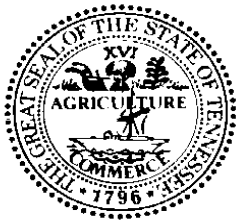

STATE OF TENNESSEE

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 AMERICHOICE

NASHVILLE, TENNESSEE

FOR THE PERIOD JANUARY 1, 2009
THROUGH DECEMBER 31, 2009

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Tennessee Department of Commerce and Insurance

VIA: Gregg Hawkins, CPA, Assistant Director
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Division of State Audit

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DATE: May 24, 2011

The Financial and Compliance Examination and Claims Processing Market Conduct Examination of the TennCare Operations of UnitedHealthCare Plan of the River Valley, Inc., Nashville, Tennessee, was completed January 24, 2011. The report of this examination is herein respectfully submitted.

I. FOREWORD

On April 27, 2010, 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 AmeriChoice of its intention to perform a market conduct, and financial statement and compliance examination. Fieldwork began on June 7, 2010, and ended on June 18, 2010. The company continued to respond to issues and provide requested documents through January 24, 2011.

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 a limited scope 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 2-12. of the Contractor Risk Agreement (CRA) for the non-risk East Tennessee Grand Region and Section 2.25 of the 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.

UnitedHealthCare Plan of the River Valley, Inc. (formerly known as John Deere Health Plan, Inc.) 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, 2009, and

the Medical Loss Ratio Reports for the East, Middle, and West Tennessee Grand Regions as of December 31, 2009.

The current market conduct examination by TDCI and the Comptroller focused on the claims processing functions and performance for UPRV 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 and subcontracts, and the demonstration of compliance with non-discrimination reporting 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 had implemented an appeal system to reasonably resolve appeals from TennCare providers in a timely manner; and

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

III. PROFILE

A. Administrative Organization

Heritage National Healthplan, Inc. (HNHI), an Illinois HMO, was incorporated under the laws of the State of Illinois on August 5, 1985, and was licensed as an HMO by the State of Illinois Department of Insurance in 1985. HNHI was licensed as an HMO by the State of Tennessee Department of Commerce and Insurance on June 20, 1995. HNHI was a wholly-owned subsidiary of John Deere Health Care, Inc., (JDHC) which was a wholly-owned subsidiary of Deere & Company (Deere).

Heritage National Healthplan of Tennessee, Inc. (HNHT), a Tennessee health maintenance organization, was incorporated under the laws of the State of Tennessee on October 25, 1985, and was thereafter licensed as an HMO by the State of Tennessee Department of Commerce and Insurance on July 1, 1986. Under its license, HNHT administered commercial plans and also participated as a contracted HMO in the TennCare program.

On September 10, 1996, HNHT, submitted to the State of Tennessee Department of Commerce and Insurance a proposed plan to merge with and into HNHI. On November 18, 1996, the merger of HNHT with and into HNHI was approved by the Commissioner of the Tennessee Department of Commerce and Insurance to be effective December 31, 1996. Effective July 1, 1999, HNHI changed its name to John Deere Health Plan, Inc. (JDHP) which was a wholly-owned subsidiary of Deere & Company.

On December 6, 2005, Deere & Company entered into a stock purchase agreement with United Healthcare, Inc. for the sale of JDHC and its subsidiaries. Effective February 24, 2006, JDHC became a wholly-owned subsidiary of United Healthcare Inc. JDHC changed its name to UnitedHeathcare Services Company of the River Valley, Inc. (USCRV). JDHP then changed its nsme to UnitedHealthcare Plan of the River Valley, Inc. (UPRV).

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, 2009, were as follows:

Officers for UPRV

Daniel Roger Kueter, President
Robert Worth Oberrender, Treasurer
Christina Regina Palme-Krizak, Secretary

Other Officers for UPRV

Bruce Chase Steffens, M.D., Chief Medical Officer

Directors or Trustees for UPRV

Daniel Roger Kueter	James Edward Hecker
William Kenneth Appelgate, PhD.	Cathie Sue Whiteside
Victoria Jean Kauzlarich	Michael Paul Radu
Bruce Chase Steffens, M.D.	Thomas Patrick Wiffler
Eric Paul	

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 John Deere Health Plan and the TennCare Bureau.

Effective July 1, 2002, the CRA with UPRV was amended for UPRV to temporarily operate under a non-risk agreement for the East Tennessee Grand Region. This period, otherwise known as the "stabilization period," was established to allow all MCOs a satisfactory period of time to establish financial stability, maintain continuity of a managed care environment for enrollees and assist the TennCare Bureau in restructuring the program design to better serve Tennesseans adequately and responsibly. UPRV agreed to reimburse providers for the provision of covered services in accordance with reimbursement rates, reimbursement policies and procedures, and medical management policies and procedures as they existed April 16, 2002, unless such a change received approval in advance by the TennCare Bureau.

During stabilization for the East Tennessee Grand Region operations, UPRV received from the TennCare Bureau a monthly fixed administrative payment based upon the number of TennCare enrollees assigned to UPRV. The TennCare Bureau reimbursed UPRV for the cost of providing covered services to TennCare enrollees. The non-risk contract ended December 31, 2008; however, UPRV continued to receive reimbursement for stabilization period claims subsequent to the contract termination.

UPRV was successful in a request for proposals to contract with the TennCare Bureau through at-risk agreements for all three grand regions of the State of Tennessee. The Middle Tennessee Grand Region CRA became effective April 1, 2007, the West Tennessee Grand Region CRA on November 1, 2008, and East Tennessee Grand Region CRA on January 1, 2009. Under at-risk agreements, UPRV receives monthly capitation payments based on the number of enrollees assigned to UPRV and each enrollee's eligibility classification.

UPRV is managed by USCRV, pursuant to a service agreement. Per this service agreement, UPRV pays a management fee to USCRV based upon a percentage of the monthly capitation payments received from the TennCare Bureau. Claims processing, payroll, office space and other services are provided to USCRV through a cost reimbursement agreement with United Healthcare Service, Inc., a related party. UPRV also pays United Behavioral Health, Inc. (UBH), a related party, a per member per month fee for the administration of behavioral health services.

For the period January 1, 2009 through December 31, 2009, UPRV received 63% of its nationwide revenue and 74% of its Tennessee revenue, from payments for providing medical and behavioral health benefits to TennCare members. As of December 31, 2009, UPRV had approximately 170,600 TennCare members jn the East Tennessee Grand Region, 187,400 in the Middle Tennessee Grand Region, and 158,200 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, and
- 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 – UBH, a related party to UPRV.

IV. PREVIOUS EXAMINATION FINDINGS

The previous examination findings are provided for informational purposes. The following were financial, claims processing and compliance deficiencies cited in the examination by TDCI for the period January 1, 2007 through June 30, 2007:

A. Financial Deficiencies

1. The following deficiencies were noted in the preparation of the TennCare operating statement for the East Tennessee Grand Region:

   - UPRV reported $85,736,072 premium revenue for the non-risk East Tennessee Grand Region. This does not agree to the total of all payments received from the TennCare Bureau for the period January 1, 2007 through June 30, 2007 of $90,222,320.

- The amount reported as investment income is based on an allocation derived from the administrative revenue received from the TennCare Bureau compared to total company premiums. This method of allocation for investment income does not appear reasonable.

2. The following deficiencies were noted in the preparation of the TennCare operating statement for the Middle Tennessee Grand Region:

   - The amount reported as investment income is based on a previously budgeted amount for pro forma income statements submitted to the TennCare Bureau as a requirement for the significant expansion into Middle Tennessee. This method of allocation for reporting investment income does not appear reasonable.

   - Expenses paid to UBH for the administration of behavioral health services were incorrectly excluded from administrative expenses.

   None of the previous financial deficiencies have been repeated in this report.

B. Claims Processing Deficiencies

1. During fieldwork, it was determined that UPRV had not submitted to TDCI data files for claims processed by all subcontractors in determining prompt pay compliance. Davis Vision processes vision claims for UPRV in the East Tennessee Grand Region, but the original data file submissions to TDCI did not include claims processed by Davis Vision. After fieldwork, UPRV submitted data files for the subcontractor from January 2007 through the current period.

2. The follow-up review to the implementation of the Middle Tennessee TennCare product on April 1, 2007, finds the problems encountered during the implementation did not materially impact accuracy and timeliness of claims processing. However, UPRV should continue to work through the remaining issues identified by UPRV on the post implementation issues log.

3. The following deficiencies were noted during the review of the procedures to prepare claims payment accuracy reports:

   - UPRV failed to include in the claims payment accuracy samples the vision claims processed by their subcontractors in both the East Tennessee Grand Region and the Middle Tennessee Grand Region.

   - The reports are not prepared by UPRV's Internal Audit Department, but rather by a Quality Assurance Unit within UPRV's Claims Operations Department. Initial resolution between the Claims Department staff and Quality Assurance staff in Moline, Illinois, does not involve input from staff based in Tennessee.

- When testing claims for claims payment accuracy, the CRAs require the plan to compare payments to the contracted rate. UPRV did not test to the contracted rate for all claims selected.

- When testing claims for claims payment accuracy, the CRAs require the plan to determine if the member's eligibility at processing date was correctly applied. UPRV's procedure for this attribute was only to verify the social security number.

4. For the 129 claims selected for testing for the Middle Tennessee Grand Region, the following discrepancies related to adjudication accuracy were noted:

   - For eight of the adjusted claims selected for testing, UPRV denied the claims on initial processing based on the fact that the enrollee also had Medicare coverage. For all eight of the claims tested, the services were non-covered services by Medicare. UPRV made a policy change on August 13, 2007 to allow certain procedures that will never be covered by Medicare to be processed as primary without waiting for a Medicare explanation of benefits.

   - For five of the adjusted claims selected for testing, the claims processor selected the incorrect provider number and associated fee schedule on first processing.

   - Five of the denied claims tested were improperly denied due to manual processing errors because the claims processing policies and procedures were not correctly applied.

   - Three of the denied claims tested were denied with the explanation that the member was not eligible on the date of service; however, the three enrollees were actually retroactively eligible for TennCare before the start of operations, April 1, 2007. UPRV is contracted to manually process claims and reimburse providers for covered services incurred prior to April 1, 2007.

   - Six of the denied claims selected were properly denied; however, the explanation reason communicated to the provider did not adequately explain the reason the claim was denied.

5. For the 129 claims selected for testing for the Middle Tennessee Grand Region, the following pricing accuracy discrepancies were noted.

   - Seven of the adjusted claims tested for emergency ambulance services were incorrectly paid. The fee schedule associated with these claims was incorrectly configured to pay $0 for each trip charge and $0.01 per each mile instead of at the established non-participating rates.

- Eight of the paid claims tested for one hospital incorrectly paid when the service was contracted to pay on the reimbursement methodology known as diagnosis related group (DRG). An external tool was utilized to price the DRG payment, but the external tool did not agree to the terms of the executed provider contract.

Findings similar to 3, 4, and 5 have been repeated in this report.

C. Compliance Deficiencies

1. The plan is currently operating in the East Tennessee Grand Region with an unapproved provider manual. Additionally, a separate provider manual for Davis Vision, Inc. has never been submitted to TDCI for approval.

2. For three of the four provider agreements selected for testing for the East Tennessee Grand Region, the following deficiencies were noted:

   - A hospital provider agreement was signed in October 2001. The agreement is deemed materially out of compliance with provider agreement language requirements of Section 2-18. of the CRA for East Tennessee Grand Region since numerous language revisions have been required for provider agreements since 2001.

   - An ancillary provider agreement was signed in December 2005 using a template approved as of September 2004. The agreement is deemed materially out of compliance with provider agreement language requirements of Section 2-18. of the CRA for East Tennessee Grand Region since numerous language revisions have been required for provider agreements since September 2004.

   - A unique ancillary provider agreement was executed in June 2004. This agreement has never been submitted to TDCI for approval as a material modification of the operational documents in accordance with Tenn. Code Ann. § 56-32-103(c)(1). The agreement is deemed materially out of compliance with provider agreement language requirements of Section 2-18. of the CRA for East Tennessee Grand Region since numerous language revisions have been required for provider agreements since June 2004.

3. A physician group provider agreement was signed in May 2001 to operate in the East Tennessee Grand Region. The provider operates in both the East and Middle Tennessee Grand Regions. The agreement is deemed materially out of compliance with provider agreement language requirements of Section 2-18. of the CRA for East Tennessee Grand Region since numerous language revisions have been required for provider agreements since May 2001. This provider has not been contracted to provide services in the Middle Tennessee Grand Region, but UPRV has included this provider in its Middle Tennessee provider directory. UPRV was cautioned numerous times during the approval process for the

expansion into the Middle Tennessee Grand Region that if East Tennessee providers also provide services in the Middle Tennessee Grand Region, a separate provider agreement must be executed for each region.

4. A community mental health center (CMHC) is contracted through an approved provider agreement template; however, UPRV and the CMHC executed a separate promissory note agreement. The promissory note agreement has was not submitted to TDCI for prior approval in violation of Tenn. Code Ann. § 56-32-103(c)(1).

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

   - One subcontract for the administration of vision services in the East Tennessee Grand Region, including credentialing services and the payment of vision claims, was prior approved by TDCI in October 2004.

     - The subcontractor contracts directly with providers of vision services. UPRV has not submitted the provider agreement between the subcontractor and vision providers for prior approval.

     - The vision subcontractor's provider manual has never been submitted to TDCI for approval in violation of Tenn. Code Ann. § 56-32-103(c)(1).

     - The contract was amended in November 2004, but the amendment was not submitted to TDCI for approval in violation of Tenn. Code Ann. § 56-32-103(c)(1) and Section 2-9. of the CRA for East Tennessee Grand Region.

   - An affiliated company provides subrogation recovery services in both East and Middle Tennessee Grand Regions. No subcontract has been submitted to TDCI for prior approval which would allow the payment for these services to a related party in violation of Tenn. Code Ann. § 56-32-103(c)(1).

6. The following deficiencies were noted in the review of the internal audit function for UPRV's TennCare operations:

   - Section 2-9.m.2. of the CRA for the East Tennessee Grand Region and Section 2.22.6.2 of the CRA for Middle Tennessee Grand Region 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.

   - As of the last day of examination field work, focused reviews of compliance with the requirements of the CRAs for East and Middle Tennessee Grand Regions had not been performed by Internal Audit. The Annual Audit plan

submitted by UPRV to the TennCare Bureau indicated an internal audit has been scheduled in January 2008.

- The Annual Audit Plan reported that the results of various audits performed will be reported to the Compliance Officer and the Chief Financial Officer at the Tennessee plan. The results of the various audits should also be presented timely to UPRV's board of directors.

7. When UPRV requests funding for medical claims processed in the East Tennessee Grand Region, it requests from the TennCare Bureau the cash to be paid at the time of processing plus any amounts of withholds computed. The request of the withhold is a violation of Section 3-10.h.2.(b) of the CRA for the East Tennessee Grand Region, since the funds are not released to providers within 24 hours. In addition, Section 3-10.h.2.(d) of the CRA for the East Tennessee Grand Region states interest generated by funds on deposit for provider payments related to the non-risk agreement period shall be the property of the State. UPRV should remit to the TennCare Bureau all interest earned from all withholds held for TennCare operations for the East Tennessee Grand Region related to dates of service since July 1, 2002, the beginning of the non-risk operations.

8. Funds related to outstanding checks for payments related to the non-risk agreement period are maintained in an interest bearing account. UPRV has failed to remit to the TennCare Bureau the interest earned on these funds in violation of Section 3-10.h.2.(d) of the CRA for the East Tennessee Grand Region. This finding was previously noted in the prior examination by TDCI and remains uncorrected.

9. UPRV has not complied with Section 2-10.h.4. of the CRA for East Tennessee Grand Region and Section 2.21.10.2 of the CRA for the Middle Tennessee Grand Region that require UPRV's external auditor to execute an agreement with the Comptroller of the Treasury. The agreement must be submitted on the standard "Contract to Audit Accounts".

10. Focused reviews of compliance with conflict of interest requirements of the CRAs for the East and Middle Tennessee Grand Regions had not been performed as of the last day of examination field work.

Findings similar to 2, 3, 4, 5 and 6 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. 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.)

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. (See Section VII.A.)

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.

   (See Section VII.A.)

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. (See Section VII.C.)

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. (See Section VII.C.2.)

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 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.

(See Section VII.C.2.)

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.

(See Section VII.F.)

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.

   (See Section VII.G.)

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.

   (See Section VII.H.)

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”.

(See Section VII.L.)

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.

   (See Section VIII.A.)

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.

(See Section VIII.B.)

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).

   (See Section VIII.B.)

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.

   (See Section VIII.C.)

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).

   (See Section VIII.C.)

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 2.12.9.48 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.

   (See Section VIII.E.)

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.

   (See Section VIII.G.)

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.

(See Section VIII.I.)

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.

   (See Section VIII.L.)

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 NAIC 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, 2009, UPRV reported $814,058,107 in admitted assets, $546,062,318 in liabilities and $267,995,789 in capital and surplus on the 2009 Annual Statement submitted March 1, 2010. UPRV reported total net income of $76,327,723 on the statement of revenue and expenses. The 2009 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 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 requirements required by TDCI, including but not limited to Tenn. Code Ann. § 56-32-112. Additionally, Section 2.21.6.3.2. of the CRAs require the minimum net worth to be recalculated for the implementation of the CHOICES program in the Middle Tennessee Grand Region on March 1, 2010. CHOICES is TennCare's program for long-term care services including care in a nursing home and certain services to help a person remain at home or in the community. The minimum net worth shall be based upon projected premiums for CHOICES and non-CHOICES members.

TennCare Payments Received for the Examination Period

For the examination period January 1 through December 31, 2009, the following is a summary of TennCare payments received as defined by UPRV:

East Tennessee Grand Region – Non-Risk	$ 47,137,223	
Performance Bonus	1,248,585	
Total reimbursements and other payments for TennCare non-risk operations		$ 48,385,808
East Tennessee Grand Region – At-Risk Monthly Capitation Payments		429,956,801
Middle Tennessee Grand Region Monthly Capitation Payments		585,113,777
West Tennessee Grand Region Monthly Capitation Payments		417,800,994
Total Payments Received from TennCare for the period January 1 through December 31, 2009		$1,481,258,383

Statutory Net Worth Calculation

As of March 1, 2010, the 2010 projected premiums for CHOICES in the Middle Tennessee Grand Region and projected premiums for non-CHOICES members in all regions is $1,748,714,530. As of December 31, 2009, reported premiums

by UPRV for operations other than TennCare were $892,626,716. The total premium basis to be utilized for the enhanced statutory net worth calculation as of December 31, 2009 was $2,641,341,246. Therefore, the enhanced statutory net worth requirement for December 31, 2009 was $43,370,119. UPRV's reported net worth at December 31, 2009, was $267,995,789 for an excess net worth of $224,625,670.

2. Restricted Deposit

Section 2.21.6.4. of CRAs for the East, Middle, and West Tennessee Grand Regions require MCOs to have on deposit an amount equal to the calculated statutory 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. 56-32-212 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 2010 projected premiums for CHOICES in the Middle Tennessee Grand Region and projected premiums for non-CHOICES members in all regions, the calculation 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 the NAIC financial statement filing date of March 1, 2010 is $29,980,718 based upon 2010 projected premiums for CHOICES in the Middle Tennessee Grand Region and projected premiums for non-CHOICES members in all regions of $1,748,714,530. UPRV currently had on file as of March 1, 2010 with TDCI safekeeping receipts totaling $35,900,000.

3. Claims Payable

As of December 31, 2009, UPRV reported $253,290,037 claims unpaid on the 2010 NAIC Annual Statement. Of the total claims unpaid reported, $186,772,551 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, 2009, through December 31, 2010, for dates of services before January 1, 2010, 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 2.30.14.2.1 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, 2010 for the period ending December 31, 2009 originally reported MLRs of 87.89% for the East Tennessee Grand Region, 86.07% for the Middle Tennessee Grand Region, and 88.98% for the West Tennessee Grand Region. TDCI reviewed the MLR reports for the same period ending December 31, 2009 but submitted on November 21, 2010. UPRV reported adjusted MLRs of 83.59% for the East Tennessee Grand Region, 81.27% for the Middle Tennessee Grand Region, and 83.74% 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. No discrepancies were noted during the review of documentation supporting the amounts reported on the MLR.

D. Management Agreement

UPRV is a wholly-owned subsidiary of UnitedHeathcare Services Company of the River Valley, Inc. (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 monthly per member per month rate. UBH is a related party to UPRV. The management agreements were previously approved by TDCI and the TennCare Bureau.

During financial test work, it was noted that 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.

Management Comments

Management agrees that the transfer of credit balances due to UPRV from medical providers is not explicitly defined in the management agreement. The management agreement does include the following under Article III Duties of the Parties, approved by TDCI October 23, 2008:

…shall provide the following services on behalf of United [UPRV] and be solely responsible financially for the costs associated therewith during the term of this Agreement:

A. Supervision and maintenance of computerized management information systems, related services and records, including claims processing, enrollment and premium billing functions, making payments to providers and other related administrative activities;

B. Development and implementation of standardized contract templates for United's relationships with providers;

H. Marketing, sales, provider relations, utilization management, member services and medical services functions; provided, however, that UHS understands and agrees it shall be strictly prohibited from engaging in any direct marketing to Covered Persons in performance of the services set forth in this subsection H and subsections I and K herein.

UPRV will submit an amendment to the management agreement that documents the assumption of responsibility for asset recovery among the functions performed by the management company on behalf of UPRV.

E. Schedule of Examination Adjustments to Capital and Surplus

As result of the examination procedures for the review of TennCare operations, no adjustments are recommended to Capital and Surplus for the period ending December 31, 2009.

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 2-9.m.1 of the CRA for the non-risk East Tennessee Grand Region 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). TDCI also tests prompt pay compliance for each CRA executed with TennCare. UPRV has four (4) CRAs: a non-risk CRA for the East Grand Region and full risk CRAs for the East, Middle and West Grand Regions.

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 Section 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 table represents the results of prompt pay testing for all TennCare claims processed by UPRV and its subcontractor for vision claims.

UPRV All TennCare Operations	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2009	98%	99.8%	**Yes**
February 2009	99%	99.7%	**Yes**
March 2009	98%	99.5%	**Yes**
April 2009	99%	99.7%	**Yes**
May 2009	99%	99.6%	**Yes**
June 2009	99%	99.7%	**Yes**
July 2009	100%	99.8%	**Yes**
August 2009	99%	99.8%	**Yes**
September 2009	100%	99.9%	**Yes**
October 2009	100%	99.9%	**Yes**
November 2009	100%	99.9%	**Yes**
December 2009	99%	100.0%	**Yes**

For TennCare operations, UPRV processed claims timely in accordance with Tenn. Code Ann. § 56-32-126(b)(1).

The results of prompt pay testing concluded that separate testing for the claims processed under the full risk CRAs for the East, Middle, and West Tennessee Grand Regions and the vision subcontractor were in compliance with Tenn. Code Ann. § 56-32-126(b)(1) for the months January through December 2009. However, the following instances of noncompliance were determined for non-risk East Tennessee Grand Region claims for the period January 1 through December 31, 2009.

East Tennessee Grand Region Non-Risk	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
February 2009	97%	99.2%	**No**
March 2009	96%	98.2%	**No**
April 2009	98%	99.4%	**No**
May 2009	97%	98.6%	**No**
June 2009	97%	99.0%	**No**

It should be noted that the non-risk East Tennessee Grand Region contract with UPRV ended with dates of service December 31, 2008. The months determined as noncompliant occurred during the run-out phase of claims processing.

Management Comments

Management concurs. Additional resources have been applied to mitigate issues with timely claims processing, including detailed processing reports to ensure focused attention on timely processing, projects to reduce the pended claims inventory, and a twice-weekly review by supervisory staff to identify claims with high priority for resolution.

Additionally, the following instances of noncompliance were determined for NEMT claims for the period January 1 through December 31, 2009:

East Tennessee Non-Risk - NEMT	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
March 2009	99%	99.0%	**No**
May 2009	98%	96.8%	**No**

Management Comments

Management concurs. Additional resources have been applied to mitigate issues with timely claims processing, including detailed processing reports to ensure focused attention on timely processing, projects to reduce the pended claims inventory, and a twice-weekly review by supervisory staff to identify claims with high priority for resolution.

Verification of Prompt Pay Submissions

TDCI utilized the November 2009 claims data files previously submitted by UPRV for prompt pay compliance to select claims for testing. TDCI judgmentally selected 115 claims from the November 2009 prompt pay data file submissions. The information submitted on the prompt pay data files was compared to the data contained in the claims processing system and the claim submitted by the provider. The following deficiencies related to the prompt pay data files were noted during the comparison.

- 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. For each request for prompt pay data files TDCI includes a file layout specification. The specification includes a requirement for a claim number and a claim line number to be provided for each claim. 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. Fully capitated claims are considered by TDCI to always have been paid within 30 days. Since UPRV has incorrectly reported claims as fully capitated, UPRV's previously calculated prompt pay compliance percentage could be inflated. UPRV should correctly report each service line claim status in the prompt pay data file.

Management Comments

Management agrees with the finding. A review of reporting logic was conducted, and corrections have been completed as of September 2010. Claims with missing service lines represented non-emergent transportation claims (NEMT). Some behavioral health claims were identified as capitation, when the funding had actually changed to reimburse as fee for services. Neither of these changes is believed to have significant impact upon the outcome of the prompt pay calculations.

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,
- 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 require that 97% of claims are paid accurately upon initial submission. UPRV was required to submit quarterly a claims payment accuracy report 30 days following the end of each quarter until September 30, 2009. Starting in October 2009, the claims payment accuracy reports are to be submitted monthly. The following table represents claims payment accuracy percentages reported by UPRV for the examination period January 1, 2009 through December 31, 2009.

All Claims	East	West	Middle
1st Quarter 2009	96.35%	96.73%	98.65%
2nd Quarter 2009	97.91%	95.69%	98.84%
3rd Quarter 2009	97.87%	97.54%	98.69%
October 2009	97.47%	100.00%	97.06%
November 2009	97.50%	98.13%	96.25%
December 2009	97.00%	97.50%	98.50%

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

Management Comments

Management concurs. Additional resources have been applied to mitigate issues with claims payment accuracy. These resources include remediation training and performance management with individual claims processors, as well as pursuit of system enhancements to allow additional types of claims to auto-adjudicate and thus eliminate manual errors.

Additionally Section A.19.5.2 of the CRAs of the East, Middle, and West Tennessee Grand Regions require 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 the following NEMT claims payment accuracy percentages for the examination period:

NEMT Claims	East	West	Middle
1st Quarter 2009	99.71%	99.52%	99.44%
2nd Quarter 2009	99.58%	99.76%	99.61%
3rd Quarter 2009	99.37%	99.86%	99.55%
4th Quarter 2009	99.84%	99.83%	99.68%

UPRV reported compliance with NEMT claims payment accuracy requirements of 97% for all regions for the examination period January 1 through December 31, 2009.

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 to 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 2009 fourth

quarter claims payment accuracy reports for all regions. Thirty-two claims reported as errors on the 4th Quarter 2009 claims payment accuracy report were selected for verification by TDCI and 19 claims reported as accurately processed by UPRV were also 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.

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

UPRV reported 32 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.

Management Comments

Management agrees with this finding. Both of these claims have been corrected. A monthly control has been implemented, to ensure that all claims with identified errors are reprocessed.

Also, 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 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.

Management Comments

Management concurs with some findings regarding Claims Payment Accuracy (CPA) testing, while disagreeing with the finding regarding the independence of Quality staff conducting the testing.

- *UPRV does not include vision claims processed by our subcontractor, Spectera, Inc., in the calculation of CPA; however, the results of the vision claims payment accuracy testing is reported as an independent measure to state oversight agencies. Based upon discussion with the Bureau of TennCare, TennCare is agreeable to UPRV conducting oversight of the Spectera claims payment accuracy testing process, and continuing the process of independent reporting. We have received approval from the Bureau of TennCare that the current process meets the requirements and expectations of this section.*

- *The Contractors Risk Agreement in Section 2.22.6.2 states "The report shall be based on an audit conducted by the CONTRACTOR. The audit shall be conducted by an entity or staff independent of claims management…"*

  As noted during the audit, Management believes that UnitedHealthcare Plan of the River Valley, Inc. (UPRV) is compliant with the intent of the claims payment accuracy requirement contained in Section 2.22.6.2 of the CRA. Claims payment accuracy reports are prepared by the Business Process Quality Management (BPQM) Department. This Department is responsible for programmatic management of processes and functional quality for UnitedHealth Group and is independent of the claims transactions Department.

  The BPQM Department, as part of its operational quality review audits Claims, Appeals, Calls (Member, Broker/Employer and Provider), Case Installation and Eligibility/Billing and Commissions, and Data Entry/Keying based on key quality metrics. The BPQM team audits certain business processes to ensure each of the departments listed above are achieving a high level of consistency and quality in its measurement system. The BPQM team performs the required evaluations to understand the functional quality at the corporate, platform, and individual levels and partners with the business to develop remediation plans to eliminate quality defects.

  In addition to the independent review of claims by the BPQM team via the Claims Payment Accuracy process, UHG Internal Audit routinely audits and monitors the BPQM processes through various internal audits and

SOX 404 testing to ensure the BPQM Payment Accuracy processes are appropriately designed and operating effectively. Internal Audit also conducts a TennCare Contract Compliance audit on a periodic basis. This audit ensures the Company's control environment is operating effectively to meet the objectives and goals for each function tested as well as validating the economical and efficient use of resources. Testing of functions does include the claims payment accuracy process that is conducted by the BPQM team. Copies of the most recent internal audit were shared during the market conduct on-site.

- *Management has discussed the separation of the BPQM testing and claims processing functions with the Bureau of TennCare. We have received approval from the Bureau of TennCare that the current process meets the requirements and expectations of this section.*

- *Management concurs that results for each attribute tested are not maintained, and wishes to provide clarification. There is an attribute checklist in place that BPQM staff utilizes to conduct the claims payment accuracy testing. Management acknowledges that individual attribute results are not retained; however, every claim is validated against the individual attributes within the checklist. A systematic notation is made on every claim indicating that the checklist was used. This notation is retained in the database for each claim and can be provided for verification purposes. We are investigating options to enhance our retention systems.*

- *Management agrees that for the time period of testing, procedures did not confirm the allowed payment to the amount defined in the providers' contract. The End to End (E2E) program was implemented in November 2010, and is a second review of a subset of the claims previously reviewed by the quality staff. This review is completed six months post processing to determine the impact of factors such as updated provider contracting, incorrect loading of a provider contract, and updated benefit information have on the processing accuracy of the original claim. There is a comparison of the provider contract to the processing outcome of the sampled claim as a component of the E2E program.*

TDCI Rebuttal

The Bureau of TennCare granted the deviation from the CRA requirements for claims payment accuracy preparation after examination fieldwork by TDCI.

D. <u>Claims Selected For Testing From Prompt Pay Data Files</u>

As previously mentioned, medical and NEMT claims are processed by the parent of UPRV, United Healthcare Inc. Vision claims are processed by the subcontractor and related party, Spectera, Inc.

TDCI utilized the November 2009 claims data files previously submitted by UPRV for prompt pay compliance to select claims for testing. 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 November 2009 data files included 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.

The claims judgmentally selected for testing by TDCI included, but were not limited to, high dollar paid claims, claims with the top occurring denial reasons, and adjusted claims. The number of claims selected for testing was not determined statistically. The results of testing are not intended to represent the percentage of compliance or non-compliance for the total population of claims processed by UPRV. The following represents the total number of claims selected for testing by processor:

- 90 claims for enrollees in the risk East, Middle, and West Tennessee Grand Regions
- 10 claims for enrollees in the non-risk East Tennessee Grand Region
- 10 claims submitted in the separate NEMT data file
- 5 vision claims processed by Spectera, Inc.

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.

F. Adjudication Accuracy Testing

The purpose of adjudication accuracy testing is to determine if claims selected were properly paid, denied, or rejected. 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. UPRV indicated coordination of benefits (COB) is a manual process. 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 claim the denial reason communicated was "non-allowed charge." However, a more appropriate denial would have explained that the procedure code billed did not relate to the diagnosis code reported.

    - For one claim, the denial reason communicated was "payment adjustment/billing error." However, a more appropriate denial would have explained that the transportation provider should not bill for in-county mileage.

- 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. The claim originally denied only for "claim may be covered by COB (coordination of benefits)." The claim was resubmitted by the provider and was denied for "no valid authorization." The claim was submitted a third time and paid properly. Tenn. Code Ann. § 56-32-126(b)(1) requires UPRV to inform "the provider that a claim has been either partially or totally "denied" and specify all known reasons for denial." UPRV should provide all known denial reasons on the first denial of the claim.

- 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. Timely filing limits for retro active eligibility are not measured from the date of service but rather the date eligibility is added by TennCare.

Management Comments

Management concurs with the findings, and offers the following clarifications of actions taken as a result.

Provider Agreements

- *UPRV agrees that executed copies of all provider agreements should be maintained, and has developed corrective actions to ensure that fully*

executed agreements are housed in a central location. This process improvement was implemented for agreements executed beginning in calendar year 2008.

Claims Processing

- *Management concurs with the claims processing errors which were identified during testing. These errors represent both processor errors, and opportunities to enhance our claims payment system for auto-adjudicated claims. Manual errors are addressed with remediation training, on both an individual processor and team level. A formalized performance management program is in place, aimed at identifying processors achieving below standard results and improving their performance. System enhancements have been identified and are being implemented to increase accuracy, and intermediate actions have been taken to provide immediate improvements. For example, a manual claim payment process was implemented in 2010 and is currently serving to mitigate the issue of inappropriate denials for timely filing on retroactive enrollment while an automated solution is implemented.*

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.

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.

Management Comments

Management concurs with the findings, and is conducting a process review to determine where additional controls should be added on the system price rules.

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 the top 100 enrollees by accumulated copayments for the period January 1, 2009 through December 31, 2009. The listing was reviewed for unusual copayments applied to individual claims. A copayment amount was determined as unusual if it does not match the copayments amounts required in the CRAs. 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.

Management Comments

Management concurs. The claims represent processor errors, and one opportunity to review a systematic correction to batch adjudication.

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

The purpose of analyzing cancelled checks 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 five cancelled checks from claims tested. 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 June 30, 2010, 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, as well as subcontractors, indicate a total of 254 claims exceeding 60 days in process. No material liability exists for claims over 60 days.

L. Electronic Claims Capability

Section 2-9.m.3. of the non-risk CRA for the East Tennessee Grand Region states, "The CONTRACTOR shall provide the capability of electronic billing." Section 2.22.2.2 of the CRAs for the East, Middle and West Tennessee Grand Regions state, "The CONTRACTOR shall have in place, an electronic claims management (ECM) capability that accepts and processes claims submitted electronically..." The electronic billing of claims allows the MCO to process claims more efficiently and cost effectively.

The Health Insurance Portability and Accountability Act, Title II (HIPAA) requires that all health plans be able to transmit and accept all electronic transactions in compliance with certain standards as explained in the statute by October 15, 2002. The U.S. Department of Health and Human Services extended the deadline until October 15, 2003, for health plans requesting additional time. Failure to comply with the standards defined for the transactions listed can result in the assessment of substantial penalties.

UPRV accepts and processes claims submitted electronically. These claims can be rejected by UPRV for accuracy and compliancy requirements. Rejected claims are returned with a rejection reason code transmitted to the provider's electronic clearinghouse. TDCI and the TennCare Bureau reviewed the rejection code reasons in relation to the approval of UPRV's provider manual during the examination period. 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".

UPRV responded to TDCI and the TennCare Bureau on December 11, 2009 and stated, "Appropriate identification of a member must be made so that the payer can

assign the claim to the member's record in the claims payment system. A process that utilizes the member ID, full name, date of birth and gender is used to assist in identifying the member. When multiple errors in these fields occur (example the member's social security number used instead of member ID and wrong date of birth) the system cannot identify the member. Therefore a rejection must be made since adequate information to match to the member was not supplied. There is special processing that does allow newborn claims to come in and are worked manually to accommodate the newborn rules."

Additionally UPRV updated comments on March 26, 2010 and stated, "Format & structure are edited through the Clearinghouse. Code sets relevant to claims adjudication are handled through the FACETS claims processing system. To follow up on error codes 22, 26 & 33, no claim would be rejected for member eligibility. It would be rejected if we were unable to find the member in our AmeriChoice system meaning they were not found as having ever been a member or currently a member of the AmeriChoice plan. That could happen if in fact they had never been a member, weren't currently a member or a significant amount of data was incorrect on the claim causing the system to not locate the member. If a member was found in the system, but not eligible at the time of date of service, the claim would be denied with appropriate reason and not rejected."

UPRV should review all rejection reasons to ensure claims are rejected for appropriate compliancy standards which include HIPAA compliance standards (Levels 1-7), National Provider Identifier and Taxonomy information for Rendering, Attending and Billing providers, and appropriate information to support J-codes procedures.

Management Comments

Management concurs with the findings, and offers the following clarifications of actions taken as a result.

"No Medical Coverage Effective for Date of Service"

- *Testing of claims which were rejected as "No Medical Coverage Effective for Date of Service" shows that these members could not be found within the UPRV system. These claims were rejected due to an error in the accuracy of the claim- membership information presented was not sufficient to match to any present or past enrollment record in the UPRV system. Without a match to a member, regardless of current eligibility status, it is not possible to process these claims to paid or deny. UPRV will review the reject message supplied for these types of claims, and correct to more accurately reflect the claim data error.*

"Duplicate Claim to Previously Submitted File or Duplicate Claim"

- *The UPRV electronic interface with the clearinghouse will be revised to comply with HIPAA duplicate claim requirements. Claims will be processed within the claim system, and will deny for duplicate submission as applicable.*

M. Mailroom and Claims Inventory Controls

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

The mailroom function is subcontracted to Firstsource Solutions USA, Inc. Claims are mailed to their Kingston, New York offices. The following responses to internal control questionnaires regarding mailroom operations noted the following controls:

- Each claim is date stamped on the date of receipt. The date of receipt is encoded on the claim during the scanning process on the same date of actual mail receipt. If scanning isn't completed on the same day as claim receipt, scanning procedures require that the actual mailroom received date is utilized, not the date the claim is scanned. Mail is delivered daily by noon, and is stamped with that day of receipt.

- The mailroom operations have extensive controls in place to ensure accurate, complete and timely processing of submitted claims. The secured facility requires a badge for entry. Inventory Control begins as soon as the work enters the facility, including electronic envelope and document counts for reconciliation. Individual document numbers are assigned to each document in order to track it through the internal system. Additionally, desktop and garbage audits are conducted to ensure that work has not been misplaced.

TDCI did not perfom a site visit of the mailroom operations during this examination. UPRV provided TDCI with an Assessment Report completed in October 2009 of the FirstSource mailroom operations by BSI Management Systems. BSI works with organizations to assess the implementation and administration of their management systems and business processes. No findings were noted in the Assessment Report. UPRV included with the Assessment Report a site visit checklist of procedures including focus areas and a summary of findings. The focus areas included:

- Facilities and Securities (including HIPAA training efforts)

- Document Destruction

- Roles and Responsibilities

- Processes

In regards to paper claims tested in the claims processing testwork in Section VII. E., F., and G. of this report, no unusual items were noted. No items were noted during review of mailroom procedures or the Assessment Report provided by UPRV. No additional testwork of mailroom procedures was considered necessary.

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.

On April 27, 2010, TDCI requested UPRV's provider complaint log for the month of December 2009. The log indicated 1,720 provider complaints were received in December 2009. The log includes for each complaint a received date, completion date, and remarks. Review of the log noted the following:

- 25 complaints did not indicate a completion date.
- 177 complaints have a resolution lag (completion date less received date) of greater than 30 days.
- 71 complaints have a resolution lag of greater than 60 days.

UPRV responded that all 25 complaints that did not report a completion date have been resolved. For claims that exceeded 30 days to resolve, UPRV indicates procedures acknowledge each claim received and informs the provider at that time that the response may take up to 60 days. For claims that exceeded 60 days, UPRV responded that it does not have a process to negotiate additional time with providers when a complaint resolution will exceed 60 days.

TDCI judgmentally selected thirteen provider complaints from the December 2009 provider complaint log for further testing. For six provider complaints, UPRV either paid or responded to the complaint within 30 days. The following deficiencies were noted for the remaining seven 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.

UPRV should enhance provider complaint procedures to ensure that:

- The provider complaint log indicates a resolution date for all resolved provider complaints.

- An acknowledgment letter is sent for all complaints which require more than 30 days to resolve.

- Complaints which require more than60 days to resolve are monitored and that providers are notified in writing of the expected response date as required by Tenn. Code Ann. § 56-32-126(b)(2)(A).

Management Comments

Management concurs. UPRV is improving both the complaint log and the tracking of issues throughout the provider complaint process to ensure a response letter is sent to providers within the requirements for Tenn. Code Ann § 56-32-126(b)(2)(A).

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 will forward 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, 2009, TDCI received and processed 234 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	71
Previous denial or underpayment partially reversed in favor of the provider	27
Responses to issues other than claims processing	35

TDCI judgmentally selected 50 UPRV provider complaints submitted to TDCI for review. For 21 of the 50 provider complaints selected, the provider complaint was received in calendar year 2010 but involved dates of service before January 1, 2010. The complaints were reviewed by analyzing 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 procedures. The detailed review of the provider complaints including TDCI questions and UPRV responses can be found in Appendix 1 of this report. The following is a summary of the significant issues in UPRV's claims processing 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 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.

The issues noted in review of provider complaints submitted to TDCI indicate several areas where improvements should be made to UPRV's claims processing systems and provider complaint and appeal procedures.

- UPRV's complaint procedures should be improved to eliminate provider complaints reversed only after submission to TDCI's complaint process.

- Errors in provider files and fee schedules should be eliminated particularly with problems noted in the relationships between individual and group provider numbers. Individual providers who are also part of a groupshould be loaded into the claims processing system as part of the provider's group for billing purposes.

- Changes to procedures codes should be updated timely.

- Responses to provider complaints should be accurate based on the information submitted by the provider with the appeal. For example, explanation and medical records submitted to support a modifier on a procedure code was not accurately considered. After the provider exhausted UPRV's provider complaint process and then submitted a complaint to TDCI, UPRV then reversed the denial based on the previously submitted information.

- Entry of authorizations should be improved. Changes made by the authorization department should be communicated timely to the claims department to prevent erroneous denials of claims.

UPRV responses to the issues addressed in the review of the provider complaint submitted to TDCI indicated the following corrective actions are being initiated:

- The complaint process is being reviewed to identify opportunities for improvement.

- Retroactive eligibility is currently a manual process but there is a project to enhance recognition of retroactive eligibility. (TDCI Comment: UPRV's system does not automatically recognize claims in which retroactive eligibility has been granted by TennCare.)

- For the review of modifiers, UPRV is looking at potential changes and improvements as necessary.

- The process to communicate authorization corrections to the claims adjustment area is a manual process that has been improved.

  Management Comments

  Management concurs with the findings, and is taking the following actions, in addition to those noted above, to enhance complaint and claims processing procedures:

  - *Process improvements are being implemented for second level review of provider complaints, including those complaints regarding timely filing and review of authorizations.*

  - *Communication of decisions back to the provider is a focus of process enhancement, to ensure a response letter is sent to providers within the requirements for Tenn. Code Ann § 56-32-126(b)(2)(A).*

  - *A detailed review of provider loading requirements is being conducted to determine where additional controls should be added.*

  - *The process to communicate authorization corrections to the claims adjustment area is a manual process that has been improved, and will be reviewed for additional opportunity to further improve performance in conjunction with provider appeals and complaints.*

Additionally, during the review of provider complaints submitted to TDCI, it was noted that 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 and 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).

Management Comments

Management concurs.

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, 2009, 50 independent reviews were initiated by providers against UPRV. The following is a summary of the reviewer decisions:

Reviewer decision in favor of the provider	12
UPRV settled with provider upon submission of the independent review	5
Reviewer decision in favor of UPRV	27
Reviewer decision in favor of UPRV in part and provider in part	3
Review request submitted by provider was ineligible	3

TDCI judgmentally selected 14 independent reviews for testing. The independent reviews were analyzed for 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 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 reviewer's decision pursuant to Tenn. Code Ann. § 56-32-126(b)(3)(C).

- Prior denial decisions were upheld on appeal when submitted by the provider through UPRV's appeal process. UPRV ultimately found the denials were incorrect during further investigation for the independent review. Examples include:

    - The corrected claim submitted during appeal did report a valid provider identification number but UPRV did not recognize the correction during the appeal.

    - An authorization had been obtained by the provider but UPRV continued deny on appeal.

  - The modifier to a procedure code submitted by the provider was correct but UPRV had delayed the loading of updated modifiers to the claims processing system.

- Claims denied incorrectly for eligibility however the members were retroactively enrolled by TennCare to include the dates of service on the claims. Determination of retroactive eligibility may be a manual process but the provider clearly demonstrated the enrollee had been retroactively enrolled with the submission of the provider appeal.

The issues noted in testing of independent review indicate several areas where improvements should be made to UPRV's claims processing systems and provider complaint and appeal procedures.

- Payments should be made within 20 days upon receipt of the reviewer's decision pursuant to Tenn. Code Ann. § 56-32-126(b)(3)(C).

- UPRV's complaint and appeal procedures should be improved to identify and correct inappropriate claims denials before they are ultimately reversed by UPRV upon the provider submisson of the denials to TDCI for independent review.

- UPRV should accurately recognize the date that the TennCare Bureau adds the enrollee to UPRV's eligibility file when determining if an enrollee is retroactively eligibile.

UPRV responses to the issues addressed in the testing of independent reviews indicated the following correction actions are being initiated:

- UPRV indicates it has initiated a "[n]ew process to streamline when responses are received, and new tracking mechanism to ensure timeliness of payment from receipt of IR directive."

- UPRV indicates that for complaint and appeal procedures, "Process is being reviewed to ensure that these issues are resolved during the dispute process."

  Management Comments

  Management concurs. Process improvements have been implemented to ensure payment to the independent reviewer as required Tenn. Code Ann. § 56-32-126(b)(3)(C). On occasion, there will be changes in the information presented by the provider during an initial denial, a complaint, and a request for review. This may necessitate a different decision by UPRV. However, the provider complaint process is being enhanced, to ensure consistency in decisions between the initial provider complaint, and any requests for

Independent Review.

Finally, during the review of provider complaints submitted to TDCI, it was noted that a subcontractor, Allied Interstate, Inc., attempted to collect on behalf of UPRV refund requests related to the determination of 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 and 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).

Management Comments

Management concurs.

D. Provider Manual

The provider manual outlines written guidelines to 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.

On October 28, 2008, TDCI and the TennCare Bureau approved separate provider manuals for UPRV and Spectera submitted by UPRV for prior approval. On February 8, 2010, TDCI and the TennCare Bureau approved an amended provider manual submitted by UPRV for prior approval during the examination period.

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, the TennCare Bureau has defined through contract with the HMO minimum language requirements to be contained in the agreement between the HMO and medical providers. These minimum contract language requirements include, but are not limited to: standards of care, assurance of TennCare enrollees' rights, compliance with all federal and state laws and regulations, and prompt and accurate payment from the HMO to the medical provider.

Per Section 2.12.2 of the CRAs for the East, Middle, and West Tennessee Grand Regions, all template provider agreements and revisions thereto must 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. Additionally,

Section 2.12.7 of the CRAs for the East, Middle, and West Tennessee Grand Regions report the minimum language requirements for provider agreements.

A total of sixteen executed provider agreements from East, Middle and West Tennessee providers were judgmentally selected for testing from the provider network directory files submitted by UPRV directly to the TennCare Bureau.

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 2.12.9.48 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. (Cherokee, Volunteer, Southeast Emergency Physician, CRNA Associates, Centerstone, St. Francis, Southeast Mental Health Center)

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

- For three provider agreements, the executed contracts were amended; however, the amendments were never submitted by UPRV to TDCI for approval. (Youth Village, Frontier Health and Vanderbilt Medical Group)

- 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. (Jennifer Utley West TN Healthcare)

UPRV should review all provider agreements to determine if they meet the appropriate language requirements of Section 2.12.7 of the CRAs for the East, Middle, and West Tennessee Grand Regions. Provider agreements, including all attachments and exhibits, should always be submitted to TDCI for approval prior to execution by UPRV. UPRV should review statutory requirements of Tenn. Code Ann. § 56-32-103 and appropriately file for prior approval any material modifications to UPRV's certificate of authority.

Management Comments

Management concurs with the findings, and offers the following clarifications of actions taken as a result.

A process has been developed to ensure that any non-standard non-approved language requests are reviewed by the Compliance Department prior to execution. If the language has not been prior approved by TDCI, the agreement is filed for approval. Once TDCI approval has been received, a stamped copy of the approved language notification from TDCI is stored in the provider agreement file. If the proposed non-standard language is not approved, UPRV will advise the provider and not allow the language to be entered into the agreement. The VP Network Management will require a copy of the stamped notice from TDCI approving the non standard language prior to countersigning any provider agreement with non-standard language.

F. Provider Payments

Capitation payments to providers were tested during 2009 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 require all subcontractor agreements and revisions thereto 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.

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. (Alpha-Maxx)

- For two medical management subcontracts, the executed subcontracts contain exhibits that do not agree to the prior approved exhibits by TDCI. (Care Core and Nurses for Newborns)

Subcontract agreements, including all attachments and exhibits, should always be submitted to TDCI for approval prior to execution by UPRV. UPRV should review statutory requirements of Tenn. Code Ann. § 56-32-103 and appropriately file for prior approval any material modifications to UPRV's certificate of authority.

Management Comments

Management concurs.

H. Non-discrimination

Section 2-24. of the CRA for the non-risk East Tennessee Grand Region and 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 June 2008 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 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.

Management Comments

Management does not agree with this finding.

The Contractors Risk Agreement in Section 2.22.6.2 states "The report shall be based on an audit conducted by the CONTRACTOR. The audit shall be conducted by an entity or staff independent of claims management…"

As noted during the audit, Management believes that UnitedHealthcare Plan of the River Valley, Inc. (UPRV) is compliant with the intent of the claims payment accuracy requirement contained in Section 2.22.6.2 of the CRA. Claims payment accuracy reports are prepared by the Business Process Quality Management (BPQM) Department. This Department is responsible for programmatic management of processes and functional quality for UnitedHealth Group and is independent of the claims transactions Department.

The BPQM Department, as part of its operational quality review audits Claims, Appeals, Calls (Member, Broker/Employer and Provider), Case Installation and Eligibility/Billing and Commissions, and Data Entry/Keying based on key quality metrics. The BPQM team audits certain business processes to ensure each of the departments listed above are achieving a high level of consistency and quality in its measurement system. The BPQM team performs the required evaluations to understand the functional quality at the corporate, platform, and individual levels and partners with the business to develop remediation plans to eliminate quality defects.

In addition to the independent review of claims by the BPQM team via the Claims Payment Accuracy process, UHG Internal Audit routinely audits and monitors the BPQM processes through various internal audits and SOX 404 testing to ensure the BPQM Payment Accuracy processes are appropriately designed and operating effectively. Internal Audit also conducts a TennCare Contract Compliance audit on a periodic basis. This audit ensures the Company's control environment is operating effectively to meet the objectives and goals for each function tested as well as validating the economical and efficient use of resources. Testing of functions does include the claims payment accuracy process that is conducted by the BPQM team. Copies of the most recent internal audit were shared during the market conduct on-site.

Management has discussed the separation of the BPQM testing and claim processing functions with the Bureau of TennCare, We have received approval from the Bureau of TennCare that the current process meets the requirements and expectations of this section.

TDIC Rebuttal

The Bureau of TennCare granted the deviation from the CRA requirements for claims payment accuracy preparation after examination fieldwork by TDCI.

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 for received in 2009 for the calendar year 2008.

K. Contract to Audit Accounts

UPRV is required to submit annual audited financial statements by May 1 for the preceding calendar year. Section 2-10.h.4. of the CRA for the non-risk East Tennessee Grand Region and Section 2.21.10.2 of the CRAs for the East, Middle, and West Tennessee Grand Regions require such audits to be subject to prior approval of the Comptroller of the Treasury and to be submitted on the standard "Contract to Audit Accounts" agreement. The "Contract to Audit Accounts" between the Comptroller of the Treasury and the external auditor defines the standards for which the audits are to be performed. UPRV has complied with this provision.

L. Conflict of Interest

Section 4-7. of the CRA for the non-risk East Tennessee Grand Region and 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 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; however, during the testing of provider agreements, it was discovered that one agreement did not have the required conflict of interest language.

Management Comments

Management concurs with the findings, and offers the following clarifications of actions taken as a result.

A process has been developed to ensure that any non-standard non-approved language requests are reviewed by the Compliance Department prior to execution. If the language has not been prior approved by TDCI, the agreement is filed for approval. Once TDCI approval has been received, a stamped copy of the approved language notification from TDCI is stored in the provider agreement file. If the proposed non-standard language is not approved, UPRV will advise the provider and not allow the language to be entered into the agreement. The VP Network Management will require a copy of the stamped notice from TDCI approving the non standard language prior to countersigning any provider agreement with non-standard language.

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.)

Complaint 2009.060 - Claim denied on first submission for invalid NPI (National Provider Identification number). A corrected claim was submitted with a legible NPI but claim still denied invalid NPI. UPRV reversed decision in response to provider complaint.

- UPRV Response: The corrected claim had a valid NPI number on it which allowed us to process for payment.

Complaint 2009.201 - Claim denied on first submission for missing Medicaid provider number. UPRV reversed decision in response to provider complaint.

- UPRV Response: The Medicaid ID numbers for CRNAs for this provider were not loaded in our system correctly, causing claims to deny.

- TDCI Follow up questions: Explain why provider numbers were not loaded.

  - UPRV Comments/Follow ups: The provider's MDs were loaded to the system; however, the individual CRNAs were not. As a result, claims submitted by the CRNAs were not processed under the group's contract. A project was done to load the CRNA's individually, and to reprocess claims that were impacted.

Complaint 2009.247 - Claims were incorrectly paid to the hospital instead of the physician. UPRV reversed decision in response to provider complaint.

- UPRV Response: The hospital name was entered into the system in error so the checks were made out to the hospital but mailed to the doctor.

Complaint 2009.260 - Provider complains no payment during the credentialing process by UPRV. TDCI requested UPRV to explain how long it took to credential the provider. UPRV reversed decision in response to provider complaint.

- UPRV Response: Contracts were mailed on 04/28/2009 and upon receipt of a correctly executed contract; provider was loaded into our system with a 05/27/2009 effective date.

Complaint 2009.279 - Claim denied on first submission for failure to submit provider identification number. Second submission denied for timely filing. UPRV reversed decision in response to provider complaint.

- UPRV Response: Provider was not required to resubmit; claim was processed and paid.

- TDCI Follow up questions: Was the system corrected to properly recognize the provider identification number?

    - UPRV Comments/Follow ups: The provider's data in the claims processing system was standardized, allowing appropriate claims reimbursement. A project was conducted to correct impacted claims.

Complaint 2009.312 - Procedure codes were incorrectly denied for payment. UPRV reprocessed 75 claims. UPRV reversed decision in response to provider complaint.

    - UPRV Response: The wrong fee schedule was loaded for this provider.

Complaint 2009.332 - Claim denial on first submission not clear from remittance advice. UPRV had requested a consent form. UPRV reversed decision in response to provider complaint.

    - UPRV Response: The original denial was for lack of consent form; this was for an ASH procedure that requires a consent form; upon receipt of consent, claim was processed and paid.

Complaint 2009.344 - Claim denied on first submission for missing Medicaid identification number. Resubmission was denied for exceeding timely filing limits. UPRV failed to recognize NPI reported correctly on the claim. UPRV reversed decision in response to provider complaint.

    - UPRV Response: There was no second claim; the original claim was closed incorrectly for NPI issue; it was processed and paid as a new claim.

Complaint 2009.369 - UPRV paid claim initially to the wrong provider for dates of service from 9/8/2008 to 8/9/2009. TDCI asked why it took so long to pay the correct provider. UPRV reversed decision in response to provider complaint.

    - UPRV Response: Provider complaint was received 08/07/2009; request for manual check was sent 08/20/2009; check was mailed 08/25/2009.

- TDCI Follow up questions: Why are phone calls not taken as seriously as written complaints to TDCI? What does your provider complaint log show for this issue?

    - UPRV Comments/Follow ups: Documentation from the provider is required for reissuing checks, as a program integrity measure. We are reviewing the complaint process to identify any opportunities for improvement. Complaint log record enclosed. (Screen shot of the complaint was submitted to TDCI).

Complaint 2009.375 - UPRV paid one procedure on a claim but denied second procedure even though procedure was filed with modifier 59. This modifier is an indication of a separate procedure. UPRV reversed decision in response to provider complaint.

  - UPRV Response: After review it was determined that the CCI (Correct Coding Initiative) edit should be overridden and claim paid.

- TDCI Follow up questions: Explain CCI edit requirements.

  - UPRV Comments/Follow ups: The provider included enough information with the complaint to justify payment; however, the underlying CCI edit was appropriate in the absence of additional documentation for this claim.

Complaint 2009.376 - Claim was denied for exceeding timely filing limits. UPRV reversed decision in response to provider complaint.

  - UPRV Response: Claim was denied for timely filing as claim was received more than 120 days since date of service.

- TDCI Follow up questions: Provider did not send in the documentation to UPRV to prove timely filing but to TDCI with the provider complaint. Why didn't UPRV perform a clearinghouse trace?

  - UPRV Comments/Follow ups: While the edi trace can be accessed in the health plan's system, our process for review of provider disputes to timely filing requires that the provider submit documentation of the edi trace. The provider's responsibility to include this information with the dispute is noted in the provider manual.

Complaint 2009.385 - Anesthesia provider indicates claim denied for no authorization but claims related to same service to the hospital have been paid without authorization. UPRV reversed decision in response to provider complaint.

  - UPRV Response: Claim was denied for no auth/no referral as it was originally processed under provider name; this was an anesthesia claim that should have been submitted, processed, and paid under group name/id.

- TDCI Follow up questions: Explain why provider numbers were not loaded.

  - UPRV Comments/Follow ups: The provider's MDs were loaded to the system; however, the individual CRNAs were not. As a result, claims submitted by the CRNAs were not processed under the group's contract. A project was done to load the CRNA's individually, and to reprocess claims that were impacted.

Complaint 2009.392 - Claims for mother and baby are denied. UPRV reversed decision in response to provider complaint.

  - UPRV Response: Claim was denied for lack of precert; it was for inpatient services; there was no precert for mom's admission to the hospital as mom was not an AMC member.

- TDCI Follow up questions: How are mother/baby claims handled?

    - UPRV Comments/Follow ups: When a mother is not enrolled with us, we do not have a trigger to authorize inpatient stay for the newborn without the facility requesting the auth. However, our claims processors manually review the claim and over-ride the authorization requirement if the DOS is less than 4 days from DOB, or if the baby is noted as retro enrolled.

Complaint 2009.393 - Provider indicates payments were incorrectly sent to the wrong bank lock box. UPRV reversed decision in response to provider complaint.

    - UPRV Response: The check was mailed to the wrong provider, not the wrong lockbox. That provider also cashed the checks and there was nothing on the back of the check to show who cashed it, so provider had to complete the affidavit process. There was also a delay in getting the forms back to AMC to complete the affidavit process.

Complaint 2009.428 - Provider complains about the inability to get payment from UPRV. Issues appear related to whether provider credentialed timely (same as complaint #2009.260). UPRV reversed decision in response to provider complaint.

    - UPRV Response: Contracts were mailed on 04/28/2009 and upon receipt of a correctly executed contract, provider was loaded into our system with a 05/27/2009 effective date.

Complaint 2009.439 - UPRV sought refunds to incorrect payments to an Anesthesia provider. UPRV reversed decision in response to provider complaint.

    - UPRV Response: The claims were originally paid to the individual provider and not the group; payments recouped and processed to the group; there are different fee schedules for the group and the individual.

- TDCI Follow up questions: Explain the incorrect payments to individuals versus group.

    - UPRV Comments/Follow ups: The provider's MDs were loaded to the system; however, the individual CRNAs were not. As a result, claims submitted by the CRNAs were not processed under the group's contract. A project was done to load the CRNA's individually, and to reprocess claims that were impacted.

Complaint 2009.461- Claim denied on first submission. Provider resubmitted with medical records attached. UPRV denied on resubmission with the explanation "The new information was considered, however additional payment cannot be issued. Please review the info listed for the explanation". Denial reason confusing since no payment was ever issued. UPRV reversed decision in response to provider complaint.

- UPRV Response: Claim denied originally for lack of consent form; second denial was for invalid/incorrect consent form as the consent form had errors.

Complaint 2009.478 - Claim was incorrectly denied for incorrect provider identification number. Resubmission was denied for exceeding timely filing limits. UPRV reversed decision in response to provider complaint.

- UPRV Response: Original claim denial was in error so resubmitted claim was not needed; original claim was reprocessed.

- TDCI Follow up questions: Were other claims affected and reprocessed for this provider?

  - UPRV Comments/Follow ups: The provider's load was corrected, and claims were identified and worked as a project to ensure appropriate payment to providers.

Complaint 2009.483 - Claim incorrectly denied for invalid procedure code. UPRV reversed decision in response to provider complaint.

- UPRV Response: Code 43239 was the invalid procedure code.

- TDCI Follow up questions: Why did system originally deny procedure code 43239 as invalid at the date of service? Are there other claims that denied for this reason when they shouldn't have?

  - UPRV Comments/Follow ups: AmeriChoice will initiate process to identify any others claims impacted by denial.

Complaint 2009.495 - Claim denied a procedure as "bundled" (payment covered under the payment of another procedure on the same claim). Provider included modifier 59 on the second submission but denied again for bundled. Medical records attached on third submission to support modifier 59. Claim denied by UPRV on third submission for exceeding timely filing of 120 days. UPRV reversed decision in response to provider complaint.

- UPRV Response: The claim received on 09/30/2009 was more than 120 days after date of service 04/13/2009; submissions of 07/14 and 08/06 were within 120 days.

Complaint 2009.501 - Emergency room claim by an out-of-network provider denied for no authorization. UPRV reversed decision in response to provider complaint.

- UPRV Response: Initial request for retro auth was denied as member was not retro eligible and claim was for OP services. After additional review, claim was paid with no auth as it was ER service.

- TDCI Follow up questions: Did it require a processor to override? Was it a manual error?

- UPRV Comments/Follow ups: The claim was auto adjudicated. It correctly denied via the system's processing, as the claim was filed with POS 22- Outpatient. Outpatient services by non-par providers must be prior authorized, and the member was not retro-enrolled, thus triggering a retroactive review for authorization. The claim should have been filed with the correct POS 23- ER.

Complaint 2009.552 - Provider requested retroactive authorization for services already performed. UPRV reversed decision in response to provider complaint.

- UPRV Response: Complaint on this member was for 10 different claims; they were denied because the auth request was for a different service than what billed; auth was loaded on 08/18/09 for 08/04/07-01/21/08 as part of auth project with the provider.

- TDCI Follow up questions: Is the provider able to get authorization properly completed now?

    - UPRV Comments/Follow ups: Provider has no issues with authorizations of services at this time.

Complaint 2009.557 - Claim denied with a date of service of 3/25/09 for medical necessity. On 3/23/2009 eligibility was effective retroactive to 1/15/2009. Claim filed on 5/29/09. Provider should have sought an authorization for the service. Retroactive eligibility process by UPRV is a manual process but currently there is a project to enhance recognition of retroactive eligibility. UPRV reversed decision in response to provider complaint.

- UPRV Response: Member was technically not retro eligible but due to short amount of time between approval of eligibility and date of service, claim was paid.

Complaint 2009.567 - Anethesia claims by a CRNA were denied. Provider appealed decision and submitted medical records. UPRV reversed decision in response to provider complaint.

- UPRV Response: Claim initially denied lack of consent form (TC-ASH); upon review, claim for ASH portion of procedure was paid; ASA charges for delivery were paid originally.

- TDCI Follow up questions: Is the provider able to get authorization properly completed now?

    - UPRV Comments/Follow ups: We are reviewing the existing dispute processes for improvement and education opportunities.

Complaint 2009.583 - Anesthesia claim underpaid. Provider originally filed claim under individual provider identification and not the group. UPRV reversed decision in response to provider complaint.

- UPRV Response: Claim was initially paid/processed under non par suffix for individual; after receipt of complaint, reprocessed under par group suffix.

Complaint 2009.596 - Provider complaint was the result of request by Johnson & Rountree for the recoupment of previous payments by UPRV. Johnson & Rountree performed the recoupment effort at the request of UPRV. The subcontract with Johnson & Rountree has not been submitted to TDCI or the TennCare Bureau for prior approval. The provider indicated the recoupment involved 200 claims and allowed the provider 10 days to respond. UPRV responded to the complaint that recoupment requests were suspended.

- UPRV Response: This was part of the iCES recoupment process.

Complaint 2009.620 - Provider submitted a three page claim but only page 1 and 3 were processed. Page 2 had reported an address which did not match the address known by UPRV for the provider. UPRV reversed decision in response to provider complaint.

- UPRV Response: There were 3 claims, one page each, submitted at the same time. The remittance address on the second claim did not match the address in FACETS.

- TDCI Follow up questions: What happened to the second claim
  - UPRV Comments/Follow ups: The claim was closed out, for the provider to correct.

Complaint 2009.621 - Anesthesiology claim denied because another anesthesiology claim paid the same day. Provider explained one anesthesia service was performed during OB care and second anesthesia service was performed during the delivery. UPRV reversed decision in response to provider complaint.

- UPRV Response: Second anesthesia charge was for services other than delivery done the same day which also required anesthesia.

- TDCI Follow up questions: Was interim letter to provider appropriate that said URPV would not pay for two anesthesia services on same day?
  - UPRV Comments/Follow ups: We are reviewing the existing dispute processes for improvement and education opportunities.

Complaint 2009.630 - UPRV requested a refund of payment in error. The provider sent a check to UPRV, however, UPRV still recouped the erroneous payment from the provider in the next payment due from UPRV. UPRV reversed decision in response to provider complaint.

- UPRV Response: Check sent to AMC by provider did not have any information on it identifying it as a refund.

- TDCI Follow up questions: What does UPRV do when it gets a check that UPRV does not know where the credit should apply?

- UPRV Comments/Follow ups: If we receive a check and it has no documentation attached to it, our process is to make two (2) attempts to contact the provider by phone to obtain the information. After the telephone attempts, if we are still unable to get information needed in order to apply the money, then a manual check is returned to the provider with correspondence stating the reason we returned the money.

Complaint 2010.001- Anesthesia claim was underpaid. UPRV reversed decision in response to provider complaint.

- UPRV Response: Services were rendered by CRNA who was not listed as par in our system, so provider was paid at nonpar rates

- TDCI Follow up questions: Is there a par/nonpar or individual/group issue?

  - UPRV Comments/Follow ups: The provider's MDs were loaded to the system; however, the individual CRNAs were not. As a result, claims submitted by the CRNAs were not processed under the group's contract. A project was done to load the CRNA's individually, and to reprocess claims that were impacted.

Complaint 2010.011 - Physician's claim for a newborn did not pay for services on selective days. UPRV paid for services within the first 30 days of birth but denied after the 30th day. Later, the TennCare Bureau provided an update to eligibility. UPRV reversed decision in response to provider complaint.

- UPRV Response: Claim was paid prior to filing of complaint; member was retro eligible and claim was paid when eligibility was updated.

Complaint 2010.025 - Claim was denied on first submission. Corrected claim was paid by UPRV but then recouped. An internal audit by UPRV determined claims submitted with a 59 modifier should be submitted with medical records. UPRV reversed decision in response to provider complaint.

- UPRV Response: Charge with 59 modifier was paid, then recouped as medical records were needed; claim was paid once medical records were received.

- TDCI Follow up questions: What have you done to insure that you do not pay claims with 59 modifiers without the proper medical records?

  - UPRV Comments/Follow ups: The health plan has a process in place today that reviews modifier 59 both prospectively via a pre-payment edit and on a retroactive basis. We are looking at potential changes and improvements to that process as necessary, with the goal being to ensure appropriate payment for services rendered within program integrity guidelines.

Complaint 2010.028 - Claim denied as a bundled services. Medical records were submitted to support the use of a 59 modifier but claim denied for no prior authorization. Later submission denied

for exceeding timely filing limitations. UPRV reversed decision in response to provider complaint.

  - UPRV Response: Charge with 59 modifier was denied as medical records were needed; medical records received then claim denied as it was then processed under incorrect nonpar suffix; claim was then paid under par suffix.

- TDCI Follow up questions: What have you done to insure that you do not pay claims with 59 modifiers without the proper medical records?

  - UPRV Comments/Follow ups: The healthplan has a process in place today that reviews modifier 59 both prospectively via a pre-payment edit and on a retroactive basis. We are looking at potential changes and improvements to that process as necessary, with the goal being to ensure appropriate payment for services rendered within program integrity guidelines.

Complaint 2010.033 - Anesthesia claim was underpaid. UPRV reversed decision in response to provider complaint.

  - UPRV Response: CRNA who performed services was loaded incorrectly as nonpar.

- TDCI Follow up questions: Are other claims incorrectly processed for this provider?

  - UPRV Comments/Follow ups: The provider's MDs were loaded to the system; however, the individual CRNAs were not. As a result, claims submitted by the CRNAs were not processed under the group's contract. A project was done to load the CRNA's individually, and to reprocess claims that were impacted.

Complaint 2010.034 - Anesthesia claim underpaid. UPRV reversed decision in response to provider complaint.

  - UPRV Response: CRNA who performed services was loaded incorrectly as nonpar.

- TDCI Follow up questions: Are other claims incorrectly processed for this provider?

  - UPRV Comments/Follow ups: The provider's MDs were loaded to the system; however, the individual CRNAs were not. As a result, claims submitted by the CRNAs were not processed under the group's contract. A project was done to load the CRNA's individually, and to reprocess claims that were impacted.

Complaint 2010.059 - Claim incorrectly denied on first submission for lack of prior authorization. Denied for exceeds timely filing limits on second submission. UPRV reversed decision in response to provider complaint.

  - UPRV Response: Auth was entered incorrectly causing claim to deny. Once auth was correctly entered, claim denied for timely filing; TF was then overridden and claim paid.

- TDCI Follow up questions: If authorization area noticed the error then why did they not forward to the claims area that it was their error?

    - UPRV Comments/Follow ups: Globally, we have a process in place to communicate authorization corrections to the claims adjustment area. This manual process has been improved upon as a result of the drive to increase provider satisfaction.

Complaint 2010.078 - Claim denied for exceeding timely filing limitation of 120 days. The 120th day fell on a weekend. Claim was received on the next Monday. Provider complained of other billing issues. UPRV reversed decision in response to provider complaint.

    - UPRV Response: Claim was denied for timely filing as claim was received more than 120 days after date of service.

- TDCI Follow up questions: Has this provider been satisfied? Do they still have billing issues?

    - UPRV Comments/Follow ups: Elk Valley is satisfied with the assistance that UPRV is providing on resolution of claims payment issues. We are currently working with the provider to address the single remaining issue, and their satisfaction was confirmed on January 4, 2010.

Complaint 2010.084 - Claim denied an inpatient admission. UPRV reversed decision in response to provider complaint.

    - UPRV Response: Claim denied for lack of inpatient preauth.

- TDCI Follow up questions: Why did UPRV overturn the denial?

    - UPRV Comments/Follow ups: New process to pay inpatient denials as observation implemented 01/01/2011.

Complaint 2010.094 - Anesthesiology claim denied because another anesthesiology claim paid the same day. Provider explained one anesthesia service was performed during OB care and second anesthesia service was performed during the delivery. UPRV reversed decision in response to provider complaint.

    - UPRV Response: According to medical records, separate services were provided by MD and CRNA.

- TDCI Follow up questions: This is same issue as log issue 2009.621.

    - UPRV Comments/Follow ups: Provider Load Issue. System Logic reviewed to reduce the # claims impacted.

Complaint 2010.104 - DME service denied for lack of authorization. After complaint UPRV amended the original authorization to include all DME equipment provided. UPRV reversed decision in response to provider complaint.

- UPRV Response: Initial authorization requested did not include all codes billed.

Complaint 2010.106 - Claim originally denied because address on claim did not match address known by UPRV for the provider. Later submission denied a procedure as not covered. This code is covered by TennCare. UPRV indicated this was a manual error. UPRV reversed decision in response to provider complaint.

- UPRV Response: Remittance address on claim did not match remittance address in our claims system.

- TDCI Follow up questions: What should the adjudicator have seen that warned them that the procedure was only non-covered for commercial not TennCare? How did the error occur and what will keep it from happening again?
  - UPRV Comments/Follow ups: The claims adjustor appropriately processed the claim, as the code in question is not typically covered for TennCare members, as well as commercial. In order to reduce issues with authorization, the authorization process has been enhanced by the addition of review by a certified DME expert.

Complaint 2010.108 - Anesthesia claims denied for incorrect Medicaid identification number. UPRV reversed decision in response to provider complaint.

- UPRV Response: Info loaded onto provider file on 02/01/10:

- TDCI Follow up questions: Were other claims affected?
  - UPRV Comments/Follow ups: The provider's MDs were loaded to the system; however, the individual CRNAs were not. As a result, claims submitted by the CRNAs were not processed under the group's contract. A project was done to load the CRNA's individually, and to reprocess claims that were impacted.

Complaint 2010.118 - Claim by an out-of-network mental health provider from Kansas was denied. Retro authorization request also denied. Provider was eventually paid after provider information was received and loaded. UPRV reversed decision in response to provider complaint.

- UPRV Response: Claim paid 06/01/2010.

Complaint 2010.072 - Claim rejected because of an invalid provider identification number. EDI clearinghouse receipt attached to complaint. UPRV upheld decision in response to provider complaint.

- UPRV Response: Claim was closed/returned for missing or invalid UPIN.

Complaint 2010.074 -Claim was rejected. EDI clearinghouse receipt attached to complaint. UPRV upheld decision in response to provider complaint.

- UPRV Response: Claim was closed/returned for missing/illegible info; poor claim image.

Complaint 2010.076 - EDI claim rejected. EDI clearinghouse receipt attached to complaint. UPRV upheld decision in response to provider complaint.

- UPRV Response: No claim on file for member, amount, and date of service indicated in complaint.

Complaint 2010.088 - Claim denied for timely filing. Provider attached internal transmission report of claims billed to UPRV. UPRV upheld decision in response to provider complaint.

- UPRV Response: On original appeal, provider stated that they mailed a paper claim to us, and attached a report from their system to show when it was mailed; this is not considered proof of filing. Claim was denied.

- TDCI Follow up questions: Reason for override of exceeding timely filing limits.

  - UPRV Comments/Follow ups: On original appeal, provider stated that they mailed a paper claim to us, and attached a report from their system to show when it was mailed; this is not considered proof of filing. Claim was denied. Decision to Override Timely and Pay - Business Decision.

Complaint 2010.092 - Claim denied for invalid NPI number. UPRV upheld decision in response to provider complaint.

- UPRV Response: Three members/claims on complaint; all were closed/returned to provider.

Complaint 2010.114 - Hospital claim denied for lack of prior authorization. Request for retro authorization denied. UPRV informed provider in claim could have been filed as outpatient or observation.

- UPRV Response: Inpatient precert request was denied for lack of medical necessity.

Complaint 2010.116 - Claim denied for provider must update Medicaid identification number Also, primary insurance paid greater than allowed by UPRV. UPRV upheld decision in response to provider complaint.

- UPRV Response: Primary insurance paid more than our allowed amount, no additional payment was made.

Appendix 2
Details of Testing of Independent Reviews (See Section VIII.C.)

IR: 1076 - Issue and IR Decision: Claim denied because other insurance is primary. Independent Reviewer (IR) reversed UPRV's decision because the enrollee was not enrolled in the other insurance on the date of service.

- TDCI Questions: Has UPRV added procedures to ensure the EOB submitted by the provider correlates to the primary coverage that UPRV has identified? A subcontractor, Allied Interstate, was involved in the processing of the claim. This subcontract has not been submitted to TDCI or the TennCare Bureau for prior approval.
    - UPRV Response: The provider, with assistance from the insured, has a responsibility to verify member's insurance coverage. In this case, provider filed under member's old termed id number with primary insurance.
- TDCI Follow up question: Why did it take so long after the IR decision to pay? Tenn. Code Ann. § 56-32-126 (b)(3)(c) says HMO must send payment in full to provider within 20 calendar days of receipt of the reviewer's decision.
    - UPRV Comments/Follow ups: New process to streamline when responses are received, and new tracking mechanism to ensure timeliness of payment from receipt of IR directive.

IR: 1079 - Issue and IR Decision: Claim was denied because services are to be billed to the behavioral health organization (BHO). IR decision: diagnosis and treatment of senile dementia is a covered expense under the UPRV plan. The CT scan used to diagnosis this condition should be paid for by UPRV.

- TDCI Questions: Explain how the claim first denied for submit to BHO? Why delay in payment after reviewer decision?
    - UPRV Response: Original denial was "rebill to correct payer/contractor". Delay in processing was due to error on the part of MCO.
- TDCI Follow up question: Why so long after the IR decision to pay? Tenn. Code Ann. § 56-32-126 (b)(3)(c) says HMO must send payment in full to provider within 20 calendar days of receipt of the reviewer's decision.
    - UPRV Comments/Follow ups: New process to streamline when responses are received, and new tracking mechanism to ensure timeliness of payment from receipt of IR directive.

IR: 1086 - Issue and IR Decision: One claim denied for billing error on a single line of service in that too many units were billed in one day. Claim was corrected and submitted after sixty days by

provider and paid by UPRV but later recouped by UPRV. Second claim denied for billing error on a single line of service in that provider billed more than 24 hours in a single day. Claim was corrected and submitted after sixty days by provider and paid by UPRV but later recouped by UPRV. Both claims denied on third submission for exceeding timely filing limits. IR decision: claims should be paid except for single line items billed in error. UPRV should have made clear in its original denial that the UPRV considered all line items to be defective as a result of the single line violations.

- TDCI Question: How do the denial reasons communicate appropriately to provider the deficiencies of the claims?
    - UPRV Response: The denial code on the EOMB indicated the deficiency.
- TDCI Follow up question: Follow up on denial code "16" applied to all lines but nothing wrong with days 1-30 causing provider confusion.
    - UPRV Comments/Follow ups: RA states two reason codes. Entire claim shows the 16, not just the one line. That one line does have additional reason code.

IR: 1107 - Issue and IR Decision: Claim denied for not filing correctly the NDC (National Drug Code) and resubmission exceeds timely filing limitations. IR decision found for the provider because UPRV did not respond in a timely manner to the IR requests. Tenn. Code Ann. 56-32-126(b)(3)(A) requires UPRV to respond to IR request and that the IR will not consider information not received within 30 days.

- TDCI Question: UPRV's response included a reminder sent to providers in October 2007. The reminder does not mention quantity and unit of measurement mentioned in the TennCare Bureau communication.
    - UPRV Response: The reminder sent to providers dated October 2007 advised providers that quantity and unit of measure is required. [Is this answer correct? It directly contradicts your statement that the reminder does not mention quantity and unit of measure.]

IR: 1220 - Issue and IR Decision: Claim denied for medical necessity. IR decision reversed UPRV decision because separate review by TennCare ruled that the services were medically necessary.

- TDCI Question: Was provider submitted payment timely after review decision?
    - UPRV Response: Claim paid 04/27/2010; decision received 01/25/2010
- TDCI Follow up question: Why so long after the IR decision to pay? Tenn. Code Ann. § 56-32-126 (b)(3)(c) says HMO must send payment in full to provider within 20 calendar days of receipt of the reviewer's decision.

- UPRV Comments/Follow ups: New process to streamline when responses are received, and new tracking mechanism to ensure timeliness of payment from receipt of IR directive.

IR: 1088 - Issue and IR Decision: Claim denied on multiple submissions and eventually for exceeding timely filing limits. UPRV response to IR stated, "AmeriChoice has researched this issue and it appears that a corrected claim, with the NPI and appropriate qualifiers, was received within the timeframe from a close-out as required. We are reprocessing this claim and provider can anticipate payment within our normal claims processing timeframes.

- TDCI Questions: Why was the corrected claim denied per UPRV response? Why does UPRV need another claim to be filed?
    - UPRV Response: A new claim was needed as member's eligibility ended during hospital stay.

IR: 1094 - Issue and IR Decision: Claim denied because number of units billed exceeded authorization. UPRV response to IR stated, "After further review, AmeriChoice has determined the remaining units on this claim should be paid."

- TDCI Question: Why weren't the additional units paid on first processing?
    - UPRV Response: The number of units billed did not match the number of units and date range authorized.
- TDCI Follow up question: Why not corrected during the provider complaint process so it did not escalate to IR?
    - UPRV Comments/Follow ups: Agree, this should have been considered in the provider dispute process. Process is being reviewed to ensure that these issues are resolved during the dispute process.

IR: 1098 - Issue and IR Decision: Claim denied because the billing of the modifier to a certain procedure code was incorrect. UPRV response to IR stated, "After further review, UPRV has determined that the modifier is correct and their system has been updated. Payment was sent to provider 4/22/09."

- TDCI Question: Why was the modifier determined to be incorrect on previous processing?
    - UPRV Response: The modifier was determined to be incorrect at first processing, and only after system update was it deemed correct.
- TDCI Follow up questions: Did the system get updated within time specified in contract? If there was a delay, why? And were there other claims affected?

- UPRV Comments/Follow ups: Yes, there was a delay in Uploading Modifier. Yes, other claims were impacted. AMC will initiate a process to reprocess all impacted claims.

IR: 10-028 - Issue and IR Decision: Four claims were denied for eligibility. Provider appealed decisions and requested appeal for authorization since the members was retroactively enrolled to cover the dates of service. For example, one enrollee was provided services beginning on May 27, 2009. On July 23, 2009, TennCare added the member eligibility retroactive to include the dates of service. The provider appealed UPRV's decision but UPRV incorrectly responded the member was not retroactively eligible since TennCare added the enrollee on May 22, 2009 before the dates of services. UPRV response to IR recognized the member was retroactively eligible and paid the claim.

- TDCI Questions: UPRV noted that is making system changes to handle retroactive eligibility. [This is not a question and doesn't make sense.]
    - UPRV Response: Retro eligibility manual process in place.

IR: 10-029, 10-030, 10-032, 10-033 - Issue and IR Decisions: Claims were denied for no prior authorization. Provider sent appeals to UPRV to reconsider the denial since an authorization from UPRV had been obtained by the provider. Provider indicates no response from appeal was received and therefore filed independent review requests. UPRV responded to IR that the claims had been submitted with an incorrect authorization but after research the claims will be paid utilizing the correct authorization number.

- TDCI Questions: Why not correct during provider complaint process so it will not escalate to IR? Provider has copy of auth on AmeriChoice fax which matches the auth printed on the claim. Why did you have to load new auth to get it paid? What happened to the first auth?
    - UPRV Comments/Follow ups: Agree, this should have been considered in the provider dispute process. Process is being reviewed to ensure that these issues are resolved during the dispute process.