OREGON DIVISION OF FINANCIAL REGULATION

INSURANCE PRODUCT REGULATION AND COMPLIANCE

LIFE AND HEALTH PROGRAM

MARKET CONDUCT EXAMINATION

REPRODUCTIVE HEALTH EQUITY ACT

OF

AETNA LIFE INSURANCE COMPANY

AS OF

DECEMBER 31, 2020

NAIC Company Code: 78700

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FORWARD

January 23, 2023

Honorable Andrew Stolfi
Director, Insurance Commissioner
Department of Consumer and Business Services
Division of Financial Regulation
350 Winter Street NE
Salem, Oregon 97301-3883

Dear Director Stolfi:

This market conduct examination report of Aetna Life Insurance Company or (insurer) was prepared by independent examiners contracting with the Oregon Division of Financial Regulation (division). A market conduct examination is conducted for the purpose of examining certain business practices of insurers licensed to conduct business in the state of Oregon. The examiners conducted the examination of the insurer in accordance with the Oregon Revised Statutes (ORS) 731.300. All work papers and data developed in the production of this report are the sole property of the division. The examiner in charge was Jimmy R Potts, CIE, MCM, FLMI, CLU, AIRC. In

Certain unacceptable or noncomplying practices may not have been discovered in the course of this examination. Additionally, findings may not be material to all areas that would serve to assist the Commissioner. Failure to identify or criticize specific insurer practices does not constitute acceptance of those practices by the division.

Respectfully Submitted,
Tashia Sizemore
Tashia Sizemore
Life and Health Program Manager

Signed and acknowledged before me on January 24, 2023 by Janet Vitus as notary in Marion County, State of Oregon.

Janet Vitus

OFFICIAL STAMP
JANET VITUS
NOTARY PUBLIC - OREGON
COMMISSION NO. 1030442
MY COMMISSION EXPIRES NOVEMBER 21, 2026

EXECUTIVE SUMMARY

In 2017, Oregon enacted House Bill (HB) 3391, known as The Reproductive Health Equity Act (RHEA). HB 3391 is now codified, in part, as Oregon Revised Statutes (ORS) 743A.067. RHEA requires, among other things, that a health benefit plan may not impose on an enrollee a deductible, coinsurance, copayment or any other cost-sharing requirements on the specific reproductive health services.

The focus of this targeted market conduct examination includes, but was not limited to, both insurer's claims as related to RHEA codified at ORS 743A.067. The examiners identified instances where the insurer was not in compliance with RHEA or other laws in its administration of claims. Additionally, the insurer's policyholder services and complaints were reviewed with regard to RHEA.

The examiners, as set forth in detail in this examination report, concluded that the insurer's claims processing systems and procedures did not identify all claims which should have been considered under ORS 743A.067. Specific findings related to the examination are summarized below:[1]

- **Noncompliance with ORS 743A.067 relating to the processing of claims** – The insurer failed to equitably settle claims when the insurer applied member cost share to services or supplies, where such services or supplies are required to be provided without member cost share under Oregon law. The insurer's claims processing system failed to accurately pay claims according to RHEA. The insurer did not consider certain services subject to RHEA when those services were billed using certain CPT codes or received in specific settings. In some instances, even though the insurer acknowledged that the underlying service was subject to RHEA, the insurer inappropriately applied criteria that limited when RHEA services were paid without member cost share, resulting in member cost share being applied inappropriately.

- **Noncompliance with the requirement to reimburse 12-month contraceptive prescription refills as required by ORS 743A.066 and noncompliance with contraception coverage requirements under 743A.067** – The examiners reviewed paid and denied prescription drug claims on the insurer's claim processing system to determine if the claim was properly adjudicated in accordance with Oregon law. The insurer wrongfully denied prescription drug claims as not being eligible for a refill due to an insufficient amount of time passing since the prior dispensing.

[1] Findings include apparent violations in handling claims and weaknesses in the insurer's policies, procedures, and processes. They do not constitute a final determination of law by the Division of Financial Regulation for the purposes of potential enforcement actions.

Number of violations per line of business

Line of Business	Total Population	Sample	Number of errors	Error rate
Large Group Paid Medical Claims	4,929	108	26	24%
Large Group Denied Medical Claims	1,881	105	35	33%
Large Group Denied Prescription Claims	312	76	28	36%
Failure to Identify all Pertinent RHEA Codes	N/A	N/A	1	N/A

The examiners conducted an extensive analysis of codes they identified as RHEA codes and found that the insurer had not identified all potential codes in its universe of claims which should have been covered without member cost share. The insurer was unable to demonstrate compliance with ORS 743A.067 as it did not capture all CPT codes subject to RHEA upon request.

This examination report, relating to RHEA claims for the period of January 1, 2019 to December 31, 2020, may be forwarded to the division's enforcement unit for enforcement consideration while the insurer responds to the corrective actions identified in the examination report.

SCOPE AND METHODOLOGY

This market conduct examination report of Aetna Life Insurance Company was prepared by independent examiners with the firm of Lewis & Ellis, LLC contracting with the Oregon Division of Financial Regulation (division).

The targeted market conduct examination of the insurer was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) and under the authority set forth in ORS 731.300 and direction from the division. The examination of the company covered the period of time from January 1, 2019 to December 31, 2020, for business reviewed. The purpose of the examination was to determine the company's compliance with ORS 743A.067, Oregon's Reproductive and Health Equity Act (RHEA).

The following is taken directly from written documentation provided by Aetna Life Insurance Company:

> Aetna Life Insurance Company (ALIC) was incorporated as an insurance company in the State of Connecticut on June 14, 1853. ALIC has been licensed as a foreign insurance company in Oregon since February 15, 1890. ALIC is licensed in all 50 states, District of Columbia, U.S. territories and Canada.

ALIC is a direct subsidiary of Aetna Inc. and an indirect subsidiary of CVS Health Corporation (CVS Health) since November 2018 after a subsidiary of CVS Health acquired Aetna Inc. CVS Health is a public company with shares traded on the New York Stock Exchange.

The targeted market conduct examination of the insurer was conducted in accordance with the standards and procedures established by the NAIC and under the authority set forth in ORS 731.300 and direction from the division. The examination of the company covered the period of time from January 1, 2019 to December 31, 2020, for business reviewed. The purpose of the examination was to determine the Company's compliance with ORS 743A.067.

The examiners utilized examination by sample. Examination by sample involves the review of a selected number of records from within the population. File sampling was based on a review of complaints and RHEA medical and prescription drug claims incurred during the period under examination and selected at random using computer software applied to data files provided by the company. Samples are tested for compliance with standards established by the NAIC and adopted by the division.

The examiners asked that the insurer provide a written response to any claims where the examiners had questions regarding the processing of such claim prior to the examiners determining if such claim was processed incorrectly and a finding of noncompliance being issued regarding that claim.

Certain unacceptable or non-complying practices may not have been discovered in the course of this examination. Additionally, findings may not be material to all areas that would serve to assist the Commissioner. Failure to identify or criticize specific insurer practices does not constitute acceptance of those practices by the division.

FINDINGS AND OBSERVATIONS – COMPLAINT REVIEW

The examiners reviewed the entire population of complaints identified by the insurer and did not find any reportable exceptions.

FINDINGS AND OBSERVATIONS –CLAIMS

Medical claims review

The examiners reviewed paid and denied medical claims on the insurer's claim processing system to determine if the claim was properly adjudicated in accordance with Oregon's RHEA law. Where apparent violations were noted, the examiners issued findings by line of business and by paid or denied status. The examiners found the claims adjudication was fairly consistent, meaning if certain Current Procedural Terminology (CPT) codes, also known as billing codes, were subject to member cost share in one instance it would most likely be subject to member cost share in other files reviewed. However, no assumptions were made that this would be true and each identified apparent violation was carefully reviewed by the examiners.

For each violation noted, the examiners requested that the company provide a PDF copy of the claim form submitted and all applicable Explanation of Benefits (EOB) related to that particular claim. Further, the examiners asked that the insurer provide a written response to any claims where the examiners had questions regarding the processing of such claim prior to the examiners determining if the claim was processed incorrectly and a finding of non-compliance being issued regarding that claim. Examiners reviewed the insurer's written response when considering whether the claim was adjudicated consistent with state law.

In instances where the primary diagnosis code would indicate that the reason for the visit was a women's well woman, preventive, or gynecological visit, the examiners required RHEA listed services to be paid without member cost share. In other instances, the examiners determined that the primary reason for the visit was not related to RHEA and a member cost share could be applied to services that were not specific to RHEA. However, without regard to the listed diagnostic code, if a service was performed that was listed in ORS 743A.067, including screenings and services identified by the US Preventive Services Task Force (USPSTF) or the Health Resources and Services Administration of the US Department of Health and Human Services (HRSA) as a recommended preventive service, and member cost share was applied to that service, then such claims were identified as an apparent violation. Further, there could be multiple apparent violations identified and reported in a single file, however, for reporting of overall violations noted, each file is only counted once by the examiners.

Inadequacies in claims processing system

Using statutory language that outlines required services, the examiners identified certain CPT codes that alone or when combined with certain diagnosis codes would require that the subject claims be paid without member cost share under ORS 743A.067. In some instances, the entire claim, including the physician office visit, should be paid without member cost share while in other instances only certain services, drugs, devices, products, and procedures submitted on the claim would need to be covered at no cost to the member.

The insurer's claims process, including system and programming, would need to be robust enough to identify, by CPT and diagnosis codes, which services should be covered without member cost share. The insurer should develop a quality control process for ensuring claims system programming is consistent with state law, including removing system limitations that are inappropriate for RHEA services. The examiners note that for some services all diagnosis codes attributed to that CPT code on the submitted claim would need to be screened to determine whether or not the service is subject to RHEA. The examiners observed during their review of sampled claims that it appeared the insurer failed to consider all pertinent regulatory requirements when determining if a service should be considered without applying member cost share. Further, there are certain covered RHEA items that are to be paid without member cost share without consideration of the reason for the visit and any associated diagnosis codes, specifically abortion and contraception.

There are other services which may not, on their face, be subject to RHEA but when considered in the context of the claim would need to be covered without member cost share. For instance, when the purpose of the visit is for a well woman or gynecological checkup then related labs would need to be covered without member cost share as part of the preventive visit.

In response to some examiner inquiries regarding the application of member cost share to claims subject to RHEA, the insurer asserted that its claims procedures did not recognize the service as a RHEA claim or that coverage was not required under the Affordable Care Act (ACA), and subsequently not subject to RHEA. In certain instances, RHEA requires coverage over and above what is required under the ACA for example RHEA removes age and gender restrictions found in federal preventive service guidelines. ACA medical management allowances are not always appropriate under RHEA, and should not be a de facto determinate, or limiter, of services or procedures required by RHEA.

In other instances, the insurer asserted that company procedures restricted coverage by location. For example, the insurer's policies denied coverage when an anemia or pregnancy test was inconsistent with claims system programming, such as pregnancy tests conducted in emergency room settings. However, under RHEA pregnancy screening is required to be covered without regard to the reason for the visit.

Further, while the examiners have identified CPT codes that under RHEA law may need to be covered without member cost share the list utilized by the examiners may not have been exhaustive. The insurer is responsible for ensuring all claims are adjudicated in accordance with Oregon law and the Insurer's policy provisions.

The insurer was not in compliance with ORS 743A.067 in that the insurer did not consider certain service encounters subject to RHEA. Further, as noted in the review of RHEA paid claims, in certain instances even though the insurer acknowledged that the service was an identified RHEA service, insurer programming decisions resulted in the application of member cost share. This indicates to the examiners that the insurer's claims adjudication programing is not robust enough to identify all instances where a RHEA claim should be paid without member cost share.

Finding 1: Non-compliance with ORS 743A.067 relating to the processing of claims

Paid medical claims
The insurer failed to equitably settle claims and was not in compliance with 743A.067. The insurer applied member cost share to services or supplies where such services or supplies are required to be provided without member cost share by Oregon law.

EXAMINER COMMENT:

The examiners reviewed a sample of 108 paid RHEA claims from a total of 4,929 paid claims. The examiners determined that violations of Oregon law occurred in the processing of certain claims.

There were 78 violations noted which affected 26 paid claims, however each claim is only counted one time.

Paid Claims

Population	Sample size	Number of errors	Error rate
4,929	108	26	24%

Denied medical claims

The insurer failed to equitably settle claims by applying member cost share to services or supplies subject to RHEA. The division instructed the insurer to consider a claim denied if any portion of the claim was denied. Examiners reviewed the claim in totality and determined if a portion of the claim was incorrectly processed. If the claim was incorrectly processed it would be cited although it was not the denied component. The examiners determined that violations of the law occurred in processing these claims.

EXAMINER COMMENT:

The examiners reviewed a sample of 105 denied RHEA claims from a population of 1,881 denied claims. The division instructed the insurer to consider a claim denied if any portion of the claim was denied. Therefore, the examiners would review the claim in totality as it was adjudicated. If upon the examiners' review it was determined that a portion of the claim was incorrectly paid, it would be cited even though it was not the denied component. The examiners determined that violations of Oregon law occurred in the processing of certain claims.

There were 161 violations noted which affected 35 denied claims, however each claim is only counted one time.

Denied Claims

Population	Sample size	Number of errors	Error rate	Underpayment
1,881	105	35	33%	$2,524.68

Prescription drug review findings

The examiners reviewed paid and denied prescription drug ("RX") claims on the company's claim processing system to determine if the claim was properly adjudicated in accordance with Oregon's RHEA law. The examiners found that the claims adjudication was fairly consistent. The primary reason for the company's denial of an RX claim was that the prescription was not eligible due to an insufficient amount of time had passed since the prior prescription had been filled. The insurer did not appear to have claims system programming that facilitated 12-month

contraceptive refills required under Oregon law, in that the system continued to apply general prescription refill limitations to contraceptives that were inappropriate for that prescription type.

Finding 2: Noncompliance with the requirement to reimburse 12-month contraceptive prescription refills as required by ORS 743A.066 and noncompliance with contraception coverage requirements under 743A.067

The examiners reviewed paid and denied prescription drug claims on the insurer's claim processing system to determine if the claim was properly adjudicated in accordance with Oregon law. A frequently cited reason for the insurer's denial of a prescription drug claims was that the prescription was not eligible for refill at the time of the request due to an insufficient amount of time passing since the previous dispensing of that drug. In some instances, the claims were denied even though the claims were made after the date of eligibility listed in the denial code.

In other instances, the eligibility date was found to be inappropriate. The examiners found evidence that the insurer uses standard utilization edits at the point-of-sale, such as a "refill too soon" denial. This limits access to contraceptives if the member has not used at least 75 percent of their current prescription. In the case of oral contraceptives, several products utilize a 28-day cycle where the first 21 pills contain hormonal drugs and the last 7 pills are a placebo sugar pill. Individuals may choose or are counseled by their provider to skip the placebo week, which could result in finishing their prescribed oral contraceptive sooner than permitted by the insurer's point-of-sale claims adjudication. While a "refill too soon" denial may catch fraud or misuse of other prescription drugs, the examination found that these denials may have resulted in limiting access to oral contraceptives.

Other reasons provided for inappropriate denials included that the drug was not in the insurer's formulary, the dosage amount was not consistent with the amounts in the formulary, the members coverage had terminated, the pharmacy was not in network or and the pharmacy had entered the members' demographic information incorrectly.

The examiners generally asked that the insurer provide a written response to any claims where the examiners had questions regarding the processing of such claim prior to the examiners determining if such claim was processed incorrectly and a finding of noncompliance was issued regarding that claim.

EXAMINER COMMENT:

The examiners reviewed a sample of 76 denied large group prescription drug claims out of a population of 312 denied prescription drug claims.

The insurer was not in compliance with claims settlement practices which requires insurers to "... promptly and equitably settle claims in which liability has become reasonably clear," which

under ORS 743A.066 requires that insurer pay for 12-month contraceptive refill. In 28 instances the insurer wrongfully denied a claim for being refilled too soon since the last dispensing. For some claims samples a revised claim was submitted by the pharmacy that allowed access to contraceptives.

There were 28 violations noted which affected 28 denied large group RX claims, however each claim is only counted one time.

Denied Prescription Drug Claims

Population	Sample size	Number of errors	Error rate
312	76	28	37%

RECOMMENDATIONS

The examiners recommend:

1. The insurer review its policies and procedures to assure that all claims are adjudicated in accordance with Oregon insurance law, including but not limited to, ORS 743A.067.
2. The insurer review its claims adjudication system and make all necessary adjustments to assure that claims are adjudicated in accordance with Oregon insurance law, including but not limited to, ORS 743A.067.
3. The insurer provide coverage for all contraceptive drug prescription refills without regard to the date of the prior contraceptive drug refill, when consistent with Oregon's 12-month refill requirements. The insurer should update claim system programming to allow contraceptive refills consistent with Oregon law.
4. That the insurer identify all pertinent CPT codes for services, drugs, devices, products, and procedures listed in ORS 743A.067, and where applicable DX, codes required to properly adjudicate RHEA claims. The insurer should also consider that the purpose of ORS 743A.067 is to improve access to the services identified in statute and limit medical management of those services to ensure access consistent with the purpose.

APPENDIX

Table 2 sets forth for each line of business the frequency that Oregon law was violated across all lines of business. The insurer only provided plans in the large group market during the examination period.

Statute	Number of violations - - Paid	Number of violations - Denied	TOTAL VIOLATIONS BY STATUTE
743A.067(2)(a) Well woman care	6	12	8
743A.067(2)(b) STD Counseling	2	1	3
743A.067(2)(c)(A) Chlamydia	4	3	7
743A.067(2)(c)(B) Gonorrhea	4	3	7
743A.067(2)(c)(C) Hepatitis B	1		1
743A.067(2)(c)(D) Hepatitis C	2	1	3
743A.067(2)(c)(E) HIV/AIDS	3		3
743A.067(2)(c)(F) Human papillomavirus		3	3
743A.067(2)(c)(G) Syphilis	1	1	2
743A.067(2)(c)(H) Anemia	4	10	14
743A.067(2)(c)(I) Urinary tract infection	3	5	8
743A.067(2)(c)(J) Pregnancy	8	17	25
743A.067(2)(c)(N) Breast cancer	4	3	7
743A.067(2)(l)(A) Education/counseling sterilization & contraception	1	3	4
743A.067(3) Improper cost share	23	29	52
Total violations count	120	161	

Table 3 sets forth for each line of business the population, sample size and financial impact of the claims which were not properly adjudicated. The insurer only provided plans for the large group market during examination period.

	Paid	Denied	Totals
TOTAL RHEA CLAIMS	4,929	1,881	6,810
RHEA SAMPLE	108	105	213
TOTAL VIOLATIONS	120	161	281
NUMBER OF CLAIMS AFFECTED	26	35	61
PERCENTAGE VIOLATION	24.00%	33.33%	28.6%

Table 4 sets forth findings for each sample in the paid large group claims.

Population:	Examination review item (Sample)	Diagnosis code	CPT code	Finding
Paid large group RHEA	4	Z11.3	99202	Improper cost share
Paid large group RHEA	6	N30.0	87491; 87591; 87086; 81001; 81025	Improper cost share
Paid large group RHEA	8	R59	87491; 87591; 87340; 87389; 82057	Improper cost share
Paid large group RHEA	9	B20	87491; 87591; 87536	Improper cost share
Paid large group RHEA	11	M54.9	82728; 85025	Improper cost share
Paid large group RHEA	17	Z11.3	86803; 87389	Improper cost share
Paid large group RHEA	23	S91.342A	81025	Improper cost share
Paid large group RHEA	28	E10.65	84703	Improper cost share
Paid large group RHEA	31	N39.0	87086	Improper cost share
Paid large group RHEA	34	Z12.31	76641; 76641	Improper cost share
Paid large group RHEA	38	G35	81001; 87086; 87088	Improper cost share
Paid large group RHEA	51	Z11.3	86803	Improper cost share

Population:	Examination review item (Sample)	Diagnosis code	CPT code	Finding
Paid large group RHEA	53	L70.0	81025	Improper cost share
Paid large group RHEA	55	Z30.430	81025	Improper cost share
Paid large group RHEA	57	Z12.31	77063	Improper cost share
Paid large group RHEA	60	Z11.4	99202	Improper cost share
Paid large group RHEA	61	Z34.91	84702	Improper cost share
Paid large group RHEA	70	Z30.017	99203	Improper cost share
Paid large group RHEA	71	Z12.31	77063	Improper cost share
Paid large group RHEA	81	Z00.00	86592	Improper cost share
Paid large group RHEA	84	Z68.29	83550; 83540; 82728	Improper cost share
Paid large group RHEA	91	Z01.419	36415	Improper cost share
Paid large group RHEA	96	Z72.51	87491; 87591	Improper cost share
Paid large group RHEA	100	Z32.02	81025	Improper cost share
Paid large group RHEA	103	Z01.419	81025	Improper cost share
Paid large group RHEA	105	Z12.31	77063	Improper cost share

Table 5 sets forth findings for samples from the denied claims population.

Population:	Examination review item (Sample)	Diagnosis code	CPT code	Finding
Denied large group RHEA	1	Z12.31	77067; 77063	Improper cost share
Denied large group RHEA	5	Z01.411	99386	Improper cost share
Denied large group RHEA	7	Z30.42	99213	Improper cost share
Denied large group RHEA	11	Z30.42	81025	Improper cost share
Denied large group RHEA	13	R92.1	77065	Improper cost share

Population:	Examination review item (Sample)	Diagnosis code	CPT code	Finding
Denied large group RHEA	19	Z00.00	99395	Improper cost share – denied
Denied large group RHEA	21	N89.8	99204; 81025; 81003	Improper cost share
Denied large group RHEA	31	Z12.31	77063	Improper cost share
Denied large group RHEA	35	Z32.02	81025	Improper cost share
Denied large group RHEA	36	N10	82025; 81001; 87086; 81025	Improper cost share
Denied large group RHEA	39	Z30.09	99203	Improper cost share
Denied large group RHEA	41	Z33.1	81025	Improper cost share
Denied large group RHEA	45	Z11.3	81025	Improper cost share
Denied large group RHEA	46	K81.1	85025; 84703	Improper cost share
Denied large group RHEA	47	Z01.411	87798; 87661; 87512; 87481	Improper cost share
Denied large group RHEA	53	Z01.419	87624	Improper cost share – denied
Denied large group RHEA	54	Z00.00	87624	Improper cost share – denied
Denied large group RHEA	57	K55.069	85025; 84703; 81003	Improper cost share
Denied large group RHEA	58	N83.202	85025; 84703; 81003	Improper cost share
Denied large group RHEA	66	Z00.00	99385	Improper cost share
Denied large group RHEA	71	Z30.42	99213	Improper cost share
Denied large group RHEA	72	Z01.419	87624	Improper cost share – denied
Denied large group RHEA	73	R51	84703	Improper cost share
Denied large group RHEA	80	N83.201	87491; 87205; 87591; 85025 ;81001; 81025	Improper cost share
Denied large group RHEA	81	N34.1	87491; 87591; 87086	Improper cost share
Denied large group RHEA	82	Z01.419	99205	Improper cost share

Population:	Examination review item (Sample)	Diagnosis code	CPT code	Finding
Denied large group RHEA	83	Unknown	84702	Improper cost share
Denied large group RHEA	84	N93.9	85025	Improper cost share
Denied large group RHEA	88	N83.201	85025; 87491; 87205; 81001; 81025	Improper cost share
Denied large group RHEA	90	Z11.4	86803	Improper cost share
Denied large group RHEA	97	N20.1	85025; 81001; 84703	Improper cost share
Denied large group RHEA	98	G89.4	82728	Improper cost share
Denied large group RHEA	99	R10.13	84703	Improper cost share
Denied large group RHEA	101	C54.1	81025	Improper cost share
Denied large group RHEA	104	B20	86592; 86593; 82025	Improper cost share – denied

Table 6 identifies findings for denied prescription drug samples.

Population:	Examination review item (Sample)	Diagnosis code	CPT code	Finding
Denied large group RHEA prescriptions	1	N/A	N/A	Improper denial – dispensing limits
Denied large group RHEA prescriptions	3	N/A	N/A	Improper denial – dispensing limits
Denied large group RHEA prescriptions	6	N/A	N/A	Improper denial – dispensing limits
Denied large group RHEA prescriptions	7	N/A	N/A	Improper denial – dispensing limits
Denied large group RHEA prescriptions	21	N/A	N/A	Improper denial – dispensing limits
Denied large group RHEA prescriptions	23	N/A	N/A	Improper denial – dispensing limits
Denied large group RHEA prescriptions	26	N/A	N/A	Improper denial – dispensing limits
Denied large group RHEA prescriptions	34	N/A	N/A	Improper denial – dispensing limits
Denied large group RHEA prescriptions	44	N/A	N/A	Improper denial – dispensing limits

Population:	Examination review item (Sample)	Diagnosis code	CPT code	Finding
Denied large group RHEA prescriptions	48	N/A	N/A	Improper denial – dispensing limits
Denied large group RHEA prescriptions	52	N/A	N/A	Improper denial – dispensing limits
Denied large group RHEA prescriptions	53	N/A	N/A	Improper denial – dispensing limits
Denied large group RHEA prescriptions	56	N/A	N/A	Improper denial – dispensing limits
Denied large group RHEA prescriptions	57	N/A	N/A	Improper denial – dispensing limits
Denied large group RHEA prescriptions	62	N/A	N/A	Improper denial – dispensing limits
Denied large group RHEA prescriptions	63	N/A	N/A	Improper denial – dispensing limits
Denied large group RHEA prescriptions	67	N/A	N/A	Improper denial – dispensing limits
Denied large group RHEA prescriptions	70	N/A	N/A	Improper denial – dispensing limits
Denied large group RHEA prescriptions	72	N/A	N/A	Improper denial – dispensing limits
Denied large group RHEA prescriptions	73	N/A	N/A	Improper denial – dispensing limits
Denied large group RHEA prescriptions	75	N/A	N/A	Improper denial – dispensing limits
Denied large group RHEA prescriptions	76	N/A	N/A	Improper denial – dispensing limits