear that a material liability exists for claims over 60 days old.

L. Mailroom and Claims Inventory Controls

The purpose for the review of mailroom and claims inventory controls is to determine if UPRV"s procedures ensure that all claims received from providers are either returned to the provider where appropriate or are processed by the claims processing system.

The mailroom function is subcontracted to Firstsource Solutions USA, Inc. (Firstsource). Firstsource's office in Kingston, New York receives, sorts, scans, enters data, and reconciles all medical claims and correspondence received from UPRV providers and members. TDCI did not perform a site visit of the mailroom operations during this examination. UPRV provided responses to internal control questionnaires, flowcharts, and claims inventory reconciliation reports regarding mailroom operations. An interview was conducted with Firstsource personnel. The following issue was noted during the review of mailroom operations at Firstsource:

The interview noted that the first flowchart provided to TDCI of mailroom operations did not reflect that claims which are initially rejected in the mailroom can be brought back as a "keyable" claim. A "keyable" claim is a claim that can be entered into the claims processing system electronically if the claim can be rescanned. While a more detailed flowchart including the missing step was provided by UPRV for review, it was noted that the inventory reconciliation sheets did not reflect the rescan of rejected claims. The inventory reconciliation sheets should clearly indicate for each day's mail receipts the final disposition of all claims received in the mail. UPRV agreed that the inventory reconciliation sheets should be updated to include rescanned claims.

Management Comments

Management concurs.

In March 2013, UPRV implemented a reporting enhancement to track and provide the status of rejected claims.

M. Budget Reimbursement Changes Effective July 1, 2011

The Budget for the State of Tennessee effective July 1, 2011 (Budget), required all TennCare managed care organizations to implement reimbursement changes to provider payments effective July 1, 2011. The Bureau of TennCare requested TDCI to review three of the reimbursement changes implemented by all TennCare managed care organizations.

1. Emergency Department Professional Fees

   The Budget required reimbursement for professional fees for non-emergent emergency department visits to be capped at $50. If the contracted rate between the provider and UPRV is lower than $50 for the service billed, then UPRV is to pay the contracted rate. UPRV determines if a claim is considered emergent when either the first or second diagnosis on the claim is listed on UPRV's predetermined emergency diagnosis code listing. The TennCare Bureau provided a data file of claims billed with procedure codes for emergency room professional fees for dates of service on or after July 1, 2011. TDCI selected 146 claims for testing from the data file. The selected claims included claims which paid less than $50, $50, and more than $50. The following deficiencies were noted:

   - For eight of the 146 claims selected for testing, UPRV incorrectly paid over $50 when neither the first or second diagnosis was considered emergent.

   - For one of the 146 claims selected for testing, UPRV incorrectly paid $50; however, the first and second diagnoses were considered emergent. The provider's contracted rate is greater than $50.

Management Comments

Management concurs.

The deficiencies noted occurred as a result of claims examiner keying errors. UPRV's process for addressing such errors includes enhanced education and performance monitoring. In addition, system edits have been added to increase auto adjudication.

2. Professional Delivery Rates

The Budget required reimbursement for professional fees to increase by 17% for normal deliveries and to pay the same rate as normal deliveries for Caesarean deliveries effective for dates of service on and after July 1, 2011. TDCI selected seven providers receiving payments for professional delivery services. The rates for normal professional delivery services were tested to confirm that the 17% rate increase was applied to all claims with dates of service on and after July 1, 2011. Also, the rates for Caesarean professional delivery services were tested to confirm that the Caesarean professional delivery rates were the same as professional delivery rates for dates of service on and after July 1, 2011. No discrepancies were noted.

3. Facility Delivery Rates

The Budget required reimbursement for hospital fees to increase by 17% for normal deliveries and to pay the same rate as normal deliveries effective for Caesarean deliveries for dates of service on and after July 1, 2011. The TennCare Bureau provided a data file of claims for hospital delivery reimbursements for dates of services before and after July 1, 2011. Through data analysis techniques, TDCI identified exception claims where individual facilities were not paid a 17% rate increase on normal delivery claims with dates of service on or after July 1, 2011, or where a Caesarean delivery payment for dates of service on or after July 1, 2011 did not agree to the normal delivery rate for the same time period.

a. Normal Delivery Reimbursement Exceptions

For the 50 normal delivery exception claims selected for testing for the 17% rate increase, TDCI noted the following:

- 19 claims remain incorrectly paid as of October 5, 2012,
- 6 claims had been adjusted to reflect the 17% rate increase as of October 5, 2012, and
- 25 claims did not require adjustment since the DRG was not included in the TennCare Bureau crosswalk or the claim involved coordination of benefits. No adjustment by UPRV was required.

Additionally, TDCI noted that 28 different providers represented the 50 normal delivery exception claims selected for testing by TDCI. The configuration on 10 of these providers had not been corrected as of October 5, 2012, to reflect the reimbursement changes for dates of service on or after July 1, 2011.

Management Comments

Management concurs.

UPRV has identified and corrected provider fee schedules as well as completed adjustments to the claims.

b. Caesarean Reimbursement Exceptions

For the 56 Caesarean reimbursement exception claims selected for testing to be paid at the normal delivery rate, TDCI noted the following:

- 10 claims remain incorrectly paid as of October 5, 2012,
- 21 claims had been adjusted to pay Caesarean deliveries at the normal delivery rate as of October 5, 2012,
- 24 claims did not require adjustment since the DRG was not included in the TennCare Bureau crosswalk or the dates of service on the claim was not applicable to the test, and
- As of the end of fieldwork for one claim, UPRV was unable to provide the computation for the correct payment.

Additionally, TDCI noted that 22 different providers represented the 56 Caesarean reimbursement exception claims selected for testing. The configuration on 4 of these providers had not been corrected as of October 5, 2012, to reflect the reimbursement changes for Caesarean deliveries for dates of service on or after July 1, 2011.

Management Comments

Management concurs.

UPRV has identified and corrected provider fee schedules as well as completed adjustments to the claims.

VIII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

A. Provider Complaints Received by UPRV

Provider complaints were tested to determine if UPRV responded to all provider complaints in a timely manner. Tenn. Code Ann. § 56-32-126(b)(2)(A) states in part:

> The health maintenance organization must respond to the reconsideration request within thirty (30) calendar days after receipt of the request. The response may be a letter acknowledging the receipt of the reconsideration request with an estimated time frame in which the health maintenance organization will complete its investigation and provide a complete response to the provider. If the health maintenance organization determines that it needs longer than thirty (30) calendar days to completely respond to the provider, the health maintenance organization's reconsideration decision shall be issued within sixty (60) calendar days after receipt of the reconsideration request, unless a longer time to completely respond is agreed upon in writing by the provider and the health maintenance organization.

UPRV's policies and procedures state, "The Health Plan will respond in writing to such provider written reconsiderations within 30 days." Adherence by UPRV to this policy should ensure compliance with Tenn. Code Ann. § 56-32-126(b)(2)(A).

TDCI selected the UPRV provider appeal complaint log for December 2011 for review. A total of 2,384 provider appeals were received for the month of December 2011. A review of the complaint log noted that only 4 provider appeals were responded to within 30 days or less. The remaining 2,380 were not responded to within 30 days and, therefore, were not processed in compliance with UPRV's policies and procedures. The following is a summary of the provider appeals to which responses were not sent within 30 days of receipt:

- 1,779 provider appeals were responded to in 31 to 60 days of receipt.
- 250 provider appeals were responded to in 61 to 90 days of receipt.
- 130 provider appeals were responded to in 91 to 120 days of receipt.
- 211 provider appeals were responded to in 121 to 257 days of receipt.
- 5 provider appeal response dates were incorrectly recorded on the provider appeal complaint log.
- 5 provider appeals with the status of pending as of December 31, 2011, were still pending as of the first date of fieldwork on October 1, 2012.

In violation of Tenn. Code Ann. § 56-32-126(b)(2)(A), UPRV did not send an acknowledgement to the provider that a response would exceed the 30-day deadline for these 2380 provider appeals. Furthermore, for the 601 provider appeals to which responses were not made within 60 days of receipt, there were no agreements made in writing with these providers for the extension of the response time.

UPRV should comply with their own provider appeal policies and procedures as well as Tenn. Code Ann. § 56-32-126(b)(2)(A) to ensure that provider appeals are responded to in a timely manner. In addition, response dates should be accurately reflected on the provider appeal log.

Management Comments

Management concurs.

In 2012, UPRV transitioned to an automated tracking system which allows for a more detailed analysis of data from triage to resolution. UPRV also has enhanced the oversight of the process through monthly reporting to the health plan Clinical Operations Subcommittee.

UPRV acknowledges receipt of the reconsideration request within 30 days of receipt of such request. The acknowledgment letter informs providers that UPRV will provide a decision within 60 days of receipt of the reconsideration request. In addition, UPRV's process includes notifying the provider if a decision is unable to be rendered within 60 days of receipt of the reconsideration.

TDCI selected fifteen provider appeals from the provider appeal log for further testing. The response dates on the provider appeal log were compared to correspondence to verify their accuracy. Claims related to the provider appeals were compared to information entered into the claims processing system. No deficiencies were noted.

B. Provider Complaints Received by TDCI

TDCI offers to medical and transportation providers a provider complaint process for disputes with TennCare MCOs. Complaints may involve claims payment accuracy and timeliness, credentialing procedures, inability to contact or obtain assistance from the MCO, miscommunication or confusion around MCO policy and procedures, etc. When a provider complaint is received, TDCI forwards the complaint to the MCO for investigation. The MCO is required to respond in writing within 14 days to both the provider and TDCI to avoid assessment of liquidated damages pursuant to the “On Request” report requirements of the CRAs. If the provider is not satisfied with the MCO's response to the complaint, the provider may seek other remedies to resolve the complaint, including but not limited to, requesting a claims payment dispute be sent to an independent reviewer for resolution or pursuing other available legal or contractual remedies.

For the period January 1 through December 31, 2011, TDCI received and processed 229 provider complaints against UPRV. The responses by UPRV to providers were categorized by TDCI in the following manner:

Previous denial or payment upheld	101
Previous denial or underpayment reversed in favor of the provider	70
Previous denial or underpayment partially reversed in favor of the provider	26
Responses to issues other than claims processing	32

TDCI judgmentally selected 11 UPRV provider complaints submitted to TDCI for review. Issues raised by the provider in the complaint were analyzed. Questions were posed to UPRV for response. Emphasis was placed on discovering deficiencies in the UPRV's claims processing system or provider complaint procedures. The detailed review of the provider complaints including the TDCI questions and UPRV's responses can be found in Appendix 1 of this report. The following issues noted in review of provider complaints submitted to TDCI indicate areas where improvements should be made to UPRV's claims processing systems and provider complaint and appeal procedures:

- Claims are incorrectly denied for exceeding timely filing limits when retroactive eligibility is involved. Providers have 120 calendar days from the date of service to submit a medical claim except in situations with retroactive eligibility, in which case the provider has 120 days from the date of notification of the retroactive enrollment to submit the claim. UPRV's claims processing system does not actively search for retroactive eligibility before a claim is denied for exceeding timely filing limits.

- An anesthesia provider sent a provider complaint first to UPRV asserting that the claim was underpaid by UPRV. UPRV responded that the payment was correct. The provider then submitted the complaint to TDCI after which the claim was reprocessed at the correct rate. UPRV should ensure that first level appeal responses to providers are accurate. Personnel responding to provider complaints should receive the proper training to identify and resolve claims payment errors.

Management Comments

Management concurs.

UPRV has provided education and enhanced the processes for claims reconsiderations. Additionally, an FTE has been added at the health plan to provide enhanced root cause analysis and remediation of the Provider Complaints.

C. Independent Reviews

The independent review process was established by Tennessee Code Ann. § 56-32-126(b)(2) to resolve claims disputes when a provider believes a TennCare MCO has partially or totally denied claims incorrectly. TDCI administers the independent review process, but does not perform the independent review of the disputed claims. When a request for independent review is received, TDCI determines that the disputed claims are eligible for independent review based on the statutory requirements (i.e. the disputed claims were submitted for independent review within 365 days from the date the MCC's first denied the claims). If the claims are eligible, TDCI forwards the claims to a reviewer that is not a state employee or contractor and is independent of the MCC and the provider. The decision of the independent reviewer is binding unless either party to the dispute appeals the decision to any court having jurisdiction to review the independent reviewer's decision.

For the period January 1 through December 31, 2011, 121 independent reviews were initiated by providers against UPRV. The following is a summary of the reviewer decisions:

Reviewer decision in favor of the provider	22
UPRV settled with provider upon submission of the independent review	22
Reviewer decision in favor of UPRV	55
Reviewer decision in favor of UPRV in part and provider in part	11
Review request submitted by provider was ineligible	11

TDCI judgmentally selected 5 independent reviews and analyzed the issues raised by the provider. Questions were posed to UPRV for response. Emphasis was placed on discovering deficiencies in the UPRV's claims processing system or provider complaint and appeal procedures. The detailed testing of the independent reviews including TDCI questions and UPRV responses can be found in Appendix 2 of this report. The following was noted in the processing of one of the independent reviews selected for analysis:

- UPRV did not send payment in full to the provider within twenty calendar days upon receipt of the reviewer's decision pursuant to Tenn. Code Ann. § 56-32-126(b)(3)(C). A decision was rendered by the independent review on December 7, 2011. The claim had not been adjusted for payment as of October 1, 2012.

Management Comments

Management concurs.

The claim in question was reprocessed and paid on October 11, 2012. In addition, UPRV has instituted a check and balance system to monitor payment of Independent Reviews that result in a reversal of the health plan's decision. Such decisions are closely tracked to ensure payment will occur within 20 days of receipt of the Independent Reviewer's decision.

D. Provider Manual

The provider manual outlines written guidelines for providers to assure that claims are processed accurately and timely. In addition, the provider manual informs providers of the correct procedures to follow in the event of a disputed claim.

UPRV's provider manual is incorporated by reference in the provider agreement templates and therefore must be filed with TDCI for prior approval as a material modification to UPRV's certificate of authority pursuant to Tenn. Code Ann. § 56-32-103(c).

An updated provider manual was submitted to TDCI for prior approval on August 15, 2011. TDCI communicated to UPRV deficiencies regarding the provider manual submission on September 2, 2011 and September 16, 2011. The deficiencies noted by TDCI included incorrect phone numbers, invalid internet links, incorrect references to "AmeriChoice", and grammatical errors. UPRV resubmitted the provider manual to TDCI on November 16, 2011. TDCI communicated deficiencies on December 16, 2011. The deficiencies noted by TDCI include invalid internet links and an issue related to the retroactive eligibility claims submission policy. UPRV resubmitted the provider manual to TDCI on December 27, 2011. TDCI communicated deficiencies on January 23, 2012. The deficiencies included an incorrect phone number and an incorrect reference to Tennessee Rules and Regulations. UPRV resubmitted the provider manual to TDCI on February 3, 2012. This filing was approved by TDCI on February 23, 2013. TDCI notes that the process from first submission of the provider manual on August 15, 2011, until final approval by TDCI on February 23, 2012, was significantly delayed. UPRV should improve its material modification procedures to promptly and accurately correct provider manual deficiencies noted by TDCI.

Management Comments

Management concurs.

UPRVs process, recently approved by TDCI, includes quarterly updates to its provider manual.

E. Provider Agreements

Agreements between an HMO and medical providers represent operational documents to be prior approved by TDCI in order for TDCI to grant a certificate of authority for a company to operate as an HMO as provided by Tenn. Code Ann. §

56-32-103(b)(4). The HMO is required to file a notice and obtain the Commissioner's approval prior to any material modification of the operational documents in accordance with Tenn. Code Ann. § 56-32-103(c)(1). Additionally, Section 2.12.2 of the CRAs for the East, Middle, and West Tennessee Grand Regions requires all template provider agreements and revisions thereto to be approved in advance by TDCI, in accordance with statutes regarding the approval of an HMO's certificate of authority and any material modification thereof. Furthermore, Section 2.12.9 of the CRAs for the East, Middle, and West Tennessee Grand Regions sets forth the minimum language requirements for provider agreements.

Ten executed provider agreements from East, Middle and West Tennessee providers were judgmentally selected for testing from the provider network directory files submitted by UPRV to the TennCare Bureau. No deficiencies were noted when provider agreements selected for testing were compared to the provider agreement templates previously submitted by UPRV to TDCI for approval.

F. Provider Payments

Capitation payments made to providers during 2011 were tested to determine if UPRV complied with the payment provisions set forth in its capitated provider agreements. Review of payments to capitated providers indicated that all payments were made per the provider contract requirements.

G. Subcontracts

HMOs are required to file notice and obtain the Commissioner's approval prior to any material modification of operational documents in accordance with Tenn. Code Ann. § 56-32-103(c)(1). Additionally, per Section 2.26.3 of the CRAs for the East, Middle, and West Tennessee Grand Regions all subcontractor agreements and revisions thereto must be approved in advance in writing by TDCI, in accordance with statutes regarding the approval of an HMO's certificate of authority and any material modification thereof.

Six executed subcontracts were judgmentally selected for testing. The following deficiency was noted:

- A subcontract for an emergency room diversion program was executed on April 1, 2011; however, this subcontract was not approved by TDCI until June 9, 2011. Subcontract agreements, including all attachments and exhibits, should always be submitted to TDCI for approval prior to execution by UPRV in accordance with Tenn. Code Ann. § 56-32-103 and Section 2.26.3 of the CRAs.

Management Comments

Management concurs.

The health plan will continue to educate its business leaders that all agreements must be filed and approved by TDCI prior to their execution.

H. Non-discrimination

Section 2.28 of the CRAs for the East, Middle, and West Tennessee Grand Regions require UPRV to demonstrate compliance with Federal and State regulations of Title VI of the 1964 Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age of Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981. Based on discussions with various UPRV staff and a review of policies and related supporting documentation, UPRV was in compliance with the reporting requirements of Section 2.28 of the CRAs for the East, Middle, and West Tennessee Grand Regions.

I. Internal Audit Function

The importance of an internal audit function is to provide an independent review and evaluation of the accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations. An internal audit function is responsible for performing audits to ensure the economical and efficient use of resources by all departments to accomplish the objectives and goals for the operations of the department. The internal audit department should report directly to the board of directors so the department can maintain its independence and objectivity.

TDCI requested from UPRV any internal audit reports for the plan. The Internal Audit Department of UPRV's parent company, UnitedHealth Group had performed an internal audit of the TennCare plan. The audit report released January 2011 included specific tests to determine compliance with the TennCare CRA requirements. The report included findings and responses through Agreed-Upon Action Plans by UPRV's management. The findings were considered by TDCI during the current examination. TDCI notes that continued internal audits of TennCare CRA requirements have been scheduled.

As previously noted, Section 2.22.6.2 of the CRAs for the East, Middle, and West Tennessee Grand Regions requires the claims payment accuracy reports be prepared by the plan's Internal Audit Department. The reports are not prepared by UPRV's Internal Audit but rather by a Quality Assurance Unit within UPRV's Claims Operations Department. The Bureau of TennCare granted a deviation to this CRA requirement to permit staff other than UPRV's Internal Audit section to prepare the claims payment accuracy reports after the issuance of TDCI's previous examination report.

J. HMO Holding Companies

Effective January 1, 2000, all HMOs were required to comply with Tenn. Code Ann., Title 56, Chapter 11, Part 2 – the Insurance Holding Company System Act of 1986. Tenn. Code Ann. § 56-11-205 states, "Every insurer and every health maintenance organization which is authorized to do business in this state and which is a member of an insurance holding company system or health maintenance organization holding company system shall register with the commissioner…." UPRV is domiciled in the State of Illinois and, therefore, the filing is regulated in Illinois. The review of the annual filing for Illinois is required to also be submitted to TDCI. No discrepancies were noted in the annual holding company registration filing received in 2012 for the calendar year 2011.

K. Health Insurance Portability and Accountability Act (HIPAA)

Section 2.27 of the CRAs for the East, Middle, and West Tennessee Grand Regions requires UPRV to comply with requirements of the Health Insurance Portability and Accountability Act of 1996, including but not limited to the transactions and code set, privacy, security, and identifier regulations, by their designated compliance dates. Compliance includes meeting all required transaction formats and code sets with the specified data partner situations required under the regulations.

UPRV's information systems policies and procedures were reviewed in relation to the HIPAA requirements of the CRAs. The policies and procedures did not include specific requirements for personnel to contact the TennCare privacy officer immediately upon becoming aware of any unauthorized use or disclosure of enrollee protected health information not otherwise permitted or required by HIPAA per section 2.27.8 of the CRAs for the East, Middle and West Tennessee Grand Regions.

Management Comments

Management concurs.

The Tennessee health plan developed a Standard Operating Procedure (SOP) to support the more general HIPAA policies and procedures. The Health Plan Standard Operating Procedures contains the specific reporting requirements as outlined in the CRA for reporting to TennCare. The reporting requirements and the SOP are reviewed with staff during HIPAA training conducted by health plan.

L. Conflict of Interest

Section 4.19 of the CRAs for the East, Middle, and West Tennessee Grand Regions warrant that no part of the amount provided by TennCare shall be paid directly or indirectly to any officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to UPRV in connection with any work contemplated or performed relative to this Agreement unless otherwise authorized by the

Commissioner, Tennessee Department of Finance and Administration.

Conflict of interest requirements of the CRAs were expanded to require an annual filing certifying that the MCO is in compliance with all state and federal laws relating to conflicts of interest and lobbying.

Failure to comply with the provisions required by the CRAs shall result in liquidated damages in the amount of one hundred ten percent (110%) of the total amount of compensation that was paid inappropriately and may be considered a breach of the CRA.

The MCO is responsible for maintaining adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the organization and for including the substance of the CRA's conflict of interest clauses in all subcontracts, provider agreements and any and all agreements that result from the CRAs.

Testing of conflict of interest requirements of the CRAs noted the following:

- The most recently approved provider agreement templates contain the conflict of interest language of the CRAs.
- The organizational structure of UPRV includes a compliance officer who reports to the CEO for TennCare operations.
- UPRV has written conflict of interest policies and procedures in place.
- The written policies and procedures outline steps to report violations.
- The policy indicates all business associates are to comply with UPRV's conflict policy.
- Employees complete conflict of interest certificates of compliance annually per the written policy and procedures.
- Internal audits are performed and include steps to determine compliance with the conflict of interest requirements of the TennCare CRAs.

TDCI noted no material instances of non-compliance with conflict of interest requirements during the examination test work.

The examiners hereby acknowledge the courtesy and cooperation of the officers and employees of UPRV.

Appendix 1

Details of the Review of Provider Complaints Submitted to TDCI (See Section VIII.B.)

Please note that UPRV's responses set forth below are the exact written responses provided to TDCI during the examination.

Complaint 2011.072 - Hospital complained about UPRV's denial of an appeal of an inpatient authorization. The denial by UPRV stated, "denied because Americhoice claimed the member ate during an NPO order- so surgery was postponed 1 day." Hospital asserts there is no indication in the medical records that the patient was non-compliant with NPO orders. UPRV upheld the denial due to a lack of preauthorization of medical necessity for an inpatient admission to meet Milliman Inpatient Admission Guidelines.

- TDCI Question: Was the provider correct about the erroneous denial reason regarding NPO orders?

- UPRV Response: No they were not. The documentation on 4/19/10 shows oral intake of 480 ml. A peer to peer review with our Medical Director and Linda Evans of the facility revealed that the member had not followed NPO orders and therefore surgery was delayed for a day.

    - TDCI Follow-up: UPRV's authorization system indicates an authorization was granted to the provider for observation but not for inpatient days. TDCI questioned the appropriateness of the denial reason, "Units exceeds UM authorization". UPRV explained that the denial is sufficient to explain the reason why the claim is denied since the authorization granted zero units (inpatient days).

Complaint 2011.114 - Physician complained about UPRV's denial of a claim for exceeding timely filing limits. UPRV reversed the denial since the provider had shown that best efforts were made to bill UPRV within a reasonable time.

- TDCI Follow-up Question: What was the date TennCare updated eligibility records to reassign the member to UPRV?

- UPRV Response: We were notified 3/31/10 that member would be coming onto our plan after 5/3/10. Provider checked with Bureau and was told they had TennCare Select on 5/4/10 and therefore filed a claim with TennCare Select. When we received claim in October we denied for timely filing. When provider filed a complaint and showed the proof of checking eligibility, we made the decision to override the denial because provider made an honest effort to check eligibility and were given misinformation on TN Anytime and we should pay the claim.

Complaint 2011.122 - Hospital complained about UPRV's denial of a claim for exceeding timely

filing limits. The provider indicated that it had submitted proof that the claim had first been filed with another insurance carrier. Upon resubmission, UPRV then denied the claim because no prior authorization for the service had been obtained. UPRV reversed the denial for timely filing since the provider had shown that best efforts were made to bill UPRV within 120 days of the notification by the primary insurance carrier of its denial.

- TDCI Follow-up Question: After the provider submitted proof of timely filing, did UPRV deny the claim for no prior authorization?

- UPRV Response: The claim incorrectly denied for no authorization. Sent claim for re-adjudication with an override for timely filing.

Complaint 2011.150 - Clinic complained UPRV inappropriately denied a claim for other insurance coverage even though proof of other insurance termination was provided to UPRV. UPRV reversed the denial and paid the claim.

- TDCI Follow-up Question: Did UPRV have the other insurance termination notice on file as the provider indicates?

- UPRV Response: No, we did not have the other insurance termination notice on file. We received the claim on 11/4/10 for date of service 8/14/10 and denied for COB. After 11/4/10 we received a phone call from provider on 11/22/10 that said you are wrong member doesn't have other insurance. CSR sent to enrollment for verification and asked that claim be reprocessed. Records were updated on 12/27/10.

    - TDCI Follow-up: TDCI reviewed the original claim submission in the claims processing system and found that it was an electronic claim submission. The proof of other insurance termination was not attached to the original claim submission.

Complaint 2011.157 - Pediatric group complained UPRV incorrectly denied a claim for exceeding timely limits because the member was retroactively eligible and the claim was submitted within 120 days of the eligibility change. UPRV responded that the provider must resubmit the claim as corrected and mark as retro eligible.

- TDCI Follow-up Question: Does UPRV routinely search for claims affected by retro eligibility changes by TennCare?

- UPRV Response: There is not a retro-eligibility report at this time, but we are working on one. We are working with the Membership Department to get the report finalized. We are in the final stages of the project and are expecting to get it operationalized no later than 10/1/12.

    - Additional TDCI Follow-up: TDCI notes the billing instructions in UPRV's provider manual have been changed to eliminate the requirement that the provider note retro eligibility on the claim. Additional procedures have been updated to review for retro eligibility changes before a claim is to be denied for exceeding the timely filing limits.

Complaint 2011.161 - Clinic complained UPRV inappropriately denied procedure codes where more than one administration of injection is billed on a claim. UPRV upheld its previous denials and referenced to the National Correct Code Initiative concerning the "maximum frequency per day policy" which can be found in UPRV's reimbursement policy.

- TDCI Follow-up: The denied claim was reviewed in the claim processing system and no further item was noted.

Complaint 2011.165 - Anesthesia provider complained that a claim was underpaid by UPRV. UPRV upheld its payment amount as correct on the first appeal by the provider. With the submission of the provider complaint to TDCI, UPRV determined that it had incorrectly paid the claim because it had not considered the effect of a modifier.

- TDCI Follow-up Question: Why did the first appeal by the provider fail to catch the payment error?

- UPRV Response: The person who reviewed it first in Customer Service required additional education in the unique requirements for anesthesia claim processing with modifiers.

    - TDCI additional follow-up: UPRV indicated that the processing of anesthesia claims is an initial skill set required of it claims adjudication personnel.

Complaint 2011.183 - Radiologist group complained that procedure codes billed as distinct and separate procedures were incorrectly denied by UPRV. UPRV upheld its decision and referred to the National Correct Coding Initiative Editing Reimbursement Policy Guidelines to support the denial.

- TDCI Follow-up: The denied claim was reviewed in the claim processing system and no further item noted.

Complaint 2011.301 - A specialist provider complained that UPRV incorrectly denied a claim for exceeding timely filing limits. The member had other insurance coverage and paid the other insurance's copay at time of services. The member later received TennCare coverage retroactively. UPRV requested that the provider re-file the claim as "corrected" and "retro eligible" to avoid timely filing limits.

- TDCI Follow-up Question: Did the provider resubmit the claim as "corrected" and "retro eligible"?

- UPRV Response: We asked provider to send us a claim marked retro-eligible for the services rendered. Timely filing is routinely waived for retro-eligible cases that meet Bureau of TennCare guidelines.

    - TDCI Additional Follow-up: As previously noted, the billing instructions in UPRV's

provider manual have been changed to eliminate the requirement that the provider note retro eligibility on the claim. Additional procedures have been updated to review for retro eligibility changes before a claim is to be denied for exceeding timely filing limits.

Complaint 2011.302 - Clinic complained that UPRV incorrectly denied a claim for exceeding timely filing limits. Provider did not file the claim with UPRV within 120 days of the date of service. UPRV responded that the provider must submit the proper documentation to override the timely filing limits and the provider did not.

- TDCI Follow-up: The denied claim was reviewed in the claim processing system and no further item was noted. [And?]

Complaint 2011.346 - DME provider complained that UPRV incorrectly denied a claim for the reason "lacks information needed for adjudication." The provider resubmitted the claim and UPRV denied a procedure code as "invalid for date of service" even though a prior authorization for the service had been issued by UPRV. In addition, all other charges on the claim were denied. UPRV responded that an authorization is on file but the procedure code is not valid. UPRV stated that the provider should resubmit claim with the proper procedure code and mark the claim as "corrected".

- TDCI Follow-up Questions: What information was lacking on the first submission of the claim? Was the authorization granted by UPRV specific to a procedure code? Why do all the charges deny because of one invalid procedure code?

- UPRV Response: Provider's first claim submission lacked a valid HCPCS code and authorization. Yes, authorizations are specific to procedure codes and given a date range for validity. The charges denied due to no authorization number submitted on the claim. One charge had an additional denial reason of invalid HCPCS code. The other procedure codes were missing authorization number.

Appendix 2

Details of Testing of Independent Reviews (See Section VIII.C.)

Independent Review (IR) 41 Issue and IR Decision - A hospital alleged UPRV inappropriately denied an inpatient claim because a criterion for inpatient admission was not met. The independent reviewer upheld the denial by UPRV and noted that the provider was given the opportunity to use the peer to peer appeal process that could have resulted in the resolution of the claim denial. As a result, independent reviewer asserted the provider has waived its opportunity to obtain a decision on the medical facts.

- TDCI Follow-up: The denied claim was reviewed in the claim processing system and no further item was noted.

IR 50 Issue and IR Decision - A hospital alleged UPRV inappropriately denied an inpatient claim because the criteria for inpatient admission were not met. The independent reviewer reversed UPRV's decision.

- TDCI Follow-up: Reviewed claims processing system and found that the claim was reprocessed and paid as an inpatient claim in accordance with the independent reviewer's decision.

IR 89 Issue and IR Decision - A hospital alleged UPRV inappropriately denied an inpatient claim because the criteria for inpatient admission were not met. The independent reviewer upheld the denial because a separate review by TennCare medical staff found the criteria for inpatient admission was not met. The independent reviewer also found that UPRV should pay hospital at the observation rate.

- TDCI Follow-up: The claim had not been adjusted as of the first date of fieldwork, October 1, 2012, even though the independent reviewer had issued the decision in August 2011. UPRV communicated to the hospital in December 2011 that the claim must be resubmitted and billed as observation and not as an inpatient readmission. The provider disagreed since other claims denied on the same issue will be reprocessed without resubmission.

- UPRV Response: UPRV will expedite the reprocessing and payment of the claim.

IR 77 Issue and IR Decision - Provider alleged claims were not paid at agreed upon rate. Before the decision was rendered by the independent reviewer, UPRV reversed its position and agreed to reprocess the claims to pay at the provider's previous fee schedule rate.

- TDCI Follow-up: Why were the claims incorrectly paid?

- UPRV Response: The physician is part of a group of providers and the group had accepted new reimbursement rates. The physician asserts he did not accept the new reimbursement

rates.

IR 138 Issue and IR Decision - Hospital alleged part of an inpatient admission was incorrectly denied for lack of medical necessity. The independent reviewer reversed the decision by UPRV because a separate review by TennCare found that the medical records substantiated medical necessity of the additional inpatient days.

- TDCI Follow-up: Reviewed the claims processing system and found that the claim was reprocessed and paid pursuant to the independent reviewer's decision.