COLORADO
Department of Health Care Policy & Financing

State Managed Care Network Claims Audit Report

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This report was produced by Health Services Advisory Group, Inc., for the Colorado Department of Health Care Policy & Financing.

HSAG HEALTH SERVICES ADVISORY GROUP

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General Audit Information

Audit Scope:	To assess the State Managed Care Network (SMCN) claim processing capability of Colorado Access' contracted claim processing vendor and to evaluate Colorado Access' monitoring efforts on this vendor (Colorado Access is the current Administrative Service Organization [ASO] contracted by the Department for SMCN)
Audit Requestor:	Teresa Craig MCO & SMCN CHP+ Contract and Program Manager, Essential Community Provider Coordinator, PPS Plus Project Director/Health Programs Office Jerry Ware Quality and Compliance Specialist/Quality and Health Improvement Unit
HSAG Audit Staff:	Holly Dolgaard, MBA, CHC, CHPC; Amrit Kerr, MBA
Audit Timeline:	January 2016 through June 2016
SMCN ASO:	Colorado Access 11100 East Bethany Drive Aurora, CO 80014
MCO Location(s):	10065 East Harvard Ave, 6th Floor Denver, CO 80231
Contact:	Bethany Himes Executive Director, CHP+ HMO & ASO
Title:	State Managed Care Network Claims Audit
Telephone:	720.744.5550
Email:	Bethany.himes@coaccess.com

State Managed Care Network Claims Audit Report

Background and Scope

Child Health Plan *Plus* (CHP+) is Colorado's low-cost health insurance program for uninsured children and pregnant women whose families do not qualify for Medicaid but cannot afford private insurance. The Colorado Department of Health Care Policy & Financing (the Department) administers the CHP+ program. Health maintenance organizations (HMOs) contract with the Department to provide medical services to CHP+ members. The Department also contracts directly (utilizing Colorado Access' provider services department) with healthcare providers to offer CHP+ services during a pre-HMO enrollment period. This network of providers is referred to as the State Managed Care Network (SMCN). Since July 2008, the Department has been contracting with Colorado Access as the Administrative Services Organization (ASO) managing the health plan- related services for SMCN. On behalf of the Department, Colorado Access is contracted to fulfill the following responsibilities:

- Benefit management and customer service for eligible members
- Provider relations, network development, maintenance, and training
- Claims administration
- Pharmacy benefit management
- Utilization review and case management
- Customer service

Since 2011, the Department has contracted with Health Services Advisory Group, Inc. (HSAG), to assess the ability of its ASO to process claims for members enrolled in CHP+ SMCN. In November 2014 Colorado Access transitioned the CHP+ SMCN claims processing to TriZetto. TriZetto's Business Management Services (BMS) uses the QNXT platform for provider maintenance, paper claim entry (manual and optical character resolution), and claim adjudication. HSAG's claims audit included review of claims processing policies, procedures, and systems for Colorado Access and TriZetto.

The fiscal year (FY) 2016–2017 claims processing audit included a desk review of the documentation submitted by Colorado Access and an analysis of the claims processed between January 1, 2016, and June 30, 2016. Specifically, the audit focused on the following areas:

- Policies and procedures from Colorado Access and TriZetto
- Department-mandated accuracy and timeliness requirements
- Eligibility at time of service
- Colorado Access' remediation activities related to the FY 2015–2016 audit findings

Methodology

Previously (FY 2015–2016), HSAG conducted a desk review, claims audit, and on-site review of systems and claims operations. The FY 2016–2017 claims audit focused on a comprehensive review of the desk review documentation, an analysis of processed claims, and Web conference interviews to validate that Colorado Access and TriZetto were meeting contractual requirements related to timely and accurate claims processing. The following sections detail the summary of findings related to the desk review and claims audit.

Desk Review

HSAG requested Colorado Access to submit updated documents related to the 23 desk review elements developed previously during the FY 2015–2016 claims audit. The desk review elements examine Colorado Access' operations and systems related to enrollment and claims processing and claims payment. Examples of documents requested were:

- Contracts and performance metrics.
- Data flows, lists of system edits for claims processing and claims payment, and claims processing system rules.
- Claims processing policies and procedures and operational reports.
- Audit policies and procedures and audit reports for procedural and payment accuracy.

Appendix A contains the completed FY 2016–2017 desk review tool. HSAG received the requested materials from Colorado Access on December 5, 2016. HSAG reviewed these documents to validate Colorado Access' and TriZetto's claims processing operations and systems. Upon completion of the initial review, HSAG requested follow-up on documentation related to data privacy and security policies, business continuity plans, claims accuracy reports, and claim reversal processes. In addition to the desk review documentation submission, Colorado Access was asked to provide additional documentation in response to some preliminary areas of focus:

- *Increase in 2016 claims despite decrease in membership.* The response was detailed in "Claim Vol_2.17.17" (Appendix C).
- *Three claims with potential anomalies related to timely filing and retroactive eligibility*. The responses to these claims were detailed in "Follow-Up_2.14.17" (Appendix C).
- *Request to review explanations of payment (EOPs) for five classifications of denied claims.* The EOPS were provided in five documents named according to type of denial.
- *Request to confirm member enrollment codes with copayments applied in claims*. Screen shots were provided that illustrated members' enrollment classifications and copayments for income levels two and six.

- *Request for examples of claims detail and processing logic related to vision benefits.* Claims screen shots were provided that illustrated all vision-related services for a given member along with the calculation of annual maximum benefit.

HSAG used the desk review materials and supplemental documentation to guide the discussions held during the desk review teleconferences held on March 24, 2017, and April 10, 2017. The agendas for the Web conferences and related clarification questions are provided in Appendix B.

The desk review core standards and key findings are summarized below:

Provider Education for Eligibility and Claims: Colorado Access has developed a comprehensive set of resources and tools to educate and support providers on confirming eligibility, copayment, prior authorization, claims submission requirements, and inquiring about claims' statuses.

Claims Processing Performance Standards: Colorado Access provided the section of the contract with TriZetto that focuses on the business services warranty and service levels. The key service metrics reported by TriZetto are as follows:

- **Claims Processing Turnaround—**Of clean claims, 90 percent will be finalized within 14 calendar days, 98 percent will be finalized and sent for payment within 30 calendar days of receipt by TriZetto, and 100 percent of all claims will be finalized and sent for payment within 60 calendar days of receipt by TriZetto.

  The TriZetto BMS report cards for January through June 2016 confirmed that TriZetto met the claims processing turnaround requirements as noted in Table 1. For additional validation, HSAG auditors compared the TriZetto report claims processing turnaround statistics with the figures calculated by Colorado Access and noticed some minor variations in outcomes. Colorado Access staff indicated during the March 23, 2017, call that the TriZetto's calculations included pre-defined caveats, per their contract, regarding the calculation formulas for these performance measures. Colorado Access figures were marginally different because the figures are calculated based upon all processed claims and not adjusted claims per TriZetto's contractual agreement.

Table 1—TriZetto Claims Processing Turnaround

Performance Standard	January 2016	February 2016	March 2016	April 2016	May 2016	June 2016
90% Finalized Within 14 Days	97.59%	97.99%	94.76%	96.47%	98.66%	98.17%
98% Finalized Within 30 Days	99.78%	99.89%	99.73%	99.97%	99.98%	100.00%
100% Finalized Within 60 Days	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

- **Financial Claims Processing Accuracy**— Before finalization, at least 99 percent of claims will exhibit financial accuracy. Financially *accurate* is defined by TriZetto as "if the amount paid is correct according to Company's Business Rules."

  The TriZetto BMS report cards for January through June 2016 confirmed that TriZetto met the financial claims processing accuracy requirement all months except February 2016 as noted in Table 2.

Table 2—TriZetto Financial Claims Processing Accuracy

Performance Standard	January 2016	February 2016	March 2016	April 2016	May 2016	June 2016
99% Financial Accuracy	99.82%	96.89%*	100.00%	100.00%	99.93%	100.00%

*Note: See Colorado Access response to financial accuracy issue included below.

During the claims review teleconference on April 10, 2017, Colorado Access staff indicated that the financial accuracy issue in February 2016 was attributable to a system edit for paper claims. The scanning technology used for paper claims captured the provider tax identification number (TIN) instead of the national provider identifier (NPI), which resulted in linking to the incorrect provider fee schedule. TriZetto's internal audit processes identified the issue. The claim was adjusted to correct the payment error. A system configuration change was also made to ensure that the provider identification number logic for paper claims defaulted to the same provider matching logic as claims received electronically. The configuration change ensured that the correct fee schedule is used by cross-referencing the NPI when processing claims.

- **Claims Processing Procedural Accuracy—**At least 98 percent of claims will be finalized accurately. *Finalized accurately* is defined by TriZetto as "if the processing is correct according to the Procedure."

  The TriZetto BMS report cards for January through June 2016 confirmed that TriZetto met the claims processing procedural accuracy requirement all six months as noted in Table 3.

Table 3—TriZetto Claims Processing Procedural Accuracy

Performance Standard	January 2016	February 2016	March 2016	April 2016	May 2016	June 2016
98% Procedural Accuracy	99.12%	98.17%	99.32%	100.00%*	98.98%	100.00%

*Note: The April 2016 calculation included a discrepancy. See Colorado Access response following.

HSAG auditors noted a discrepancy in the calculation reported for April 2016 because the figures originally reported the numerator as 119 claims and the denominator as 199 claims. During the claims review teleconference on April 10, 2017, Colorado Access stated that TriZetto indicated that

the original reported denominator should have been 119 claims, which supported the 100 percent accuracy rate reported.

- **Claims Adjustment Turnaround—**At least 99 percent of clean claims adjustments will be finalized within 60 calendar days of the claims' receipt by TriZetto.

  The TriZetto BMS report cards for January through June 2016 confirmed that TriZetto met the claims adjustment turnaround requirement all months as noted in Table 4.

Table 4—TriZetto Claims Adjustment Turnaround

Performance Standard	January 2016	February 2016	March 2016	April 2016	May 2016	June 2016
99% Finalized Within 60 Days	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

- **Paper Claims Entry in the System—**At least 99 percent of clean paper claims submitted to TriZetto will be entered in the system within five business days of receipt of the claim by TriZetto.

  The TriZetto BMS report cards for January through June 2016 confirmed that TriZetto met the paper claim entry turnaround requirement all months as noted in Table 5.

Table 5—TriZetto Paper Claims Entry in the System

Performance Standard	January 2016	February 2016	March 2016	April 2016	May 2016	June 2016
99% Entered Within 5 Days	99.96%	99.98%	100.00%	100.00%	99.98%	100.00%

- **Configuration Turnaround Time—**For each business rule configuration (BRC) request ticket that is not a BRC incident, TriZetto will meet the estimated time to complete (ETC) at least 98 percent of the time, excluding time waiting for company or time waiting on software or system updates required to finalize the configuration.

  The TriZetto BMS report cards for January through June 2016 confirmed that TriZetto met the configuration turnaround requirement all months as noted in Table 6.

Table 6—TriZetto Configuration Turnaround Time

Performance Standard	January 2016	February 2016	March 2016	April 2016	May 2016	June 2016
98% Configuration Requests Meet ETC	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

- **Configuration Accuracy—**At least 98 percent of provider and benefit maintenance transactions completed by TriZetto will be accurate. Configuration accuracy is defined as "if it correctly reflects the information in the form submitted to TriZetto."

  The TriZetto BMS report cards for January through June 2016 confirmed that TriZetto met the configuration accuracy requirement all months as noted in Table 7.

Table 7—TriZetto Configuration Accuracy

Performance Standard	January 2016	February 2016	March 2016	April 2016	May 2016	June 2016
98% Configuration Accuracy	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Claims Processing Operations and Procedures

The claims processing operations documentation submitted for the desk review remained largely unchanged from the FY 2015–2016 audit. As reported in the prior audit, the operational claims processing policies and procedures align with industry best practices and contractual requirements. Modifications were noted for the Colorado Access fee schedule configuration team processes and the QNXT claims system regarding non-covered procedure codes and the ClaimCheck™[1] editing actions (pend, deny, warn, ignore, and enable). These types of process and system modifications have improved efficiency and accuracy of claims processing for Colorado Access.

As a result of last year's audit findings regarding the system anomaly with the QNXT claims system logic for auto-reversing specific claims, Colorado Access worked with TriZetto to implement defined business processes to monitor claims with REV and REVSYNCH statuses. These operational standards address the situations wherein claims with REVSYNCH statuses could have remained unprocessed indefinitely. This new operational standard is addressed as follows:

When a claim is determined to have been over or underpaid, the claim is assigned a REV status when the claim is reversed, so that adjustments may be made. A REVSYNCH status is then assigned to the affected claim so that the claim payment will be withheld until the associated adjustment claims have been finalized. Under certain conditions the REVSYNCH status could delay payment to the provider indefinitely. TriZetto has identified two circumstances wherein manual intervention may be required to finalize and pay the adjusted claim(s). To mitigate this situation, the TriZetto BMS runs the Colorado Access REV and REVSYNCH status reports daily and reviews each transaction. TriZetto BMS and Colorado Access staff members stated that personnel work together to repair the affected claims and train staff members, as appropriate.

[1] ClaimCheck is a McKesson claims processing and payment audit tool that seamlessly integrates with the QNXT claims system.

Claims Monitoring and Audit Controls

The claims monitoring and audit controls established by Colorado Access and TriZetto BMS are consistent with the processes and reports detailed in the FY 2015–2016 audit, except for the audit thresholds. Colorado Access noted during the teleconference on March 24, 2017, that staff members audited all claims $10,000 and higher prior to payment; whereas the claims audit procedure documentation provided in the desk review states that only 40 to 50 percent of high dollar claims were audited. HSAG confirmed during the claims analysis teleconference on April 10, 2017, that Colorado Access reviewed 100 percent of claims with payments over $10,000. The Colorado Access auditors documented these reviews in both the QNXT claims system and the auditor reports. The claims auditing procedure documentation should be updated to reflect actual business processes.

HSAG's desk review included the reconciliation of the SMCN Inventory Report. The SMCN Inventory Report quantifies the daily inventory of claims received (electronic and paper), the count of claims by adjudication status (e.g., pended, adjudicated, REV, REVSYNCH, ready to pay or deny, and number of claims paid and denied. Review of the claims payment figures confirmed that Colorado Access is processing provider claim payment checks weekly. HSAG auditors inquired about the increase in pended claims in late February and early March and again in early May. Colorado Access was unable to identify any explanations for the increase in pended claims, although the current processes for managing pended claims were consistent with industry standards. The SMCN Inventory Report further illustrated that the number of pended claims have returned to typical rates.

The claims analysis teleconference on April 10, 2017, included a discussion around Colorado Access' current processes for reviewing pended and denied claims. Claims denied for eligibility or prior authorization issues were pended for manual review prior to being finalized. Colorado Access also monitored for trends in pended claims identified in the SMCN Inventory Report to proactively resolve any unanticipated issues. One such example is Colorado Access' staff identification of an issue in 2015 related to continuous enrollment. The issue is described in more detail in the "Enrollment Processing and Reconciliation Systems" section following.

In previous years, Optumas (the Department's actuarial vendor) produced the Claim Anomaly Report. Colorado Access staff reported that the report was originally distributed monthly, then quarterly, and then sporadically in 2015. At the time of this claims audit, Colorado Access was no longer receiving the Claim Anomaly Report from Optumas. Colorado Access confirmed on April 10, 2017, that claims data continue to be submitted to Optumas for actuarial purposes.

In recognition of 42 Code of Federal Regulations (CFR) §438.608 requiring states to implement contractual mechanisms beginning in July 2017 to ensure that managed care organizations implement and maintain arrangements or procedures designed to detect and prevent fraud, waste, and abuse, HSAG auditors inquired whether or not Colorado Access currently has any other audit activities focused on detecting and preventing fraud, waste, and abuse. Colorado Access responded on April 11, 2017, that it contracts with an external audit vendor, SCIO Health Analytics (SCIO®). SCIO performs inpatient diagnosis related group (DRG) validation audits for SMCN by reviewing medical records to confirm that all diagnosis and procedure codes are documented and billed appropriately. If SCIO determines that

a hospital billed a code in error, SCIO sends Colorado Access the findings to reprocess the claim. This generally results in a lower DRG/severity payment. SCIO also performs data mining, wherein staff members search for overpayments on a macro level based on certain criteria such as duplicate payments as well as overlapping inpatient and outpatient claims. Colorado Access performs adjustments on these findings if Colorado Access is in agreement with SCIO's findings. Colorado Access further indicated that provider billing anomalies are identified and acted upon accordingly. SCIO's current audit methodologies do not include investigations for fraud, waste, or abuse.

Overall, based on the desk review documentation and teleconference discussions, Colorado Access demonstrated that the biweekly meetings with the TriZetto BMS team and operations staff members ensured that claim monitoring and audit activities identify and resolve procedural and system-related issues as they occur. The supplemental auditing activities performed by SCIO further help to ensure that claims are paid appropriately.

Enrollment Processing and Reconciliation Systems

The FY 2015–2016 claims audit report recommended that Colorado Access continue to focus on resolving eligibility and enrollment issues with the Department. The desk review documentation and discussions revealed that Colorado Access staff did work with the Department's enrollment vendor on resolving eligibility discrepancies. Colorado Access staff sent to the vendor daily spreadsheets listing information for members requiring research and subsequently received daily spreadsheets listing members requiring manual enrollment into the QNXT claims system. Colorado Access sent monthly reports to the Department when members appeared to be in the SMCN longer than they should have been. Colorado Access also indicated having sent to the Department weekly reports of members also holding other health insurance coverage.

HSAG's preliminary analysis of claims data revealed an increase in claims processed in the first half of 2016, despite the decrease in enrollment. Colorado Access subsequently shared that *"In 2015 the State's continuous eligibility function broke. The break prevented 12-month continuous eligibility from locking children into CHP+ membership for 1 year. This issue resulted in many children spontaneously losing their CHP+ coverage. Uninsured children would discover at the point of service that they were no longer covered by CHP+. This discovery would trigger an immediate manual enrollment that would get the child back on the plan so that they could access services in their time of need. Many of these children were added back to SMCN for the pre-HMO period."* According to Colorado Access, for the Kids (aged 1–18), an *"adverse selection to the SMCN risk pool, as only utilizers were being added to the plan. Conversely, other, healthier children who were also improperly terminated from CHP+ were unaware of their lack of coverage and did not get added back to the plan, resulting in lower overall membership, yet higher utilization rates. Therefore, although there were approximately 45% fewer children on the plan in 2016 than in 2015, there were approximately 30% more utilizers of health benefits in 2016 than there were in 2015."*[2]

[2] Claim Vol_2.17.17 located in Appendix C of this report.

Colorado Access staff indicated that managing eligibility and enrollment requires ongoing oversight and that staff members continue to work closely with the Department to resolve eligibility and enrollment discrepancies.

Technical Infrastructure and Standards

The data privacy and security policies and procedures established by Colorado Access were consistent with the information shared during the FY 2015–2016 audit. Section C of the Security of Electronic Protected Health Information (ePHI) policy stated *"any entity that exchanges ePHI with Colorado Access is required to sign a formal business associate agreement, or be bound by contractual requirements at least as restrictive as those contained in a Business Associate Agreement…"* HSAG auditors were informed that some of TriZetto's claims operations are performed off shore by a subcontractor. 45 CFR § Part 164 requires that Colorado Access, as the covered entity, ensure that its business associate, TriZetto, has appropriate safeguards in place to protect the privacy and security of members' protected health information (PHI).

During the March 24 teleconference, HSAG requested a copy of the business associate agreement (BAA) with TriZetto. The Colorado Access staff responded that its legal department had ensured that all appropriate data privacy and security requirements were in place. On April 11, 2017, HSAG received a copy of the BAA executed by Colorado Access and TriZetto in August 2014. The BAA was comprehensive and included a number of provisions to ensure that the business associate upholds the federal data privacy and security standards for itself and any subcontractors and meets ongoing training requirements. The BAA includes a provision that Colorado Access may audit the business associate to validate that these data privacy and security standards are met.

The FY 2015–2016 claims audit report recommended that Colorado Access and TriZetto complete the combined business continuity and disaster recovery (BCDR) strategy discussed during the 2016 on-site review and update the BCDR plan. Last year's claims audit report further advised Colorado Access to complete a desk review of the BCDR during the third or fourth quarter of 2016 and execute a full end-to-end test of the BCDR before year's end 2017. The desk review documentation and teleconference discussions confirmed that Colorado Access completed tabletop and functional BCDR tests within departments. In addition, Colorado Access conducted an integrated, functional test of the BCDR plans across the departments from April 11 through April 13, 2017. Similarly, TriZetto conducted a comprehensive functional BCDR test from April 17 through April 19, 2017. TriZetto's BCDR testing included a full restore of the Colorado Access claims environment. Colorado Access provided HSAG with summaries of both testing activities on May 19, 2017. The key findings related to these BCDR plans and outcomes are:

- Colorado Access' functional testing was comprehensive, with nine departments and 23 employees participating.
- Colorado Access' functional testing results were reported to be very good and confirmed that a workstation imaging issue identified during the previous testing (late 2016) was resolved.
- Colorado Access' functional testing identified a new issue with making the Structured Query Language (SQL) and Oracle databases available to Colorado Access' business developers and

business users in the failover systems. The information technology disaster recovery desktop procedures will be enhanced to address the SQL and Oracle accessibility issue.

- Colorado Access testing outcomes identified that some department-specific business continuity plans require updates to identify critical website links and instructions for accessing these applications in the event of a disaster.
- The TriZetto BCDR team successfully performed a test data refresh of the Colorado Access production environment and released it to the Colorado Access BCDR team for validation within the turnaround time frames specified in the contract.
- The TriZetto BCDR testing revealed that the failover system, Region 2 environment (R2B), was missing a script important to claims processing in the production environment. The issue was resolved quickly by adding the script file to the R2B environment.
- Future mitigation plans included the recommendation that any changes applied to the Colorado Access claims production environment also be applied to the R2B environment to ensure that these claims systems are in sync should disaster recovery be required.

In conclusion, Colorado Access and TriZetto appropriately addressed the FY 2015–2016 claim audit recommendation to complete the combined BCDR strategy and BCDR plan updates. Furthermore, the continued activities related to testing of these BCDR plans help to ensure that Colorado Access and TriZetto will be able to continue claims processing operations in the event of unplanned systems downtime.

Encounter Data Submission

Desk review documentation and discussions confirmed that Colorado Access prepares and submits the encounter files in accordance with the Department standards.

In summary, the desk review of Colorado Access and TriZetto's contracts, policies, procedures, and reports confirmed that standards are in place to meet the contractual requirements related to timely and accurate claims processing. The next section of this audit report provides an overview of the claim analyses performed on a random selection of claims to validate that the actual claims operations processes and systems produced the expected results.

Analyses of QNXT Claims Extracts

HSAG received a file titled Medical_Standard_Claims_Extract_CHPSMCN in December 2016. The claims extract included all SMCN claims processed in the QNXT claims system from January 1, 2016, through June 30, 2016. Supplementing this information, member eligibility and provider data files for the same review period were received concurrently with the extracts. Analyses focused on the following areas:

- Evaluation of whether or not claims were paid/denied appropriately following timely filing requirements.
- Validation that claims were adjudicated in accordance with Colorado Access' claims processing policies and standards.
- Evaluation of claims processed, ensuring appropriate eligibility coverage under the CHP+/SMCN program.

HSAG preliminary review of claim files revealed that 24,060 unique claims and 59,052 claim lines were processed. Of the 24,060 claims, 84 percent (20,176) were paid either through an auto-adjudication process or using the "pend" functionality in QNXT—to be handled manually by a TriZetto BMS claims examiner. Approximately 14 percent (3,384) of claims processed were denied, with the remaining 2 percent of claims being voided for various reasons. The percentage of paid, denied, and voided claims are consistent with the trends reported in the FY 2015–2016 claims audit report as illustrated below in Table 8. The increase in volume of claims is reported to be attributable to the issue that occurred in 2015 with the break in continuous eligibility, as noted previously in the "Enrollment Processing and Reconciliation" section of this report. In the claims analysis discussion on April 10, 2017, Colorado Access indicated that the increase in claims with "void" and "warn" statuses seemed unattributed to any specific reason, although staff indicated that numbers of provider requests to void claims have increased from prior years.

Table 8—Comparison of 2015 and 2016 Claim Counts by Month and Claim Status

Status	January through June 2015[A]	January through June 2016[A]	Increase in Claims	Percentage Increase
Unique Claims				
Denied	2,484	3,384	900	36.23%
Paid	15,656	20,176	4,520	28.87%
Void	259	411	152	58.69%
Warn	39	89	50	128.21%
Total	**18,438**	**24,060**	**5,622**	**30.49%**
Total Claim Lines				
Denied	6,873	9,258	2,385	34.70%
Paid	37,888	48,633	10,745	28.36%
Void	626	1,014	388	61.98%
Warn	83	147	64	77.11%
Total	**45,470**	**59,052**	**13,582**	**29.87%**

[A] Claim counts will not equal the sum of individual months because a claim may be present in one or more monthly file(s) but counted only once in the aggregate, six-month counts.

The claims analyses objectives included examination of key indicators previously reviewed during the FY2015–2016 audit, along with a comprehensive review of top reasons for claims denials.

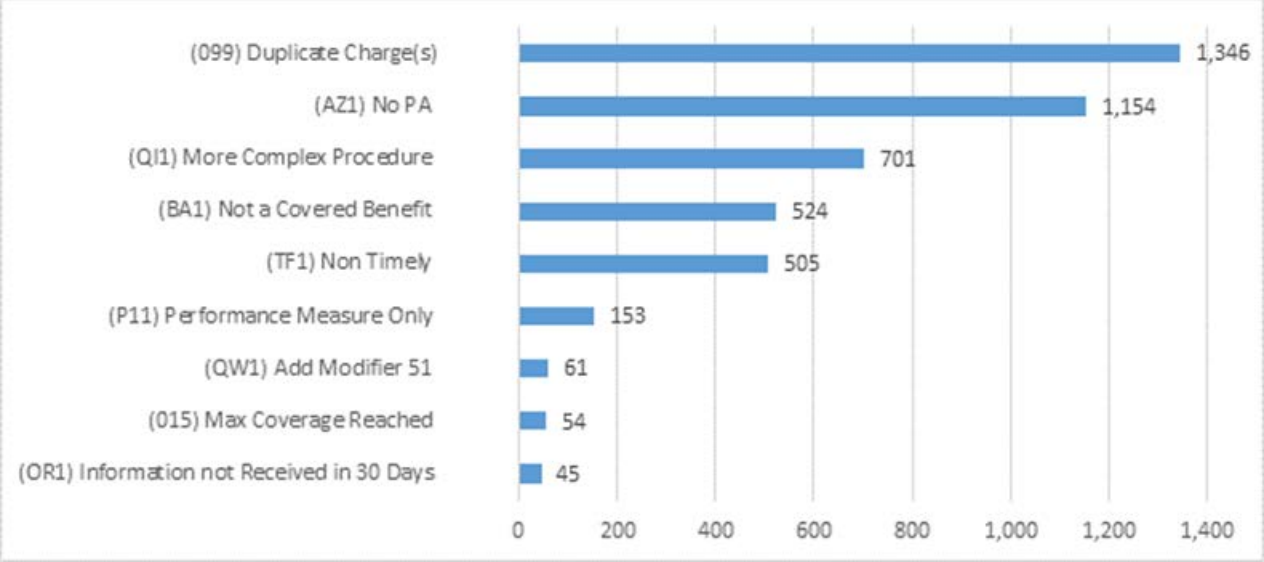
Analysis of Denied Claims. When a claim or service within a claim is denied, the provider is sent a remittance advice letter with the description of the applicable denial reason. Table 9 and Figure 1 provide the frequency of denial reasons for claims processed January 2016 through June 2016.

Table 9—Denied Claims Listed by Denial Reason

Payment Denial Explanation Code	Denial Code Description	Count of Denials[3]
099	Duplicate charge(s), previously processed.	1,346
AZ1	Service denied. No prior authorization obtained.	1,154
QI1	Code denied as incidental to more complex procedure.	701
BA1	Not a covered benefit under health plan.	524
TF1	Claim not filed within timely filing guidelines.	505
PF1	Claim line submitted as performance measure only, no payment required.	153
QW1	Current line replaced to add Modifier 51 as a secondary procedure.	61
015	Maximum coverage amount reached.	54
OR1	Claim denied. Requested information not received within 30 days.	45

[3] Denial count methodologies differentiated between denials denied at a claims level (e.g., TF1, OR1) and denials wherein only one claim line within the claim was denied (e.g., QI1, QW1).

Figure 1—Frequency of Denied Claims Listed by Denial Reason



HSAG performed a high-level review of claims denied for all denial reasons along with a targeted review related to the following denial reasons:

099: Duplicate charge(s), previously processed—1,346 unique claims denied.

Duplicate charge denials were examined by claim format (electronic versus scanned), place of service, and date of service; then grouped by provider name to identify potential trends with this type of denial. Some key observations noted:

- Fifty-two percent (697) of claims had dates of service prior to 2016.
- Eighty-two percent (1,107) of claims were electronic.
- Thirty-eight percent (506) of claims originated in independent laboratories. Most duplicate claims were from Laboratory Corporation of America (LabCorp) and Metwest Clinical Laboratory (Metwest).
- The claims analysis teleconference on April 10, 2017, included review of a sample of claims from LabCorp and Metwest. The auditors noted that these laboratories frequently submitted the same claim multiple times. It is important to note, however, that the QNXT claims system edits were sufficient to identify and deny all duplicate claims.

AZ1: Service denied. No prior authorization obtained—1,154 unique claims denied.

To conduct analysis of claims denied for no prior authorization, HSAG compared the service codes in these denied claims with the list of services requiring a prior authorization available on the Colorado Access website available at: *http://www.coaccess.com/documents/MasterAuthorizationList.pdf*. These claims were also examined

by place of service, providers, and diagnoses to identify potential trends with this type of denial. Some key observations noted:

- When 1,154 denied claims were compared to the service codes identified in the master authorization list from Colorado Access, 7.8 percent (90 claims) were denied because the claims were for services that require prior authorization. This low percentage of claims suggests another reason for claims being denied for no prior authorization.
- While the claims data file had no clear mechanism to identify out-of-network provider claims, many claims denied for no prior authorization were for services such as established office visits, infusion supplies, blood draws, pediatric enteral formula, nebulizers and respiratory supplies, ophthalmology visits, and injectable contraceptives. Every claim that HSAG auditors reviewed in detail with Colorado Access staff was submitted by an out-of-network provider. Colorado Access staff indicated that circumstances exist wherein a claim for an out-of-network provider would be authorized for continuity of care purposes. In many of these cases, however, Colorado Access staff replied that it is the member's responsibility to use an in-network provider and that the member could be liable for those denied claims.

  A review of the member handbook confirmed that members are informed about the consequences of using out-of-network providers. A review of the Colorado Access CHP+ SMCN website also confirmed the presence of content regarding in-network provider directories and high-level information regarding prior authorization requirements.
- The sampling of inpatient claims related to newborns denied for no prior authorization was reviewed with the Colorado Access staff. The underlying reason for these denials was that a newborn hospital stay that does not require neonatal intensive care unit (NICU) services is covered under the DRG derived from the mother's inpatient stay. These facilities should not be billing the newborn hospital stay separately unless the newborn is admitted to the NICU.
- An inpatient claim related to an acute respiratory infection stay was reviewed. No emergency department services were associated with this inpatient claim. The detailed claim notes in QNXT confirmed that the hospital had never, as required, contacted Colorado Access for prior authorization for the inpatient admission. Colorado Access staff indicated that, in situations involving retroactive eligibility, if the hospital submits documentation confirming medical necessity and retroactive eligibility, Colorado Access will pay the claim. Regarding this specific claim's history, rather than submitting an appeal with the referenced documentation, the hospital submitted and was denied payment for this inpatient claim multiple times.

QI1: Code denied as incidental to a more complex procedure—701 unique claims denied.

Colorado Access indicated that the ClaimCheck editing software identifies claim lines that should be excluded from the claim payment because the service is incidental to another procedure. These denied claims were examined by service code and provider name to identify potential trends with this type of denial. The services outlined below are consistent with ClaimCheck's editing rules. Service codes denied as incidental were for:

- Specimen handling fees (Current Procedural Terminology [CPT] codes 99000 and 99001)—281 denials.
- Blood collection for laboratory tests (CPT codes 36415 and 36416)—273 denials.
- Pulmonary diagnostic tests (CPT codes 94150, 94760, and 94761)—97 denials.
- Surgical trays (Healthcare Common Procedure Coding System [HCPCS] A4550)—24 denials.

BA1: Not a covered benefit under health plan—524 services denied.

The claims with non-covered benefit denials were examined by claim line and service code. These denied services were also validated against the SMCN List of Non-Covered Codes provided by Colorado Access on December 13, 2016. Some key observations noted:

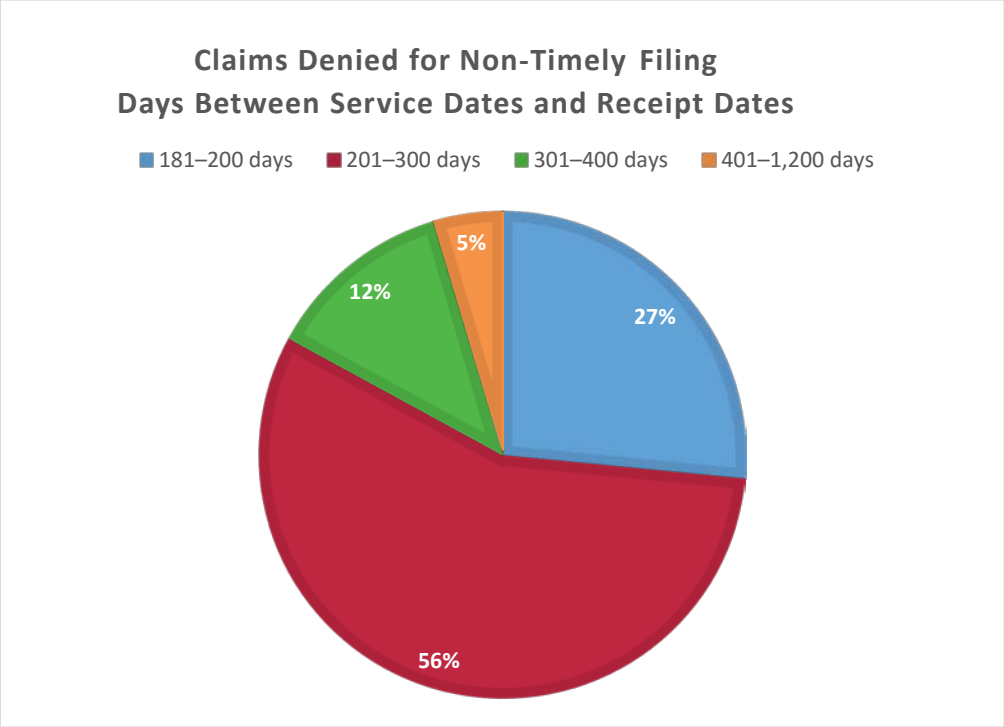
- Highest frequency of non-covered benefit denials occurred for services related to genetic molecular pathology (296 services).
- Other frequent non-covered services denials included alcohol and drug abuse services (75), after-hours fees (59), fees for providing services in urgent care (26), targeted care management (21), and tubal ligation (12).
- When reviewing the 524 services denied against the SMCN List of Non-Covered Codes, HSAG auditors confirmed that all services were appropriately denied.

TF1: Claim not filed within timely filing guidelines—505 unique claims denied.

Colorado Access is required to accept original claims submissions up to 180 calendar days after services are rendered or eligibility is loaded, whichever is last. Colorado Access is further required to accept a provider claim appeal within 90 days after processing the claim.

The first part of the analysis examined the number of days between the service date and the date the claim was received, as illustrated in Figure 2.

Figure 2—Days Between Service Dates and Receipt Dates



These denied claims were further examined according to place of service and date of service, then grouped by provider name to identify potential trends with this type of denial. Some key observations noted:

- Twenty-seven percent (one hundred thirty-four claims) were submitted narrowly missing the filing deadline (within 20 days after).
- Three percent (sixteen denied claims) had dates of service prior to 2015. The remaining claims had dates of service in 2015.
- Thirty-five percent of timely filing denials (176 claims) were for services in an office setting. Of these, only nine providers had denials exceeding two claims. The maximum number of denials for any provider was five.
- Sixteen percent of timely filing denials (82 claims) were for services provided in emergency rooms. Providers most impacted were Children's Hospital Colorado (16 claims), Diversified Radiology of Colorado (10 claims), Front Range Emergency Specialists (8 claims), and North Colorado Medical Center (6 claims).
- Fifteen percent of timely filing denials (76 claims) were for outpatient services. Only four providers had denials exceeding three claims.

- Twelve percent of timely filing denials (60 claims) were for independent laboratories. Only four providers had denials exceeding four claims. Of these, most denials occurred with Metwest (17 claims), LabCorp (16 claims), and Labone Inc. (12 claims).
- Ten percent of timely filing denials (53 claims) were for inpatient services. The providers most impacted were University Physicians Incorporated (4 claims) and Exempla Lutheran Medical Center (3 claims).
- The second audit objective regarding timely filing analysis examined claims paid after the 180-day receipt requirement. Of these 827 unique paid claims processed, 728 were identified as adjusted claims, which means that adjustments were made to the same claim number after the original claim was processed. The claim-received date is attributed to the entire claim; therefore, when the adjusted claim-paid date is compared to the claim-received date, it may often exceed the 180-day time frame requirement. Adjusted claim payment time frames are not generally relevant to this calculation except as they relate to provider claim appeals, in which case a 90-day receipt requirement exists. The claims data that HSAG auditors received did not include information about claim appeals. HSAG auditors reviewed a small sampling of the non-adjusted claims with Colorado Access staff, who provided viable explanations for accepting the claims outside the 180-day window.

Discussions with Colorado Access revealed that the organization has processes in place to review claims previously denied after retro-enrollment information is received. Additionally, Colorado Access staff indicated that providers are able to submit provider appeals within 90 days after the original processing date. In cases wherein a claim is filed outside the 180-day submission window due to receipt of retroactive-eligibility information, Colorado Access staff indicated that the claim will be reprocessed if the provider submits information that supports the retroactive eligibility. One example of such supportive information would be a screen shot of the member's eligibility taken from either Colorado Access' or the Department's enrollment system.

PF1: Claim line submitted as a performance measure only—153 claim lines denied.

When analysis of denied claims revealed that 153 claim lines were denied with the PF1 code, HSAG auditors asked the Colorado Access staff to clarify the definition of this denial code. Colorado Access indicated that business rules have been established to identify service lines within a claim that are not billable but are instead captured to meet pre-defined quality and performance standards. HSAG auditors determined that no further analysis of the claims with PF1 denial codes was required. Examples of these HCPCS codes were G8510 (negative screen for clinical depression) and G8783 (normal blood pressure reading documented).

QW1: Current line replaced to add Modifier 51 as a secondary procedure—61 claim lines denied.

Colorado Access indicated that the ClaimCheck editing software identifies claim lines that should be excluded from the claim payment because the services are considered secondary procedures. These claims were examined at the individual claim-line level, focusing on the procedure code. Approximately one third of these denied claims were for services associated with maternity care and delivery. No other common themes or concerns were identified.

015: Maximum coverage amount reached—54 unique claims denied.

Fifty-three of the fifty-four claims denied for maximum coverage amount reached were related to eyewear. The other denied claim was for cushioning materials related to an orthotic. During the claims analysis discussion with Colorado Access on April 10, 2017, HSAG reviewed a sampling of eyewear claims related to these member claims to ensure that these members received the $50 benefit per calendar year prior to the eyewear claims being denied due to maximum coverage amount having been reached. The claims review did not find any inappropriate denials related to the maximum coverage threshold.

OR1: Requested information not received within 30 days—45 unique claims denied.

To identify potential trends with this type of denial, these denied claims were examined by claim type (institutional versus professional), place of service, and date of service and billed amount. Some key observations noted:

- Twenty-nine of these denied claims (64 percent) were institutional claims. Facilities with highest *numbers* of claims denied for not submitting requested information within thirty days included Wellington E. Webb Center for Primary Care (six claims denied), Denver Health and Hospital Authority (four claims denied), Children's Hospital Colorado (three claims denied), and Memorial Health System (three claims denied).

  A detailed review of a denied emergency room claim from Children's Hospital Colorado revealed a complex situation wherein the member was seen and treated at two acute care facilities on one day, resulting in three different claims. The member was seen in the Porter Adventist Hospital emergency department and then transferred to the Children's Hospital Colorado emergency department prior to be admitted. The inpatient claim to Children's Hospital Colorado and the emergency department claim for Porter Adventist Hospital were paid appropriately. Children's Hospital Colorado most likely did not submit the requested information for the emergency room claim because they determined that the payment for the emergency room services would be bundled into the inpatient claim.

- Sixteen of *these* denied claims were professional claims. The providers with the highest number of claims denied for not submitting requested information within thirty days included Peter Aldoretta (four claims denied), Jennifer Hanslick (three claims denied), and Stephen M. Volin (three claims denied).

During the claims analysis discussion on April 10, 2017, Colorado Access staff confirmed that providers have the option to submit a claim appeal when the claim is denied for not submitting the information within the required 30-day time frame. Colorado Access staff further indicated that they will work with the provider when extenuating circumstances exist. TriZetto and Colorado Access claims processing staff enter into the QNXT claims system detailed notes about the status history of each of these claims.

Review for Claims Payments Greater Than Allowed Amount

The claims analysis included a review of any paid claim lines wherein the paid amount was larger than the allowed amount. The few occurrences transpired because the allowed amount was $0. The in-depth review of these specific claims raised no further concerns.

Evaluation of Claims Paid During Dates of Services Outside of Eligibility Dates

The claims analysis included a sampling of claims that appeared to have been paid outside of the members' eligibility dates. At the time of analysis, HSAG was aware that the eligibility files HSAG received did not consistently provide a comprehensive view of each member's eligibility and enrollment history in the CHP+ SMCN plan. Furthermore, the eligibility data that HSAG received did not include the system dates that each enrollment transaction (including retro-terminations and retro-additions) were received into Colorado Access' enrollment system. On April 11, 2017, HSAG provided a list of 35 claims that appeared to have been processed outside the eligibility time frames of the claims sample reviewed by HSAG. The Colorado Access staff reviewed the member eligibility information and claims details to provide detailed justification for each claim's status. Explanations are grouped into common categories:

- Colorado Access comprehensive eligibility files confirmed that, for 22 of the claims, the member was eligible at the time of service.
- Colorado Access confirmed that six paid claims were subsequently reversed and adjusted in the first quarter of 2017 to account for the retro-termination eligibility information received after these claims had been paid.
- Colorado Access staff reported that four of the claims were paid months before Colorado Access was informed that these members had other coverage. Colorado Access reported that the staff now have a process to receive a report monthly related to members with other coverage, to ensure that the paid claims are adjusted accordingly.
- Three claims processed while the members had gaps in eligibility were determined to have been paid nothing; however, the allowed amount reduced the member's copay amount. HSAG auditors confirmed with Colorado Access that the members incur the copay obligation regardless of eligibility.

HSAG recognizes the complexities related to eligibility and enrollment with this member population, especially when retro-termination and retro-enrollment transactions have a downstream impact on claims previously paid or denied. Colorado Access provided evidence of the take-back report used to reverse and adjust claims when a member is retro-terminated. While Colorado Access staff indicated that monthly take-back processes now exist, HSAG saw no evidence of documented policies and procedures.

Review of Member Copayment Information

The CHP+ member handbook stated that standard copayments range from $0 to $50 per visit and that no copayments are collected for preventive visits, family planning, or prenatal care services. The copayments were calculated in the QNXT claims system based upon the types of services and the annual family income level associated with the member enrollment record.

Unique claims with copay calculations and numbering 5,094 were examined by place of service and service code to validate that the copayment calculations were consistent with the SMCN copayment structure. Some copay amounts were not consistent with the published copay amounts. Colorado Access staff explained that this occurs when the calculated copayment is greater than the total amount allowed for the approved claim lines, in which cases the copayment calculations are adjusted to equal the total amount allowed for the approved claim lines. In other words, the member does not pay a copay higher in amount than what the provider will be reimbursed for the service.

For the second level of analysis, Colorado Access staff submitted the eligibility information for a random sample of claims with copayments to ensure that the calculated copayments were consistent with the income levels of the members. HSAG auditors confirmed that the calculated copayment amount for each was included in the explanation of payment to the provider. Overall, no concerns were identified regarding copayment calculations or how copays were tracked in the QNXT claims system.

Conclusions

Colorado Access' claims administration and oversight of the delegated claims processing has been appropriate for ensuring timely and accurate claims processing. The Colorado Access staff members were very responsive in providing information and responses to HSAG auditors. The FY 2016–2017 claims audit further confirmed that the information submitted for the desk review met the desk review standards. Additionally, desk review documents and analysis of claims data processed between January and June 2016 confirmed that Colorado Access and TriZetto met the contractual requirements for timely and accurate claims processing. Based upon performance statistics and Web conference discussions, HSAG auditors determined that Colorado Access and TriZetto claims processing and audit staff members work effectively as a team in managing claims volume and resolving any issues. Inherent complexities related to eligibility and enrollment with this member population, particularly with retroactive eligibility, require that Colorado Access staff remain diligent in monitoring enrollment transactions and taking appropriate action (e.g., recouping paid claims for retro-terminations and reprocessing denied claims for retro-enrollment.)

This audit also confirmed that Colorado Access had implemented remediation activities for the FY 2015–2016 audit recommendations listed following:

- Complete a desk review of the business continuity and disaster recovery plan in late 2016 and conduct an end-to-end test in 2017. ***(Completed April 2017.)***

- Implement processes and procedures to ensure that any claims in REVSYNCH status are worked frequently to ensure that provider reimbursements are not adversely impacted or delayed. ***(Implemented September 2016.)***
- Continue monitoring and oversight of enrollment and reconciliation processes, claims for ineligible members, and take-back processes. ***(Ongoing.)***
- When the FY 2015–2016 claims audit report was released in June 2016, the CHP+ SMCN contract was slated to transition to a new vendor beginning November 2016. At that time, Colorado Access would be processing claims related to retroactive eligibility only. The audit report recommended an audit in January 2017 to verify that transition plans were implemented properly and that Colorado Access maintained required service levels during the transition. ***(As of the time period that the FY 2016–2017 claims audit was performed, the CHP+ SMCN transition plans were on hold; therefore, the audit was not applicable at this time.)***

In conclusion, the FY 2016–2017 claims audit confirmed that Colorado Access met the contractual requirements for timely and accurate claims processing. To ensure continued success in managing claims processing for SMCN, HSAG provides Colorado Access the following recommendations.

Recommendations

HSAG has been evaluating the Department's ASO CHP+ SMCN claims processing since 2011. The audit methodologies have been adapted each year to maintain alignment with regulatory and contractual requirements and to re-assess claims administration capabilities after Colorado Access transitioned the delegated claims processing to TriZetto in 2013. With the assumption that the Department will continue to contract with Colorado Access for CHP+ SMCN claims processing, opportunity exists to refine some organizational processes to optimize claims processing resources and outcomes. The following recommendations are based upon the current audit findings, contractual requirements, regulations, and industry trends.

- The scope of audit services provided by HSAG would benefit from analysis beyond the current scope of processed and paid claims. Expansion areas may include validation that services were provided, identification of trends in pended claims, examination of claims that incurred manual overrides, and monitoring for claims anomalies known to be indicators of potential billing fraud. These audit enhancements will further validate that Colorado Access and TriZetto's internal auditing activities continue to be sufficient and will help identify areas at risk for fraud.
- While Colorado Access and TriZetto have well-established claim-by-claim processes for monitoring and managing pended and denied claims, Colorado Access' claims processing oversight activities should include policies, procedures, and reports for analyzing claims in aggregate to identify and mitigate trends with pended and denied claims. A current example is the reported increase in denied claims after the March 1, 2017, deadline for provider revalidation. Colorado Access staff indicated that they have been instructed to deny claims for any provider who has not completed the revalidation process by March 1. Procedures and reports should be developed to ensure that non-

validated provider claims are being monitored and reprocessed after the provider completes the revalidation process.

- Colorado Access should have written policies and procedures to retrospectively review claims paid or denied for any member with a retroactive change in eligibility or enrollment status. The documented policies and procedures should include well-defined mechanisms for the reprocessing of affected claims to recover overpayments related to retro-terminations as well as documented processes to track activities related to adjusting claims previously paid or denied due to retroactive eligibility information received impacting final status of those claims.
- The analysis of claims denied due to no prior authorization revealed that many were submitted by out-of-network providers. Colorado Access should develop policies, procedures, and reports for analyzing out-of-network provider claims to understand the members' reasons for using out-of-network providers and/or the providers' lack of knowledge about prior authorization requirements. Members and providers may require extra assistance and resources for identifying in-network providers for specialized services such as infusion supplies, nebulizers and respiratory supplies, and pediatric enteral formula.
- While the BAA between Colorado Access and TriZetto provides appropriate provisions to hold the business associate (TriZetto) and its subcontractors accountable for data privacy and security, Colorado Access should validate that TriZetto is in compliance with the BAA terms. Examples of validation may include reviewing TriZetto's BAA with its claims processing subcontractors, reviewing TriZetto's training materials and completion statistics, and conducting a desk audit of TriZetto's data privacy and security standards.
- Colorado Access' claims procedure documents should be updated to reflect current processes (e.g., auditing 100 percent of all claims paid in excess of $10,000) and to ensure that procedure documents identified as "Colorado Access SMCN Processes" include effective dates, process owners, and approval status tracking.

Appendix A. Desk Review Tool

The FY 2016–2017 desk review tool follows this cover page.

FY 2016–2017 Desk Review Tool		
Requirements and References	**Evidence/Documentation as Submitted by COA**	**Score**
1. Contract requirements/guidelines (Provider requirements for submitting claims – provider manual) regarding the collection and processing of claims/encounters for SMCN providers as well as guidelines/instructions and/or sample reports related to assistance given to providers related to submitting claims/encounters appropriately. a. Documentation related to corrective action plans for offending providers	• SMCN Complete Contract • COA Amendment 8 – July, 2015 amendment • Provider Training Slides – slides 40-44 • SMCN Provider Manual – pg 20-24 • SMCN Web Page Link • Provider Bulletin – Spring 2016- pg 3 • Corrective Action Template	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Met		
Required Actions: None		
2. Contract requirements with TriZetto, including performance standards established for claims processing. a. A "snapshot" of this section of the contract is acceptable.	• Trizetto Contract Requirements Snapshot –No Change • COA Report Card_AMS_BMS x2 - Updated	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Met		
Required Actions: None		

FY 2016–2017 Desk Review Tool		
Requirements and References	**Evidence/Documentation as Submitted by COA**	**Score**
3. Documentation describing secure transmission of data among SMCN providers, TriZetto, and Colorado Access. This includes data security and privacy policy and procedures. Documentation should also be provided regarding corrective actions planned in the event of a possible breach in data integrity (if changed from FY 2015-2016 audit).	• Day In the Life of a COA QNXT Claim – No Change • IT Data Storage Flowchart – No Change • IT Process 408 – EDI Claims Sweep Transfer to QNXT – No Change • Network Operations Policies – No Change • HIP 201 – Protection of Member Individually Identifiable Health Info and Protected Health Info – No Change • HIP 204 – Security of EPHI - updated	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Met		
Required Actions: None		
4. Documentation demonstrating that TriZetto and Colorado Access have disaster recovery plans to ensure business continuity in the event of a catastrophic incident. This documentation should include a copy of the disaster recovery and business continuity plans and an inventory of the core systems specifically used to process and support SMCN claims processing.	• Trizetto Business Continuity Management Program Summary – No Change • CAO DRP External • Colorado Access Business Continuity Management	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Met		
Required Actions: Colorado Access to provide HSAG with a summary of the integrated business continuity and disaster recovery (BCDR) testing conducted April 17 through April 19, 2017. The summary of BCDR testing will be available sometime after May 14, 2017.		

FY 2016–2017 Desk Review Tool		
Requirements and References	**Evidence/Documentation as Submitted by COA**	**Score**
5. Documentation describing the data structure and data flow in the QXNT system for processing, validating, and accepting claims and encounters (if changed from FY 2015-2016 audit).	• Day In the Life of a COA QNXT Claim – No Change • IT Data Storage Flowchart – No Change • IT Process 408 – EDI Claims Sweep Transfer to QNXT – No Change	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Met		
Required Actions: None		
6. Documentation describing the maintenance of fee schedule and rates for capitated and/or fee-for-service providers in the QXNT system.	• General Fee Schedule COA Config Team Process QNXT - updated	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Met		
Required Actions: None		
7. System edits and business rules in the QXNT system used to check submitted claims/encounters for format and value accuracy.	• Claim Check Auditing Process – No Change • Claim Check PAM Procedure- No Change • SMCN Rules- 2016- updated	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Met		
Required Actions: None		

FY 2016–2017 Desk Review Tool		
Requirements and References	**Evidence/Documentation as Submitted by COA**	**Score**
8. Documentation demonstrating that the claims system checks claims payment logic in the QXNT system to identify erroneous billing from providers as well as pricing applied to claims before payments. a. Documentation should include a description of system edits as well as a list of reports (including the claims anomaly reports) used to identify claim processing trends and anomalies. b. If Colorado Access or TriZetto uses additional vendors to perform claims verification, documentation should be provided of the contract with the external vendor as well as oversight policies and procedures and any related performance standards.	• Claim Check Auditing Process – No Change • Claim Check PAM Procedure- No Change • Configuration & Rule Settings – No Change • EE DP09 Enrolling a Newborn- No Change • Trizetto Contract Requirements – No Change • SMCN Non-Covered Codes - updated • SMCN Rules- 2016- updated • COA Pend Edit Report - updated • SMCN Inventory Report - updated • Anomaly Report Workflow- Discontinued • Anomaly Reports Jan-June, 2015- Discontinued	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Met		
Required Actions: None		
9. Documentation demonstrating adjudication rate reports. Documentation regarding claim processing policy that details turnaround time frames and steps for managing pended claims. Additionally, reports demonstrating claims processing statistics such as average number of daily/monthly claims processed, pended, and denied; paper claims; etc.	• Claims Policy CLM 301 – No Change • BMS_OCR CMS 1500 Claims Form Business Rules- No Change • BMS_OCR UB04 Claims Form Business Rules-No Change • CHP SMCN Claims TAT Performance Target x 2 – Updated • SMCN Inventory Report- Updated • COA Pend Edit Report - Updated	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Met		
Required Actions: None		

FY 2016–2017 Desk Review Tool		
Requirements and References	**Evidence/Documentation as Submitted by COA**	**Score**
10. Performance standards related to the submission, accuracy, and timeliness of claims and encounter data (standards established by the Department and/or internally developed by Colorado Access).	• COA Report Card 2016 x 2 - updated • SMCN Claims Accuracy from SMCN Annual Report - updated • SMCN Complete Contract- No Change • Colorado Access SMCN Contract Amendment 8- updated • SMCN Inventory Report - Updated	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Met		
Required Actions: None		
11. Quarterly performance reports submitted to the Department for calendar year 2016.	• SMCN Annual Report (Quarterly reports were discontinued in FY 2016)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Met		
Required Actions: None		

FY 2016–2017 Desk Review Tool		
Requirements and References	**Evidence/Documentation as Submitted by COA**	**Score**
12. Communication documents sent to providers related to data validation results (e.g., policies and procedures, rejection reports). a. Include sample explanation of payments to providers (EOPs) b. Example/explanation of how/why Colorado Access paid an institutional and a professional claim.	• SMCN Provider Manual – No Change • Any specific EOPS are available upon request	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Met. Colorado Access provided sample EOPs as requested.		
Required Actions: None		
13. Internal policies and procedures, studies, and reports for monitoring claim volume, patterns, or trends of claim errors (including the claim anomaly reports).	• BMS Quality & Compliance Monitoring- No Change • COA Audit Guide- No Change • Anomaly Report – Discontinued • SMCN Claims Audit Report – Updated • SMCN Inventory Report- Updated	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Met		
Required Actions: None		

FY 2016–2017 Desk Review Tool		
Requirements and References	**Evidence/Documentation as Submitted by COA**	**Score**
14. Colorado Access' internal claims processing audit methodology and any associated audit results and reports.	• ATA Audit Report – Updated • CHP_SMCN claims Audit – Updated • COA Lesser Of Report – Updated • Large Claim and Pay Deny Audit- updated • BMS Quality & Compliance Monitoring – No Change • Claims Auditing Procedures – No Change • COA – Audit Guide – No Change • High Dollar Desktop Procedure – No Change • High Dollar Eligibility Verification – No Change	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Met		
Required Actions: None		
15. Reports submitted to the Department/Optumas that reflect encounter data submission activities to the Department (e.g., submission statistics).	• Data Auto Submission Process –No Change • Optumas File Specs – No Change	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Met		
Required Actions: None		
16. Process documentation outlining the approaches used to address issues identified in the Department's anomaly reports; including prepared responses.	• Anomaly Report Workflow – Discontinued, No Change	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Met		
Required Actions: None		

FY 2016–2017 Desk Review Tool		
Requirements and References	**Evidence/Documentation as Submitted by COA**	**Score**
17. Claims extract of all professional and institutional SMCN claims processed and paid in the QXNT system and submitted to the Department by Colorado Access during 2016 with processed and paid dates between January 1, 2016, and June 30, 2016.	• Medical Standard Claims Extract	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Met		
Required Actions: None		
18. Data file layout used by Colorado Access for submitting to the Department the SMCN claims/encounters processed in the QXNT system (if changed from FY 2015-2016 audit).	• CHP+ Encounter File Specs – No Change	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Met		
Required Actions: None		
19. Data file layout by which Colorado Access receives and ultimately determines member eligibility (if changed from FY 2015-2016 audit).	• PHP guide for Managed Care Plans V1.4 – No Change	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Met		
Required Actions: None		

FY 2016–2017 Desk Review Tool		
Requirements and References	**Evidence/Documentation as Submitted by COA**	**Score**
20. An extract of the QNXT provider file for the period of January 1, 2016, through June 30, 2016.	• Provider Extract CHP SMCN	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Met		
Required Actions: None		
21. Eligibility files for the months ending: a. June 2015, July 2015, August 2015, October 2015, November 2015, December 2015, January 2016, February 2016, March 2016, April 2016, May, 2016, June 2016, and July 2016, August 2016, September 2016	• Eligibility Extract CHP SMCN	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Met		
Required Actions: None		
22. Copies of the April 2016, May 2016, and June 2016 Current Timely Processing reports. a. Turnaround time for processing.	• CHP SMCN TAT Performance Target	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Met		
Required Actions: None		

FY 2016–2017 Desk Review Tool		
Requirements and References	**Evidence/Documentation as Submitted by COA**	**Score**
23. Documentation on how Colorado Access addressed recommendations from the FY 2015 – 2016 audit: a. Colorado Access and TriZetto should complete the combined business continuity and disaster recovery (BCDR) strategy discussed during the on-site review and update the BCDR plan. Submit a copy of the combined BCDR.	• Business Continuity Management –Program Summary • Business Continuity Plan – Accounting – *Note: This is one example of the many BCP plans that we have for each IT Tower as referenced in the Program Summary document.* • DRP – Network & Telecom – *Note: This is one example of the many DR plans that we have for each IT Tower as referenced in the Program Summary document.* • Consolidated BIA Results	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Met		
Required Actions: None		
b. Colorado Access should complete a desk review of the BCDR during third or fourth quarter 2016 and ultimately execute a full end-to-end test of the BCDR before year-end 2017. Provide a status update on the desk review.	• 2016 BC-DR Test – Test Evaluation • COA DR Table Top Test *Note: Tabletop exercise was completed with Trizetto on 11/16/16 and a functional test was performed at COA on 11/7/16-11/10/16*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Met		
Required Actions: Colorado Access to provide HSAG with a summary of the integrated business continuity and disaster recovery (BCDR) testing conducted April 17 through April 19, 2017. The summary of BCDR testing will be available sometime after May 14, 2017.		
c. During the on-site visit, HSAG and Colorado Access discovered that QNXT could systematically reverse a claim or a claim line and pend it to a RevSynch classification, even if a claim examiner had manually reversed the same claim or claim line. Submit evidence that the folder was worked daily and submit policies and procedures supporting the new process.	• COA REV – REVSYNCH Claim Status • Rev_Synch Monitoring Example – more data available upon request	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Met		
Required Actions: None		

FY 2016–2017 Desk Review Tool		
Requirements and References	**Evidence/Documentation as Submitted by COA**	**Score**
d. Update on any actions over the past year taken with the Department to address CHP+ SMCN enrollment challenges.	*We work with CMAP, the State's enrollment vendor to work through eligibility discrepancies. We send daily spreadsheets with members that need research and we receive daily spreadsheets back from CMAP for members we need to manually enroll into the program.* See: • EE DP27 CHP Manual Enrollment Research • CHP Manual Spreadsheets *We send monthly reports to HCPF when members looks to be in the SMCN longer than they should be.* See: • Running SMCN Outside of Pre-HMO Period • CAMC KID Members in Spec Counties *We send weekly reports of members we verified had other coverage.* See: • Running CHP Disenrollment Due to COB Report • CHP Duals Report	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Met		
Required Actions: None		

FY 2016–2017 Desk Review Tool		
Requirements and References	**Evidence/Documentation as Submitted by COA**	**Score**
e. Update on any actions taken internally over the past year to improve enrollment reconciliation processes.	• EE DP08 Reading MMIS Files • EE DP42 CAP Compare Reconciliation • EE DP44 Running Elig Load Error Reports • EE DP45 Elig Load Error Reports • Running Cap Compare Report	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Met		
Required Actions: None		

Results for Claims Processing Audit Desk Review							
Total (27 elements)	Met	=	27	X	1.00	=	27
	Partially Met	=	0	X	.50	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	27	**Total Score**		=	27
Total Score ÷ Total Applicable						=	100%

Colorado Department of Health Care Policy & Financing—SMCN Claims Processing Audit

Information for Health Care Improvement HSAG

Colorado Department of Health Care Policy and Financing

State Managed Care Network Claims Audit Teleconference Meeting

Friday, March 24, 2017
WebEx Conference Bridge: 1-800-747-5150, passcode 8016658#
10:00 a.m. – 1:00 p.m. Mountain Time

AGENDA

I.	10:00 – 10:05 a.m.	**Welcome and Introductions**	**HSAG Claims Audit Lead** Holly Dolgaard, MBA, CHC, CHPC **HSAG Claims Analyst** Amrit Kerr, MBA
II.	10:05 – 10:30 a.m.	**Questions and Clarifications with Colorado Department of Health Care Policy and Financing (HCPF) and Colorado Access**	**Request State participation in this session only. The State's participation for the remainder of the discussions is optional.* • Review of Eligibility and Enrollment Information that Impacted Claims Processing
III.	10:30 – 11:15 a.m.	**Desk Review Documents Questions and Clarifications**	• Claims Processing Contractual Requirements and Performance Standards • Claims Processing Procedures • Claims Monitoring and Audit Controls • Review/confirmation Claims Operations Discussions from Onsite Visit March 2016
IV.	11:15 – 11:30 a.m.	**Technical Infrastructure and Standards Overview**	• Encounter Data Submission • Ensuring Data Privacy and Security • Business Continuity and Disaster Recovery
	11:30 – 11:40 a.m.	**Break**	
V.	11:40 a.m. – 1:00 p.m.	**Claims Data Analysis Preliminary Findings and Questions** ***(Note: may require access to QNXT system)***	• Claims denied for duplicate charges • Claims denied for no prior authorization • Claims denied for non-covered services • Claims denied for non-timely filing • Claims received/finalized > 180 days from date of service • Claims paid amount > allowed amount • Claims with co-pays • Claims denied or pended for OON providers • Pended Claims • Claims with REV and REVSYNCH transactions

HSAG HEALTH SERVICES ADVISORY GROUP

Colorado Access
State Managed Care Network Claims Audit

April 10, 2017
10:30 A.M. – 12:30 P.M. (Mountain Time)
Conference Call-In Number: 1-800-747-5150
Access Code: 8016658

Agenda

10:30 a.m. Introductions/Opening Remarks ..... HSAG

10:35 a.m. Online review of claims identified for research ..... HSAG/Colorado Access

12:00 p.m. Discuss attached list of clarification questions ..... HSAG/Colorado Access

12:30 p.m. Adjournment

1. TriZetto BMS Report Card data

   - TriZetto fell below the 99% requirement for financial processing accuracy (96.89%) in Feb. 2016. Please provide more information about the $9144.08 overpayment and any actions taken by either Colorado Access or TriZetto to improve the financial accuracy.

   - TriZetto's calculation for April 2016 for procedural claims processing accuracy appears to be incorrect. Based on the claim counts it should be 60% (119/199), not 100%. Please confirm and discuss what actions were taken by either Colorado Access or TriZetto to address this issue. Please also discuss any actions related to February and May not meeting the target of 99%.

2. The Claims Auditing Procedures document appears to state that 40-50% of claims (Large claims?) are reviewed. During the call on March 24th, it was stated that 100% of all claims in excess of $10K are reviewed. Please confirm HSAG's understanding of this internal audit process.

3. In the prior audit it was noted that Colorado Access submits claims data to OPTUMAS. Since OPTUMAS is no longer providing the Anomaly Reports, does this mean that Colorado Access no longer submits claims files to OPTUMAS?

4. Is Colorado Access able to provide the exact date(s) the Business Continuity and Disaster Recovery test will be conducted with TriZetto? On March 24th, it was suggested that the testing will occur in April 2017. Additionally, can Colorado Access provide a date that HSAG can expect to receive a summary of the testing activities and findings?

5. HSAG calculated the Claims Count Comparison for 2015 and 2016 claims received as shown below. HSAG has noted the increase in Voids and Warns in 2016. Are there any particular reasons for the increase in these two categories?

Comparison of 2015 and 2016 Claim Counts by Month and Claim Status				
Status	January - June 2015[A]	January - June 2016	Increase in Claims	% Increase
Unique Claims				
Denied	2,484	3,384	900	36.23%
Paid	15,656	20,575	4919	31.42%
Void	259	400	141	54.44%
Warn	39	89	50	128.21%
TOTAL	**18,438**	**24,448**	**6010**	**32.60%**

Total Claim Lines				
Denied	6,873	9,258	2385	34.70%
Paid	37,888	48,633	10745	28.36%
Void	626	1,014	388	61.98%

6. HSAG has identified a number of denied claims with the EOP Denial reason code PF1. HSAG is unable to locate the description of this reason code. Please define PF1.

7. HSAG will also ask to review a couple of claims that were denied for maximum coverage amount reached. All the claims in this denial category are related to eyewear. We would like to see any related claims for a couple of those members, to confirm that the member did receive $150 in eyewear benefits within the same calendar year.

8. Does ClaimCheck determine which claims lines will be denied for the following denial reasons? HSAG needs to confirm whether this is an 'industry standard' rule versus an internal claims processing rule developed by TriZetto.
   - Code denied as incidental to a more complex procedure.
   - Current line has been replaced to add modifier 51 as a secondary procedure.

9. Additionally, during the call HSAG will identify a few members with copayment calculations in the claims records. HSAG would like to see the corresponding eligibility/enrollment record to confirm that the copayment amount is consistent with the Income Level classifications and corresponding copayment amount in the member handbook.

10. Also, related to enrollment records, does the system track and display when an enrollment record was loaded and/or updated in the system? HSAG is particularly interested in any situations where a retro-enrollment record is received that may now require Colorado Access to reprocess previously denied claims. We would like to confirm whether the QNXT system tracks the date the enrollment record was loaded into the system.

Colorado Department of Health Care Policy and Financing
State Managed Care Network Claims Audit Teleconference Meeting
Discussion Topics

Desk Review Documents

HSAG has completed the initial desk review of the claims processing related contracts, policies, procedures, and reports submitted by Colorado Access. HSAG is requesting clarification to ensure we have a comprehensive understanding of Colorado Access' current claims processing and payment procedures. Where applicable, the referenced documents identified in the FY 2016-2017 SMCN Document Request and Evaluation Tool submitted by Colorado Access are bolded and the corresponding FY 2016-2917 Desk Review Tool element numbers are noted in parentheses in the questions below.

The questions to be discussed include, but are not limited to the following:

1. Colorado Access recently provided a detailed response regarding HSAG's inquiry about the general increase in claim volume in 2016 despite the decrease in total membership. HSAG would like to review Colorado Access' processes for identifying, researching, and rectifying enrollment discrepancies incrementally and when a systemic issue occurs such as the continuous eligibility issue in 2015.

2. HSAG requests final enrollment counts for each month (Jan-June 2016) to reference as part of the claims volume analysis.

3. Page 14 of the **Colorado Access Amendment 8** requires that claims processing and encounter tracking systems contain the 5 digit ICD-10 diagnosis codes. The **Medical Standard Claims Extract** file include a small amount of claims from 2015 submitted and paid that included ICD-9 codes. Please provide more information on Colorado Access' provider communications and requirements regarding ICD-10 codes. (Desk Review Element 1)

4. The **TriZetto Contract Requirements Snapshot** – Section 6 Business Services Warranty; Service Levels appear to be missing items 1 and 2. If this information was not redacted for confidentiality purposes, HSAG would like more information about these service level metrics. (Desk Review Element 2)

5. HSAG would like to walk-through the definitions and logic for each of the metrics defined in **TriZetto Contract Requirements Snapshot** and compare this information with the **COA Report Card_AMS_BMS** for the first and second quarters of 2016. (Desk Review Element 2)

6. HSAG would like to review any per member/per month statistics related to enrollment, claims, and utilization that Colorado Access may track for the CHP+ SMCN population. For example, the average number of claims per member/per month. Ideally, HSAG would like to see any relevant figures for 2015, 2016, and 2017.

7. HSAG would like to confirm its understanding of the processes and systems in place between Colorado Access and TriZetto for supporting operational issues identified during claims processing. *(For example, when a claim is pended because the provider is not in the claim system. How are these types of issues communicated to the responsible parties, how do the necessary changes get put into the system, and how does the claim ultimately get finalized?)*

8. HSAG would like to briefly review the claim edits detailed in **Configuration and Rules Settings_FINAL_SMCN** to better understand the processes and systems confirm these actions during claims processing. Additionally, are there any Rule 838: Claim Check: Wizard user Defined rules set up for Colorado Access? (Desk Review Element 8)

9. HSAG would like to review the claim status classifications in **SMCN Inventory Report** to reconcile the claims volume among the categories. (Desk Review Element 8)

10. HSAG would like to review the information provided in **COA Pend Edit Report** and understand its correlation to the number of claims pended in the **SMCN Inventory Report.** (Desk Review Element 8)

11. Colorado Access indicated that the anomaly audits performed by Optimus have been discontinued. Does Colorado Access anticipate any future audits by the State's actuary? (Desk Review Element 8)

12. HSAG would like to confirm the business owner for the **CHP SMCN Claims TAT Performance Target Reports** and how that information relates to the report cards prepared by TriZetto. (Desk Review Element 9)

13. HSAG would like to review explanation of payment examples for one of each of the following denial codes: no prior authorization (AZ1), non-timely filing (TF1), not a covered benefit (BA1), modifier 51 added as secondary procedure (QW1), maximum coverage reach (O15), and claim denied, information not received within 30 days (OR1). (Desk Element 12)

14. HSAG would like to review the **SMCN Claims Audit Report March 2016** and the **COA Lesser of Report 1.1.16 to 6.30.16** detail and related processes to confirm Colorado Access' auditing methodologies. (Desk Elements 13 and 14)

15. HSAG would like to walk through the actions taken with the Department to address CHP+SMCN enrollment challenges in the past year and the expected outcomes. Additionally, HSAG requests the password for **Running SMCN Outside of Pre-HMO Period**. (Desk Element 23d)

Technical Infrastructure

HSAG would like an overview of the technical processes and systems for supporting the following requirements:

- Encounter Data Submission
- Ensuring Data Privacy and Security
- Business Continuity and Disaster Recovery

Claims Data Analysis

HSAG has completed its preliminary review and analysis of the claims data. This portion of the teleconference is intended to clarify findings and identify the root cause of certain outcomes identified in the following claim queries:

Claim Queries	Additional information requested
Claims denied for duplicate charges	HSAG may request information about the corresponding claims that were previously received.
Claims denied for no prior authorization	HSAG may request validation of the prior authorization confirmation processes.
Claims denied for non-covered services	HSAG anticipates reviewing a sample of these claims and requesting explanations regarding the outcomes.
Claims denied for non-timely filing	HSAG may request validation of the claims receipt dates.
Claims received/finalized > 180 days from date of service	HSAG may request prior year enrollment information that corresponds with these claims.

Claim Queries	Additional information requested
Claims paid amount > allowed amount	HSAG anticipates reviewing a sample of these claims and requesting explanations regarding the outcomes.
Claims with co-pays	HSAG anticipates reviewing a sample of these claims and requesting explanations regarding the outcomes.
Claims denied or pended for OON providers	HSAG anticipates reviewing a sample of these claims and requesting explanations regarding the outcomes.
Pended claims	HSAG anticipates reviewing a sample of these claims and requesting explanations regarding the activities related to the pend statuses.
Claims with REV and REVSYNCH transactions	**Rev_Synch_Monitoring Example** identified a couple of claims with the REVSYNCH status. HSAG would like to see the corresponding information for the initial claims.

Claim Vol_2.17.17

Question:

In a comparison between 2015 and 2016, can you explain why there was an increase in total claim volume while there was a decrease in total membership?

Background:

In 2015, the State's continuous eligibility function broke. The break prevented 12 month continuous eligibility from locking children into CHP+ membership for 1 year. This issue resulted in many children spontaneously losing their CHP+ coverage. In 2015, Colorado Access lost approximately 15% of our CHP+ membership between our SMCN and HMO lines of business.

Uninsured children would discover at the point of service that they were no longer covered by CHP+. This discovery would trigger an immediate manual enrollment that would get the child back on the plan so that they could access services in their time of need. Many of these children were added back to SMCN for the pre-HMO period.

Result:

Kids (Age 1-18)

The above described cycle created adverse selection to the SMCN risk pool, as only utilizers were being added to the plan. Conversely, other, healthier children who were also improperly terminated from CHP+ were unaware of their lack of coverage and did not get added back to the plan, resulting in lower overall membership, yet higher utilization rates.

Therefore, although there were approximately 45% fewer children on the plan in 2016 than in 2015, there were approximately 30% more utilizers of health benefits in 2016 than there were in 2015.

Prenatal Women (Age 19+) and Newborns (Age 0)

Continuous eligibility is not applicable to the prenatal and newborn population, as they are on SMCN for a determinate period – gestation + 60 days. Therefore we did not see the same utilization fluctuations between 2015 and 2016 among this population as we did in the kid population.

Although there was a drop in overall membership for SMCN, the prenatal population (women age 19+) grew by approximately 18% between 2015 and 2016. Utilization in the prenatal population grew commensurately by 14% between 2015 and 2016.

Conclusion:

Adverse selection, due to a systemic malfunction in continuous eligibility, led to a smaller population that contained a higher proportion of health benefit consumers.

Follow-Up_2.14.17

Primary Colorado Access Contact: Janet Milliman janet.milliman@coaccess.com 720-744-5306
Secondary Contact: Bethany Himes Bethany.Himes@coaccess.com 720-744-5550

1. Claim #: XXXXXXXXX
   Issue: claim appears to be paid 201 days after DOS – timely filing is 180 days (6 months)
   Response: DOS was X/X/XX. Claim was received X/X/XX, on the cusp timely filing. Claim was processed X/X/XX, and check was cut X/X/XX. Although it appears that the claim was processed outside of timely filing, the provider did get it in to us just under the wire. The time taken to process and pay the claim (21 days) added extra time to the turnaround, but all parties operated within required timeframes.

2. Claim #: XXXXXXXXX
   Issue: Claim was paid for DOS X/X/XX. Member's eligibility ended X/X/XX
   Response: Our eligibility team found that the member's eligibility span was changed on July 12, 2016 by a HCPF representative to retro-terminate the member's span on X/X/XX. It seems that this measure was taken due to a discovery that the member had other insurance.

   We did receive a report with this eligibility correction on X/X/XX at 3:00:30 PM. This report then goes through some data scrubs to determine if manual research is required before doing a take back. Because this member was flagged as having other coverage, it was not sent through for manual research and automatically exported to a report for the Claims department to do the take back that was exported on X/X/XX at 3:33:07 PM. There were 2 reports that were sent that day but the report with the COB records was not included in the email (see attached) due to manual error.

   
   CIM Take-Back Reports.msg

3. Member #: XXXXXXXXX (no claim # provided, but DOS was X/X/XX)
   Issue: DOS was X/X/XX; claim was paid X/X/XX.
   Response: We received a grievance from the member on June 7, 2016 saying that the bills had gone to collections. Further inspection showed that at DOS, member did not show eligible. Eligibility was updated X/X/XX to cover the member on DOS. The State has given us permission to override timely filing in these types of situations without special permission, if the claim is less than 2 years old. Teresa Craig stated in our call on X/X/XX that this is HCPF's accepted practice.