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FINANCIAL INSTITUTIONS &  
PROFESSIONAL REGISTRATION

**DEPARTMENT OF INSURANCE, FINANCIAL  
INSTITUTIONS AND PROFESSIONAL REGISTRATION**

P.O. Box 690, Jefferson City, Mo. 65102-0690

TO: Office of the President  
BlueCross BlueShield of Kansas City  
2301 Main St.  
P.O. Box 419169  
Kansas City, MO 64108-2428

RE: Missouri Market Conduct Examination 0612-57-TGT  
Good Health HMO, Inc. d/b/a Blue-Care, Inc. (NAIC #95315)

**STIPULATION OF SETTLEMENT  
AND VOLUNTARY FORFEITURE**

It is hereby stipulated and agreed by John M. Huff, Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration, hereinafter referred to as "Director," and Good Health HMO, Inc. d/b/a Blue-Care, Inc., (hereafter referred to as "Good Health"), as follows:

WHEREAS, John M. Huff is the Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration (hereafter referred to as "the Department"), an agency of the State of Missouri, created and established for administering and enforcing all laws in relation to insurance companies doing business in the State in Missouri; and

WHEREAS, Good Health has been granted a certificate of authority to transact the business of insurance in the State of Missouri; and

WHEREAS, the Division conducted a Market Conduct Examination of Good Health and prepared report number 0612-57-TGT; and

WHEREAS, the report of the Market Conduct Examination has revealed that:

1. Good Health issued small employer group health insurance policies that limited eligibility to employees who work some greater number of hours per week than 30, thereby violating §§379.930(15) and 379.940.2(5), RSMo.
2. In some instances, Good Health improperly denied claims, in violation of § 376.1361 RSMo, and 20 CSR400-10.200.
3. In some instances, Good Health failed to conduct a reasonable investigation prior to denying certain claims, thereby violating §§375.1007(3), (4), and (6), and 376.1367, RSMo, and 20 CSR 400-2.030(2)(F)4.F.
4. In some instances, Good Health failed to accurately calculate the 45-day time period from date of receipt for certain electronically filed health care claims and underpaid or failed to pay any interest that may have accrued, thereby violating §§376.383 and 376.384, RSMo.

WHEREAS, Good Health hereby agrees to take remedial action bringing it into compliance with the statutes and regulations of Missouri and agrees to maintain those corrective actions at all times, including, but not limited to, taking the following actions:

1. Good Health agrees to take corrective action to reasonably assure that the errors noted in the above-referenced market conduct examination reports do not recur;
2. Good Health agrees to review all paid claims received from January 1, 2003, through the date a final Order is entered closing this examination, recalculate the time period for payment using the date that ASK received the claim as the received date, send any additional interest payments resulting from this recalculation to the claimants with a letter stating that the interest payments are being paid "as a result of findings from a market conduct examination performed by the Missouri Department of Insurance, Financial Institutions and Professional Registration" and provide evidence to the DIFP that all such payments have been made within 120 days after a final Order concluding this exam is entered by the Department.
3. Good Health agrees to file documentation of all remedial actions taken by it to implement compliance with the terms of this Stipulation and to assure that the errors noted in the examination report do not recur, including explaining the steps taken and the results of such actions, with the Director within 120 days of the entry of a final Order closing this examination.

WHEREAS, Good Health neither admits nor denies the findings or violations set forth above and enumerated in the examination report; and

WHEREAS, Good Health is of the position that this Stipulation of Settlement and Voluntary Forfeiture is a compromise of disputed factual and legal allegations, and that payment of a forfeiture is merely to resolve the disputes and avoid litigation; and

WHEREAS, Good Health, after being advised by legal counsel, does hereby voluntarily and knowingly waive any and all rights for procedural requirements, including notice and an opportunity for a hearing, which may have otherwise applied to the above referenced Market Conduct Examination; and

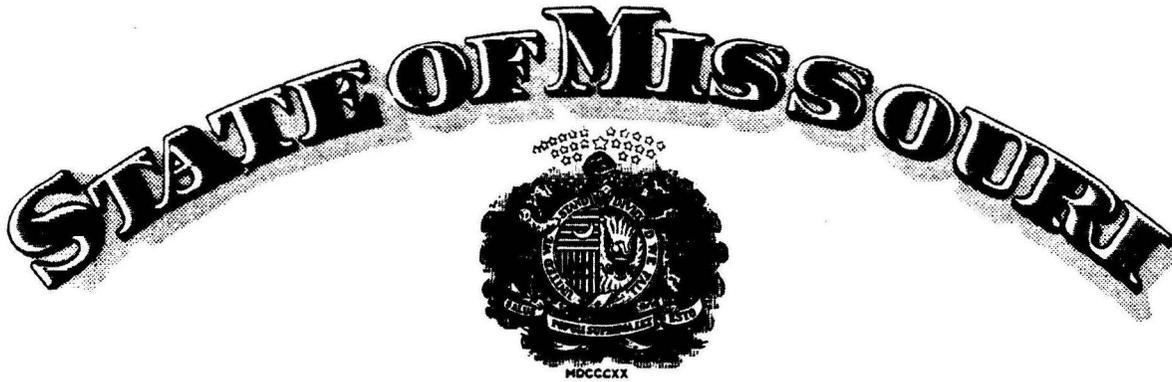
WHEREAS, Good Health hereby agrees to the imposition of the ORDER of the Director and as a result of Market Conduct Examination #0612-57-TGT further agrees, voluntarily and knowingly to surrender and forfeit the sum of \$28,552.00.

NOW, THEREFORE, in lieu of the institution by the Director of any action for the SUSPENSION or REVOCATION of the Certificate(s) of Authority of Good Health to transact the business of insurance in the State of Missouri or the imposition of other sanctions, Good Health does hereby voluntarily and knowingly waive all rights to any hearing, does consent to the ORDER of the Director and does surrender and forfeit the sum of \$28,552.00, such sum payable to the Missouri State School Fund, in accordance with §374.280, RSMo.

DATED: 12-24-09

  
\_\_\_\_\_

President and CEO Elect  
Good Health HMO, Inc. d/b/a Blue-Care, Inc.



**DEPARTMENT OF INSURANCE, FINANCIAL  
INSTITUTIONS AND PROFESSIONAL REGISTRATION**

P.O. Box 690, Jefferson City, Mo. 65102-0690

In re: )  
 ) Examination No. 0612-57-TGT  
Good Health HMO, Inc., )  
d/b/a Blue-Care, Inc. (NAIC #95315) )

**ORDER OF THE DIRECTOR**

NOW, on this 30<sup>th</sup> day of DECEMBER, 2009, Director John M. Huff, (hereafter referred to as the "Director") after consideration and review of the market conduct examination report of Blue Good Health HMO, Inc., d/b/a Blue-Care, Inc. (NAIC #95315), (hereafter referred to as "the Company") report numbered 0612-57-TGT, prepared and submitted by the Division of Insurance Market Regulation pursuant to §374.205.3(3)(a), RSMo, and the Stipulation of Settlement and Voluntary Forfeiture ("Stipulation") does hereby adopt such report as filed. After consideration and review of the Stipulation, report, relevant workpapers, and any written submissions or rebuttals, the findings and conclusions of such report is deemed to be the Director's findings and conclusions accompanying this order pursuant to §374.205.3(4), RSMo.

This order, issued pursuant to §§374.205.3(4) and 374.280, RSMo and §374.046.15. RSMo (Cum. Supp. 2006), is in the public interest.

IT IS THEREFORE ORDERED that the Company and the Division of Insurance Market Regulation have agreed to the Stipulation and the Director does hereby approve and agree to the Stipulation.

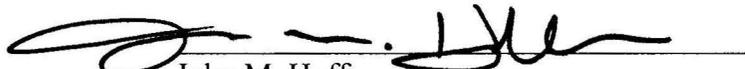
IT IS FURTHER ORDERED that the Company shall not engage in any of the violations of law and regulations set forth in the Stipulation and shall implement procedures to place the Company in

full compliance with the requirements in the Stipulation and the statutes and regulations of the State of Missouri and to maintain those corrective actions at all times.

IT IS FURTHER ORDERED that the Company shall pay, and the Department of Insurance, Financial Institutions and Professional Registration, State of Missouri, shall accept, the Voluntary Forfeiture of \$28,552.00, payable to the Missouri State School Fund.

IT IS SO ORDERED.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of my office in Jefferson City, Missouri, this 30<sup>TH</sup> day of DECEMBER, 2009.

  
John M. Huff  
Director

**STATE OF MISSOURI**  
**DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS**  
**AND**  
**PROFESSIONAL REGISTRATION**



**FINAL MARKET CONDUCT EXAMINATION REPORT**  
**Of the Health Maintenance Organization Business of**

**GOOD HEALTH HMO, INC., d/b/a BLUE-CARE, INC.**  
**NAIC # 0537-95315**

**MISSOURI EXAMINATION #0612-57-TGT**

**NAIC EXAM TRACKING SYSTEM #MO268-M28**

**December 21, 2009**

**Home Office**  
**2301 West Main Street**  
**Kansas City, Missouri 64108**

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## **FOREWORD**

This Market Conduct Examination Report is, in general, a report by exception. However, failure to comment on specific products, procedures or files does not constitute approval thereof by the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP). In performing this examination, the DIFP selected a small portion of the Company's operations for review. As such, this report does not reflect a review of all practices and all activities of the Company. The examiners, in writing this report, cited errors made by the Company. The final examination report consists of three parts: the examiners' report, the response of the Company, and administrative actions based on the findings of the Director.

Wherever used in this report:

- “BCBSKC” refers to Blue Cross and Blue Shield of Kansas City.
- “Company” refers to Good Health HMO, Inc., d/b/a Blue-Care, Inc.
- “CSR” refers to the Code of State Regulations.
- “DIFP” and “Department” refer to the Missouri Department of Insurance, Financial Institutions and Professional Registration.
- “Facets” refers to the claims system used by the BCBSKC group.
- “HIPAA” refers to the federal “Health Insurance Portability and Accountability Act of 1996.”
- “Member” refers to an individual covered under a Blue-Care plan.
- “NAIC” refers to the National Association of Insurance Commissioners.
- “RSMo” refers to the Revised Statutes of Missouri.

## **SCOPE OF THE EXAMINATION**

The authority of the DIFP to perform this examination includes, but is not limited to, §§354.465, 374.110, 374.190, 374.205, 375.445, 375.938 and 375.1009, RSMo.

The company examined was Good Health HMO, Inc., d/b/a Blue-Care, Inc. The examination was conducted in conjunction with an examination of Blue Cross and Blue Shield of Kansas City's Blue-Advantage HMO.

The time period covered by this examination is from January 1, 2003, through December 31, 2005, unless otherwise noted.

The purpose of this examination is to determine whether the Company complied with Missouri laws and DIFP regulations. In addition, the examiners reviewed Company operations to determine if they are consistent with the public interest.

This was a "target" examination, meaning that it was limited in scope. The examination focused primarily on the following areas:

- The Company's small employer group health insurance underwriting and rating practices to determine if those practices were consistent with the requirement of Missouri's Small Employer Health Insurance Availability Act.
- The handling of grievances filed against the Company by its enrollees. This review of grievances and related claim files was conducted to identify the various circumstances that gave rise to those grievances, the timeliness of the Company's response to concerns of their enrollees, and how effectively the grievances were resolved or concluded.
- The Company's handling of claims in connection with selected benefits mandated by Missouri statutes. Extracts of paid and denied claims for childhood immunizations, denied claims for emergency room and ambulance services, and denied claims for wellness benefits related to mammograms, Pap smears and PSA screenings were reviewed.
- The Company's handling of out-of-network claims. This review focused primarily on claims for radiology, anesthesiology, pathology, and laboratory services.
- The Company's process for providing refunds to members when copayments exceed the limitations prescribed by 20 CSR 400-7.100.
- A review of the Company's process for complying with Missouri's prompt payment laws (§§376.383 to 376.384, RSMo) as a follow-up to Market Conduct Examination #0404-34-PPE.

This market conduct examination was performed, in part, at the home office of the Company: 2301 Main Street, Kansas City, Missouri. Examiners were able to conduct the remainder of the examination in the DIFP offices at 301 West High Street in Jefferson City, Missouri, and at 111 North Seventh Street in St. Louis, Missouri.

## **COMPANY HISTORY**

Good Health HMO, Inc. is a wholly-owned subsidiary of Blue Cross and Blue Shield of Kansas City. According to the records of the Missouri Secretary of State, Good Health HMO, Inc. was incorporated as a “General Business Corporation” on October 12, 1988. The name under which the Company currently does business, Blue-Care, Inc., was registered as a “Fictitious Name” with the Secretary of State’s office on February 7, 1990. Currently, the Company’s status is listed as being in “Good Standing” and its fictitious name registration is listed as “Fictitious Active” with the Secretary of State’s office.

The Company is part of an “Insurance Holding Company System” within the meaning of §382.010, RSMo., along with several other subsidiaries of Blue Cross and Blue Shield of Kansas City (i.e., New Directions Behavioral Health, LLC; The EPOCH Group, LC; Preferred Health Professionals, LLC; Premier Workcomp Management, LLC; Missouri Valley Life and Health Insurance Company; and Blue-Advantage Plus of Kansas City, Inc.). The Company has entered into an agreement with Blue Cross and Blue Shield of Kansas City whereby the parent will provide all administrative services to the Company.

The Company is licensed as a health maintenance organization (HMO) in the states of Missouri and Kansas, and conducts business in an 11 county service area consisting of the Missouri counties of Andrew, Buchanan, Cass, Clay, Jackson, Johnson, Lafayette, Platte, and Ray, and the Kansas counties of Johnson and Wyandotte. The Company offers its individual practice association HMO product in the individual market, the small employer market and the large employer market in Missouri (although the Company ceased actively marketing the product in the individual market in May 2007, it does make it available through direct sales). During the exam period, the Company’s HMO product was offered along with the Blue-Advantage HMO product that Blue Cross and Blue Shield of Kansas City underwrites as a separate line of business. With the phase-out of the Blue-Advantage product by Blue Cross and Blue Shield of Kansas City, the Company’s Blue-Care product has become the primary commercial HMO offering of the holding company system.

## EXECUTIVE SUMMARY

### I. SMALL EMPLOYER GROUP UNDERWRITING AND RATING PRACTICES

#### **A. Small Employer Group Health Insurance Underwriting**

**1. Small Employer Group Health Insurance Policy Files:** In 12 of 28 files, the Company allowed small employers to define a full-time employee for eligibility purposes as requiring more than 30 hours per week, contrary to §379.930(15), RSMo. This resulted in the Company not offering coverage to all “eligible employees” as required by §379.940.2(5), RSMo. (*Pages 10-12.*)

**2. Small Employer Group Health Insurance Underwriting and Rating Manual**  
(a) Basic and Standard Plans: The Company’s manual stated that only Missouri Valley Life and Health Insurance Company would issue the Basic and Standard Plans. This was contrary to the Company’s agreement pursuant to a prior market conduct exam. Although the Company indicated this statement was an oversight and would be corrected, documentation provided by the Company indicated that it did not begin offering the Basic and Standard Plans until at least four and one-half months after the Department had approved the Company’s forms, contrary to §§379.940.1 (1) and 379.952.1, RSMo. (*Pages 12-13.*)

(b) Definition of “full-time” employee for small employer eligibility purposes: The Company’s manual states in two places that an employer may define “full-time” as working some greater number of hours per week than 30 for purposes of being eligible for coverage under a small employer group health plan contrary to §§379.930.2 (15) and 379.940.2(5) (a), RSMo. (*Page 13.*)

**B. Small Employer Group Health Insurance Rating:** Other than some referencing errors noted in the manual, no exceptions to the rating requirements of §379.936, RSMo, were noted. (*Page 13.*)

### II. COMPLAINTS AND GRIEVANCES

- In seven cases, the Company incorrectly denied claims even though prior authorization had been received, contrary to §376.1361, RSMo, and 20 CSR 400-10.200. (*Page 19.*)
- In three cases, the Company incorrectly denied claims for services that were actually covered, contrary to §375.1007(6), RSMo. (*Page 19.*)
- In 14 cases, the Company incorrectly denied claims without conducting a reasonable investigation, contrary to §375.1007(6), RSMo. (*Pages 20-21.*)

### III. CLAIM PRACTICES

#### **A. Claim Handling – Mandated Benefits**

- 1. Childhood Immunizations – Denied Claims:** Many immunization claims were denied as being the “Wrong PCP” due to the Company’s process of automatically assigning the mother’s PCP to a newborn. (*Page 23.*)
- 2. Childhood Immunizations – Paid Claims:** Immunization claims were initially denied due to the CPT code used being inconsistent with the age of the child even though the actual service is covered. The Company was criticized in a previous market conduct exam for denying such claims without investigation, contrary to §375.1007(3), (4) and (6), RSMo. (*Pages 23-24.*)

3. **Emergency Services – Denied Claims:** Claims for emergency services were initially denied and subsequently paid when the examiners asked for explanations as to why they were denied. The Company was criticized in a previous market conduct exam for denying such claims without investigation, contrary to §375.1007(3), (4) and (6), RSMo. *(Pages 24-25.)*
4. **Mammography – Denied Claims:** Out of 18 denied claim lines, 14 were denied as being out-of-network. *(Page 25.)*
5. **Colon Cancer Screenings – Denied Claims:** Out of 34 denied claim lines, 26 were denied as being out-of-network (of which, 20 were lab claims). *(Page 25.)*
6. **Pap Smear Cancer Screenings – Denied Claims:** Out of 78 denied claim lines, 67 were denied as being out-of-network (of which, five were lab claims). *(Pages 25-26.)*
7. **PSA Cancer Screenings – Denied Claims:** Out of 38 denied claim lines, 24 were denied as being out-of-network (of which, five were lab claims). *(Page 26.)*

**B. Claim Handling – Out-of-Network**

1. **Denied Pathology/Laboratory Claims:** Out of 6,659 denied claim lines, 1,211 were denied as being out-of-network. *(Pages 26-29.)*
2. **Denied Anesthesiology Claims:** A secondary COB claim, which was determined by the Company to be emergent and paid upon questioning by the examiners, was initially denied without further investigation, contrary to §§375.1007(6) and 376.1367, RSMo. *(Page 29.)*
3. **Denied Radiology Claims**
  - In two claims where members with debilitating illnesses were confined to network skilled nursing facilities and under the care of network physicians, the Company denied claims for portable x-ray services provided in the facility because the provider was out-of-network. *(Pages 32-33.)*
  - A “Medicaid Reclamation” claim that was both in-network and emergent was denied as being out-of-network without further investigation, contrary to §375.1007(6), RSMo, and 20 CSR 400-2.030(2)(F)4.F. *(Pages 33-34.)*
  - A claim related to an inpatient stay was denied without further investigation due to a date of service error, contrary to §375.1007(6), RSMo. The Company readjudicated and paid the claim during the course of the examination. *(Page 34.)*
  - A radiology claim that was emergent in nature was denied without further investigation, contrary to §375.1007(6), RSMo. The Company readjudicated and paid the claim during the course of the examination. *(Page 34.)*
4. **Access Plan:** The Company’s access plan appears to indicate that any services provided in a network hospital by a “hospital-based provider” will be covered; however, the Company’s definition of what constitutes a hospital-based provider is much narrower than the Company’s access plan response would seem to indicate. The Company should amend its access plan filing to more accurately reflect its processes pursuant to §354.603.2, RSMo. *(Pages 35-37.)*

**5. Out-of-Network Claims Generally:** There appears to be confusion among the Company's members as to when they are out-of-network and when out-of-network claims are payable. To alleviate such problems, the Company needs to be proactive in educating its members as to the differences between "Par" and "network" providers, and the circumstances under which the Company would pay claims that are initially denied as being out-of-network. The Company should also work on improving claim processes so that claims payable as exceptions are identified and investigated rather than automatically denied. (*Pages 37-38.*)

**C. Refunds of Excessive Copayments:** The Company does not have any process in place to monitor whether or not providers make refunds of copayments that exceed 50% of a single service in compliance with 20 CSR 400-7.100. (*Pages 38-39.*)

**D. Prompt Payment of Claims:** The Company is not correctly calculating the 45-day period for the payment of interest required by §§376.383 to 376.384, RSMo, because:

- The Company does not regard an electronic claim as being received until it receives it from its contracted electronic claim vendor.
- If a claim is denied in whole or in part and the provider and/or member subsequently furnishes additional information, makes an inquiry or files an appeal regarding the denied claim, it appeared from standard operational procedure documents that the Company may regard this event as a new "received" date in many instances. (*Pages 39-44.*)

## **EXAMINATION FINDINGS**

### **I. SMALL EMPLOYER GROUP UNDERWRITING AND RATING PRACTICES**

This section of the report details the examination findings regarding underwriting and rating practices. Such practices include the use of policy forms, adherence to underwriting guidelines, assessment of premiums for coverage, and procedures used to decline or terminate coverage. The examiners reviewed underwriting and rating practices for correctness and to assure the Company's compliance with Missouri statutes and regulations. Examiners limited the review of underwriting and rating practices to only the small employer group health insurance business of the Company.

To minimize the duration of the examination, while achieving an accurate evaluation of small employer group underwriting and rating practices, the examiners reviewed a statistical sample of the policy files. A policy file, as a sampling unit, is defined as a contract of insurance between an insurer and the policy owner/insured, which includes all the obligations of the parties to the contract.

The percent of files found to be in error is the most appropriate statistic to measure compliance with Missouri law regarding rating and underwriting. An underwriting or rating error is defined as any of the following:

- A miscalculation of premium;
- An improper acceptance of an application;
- An improper rejection of an application;
- A misapplication of the company's underwriting guidelines; or
- Any other underwriting or rating action that violates Missouri law.

#### **A. Small Employer Group Health Insurance Underwriting**

The examiners reviewed the Company's policy files and underwriting and rating manual to determine whether the Company adhered to prescribed and acceptable underwriting criteria and complied with Missouri laws and regulations.

##### **1. Small Employer Group Health Insurance Policy Files**

<b>Field Size:</b>	<b>564</b>
<b>Sample Size:</b>	<b>28</b>
<b>Type of Sample:</b>	<b>Random</b>
<b>Number of Errors:</b>	<b>12</b>
<b>Error Rate:</b>	<b>43%</b>
<b>Within DIFP Guidelines:</b>	<b>No</b>

In this review, the examiners focused on groups that were subject to Missouri's "Small Employer Health Insurance Availability Act", §§379.930 through 379.952, RSMo, (i.e., those employers with 3-25 employees) that were

underwritten between January 1, 2003, and December 31, 2005. Of this group of 564, the examiners chose a random sample of 28 for review of the Company's policy files. Appearing in each of these underwriting files were one of the following application forms:

BCBSKC –GrpApp (Under 100) MetLife -4/03  
BCBSKC –GrpApp (Under 100) MetLife -4.03  
BCBSKC –GrpApp (Under 100) Life -1/04  
BCBSKC –GrpApp (Under 100) -8/04  
BCBSKC –GrpApp (Under 100) -8-04

These application forms are used by the Company for employer groups of less than 100. This means that these application forms are used in the HIPAA-defined small group market (2-50 employees) and large group market (over 50 employees) as well as for those employers subject to Missouri's "Small Employer Health Insurance Availability Act." Each of these application forms contained a blank for the employer to designate the number of hours that it would consider as "full-time" for the purposes of plan eligibility. This blank included an instruction that it could not be less than 30 hours.

While HIPAA does not define what will be considered an "eligible employee" for the purposes of either the small group market or the large group market, §379.930(15), RSMo, of Missouri's "Small Employer Health Insurance Availability Act" does contain such a definition:

*"Eligible employee" means an employee who works on a full-time basis and has a normal work week of thirty or more hours. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a part-time, temporary or substitute basis. For purposes of sections 379.930 to 379.952, a person, his spouse and his minor children shall constitute only one eligible employee when they are employed by the same small employer;*

In addition, §379.940.2(5), RSMo, also requires that:

*If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group or to only part of the group, except in the case of late enrollees as provided in subdivision (3) of this subsection.*

The Department interprets these provisions as prohibiting companies from issuing plans that limit eligibility to employees who work some greater number of hours per week than 30, such as 32, 35 or 40 hours per week. In the following 12 cases, the Company issued plans that limit eligibility to employees working a greater number of hours per week than 30:

GROUP #	# EEs	Group Application Information
26813000	8	full time = 35 hrs. per week
26899000	4	full time = 40 hrs. per week
27046000	6	full time = 40 hrs per week
27050000	4	full time = 40 hrs. per week, with 14 “part time” EEs
27711000	4	full time = 32 hrs. per week
27906000	3	full time = 32 hrs. per week
28417000	8	full time = 32 hrs. per week
28488000	12	full time = 40 hrs. per week
25650000	9	full time = 40 hrs. per week
26617000	12	full time = 35 hrs. per week
27211000	5	full time = 35 hrs. per week
28592000	10	full time = 32 hrs. per week

Reference: §§379.930(15) and 379.940.2(5), RSMo.

In response to Criticism #4, the Company disagreed, stating, in part, that:

*[The Company] offers health insurance coverage to all Small Employers who employ individuals who work a normal work week of thirty or more hours. However, some Small Employers do not consider these individuals to be “full-time” employees eligible for health coverage or other employee benefits.*

The Company went on to explain how its actions comply with the statute stating that:

*379.930 RSMo defines an eligible employee as an employee who (1) works on a full-time basis and (2) has a normal work week of thirty or more hours. While these employees may meet the second component of the definition, they do not meet the first component as defined by the employer. It appears the legislators in defining “eligible employee” contemplated the employer’s role in defining full-time. [The Company] is unable to force an employer to offer coverage to employees the employer has determined are not eligible for benefits.*

## **2. Small Employer Group Health Insurance Underwriting and Rating Manual**

The examiners reviewed the underwriting guidelines in the manual and noted the following:

(a) Basic and Standard Plans: Examiners noted that the Company’s underwriting manual states that only Missouri Valley Life and Health Insurance Company would offer and issue the Basic and Standard benefit plans on behalf of all companies within the Blue Cross and Blue Shield of Kansas City group of affiliated companies. The Company had been cited for failing to offer the Basic and Standard plans in market conduct examination #0040-11-HMO dated December 20, 2001, and the Company had agreed, in a “Stipulation of Settlement” signed by the Company’s president on July 25, 2002, to remedy this situation.

In response to Formal Request #47 questioning this statement in the underwriting manual, the Company stated that “this information was copied out of a document that was last updated in 2001” (although the page of the manual in question showed a “policy written” date of “06/06/2006”). The Company indicated it had been offering the Basic and Standard plans, and as proof, furnished a copy of a TD-1 form for the filing of a “Blue-Care Basic/Standard Certificate” form with a Department received date of November 12, 2002, and an approval date of January 1, 2003. The Company also furnished a copy of the certificate along with a “Contracts and Compliance State Approval Bulletin” dated May 16, 2003, that indicated the form had been approved by the Department and internal units of the organization “are in the process of programming this document for distribution and a marketing strategy will be developed for new business.” The Company said that it would correct its underwriting manual. From the documentation provided, however, it appears the Company did not begin actively offering the Basic and Standard plans until at least four and one-half months after the Department had approved the forms.

Reference: §§379.940.1 (1) and 379.952.1, RSMo.

(b) Definition of “full-time” employee for small employer eligibility purposes: The underwriting manual states in two places that an employer may define “full-time” as working some greater number of hours per week than 30 for purposes of being eligible for coverage under a small employer group health plan. As indicated above, the Department believes this to be contrary to Missouri statutes.

Reference: §§379.930.2 (15) and 379.940.2(5) (a), RSMo.

## **B. Small Employer Group Health Insurance Rating**

Examiners reviewed the Company’s rating manual and the description of the small employer group health insurance rating process that the Company provided with the underwriting file sample. Although the examiners noted some referencing errors in the manual, which the Company indicated it would correct, no exceptions to the rating standards set forth in §379.936, RSMo, were found.

## II. COMPLAINTS AND GRIEVANCES

This section of the report details the examination findings regarding complaints and grievances that members submitted to the Company. Sections 354.455, 375.936(3), and 376.1375 to 376.1389, RSMo, 20 CSR 300-2.200(3)(D) and 20 CSR 400-7.110 require health maintenance organizations to establish a procedure for receiving and resolving complaints/grievances and to maintain a complete record of the handling of all complaints/grievances that it has received. The examiners reviewed complaints and grievances submitted directly to the company or through the DIFP for calendar years 2003, 2004 and 2005.

The Company provided the examiners with a spreadsheet listing 1,984 first level grievances involving both the Company's Blue-Care product and BCBSKC's Blue-Advantage product. The Company referred to the files in this listing as "appeals" and indicated that the listing included both member-submitted and provider-submitted appeals. The provider-submitted appeals included appeals the provider submitted on behalf of the member as well as appeals the provider submitted on their own behalf. Of the 1,984 appeals listed, 1,162 were appeals involving the Company's Blue-Care product. The Company categorized the appeals into "Types" and "Subtypes" in the listing. The incidence of the various Types in the listing was as follows:

Type	Count	Percent of Count
Benefit/Benefit Design	210	18.07%
Claims Adjudication	683	58.78%
Customer Service-Access/Service	15	1.29%
Medical Necessity	178	15.32%
Membership	13	1.12%
Other	10	0.86%
Provider Access	53	4.56%
<b>Totals</b>	<b>1,162</b>	<b>100%</b>

The examiners decided to select a sample of 100 files for review from the Type categorized as "Claims Adjudication". This sample included both upheld and overturned appeals and both member-submitted and provider-submitted appeals. The Subtypes and their frequency within the sample were as follows:

<b>“Claims Adjudication” Subtype</b>	<b>Count</b>
Accuracy	2
COB	1
Denial	36
Medical Necessity	9
No Claim	1
Non-Covered	3
Not Assigned PCP	1
Out of Network	33
Prior Authorization	14
<b>Total</b>	<b>100</b>

In reviewing the sample of 100 appeals, the examiners noted the following:

Formal Request #4, Appeal #03000097: This appeal involved a claim for emergency eye surgery to repair a detached retina. The member had been referred to an out-of-network provider (who performed the surgery in an out-of-network hospital) by an in-network provider. The examiners questioned why this emergency claim had been denied based upon the provider being out-of-network. The Company responded that:

*This appeal was overturned by BCBSKC upon a Second Level appeal request, prior to the Second Level Grievance panel. There is an e-mail in the folder indicating the appeal was overturned, however, the overturn letter was errantly not included in the initial documents. I apologize for the oversight.*

*The reason this claim was not processed as an emergency claim was because the situation evolved over several days. The member saw multiple in-network providers, and indicated in her appeal that she assumed the provider who performed the surgery, as well as hospital, were in-network.*

*Upon review at the second level of appeal, it was determined that the confusion between the medical network and the vision network were great enough to warrant an exception and provide payment to the providers on behalf of this member. The claims were reprocessed on July 7, 2003.*

Formal Request #5: Noting that a third of the sample of first level appeals dealt with out-of-network care, the examiners asked why this was the case and what materials are used to educate the members about the difference between a BCBSKC provider and Blue-Care network providers. The Company responded that:

*The Blue-Care HMO is an Open Access HMO, and therefore does not require referrals from a Primary Care Physician in order to receive care from a Specialist. It is the member's responsibility to ensure that the providers they are seeing are in-network providers. In a closed HMO, if the member is referred to an out-of-network provider, it is the referring provider's financial responsibility. In an Open-Access HMO, the member can seek specialist services, but if they receive services from an out-of-network provider, regardless of whether or not the services are covered services, the member is responsible for the cost.*

*There are multiple locations where the member is informed of the need to obtain services in-network. In the Certificate of Coverage it is outlined at the beginning of the Covered Services section and is the first Exclusion in the Exclusions and Limitations section (see pages 1 and 2 of Attachment A). Page 3 of Attachment A is the opening page of the Blue-Care provider directory, which also indicates that services must be obtained from a network provider. Page 5 of Attachment A is a copy of a Benefit Plan Summary that is used by Marketing to show groups the difference between the HMO and the PPO. In the Blue-Care column, it indicates services must be received from a network provider.*

Formal Request #14: The examiners asked about 19 claims that had initially been denied and overturned after further investigation upon appeal. The Company was asked what investigation had taken place prior to denial. The Company was also asked whether any of the claims were automatically denied by the claim system, and if so, what information caused this. The Company indicated that no investigation had taken place prior to denial in 14 of the claims listed, and that 12 of these 14 had been automatically denied by the system for being out-of-network. One additional claim was indicated to have been automatically denied by the system as being out-of-network, but the Company also indicated some investigation took place prior to the denial (i.e., requesting an "Explanation of Medicare Benefits").

Formal Request #15: This request asked about several appeals. Of particular note, were the following:

Appeal #05003320: The examiners questioned why charges for a newborn screening conducted at an in-network hospital were denied. The Company replied that they were initially denied because the provider was out-of-network and reversed on appeal when it was determined that there was no other available option at the hospital.

Appeal #04001920: In this upheld appeal, the examiners questioned why the claim from an out-of-network hospital was denied when the member's participating physician advised the member to go there and also questioned why the provider rather than the member wasn't the one held responsible. The Company replied that there was no evidence of emergency in the information supplied with the

claim. The Company also explained that it had no contractual way to hold the provider responsible for the claim since referrals are not required and the providers are not capitated. “The members are responsible for staying in the network.”

Appeal #05003879: The examiners asked why this claim for a “Wound Vac” was underpaid and why the member was balance billed. The Company replied that this was actually two claims. One had been paid at billed charges and the second had been paid at a negotiated rate. The second claim had incorrectly assigned a portion as member responsibility due to the negotiated rate not being loaded into the system. This oversight was corrected upon appeal.

Appeal #05002073: The examiners questioned why this out of network claim was denied when the member was following her participating provider’s instructions. The Company said the claim was denied as the wrong PCP, there was no information as to who referred her, and a change in PCP was implemented once the member notified the Company. The denial was upheld upon appeal.

Appeal #s 05003866 and 05002404: The examiners requested confirmation that the claims involved in these two overturned appeals had been improperly denied when initially submitted. The Company confirmed that appeal #05003866 had been incorrectly denied because the member’s website PCP change had not been recorded, and confirmed that appeal #05002404 had been initially denied because there was no indication of an emergency for this out-of-network treatment. Both were overturned upon appeal after further investigation.

Appeal #s 03000630, 03001086, 03000935, 05001996, 03003638, 05003432, and 05002073 and Appeal #s 0500589, 05001147, and 05002256: As to the first set of appeals, the examiners questioned why the claims were denied and the denials upheld upon appeal when a participating provider had referred the member to an out of network provider. The Company responded that they were denied because they were out of network or because the PCP was not the member’s PCP. As to the second set of appeals, the examiners questioned why these claim denials, which were similar to the first set, had been overturned upon appeal. The Company responded that they were overturned due to internal policy-related management exceptions.

Appeal #03003638: The examiners questioned the denial of a claim because the provider was not contracted at the address where the member was treated. The Company explained that, “The answer provided at first level of appeal was not completely correct.” The Company went on to explain that the denied claim used a non-Blue-Care provider number that “had not been a Blue-Care network provider since [over two years before the claim].”

Due to the results of the review of the 100 file sample, the examiners decided to request and review all overturned, first level grievances in which the “Type” was designated as “Claims Adjudication” or “Medical Necessity”, excluding those files where the provider

was appealing on their own behalf. This resulted in a group of 322 first level files where either the member or someone on the member's behalf was appealing. The examiners noted the following:

Formal Request #20: The examiners asked if it were true that: (1) claims for out-of-network laboratory tests or claims for out-of-network providers reading laboratory tests were automatically denied; and (2) the Company's formal process was to overturn such claims upon appeal if it were determined that the member had no control over where the laboratory test was sent or who read the test. The Company responded that:

*Yes, any non-emergent claim from a non-HMO provider is automatically denied by the system as a non-covered service.*

*Yes, in the Corporate Policy, Approval of Benefit Exceptions, (a copy of this policy was provided earlier this week) there are documented situations under which an out-of-network provider can be paid for services rendered to an HMO member. These services include:*

- *Documented situation in which a medically necessary covered service is not available within the network.*
- *For ER, radiology, anesthesiology, pathology (including laboratory services) provided as part of an inpatient admission to a network hospital when provided by a non-network provider or outpatient services associated with an outpatient procedure at a network facility when provided by a non-network provider.*
- *For services provided at a network hospital if that hospital has a sole contract with a specific group of providers for selected services (e.g. only one provider group at XYZ hospital can read EKGs and this group of providers is not in the network).*
- *Other specialty services provided as part of an inpatient admission to a network hospital or outpatient services associated with an outpatient procedure at a network facility are subject to approval by the Vice President of Provider Contracting and Reimbursement.*
- *For services provided by non-network providers in an emergency situation over which a member had no control once admitted to a network hospital by a network physician (e.g. once admitted to the hospital, an additional consultant is required due to a presenting emergency condition and this consultant is not in the network). For purposes of this exception, emergency situation is defined as a situation in which the provider does not have adequate time to call us for an authorization without jeopardizing the health of the patient.*
- *For laboratory services when a specimen is sent by a network physician to a non-network lab.*

Criticism #1: The examiners identified 21 overturned appeals in which the claim was initially denied although it appeared prior authorization for the service or supply had

been obtained from the Company. The Company responded to the various appeals as follows:

Appeal #s 03002063, 03002569, 03003481, 04001820, 04002351 and 05002746: For these six appeals, the Company agreed that the original claims had been prior-authorized and were denied incorrectly.

Reference: §376.1361 and Regulation 20 CSR 400-10.200.

Appeal #04000916: For this appeal, the Company agreed that “a prior-authorization was retro-actively approved and the claim was not adjusted. Upon receipt of the appeal, it was noted that the authorization was now in the system and the claim was paid.”

Reference: §376.1361 and Regulation 20 CSR 400-10.200.

Appeal #s 03001631, 03003612 and 05002074: The Company disagreed on these three appeals indicating that “there was not a prior-authorization on file, but the claim denied incorrectly because the service being billed was a covered service.” These denials do not appear to comply with the reasonable investigation requirements of Missouri’s “Unfair Claims Settlement Practices Act.”

Reference: §375.1007(6), RSMo.

Appeal #03001960: The Company disagreed on this appeal stating that the original claim “was denied correctly, but was overturned upon appeal based on incorrect customer service information that was provided prior to the service being rendered.”

Appeal #s 03001205, 03001531, 03002362, 03003793, 04002365, 05001168: The Company disagreed on these six appeals stating that the original claims “were correctly denied as out-of-network claims” and “were paid upon receipt of additional information, which was provided as part of the appeal process.”

Appeal #s03000947, 03001867: The Company disagreed on these two appeals, indicating that they “were related to payment levels, and not to denials of claims.” To resolve the appeals, the Company said that an “exception was made to pay billed charges as opposed to allowable charges, as a courtesy to the member.”

Appeal #03001436: The Company disagreed on this appeal stating that the original claim “was related to an out-of-network x-ray that denied correctly. This x-ray was performed by an out-of-network doctor as follow-up to an approved out-of-network surgery. Therefore, an exception was made by a BCBSKC Medical Director to pay this claim based on continuity of care.”

Appeal #04002063: The Company disagreed on this appeal stating that the original claim was “denied appropriately as out-of-network. This claim was follow-up care for a student who was residing outside the service area temporarily. There was no authorization on file for an out-of-network visit. This claim was incorrectly paid upon appeal.”

Criticism #2: The examiners identified 48 appeals where the original claim had been denied because the provider was out-of-network and the denial was overturned on appeal. These claims fell into four categories:

1. Member inpatients at participating hospitals were subjected to tests, given medical services, or furnished with durable medical equipment or devices provided by out-of network providers.
2. Members received care, services or supplies from out-of-network facilities or providers in connection with urgent or emergent conditions.
3. Members received durable medical equipment from their primary care physicians or from participating specialists that were supplied by out-of-network durable medical equipment suppliers.
4. Members were referred by their primary care physician to out-of-network providers for medical tests.

It appeared to the examiners that these claims would not have been denied initially if the Company had conducted a reasonable investigation as required by Missouri’s “Unfair Claims Settlement Practices Act.”

Reference: §375.1007(6), RSMo.

The Company indicated its agreement on six of the 48 files listed in the criticism and indicated its disagreement on the remainder, stating that:

*For categories 1, 3, and 4, the Company disagrees that it is required to pay out of network claims under the terms of its member contracts. In the appeal process, we granted exceptions to pay for out of network claims in the circumstances cited above. However, payment was not required and additional investigation would not have changed the Company’s position.*

*For category 2, the Company agrees that there were claims denied that may have been paid if there was an indication on the claim that it was related to an urgent or emergent visit. However, additional investigation may or may not have resulted in payment depending upon the timing of the emergent claim submission.*

Criticism #3: The examiners identified 32 overturned appeals. In the majority of these cases, the original claim had been denied for the same reasons set forth in Criticism #2. Some of the original claims in several of these appeals, however, had been denied for coverage reasons. As in Criticism #2, it appeared to the examiners that these claims

would not have been denied initially if the Company had conducted a reasonable investigation as required by Missouri's "Unfair Claims Settlement Practices Act."

Reference: §375.1007(6), RSMo.

The Company indicated agreement on eight files relating to claims for emergency services, disagreed on the remainder, and gave the exact same rationale as set forth in its response to Criticism #2.

### **III. CLAIM PRACTICES**

This section of the report details examination findings regarding the Company's claim practices. The examiners reviewed such practices to determine whether claims are efficiently processed and accurately paid and for adherence to contract provisions and Missouri statutes and regulations.

Because this was a target examination, the scope of the examiners' review was limited to the following areas:

- **Mandated Benefits**: This included a review of paid and denied claims for childhood immunizations, denied claims for emergency services, and denied claims for mammography, colon, Pap smear and PSA cancer screening services.
- **Out-of-Network Benefits**: This included a review of denied claims for pathology and laboratory services, anesthesiology services, and radiology services (all of which are typically provided on an inpatient or referral basis) as well as a review of the Company's access plan as it related to the handling and provision of out-of-network services.
- **Copayment Limitations**: This involved a review of the Company's processes for assuring compliance with the copayment limitations in 20 CSR 400-7.100.
- **Prompt Payment**: This involved a review of the Company's processes for compliance with §§376.383 to 376.384, RSMo, as a follow-up to the findings from a previous market conduct examination.

#### **A. Claim Handling – Mandated Benefits**

In response to a data request made prior to the commencement of the examination, the Company provided claims data for the period January 1, 2005, to December 31, 2005, divided into three categories: "Paid Claims," "Denied Claims," and "Pending Claims". Extracts of claims from the "Denied Claims" database for the mandated benefits of childhood immunizations (§376.1215, RSMo); emergency services (§376.1367, RSMo); mammography (§376.782, RSMo); and colon, Pap smear, and PSA cancer screenings (§376.1250, RSMo) were made. Of these, claims with "Denial Reason" codes that appeared to be self explanatory (such as coverage terminated) were excluded, and the Company was requested to give explanations as to why the remaining claims had been denied.

In addition, the examiners reviewed childhood immunization claims in the "Paid Claims" data to determine if any showed the imposition of a deductible or copayment, contrary to §376.1215, RSMo, and to see if any childhood immunization claims in the "Paid Claims" data could be considered denied in whole or part.

## 1. Childhood Immunizations – Denied Claims

The Company was given a list of 45 claim numbers and requested to give explanations as to why they had been denied. The explanations given can be categorized as follows:

<b>Denial Explanation</b>	<b>Number</b>
Diagnosis	1
Excessive charge	20
No referral/authorization	4
Paid	5
Redundant procedure	5
Wrong PCP	10
<b>Total</b>	<b>45</b>

Further analysis of the data revealed additional claims for which a childhood immunization claim line item was labeled as being denied for being the wrong PCP. The examiners noted that the percentage of childhood immunization claim lines denied for this reason (78 out of 607 or 12.85%) was much higher than the percentage of claim lines denied for this reason in the rest of the denied claims data (1,482 out of 60,88 or 2.43%). The Company explained that:

*On the first occurrence of receiving notification of the birth of a baby, the baby is added to the Blue Care policy. Most of the time, our first notification is a bill on the mother for the delivery. The baby is added to the policy, assigning the mother's PCP to the newborn. When we are notified of the PCP selection for the newborn, the PCP is changed with the effective date being the date of birth. Claims history is reviewed and all claims submitted by the selected PCP are reprocessed.*

The Company explained that this process was implemented in order to provide immediate coverage in compliance with Missouri's newborn statute (§376.406, RSMo). According to the Company, however, only seven of the 28 claim numbers represented by the 78 claim lines had been readjudicated.

## 2. Childhood Immunizations – Paid Claims

The "Paid Claims" data was reviewed to determine whether the Company had imposed any deductibles or copayments in connection with claims for childhood immunization benefits. No claims imposing deductibles or copayments on childhood immunization claims were detected in the data provided by the Company.

An extract of claims with childhood immunization CPT codes and a zero paid amount was also made from the "Paid Claims" data supplied by the company.

Claims with a denial code of N16 “Age > extreme range for procedure – N” were scrutinized further on the Facets system. These claims were denied because an incorrect CPT code had been submitted. Most of the claims were paid upon resubmission with a corrected code, but four of the claims were unclear as to their processing. The Company indicated that three of these four were never corrected and resubmitted. The Company stated that:

*It is the practice of BCBSKC to process claims with the information as it is submitted on the claim, therefore, if a claim (or claim line) is filed without complete or valid information, the claim (or claim line) is denied with an explanation for the denial. If the provider submits a corrected claim, the original claim is adjusted to reflect the corrected information; therefore, if the provider never resubmits the claim with accurate procedure codes, the claim is not adjusted.*

In the Company’s 2001 market conduct examination (exam #0040-11-HMO), the Company was criticized for denying such incorrectly coded claims without further investigation.

Reference: §375.1007(3), (4) and (6), RSMo.

### 3. Emergency Services – Denied Claims

A list of 228 denied claim lines was given to the Company requesting an explanation for their denial. The following explanations were given:

<b>Denial Explanation</b>	<b>Number</b>
Blue Card	2
Capitated	1
Company error	2
Dental	124
Diagnosis	5
Duplicate	2
Exclusion	7
Medicare primary, need EOMB	1
No referral/authorization	7
Not medically necessary	2
Other BCBS plan pays	1
Paid	27
Primary paid	2
Provider error	12
Provider refund	13
Provider write-off	3
Redundant procedure	5
Workers’ compensation	12
<b>Total</b>	<b>228</b>

Examiners reviewed in greater detail those seven claim lines (five claim numbers) that were denied because the insured had not obtained a referral or authorization to go outside the HMO network. After reviewing the claims on the Company's Facets claim system, the examiners asked for explanations as to why they had not been paid. Upon further review, the Company determined that three of the five claim numbers should be paid and proceeded to adjust them (the other two claim numbers had been paid previously). The Company also adjusted and paid a claim related to one of the three claims that were the subject of the examiners' inquiry. In the Company's 2001 market conduct examination (exam #0040-11-HMO), the Company was criticized for denying such emergency claims without further investigation.

Reference: §375.1007(3), (4) and (6), RSMo.

#### 4. Mammography – Denied Claims

A list of 18 denied claim lines was given to the Company requesting an explanation for their denial. The following explanations were given:

<b>Denial Explanation</b>	<b>Number</b>
Out-of-network (of which, 12 were facility related and two were professional related)	14
Paid	4
<b>Total</b>	<b>18</b>

#### 5. Colon Cancer Screenings – Denied Claims

A list of 34 denied claim lines was given to the Company requesting an explanation for their denial. The following explanations were given:

<b>Denial Explanation</b>	<b>Number</b>
Out-of-network (of which, 20 were lab claims)	26
Paid	6
Primary insurer paid	1
Wrong PCP	1
<b>Total</b>	<b>34</b>

#### 6. Pap Smear Cancer Screenings – Denied Claims

A list of 78 denied claim lines was given to the Company requesting an explanation for their denial. The following explanations were given:

<b>Denial Explanation</b>	<b>Number</b>
Coordination of benefits (need EOB from primary carrier)	1
Excessive charge, provider write-off	1
Out-of-network (of which, five were lab claims)	67
Subprocedures already paid for within a primary procedure	3
Paid	5
Utilization review denial	1
<b>Total</b>	<b>78</b>

## 7. PSA Cancer Screenings – Denied Claims

A list of 38 denied claim lines was given to the Company requesting an explanation for their denial. The following explanations were given:

<b>Denial Explanation</b>	<b>Number</b>
Exclusions	5
Out-of-network (of which, five were lab claims)	24
Paid	3
Utilization review denial	6
<b>Total</b>	<b>38</b>

## B. Claim Handling – Out-of-Network

Of the 1,162 first level appeals/grievances listed as being for the Blue-Care product, almost one quarter (i.e., 290 out of 1,162 or 24.2%) were described as concerning denials for out-of-network care. Due to the significant number of such appeals, the examiners decided to look at these denied claims in greater detail.

### 1. Denied Pathology/Laboratory Claims

Of the claim lines in the “Denied Claims” database supplied by the Company, 6,659 were determined to involve pathology/laboratory services. Of this number, 1,211 were identified as being denied as out-of-network pursuant to the instructions for identifying such claims provided in the Company’s response to Formal Request #48. This represents 18.2% of the total number of denied pathology/laboratory claim lines. The examiners selected a sample of 50 out-of-network claims to review in greater detail and requested copies of the claim file documents from the Company. The breakdown of the characteristics of these claims was as follows:

		IN – Out of Service Area Provider				IN – In Service Area Provider		PAR – Out of Service Area Provider	PAR – In Service Area Provider			OUT – Out of Service Area Provider	OUT – In Service Area Provider
		PLACE OF SERVICE											
		Office	Outpatient Hospital	Indep. Lab	Facility	Office	Indep. Lab	Indep. Lab	Office	Indep. Lab	Facility	Indep. Lab	Office
P R O V I D E R T Y P E	ENT (Otolaryngology)					1							
	Dermatology					2							
	Family Practice					1							
	Gastroenterology					2							
	Internal Medicine					1							1
	Obstetrics & Gynecology	2				2							
	Pathology						1						
	Hematology & Oncology					1							
	Chiropractor								2				
	Independent Lab						1	1			1		
	Mixed Specialty Group		1	13								5	
	Rheumatology								1				
	Endocrinology					4							
	Reproductive Endocrinology & Infertility					1							
	Advanced Practice Nurse												3
	Urgent Care					1							
	Facility				1						1		
<b>TOTALS</b>	<b>2</b>	<b>1</b>	<b>13</b>	<b>1</b>	<b>16</b>	<b>2</b>	<b>1</b>	<b>3</b>	<b>1</b>	<b>1</b>	<b>5</b>	<b>4</b>	

For the purposes of the preceding table and subsequent tables:

**“IN – Out of Service Area Provider”** means the provider delivering the service was out of the Company’s service area but in the network of the Blue Cross Blue Shield plan where the service was delivered.

**“IN – In Service Area Provider”** means the provider delivering the service was both in the Company’s service area and in the Company’s network.

**“PAR – Out of Service Area Provider”** means the provider delivering the service was out of the Company’s service area but had only signed a Blue Cross Blue Shield participating agreement and not a network agreement.

**“PAR – In Service Area Provider”** means the provider delivering the service was in the Company’s service area but had only signed a Blue Cross Blue Shield participating agreement and not a network agreement.

**“OUT – Out of Service Area Provider”** means the provider delivering the service was outside the Company’s service area but had no agreement in place.

**“OUT – In Service Area Provider”** means the provider delivering the service was in the Company’s service area but had not signed any kind of agreement.

In response to Formal Request #40 requesting further information as to any appeal or customer service inquiry that had resulted in any of the claims being overturned or upheld, the Company provided information indicating that seven of the denials had been the subject of inquiries. The characteristics of these seven claims were as follows:

- Four claims were “IN – Out of Service Area Provider”, with the “Place of Service” as “Independent Laboratory” and the “Provider Type” as “Mixed Specialty Group”. One of these claims was resubmitted and paid.
- One claim was “IN – In Service Area Provider”, with the “Place of Service” as “Office” and the “Provider Type” as “ENT (Otolaryngology).”
- One claim was “PAR – In Service Area Provider”, with the “Place of Service” and the “Provider Type” as “Facility”.
- One claim was “PAR – In Service Area Provider”, with the “Place of Service” as “Independent Laboratory” and the “Provider Type” as “Independent Lab”. This claim was subsequently adjusted and paid.

One claim that was not the subject of an inquiry was subsequently resubmitted and paid according to the Company. None of the claims were the subject of an appeal.

The examiners noted that network providers that are not contracted as lab/pathology providers are held responsible for such charges if they provide them, but the member is held responsible if that provider chooses an out of area lab/pathology provider to provide the service. When asked, the Company responded in Formal Request #55, and confirmed that:

- “Blue-Care network specialists who are not contracted laboratory or pathology providers, and choose to provide these services in their office, are

held responsible for the cost of such services when they or their associates provide them.”

- “[I]n the absence of a prior authorization, if that same network provider selects an out-of-area lab or pathologist to provide the lab or pathology service the claim is processed through the ITS claim system, and the member is held responsible for the cost of the service.” (The ITS or Inter-Plan Teleprocessing Services system is the system used by the various Blue Cross and Blue Shield plans for administering claims filed outside of the responsible plan’s service area.)
- Such out-of-area claims “for lab/pathology services ... may only be paid pursuant to a management exception granted in response to a member appeal.”

## 2. Denied Anesthesiology Claims

Of the claim lines in the “Denied Claims” database supplied by the Company, 131 were determined to involve anesthesiology services. Nine of these were coded as being out-of-network. The type of provider delivering the service in all nine cases was a certified registered nurse anesthetist. Otherwise, the breakdown was as follows:

		<b>IN – Out of Service Area Provider</b>	<b>OUT – In Service Area Provider</b>
<b>PLACE OF SERVICE</b>	Office		2
	Inpatient Hospital	2	1
	Outpatient Hospital		4
	<b>TOTALS</b>	<b>2</b>	<b>7</b>

For two of the claims in which the Company indicated that it was the secondary carrier for coordination of benefits purposes, the examiners criticized the Company’s failure to pay the claims as it had agreed to do in the settlement agreement that resolved the 2001 market conduct report. The Company responded that one of these claims had been paid under a different claim number and the other was incorrectly denied since it should have been paid as emergent care. The Company indicated it would reprocess and pay this claim.

Reference: §§375.1007(6) and 376.1367, RSMo.

## 3. Denied Radiology Claims

Of the claim lines in the “Denied Claims” database supplied by the Company, 125 were coded as being out-of-network radiology claims. Twenty-five of these claim lines (23 claim numbers) were identified as being for services delivered out of the Company’s service area by providers that were in the other plan’s

network (IN – Out of Service Area Provider). The breakdown of the characteristics of the 23 claim numbers was as follows:

		<b>PROVIDER TYPE</b>			
		Chiropractor	Mixed Specialty Group	Obstetrics and Gynecology	Facility
<b>PLACE OF SERVICE</b>	Office	2	6	1	
	Inpatient Hospital		3		
	Outpatient Hospital		3		
	Facility				8
	<b>TOTALS</b>	<b>2</b>	<b>12</b>	<b>1</b>	<b>8</b>

The Company indicated that it had subsequently received authorization and paid five of these claims (two “Facility” claims and three “Outpatient Hospital”/“Mixed Specialty Group” claims).

The examiners selected 64 of the remaining claims numbers for a more detailed review. All of these out-of-network claim numbers indicated that the services were rendered in the Company’s service area to patients covered under Missouri-situated contracts where the Company was primary for COB purposes. The breakdown of the characteristics of these 64 claim numbers was as follows:

*(See next page)*

		PLACE OF SERVICE					
		Office	Inpatient Hospital	Outpatient Hospital	Military Treatment Facility	Skilled Nursing Facility	Facility
P R O V I D E R T Y P E	Cardiovascular Disease	1 (1)	1				
	Internal Medicine	4 (1)					
	Obstetrics & Gynecology	1					
	Oral & Maxillofacial Surgery	2					
	Orthopedic Surgery	1					
	Diagnostic Radiology			1			
	Urology	1					
	Chiropractor	5					
	General Dentistry	2					
	Podiatry	2					
	Portable X-Ray Supplier					2	
	Mixed Specialty Group	1					
	Blue Cross Part A Provider				1 (1)		
	Family Nurse Practitioner	2					
	Freestanding Radiology Facility	29					
	Pain Management Facility	1					
	<b>TOTALS</b>	<b>52 (2)</b>	<b>1</b>	<b>1</b>	<b>1 (1)</b>	<b>2</b>	<b>7 (3)</b>

**In the table above, the numbers shown in parentheses represent the number of the total claims shown in each cell that were rendered by providers that had signed a BCBSKC participating contract (i.e., “PAR”) but had not signed a Blue-Care HMO network contract.**

Of the 64 claim numbers, the examiners identified 18 (coded as “member responsibility”) that had characteristics that caused the examiners to question why they had not been paid. The Company responded to Formal Request #67 and Criticism #6 as follows:

Claim #05053F241500, #05073F824200, #05228F2B5B00, #05228F2ED500, and #05293F25C200: The referring physician shown for each these five claims was the member’s in-network PCP. The Company explained that it had never received a referral form for any of these claims, so they were denied. It also indicated that they would not be payable as an “Administrative Benefit Exception” because they were provided in an office rather than an inpatient/outpatient facility.

Claim #05195F1EF800, #052570206700, #05336F3B1500, and #05341F432100: The referring physician shown for each of these four claims was in-network but was not the member’s in-network PCP. The Company explained that the referring provider was not a “covering provider” for the PCP and that the services did not appear to be emergent. It also indicated that they would not be payable as an “Administrative Benefit Exception” because they were provided in an office rather than an inpatient/outpatient facility. For one of the claims, the Company indicated that the primary claim had been denied as investigational.

Claim #05216F069000 and #05270F0B1500: Both the referring physician (not the member’s PCP) and the facility in which the services were delivered were in-network for each of these two claims. The Company explained that the referring provider in both cases was not a “covering provider” for the PCP and that the services did not appear to be emergent. Although the portable x-ray services were provided at in-network skilled nursing facilities, the entity providing them was not a participating provider. The Company’s position was that the member could have obtained these services from a network provider.

The Company’s response prompted the examiners to review the diagnostic codes for all the other claims submitted in 2005 for these members in order to gain some insight into the health conditions that caused them to be confined to a skilled nursing facility. From the codes given for the other claims, it was clear that these members were afflicted with debilitating illnesses. As a consequence, Formal Request #72 asked the Company: (1) If members as ill as these two were expected to interrogate the physician and skilled nursing facility (both of which were participating) to make sure the entity supplying the x-ray services was a participating provider; (2) If such members were required to arrange for transportation from the skilled nursing facility to a different network provider for the x-ray services; (3) If any investigation had been conducted to determine whether the skilled nursing facility had a contract with the x-ray provider (which might fit within a Company benefit exception); and (4) Why the circumstances in

these two cases did not fit within one of the following two benefit exceptions in the Company's "Corporate Policy and Procedures."

- *"For ER, radiology, anesthesiology, pathology (including laboratory services) provided as part of an inpatient admission to a network hospital when provided by a non-network provider or out patient services associated with an out patient procedure at a network facility when provided by a non-network provider."*
- *"Other specialty services provided as part of an inpatient admission to a network facility are subject to approval by the Vice President of Provider Contracting and Reimbursement."*

The Company responded that:

*By its nature an HMO does have policy limitations (e.g., network coverage), and BCBSKC strives to educate existing and potential members of the importance of understanding their policy and its limitations. BCBSKC does not know the circumstances of why the member utilized an out of network provider (US XRAY LLC) for the services provided. BCBSKC Customer Service or the published Provider Directory are resources that either the member or the facility could have leveraged. In each situation, the provider called after services were rendered requesting claim information and was told no payment was made because the provider was Out of Network. There were no appeals filed, either from the member or provider.*

*Investigation of a contract between the facilities and US XRAY LLC would not have impacted the determination of benefits for the claims. The benefit determination was made based on the fact that there was not a contract between BCBSKC and US XRAY LLC.*

*The exception language in the policy excerpted in the first bullet above applied to network hospitals. Skilled Nursing Facilities were not included in the exception.*

*The exception language in the policy excerpted in the second bullet applies to the Appeals process. In this case there were no appeals filed, either from the member or provider.*

Claim #05091X138700: The referring physician in this claim was in-network. The Company did not indicate whether or not this provider was the member's PCP, but it did explain that the claim had been paid under a different claim number as an out-of-area, Blue-Card claim.

Claim #052000048300: The facility in this claim was in-network. The Company explained that the claim, which was a "Medicaid Reclamation claim," had been paid under a different claim number when later submitted with

additional charges for emergency room services and that the original denial as being out-of-network was “incorrect.” Although the impact on the member and the provider may have been minimal since it was Medicaid seeking reimbursement, it appears the Company failed to adequately investigate both the in-network and emergent nature of the claim as well as failing to recognize the excess status of Medicaid coverage prior to denying the claim.

Reference: §375.1007(6), RSMo and 20 CSR 400-2.030(2)(F)4.F.

Claim #05241P164000: The referring physician, the facility and the signing physician shown in the claim documentation were all in-network. The Company explained that the claim was “keyed” with an incorrect date of service, prompting the denial for no authorization, and that the incorrect date had never been brought to its attention after the denial. The Company adjusted and paid the claim as a result of the examiners’ questions.

Reference: §375.1007(6), RSMo

Claim #05034F025500, #050380184100, and #05272X095800: The nature of the injuries in these claims appeared as though they might involve emergencies. Because of the examiners’ questions, the Company realized that it should have paid claim #05034F025500 and issued a payment for \$286.48 (\$212.91 provider charge plus \$73.57 interest). The Company explained that there was nothing about claim #050380184100 (which was the only claim for that member that year) to indicate it was emergent in nature. With regard to claim #05272X095800, the Company explained that it had originally been denied incorrectly and had been reversed when the Company’s claims examiner realized their mistake.

Reference: §375.1007(6), RSMo

Claim #05210Y002900: It was not clear whether the attending physician shown on this claim was the same as one listed in the Company’s provider directory. The Company explained that the provider was participating but was not the member’s PCP, which is why it was denied for lack of a referral. Because the Company indicated the provider was an “Emergency Medicine Specialist” and the treatment was for kidney stones, Formal Request #71 asked the Company why the claim had not been considered an emergency and what investigation the Company had conducted to make this determination. The Company responded that services billed by the facility did not include an emergency room revenue code, and there was no further investigation because of the way it was coded. The Company indicated that claims for the physician and the radiologist for this service date had been paid.

#### 4. Access Plan

The examiners reviewed the Company's access plans for 2005 and 2007 and discussed the access plans with personnel from the Department's Managed Care Section. The following response to an informational request on the access plan seemed confusing to the Department (the Department's informational request is in bold italics and the Company's response is in regular italics):

***Information as follows regarding network hospitals which utilize non-network service providers i.e. radiologists, anesthesiologists, pathologists, laboratories (or other hospital-based service providers):***

- a) Name(s) and address(es) of participating facilities where this occurs.***
- b) Identify which specific hospital-based service providers are not contracted at that hospital.***
- c) Method of payment for the non-network services and/or enrollee's financial obligation.***
- d) Copy of disclosure provided to all enrollees (including POS enrollees) regarding the hospital and the enrollee's possible financial obligation.***

*BCBSKC works diligently to ensure that all hospital based specialties are included in each HMO network in which the hospital is included. In the event that the hospital based service providers are not included in the HMO network, BCBSKC would first access the physician group's base agreement with BCBSKC. This base (participating) agreement ensures direct payment to the provider and protects the HMO member from any financial responsibility. BCBSKC would pay the physician group 100% of the base fee schedule that this group has agreed to accept as payment in full. Absent a base agreement with the hospital based provider, BCBSKC would pay the provider 100% of the billed charge to once again protect the member from any financial responsibility.*

*BCBSKC has two different contracts in place with most physicians. Physicians who participate in the HMO networks will have signed a network agreement which has product specific addenda attached. In addition, every physician who has signed a network agreement, and many physicians who have chosen not to participate in the network, will have executed a base, participation agreement with BCBSKC. It is this participation agreement that we would first rely on, if one is available, if a HMO member is seen by an out of network physician and the service is authorized. The participation agreement also has a hold harmless provision so the member would be protected from balance billings. If the physician has no participation agreement*

*with BCBSKC and the out of network service is authorized, BCBSKC would pay total charges to protect the member from balance billing.*

The first paragraph in the Company's response above was included in both the 2005 and 2007 access plans. The second paragraph of the response appears only in the 2007 access plan. Because of perceived inconsistencies between this response and the handling of certain claims, the examiners asked for clarification in Formal Requests #50 and #54. The Company explained that:

- *As documented in BCBSKC's 2005 access plan, Blue-Care members who receive services from a hospital-based physician or physician group while a patient at an "in-network" Blue-Care hospital will not receive a claim denial. If the hospital-based physician or physician group is not in the Blue-Care network, the claim would be paid in full using the Blue Cross and Blue Shield of Kansas City (BCBSKC) participation fee schedule (if the physician/group has a participation agreement with BCBSKC) or using the non-contracted physician's/group's billed charge as the allowed amount.*
- *Hospital based physicians are defined based on specialty. Practitioners with a specialty of Emergency Medicine, Radiology, Anesthesiology, or Pathology are considered hospital based. These are providers who have a contract with a hospital to provide services to these hospitals, and there are no other providers contracted to provide this service.*
- *The Facets system is programmed to pay out of network "hospital-based physician or physician group" claims. "Hospital-based physician or physician group" claims include ER, radiology, anesthesiology, pathology (including laboratory services) provided in either an inpatient or outpatient setting at a network hospital when provided by a non-network provider.*
- *This exception to our contracted benefits is supported by BCBSKC's Corporate Policy and Procedure, CP&P VII-6 Approval of Administrative Benefit Exceptions: "For ER, radiology, anesthesiology, pathology (including laboratory services) provided as part of an inpatient admission to a network hospital when provided by a non-network provider or outpatient services associated with an out patient procedure at a network facility when provided by a non-network provider."*
- *This Policy & Procedure documents a benefit exception that has been programmed into the claims system to pay these claims when they are initially submitted.*

The Company's definition of what constitutes a "hospital-based provider" is narrower than what the Department conceived in the request for information in the access plan since the request asks for "other hospital-based service providers" beyond those listed. This narrower definition led to the denial of

various claims for services in a network hospital where the provider appeared to the examiners to be “hospital-based” but was not one of the enumerated specialties. The Company should amend its access plan to clarify which hospital-based providers would be paid without prior authorization and which would not be paid.

Reference: §354.603.2, RSMo.

## **5. Out-of-Network Claims Generally**

As with all other administrative functions of the Company, BCBSKC is responsible for contracting with providers for the Company’s network. BCBSKC has two different types of contractual agreements with providers of health care:

- Participating or “Par” Agreement – This is the basic agreement by which BCBSKC establishes a contractual arrangement with a health care provider. In this agreement, the health care provider agrees to accept the amount that BCBSKC is willing to pay for covered services and not bill the member for any amount other than “Copayments, Coinsurance and Deductibles and/or amounts due for non-Covered Services.” In return, BCBSKC agrees to pay the health care provider directly.
- Network Agreement – Under this agreement, a health care provider agrees to become part of one or more product-specific networks (i.e., PPO and/or HMO) and to accept payment for services at a lesser rate than provided under the Par Agreement. The Company’s Blue-Care plan is one of the product-specific networks that a health care provider can select. The “Physician Network Agreement” will list each product in which the physician is participating and whether they are participating as a PCP or a specialist in the agreement’s “Exhibit One.”

A large number of providers have entered into “Par” Agreements, but a smaller number of those with “Par” Agreements have also entered into Network Agreements. Consequently, the universe of providers that identify themselves as Blue Cross/Blue Shield providers is larger than the Blue-Care network. This two-tier contractual arrangement, which is peculiar to Blue Cross/Blue Shield companies, can be a source of confusion for the uninitiated member (given that it confused more knowledgeable individuals in the Department’s Managed Care Section) and lead to a member believing that a Blue Cross/Blue Shield participating provider is in the Blue-Care network. This is reinforced by the branding of all marketing and benefit materials as being provided by BCBSKC.

Within the Blue-Care network, an additional source of confusion to the member is the Company’s contracting with physicians as either a PCP or a specialist. Since the Company designated the Blue-Care plan as an “open referral” plan, a member may believe that they can go to any physician in the Blue-Care network without a referral or an authorization. If that physician is contracted as a PCP

rather than a specialist, however, the claim will be denied because the physician is not the member's PCP.

Additionally, if the member should unwittingly receive care from a non-network provider while being treated in a network facility or because of a referral from a network provider, the Company regards such services as not covered and may deny the claim. Granted, for certain "hospital-based" providers, the Company has indicated that it has programmed its claims system to automatically pay such claims as administrative benefit exceptions, but the member will end up being billed by the provider if the provider is not of the proper specialty or the system does not otherwise recognize the claim as in-network. Since the Company regards such services as not covered, it is not even clear that its payment of a "Par" provider at the "Par" rate in such circumstances would prohibit the provider from balance billing despite the Company's representation to the contrary in its access plan filing.

The Company has built some flexibility into its procedures by instituting certain "Administrative Benefit Exceptions" to pay out-of-network claims when circumstances arise. In general, however, such exceptions are not automatically granted, but require the member to file an appeal (grievance) and go through the appeal process. Unaware of the existence of such exceptions, many members will not file an appeal when presented with an initial denial and will get stuck with the bill. Only some will pursue the matter and be able to take advantage of the exceptions. This leads to disparate treatment between members.

While the Company is to be commended for realizing the complexities and vagaries of the health care system and building some flexibility into its processes, it would be wise to better educate its members as to the issues involved. Specifically, it should:

- Better explain to its members the difference between "Par" and "network" providers.
- Better explain to its members the circumstances that would cause them to reconsider and pay an out-of-network claim and encourage the members to provide additional information when a claim is denied for out-of-network reasons.
- Continuously work on refinements to its claims handling so that claims that should be paid as an "Administrative Benefit Exception" are identified and further investigated rather than automatically denied.

### **C. Refunds of Excessive Copayments**

Regulation 20 CSR 400-7.100 places limitations upon the amount of copayments imposed upon enrollees (i.e., 50% of the cost of any single service, 20% of the aggregate total cost of providing basic health services, and 200% of the total annual premium). In practice, this can lead to situations where an HMO enrollee has paid

copayments in excess of these limitations and is entitled to a refund. Accordingly, the examiners asked the Company to explain its procedures for refunding excessive copayments to its members.

- 50% of any single service: In those situations where a member has paid a copayment to a provider that exceeds 50% of the provider payment rate, the Company stated that it pays the provider the full payment rate and sends the provider a remittance showing the copayment amount due from the member. The Company also sends the member an “Explanation of Benefits” showing an amount due the member from the provider. The Company said it expects the provider to reimburse the member for the excessive copayment collected, but it does not monitor the providers to make sure the refund occurs.
- 20% of the aggregate total cost of providing basic health services and 200% of the total annual premium: The Company indicated that it has manual processes to determine when these limits have been exceeded. If this occurs, the Company would issue a check to the member to reimburse them for any excessive out-of-pocket payments.

The Company should have some process in place to monitor whether or not providers that collect copayments in excess of 50% of any single service make the necessary refunds to members.

Reference: 20 CSR 400-7.100.

#### **D. Prompt Payment of Claims**

An examination of the Company’s compliance with §§376.383 to 376.384, RSMo, (the “prompt payment law”) was conducted in 2004 (Exam #0404-34-PPE) covering claims adjudicated from April 1, 2002, through September 30, 2002. As a follow-up to that examination, the examiners reviewed the claims data submitted by the Company for compliance with the prompt payment law. This included a review of the process for receipt of electronic claims from providers.

Effective January 1, 2003, §376.384.2, RSMo, requires providers to submit their claims electronically in order to be subject to the prompt payment law. Paper claims submitted by insureds, however, continue to be subject to the prompt payment law. Section 376.383.5, RSMo, states that:

*If the health carrier has not paid the claimant on or before the forty-fifth day from the date of receipt of the claim, the health carrier shall pay the claimant one percent interest per month. The interest shall be calculated based upon the unpaid balance of the claim. The interest paid pursuant to this subsection shall be included in any late reimbursement without the necessity for the person that filed the original claim to make an additional claim for that interest. A health*

*carrier may combine interest payments and make payment once the aggregate amount reaches five dollars.*

This requirement to pay interest if a claim is not paid within 45 days of receipt is independent of other claim processing timeframes in the statute. The counting of the 45 days is not postponed or delayed by any issues with the information contained in the claim when first submitted. In other words, Missouri's prompt payment law relative to the payment of interest does not contain the type of "clean claim" standard set forth in the "Kansas health care prompt payment act," K.S.A. 40-2440 through 40-2442. Under Kansas law, the calculation of when interest is payable hinges upon receipt of a "clean claim," and K.S.A. 40-2440 defines a "clean claim" as follows:

*(a) The term "clean claim" means a claim that has no defect or impropriety, including any lack of required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under the Kansas health care prompt payment act.*

In 2004, the Department cited the Company for failing to pay interest on two claims that were not paid within 45 days of receipt. Although the Company agreed to pay these claims as part of the settlement, it expressed disagreement with the application of Missouri's prompt payment law. In its reply to the report, it stated:

*Good Health disagrees that the 2 claims cited in the exam report were not paid within 45 days of receipt of information from the provider. Both of these claims required additional information after the provider originally submitted the incomplete claim to Good Health. In one case, the claim was adjudicated within the required 10 days after receipt of additional information needed to process the claim. In the other case, adjudication was not performed within 10 days and the applicable interest of \$0.14 was paid. Therefore, no additional interest is due to the providers.*

From this response, it appears that the Company was applying a "clean claim" standard to determine when interest was payable on a claim. This thinking appears to have continued through the time period covered by this examination based upon the following excerpt from the standard operational procedure document supplied by the Company in response to Formal Request #64:

*Effective January 1, 2001, State of Kansas requires BCBSKC to pay interest penalties. The mandates for Missouri and Kansas are different. However a business decision was made to standardize the process for interest paid on all claims and adjustments including Medicare Risk. Clean claims pay interest if not paid within 30 days,*

*additional information 10 days, and interest rate for all is 12% per year – 1% per month.*

The examiners’ review of the Company’s claim process appeared to be consistent with this statement.

As in the previous exam, BCBSKC continues to contract with Administrative Services of Kansas, Inc. (“ASK”) to receive electronic claims for both BCBSKC and the Company. ASK is a subsidiary of Blue Cross and Blue Shield of Kansas, Inc. When ASK receives electronic claims, it conducts a check of the data for compliance with the “Administrative Simplification” data standards of HIPAA (ANSI X12N 837), general data standards for health claim payers, and Company specific data standards. ASK then issues one or more reports to the claim submitter acknowledging receipt and indicating acceptance or rejection of the claim (i.e., the TA1 Report, the Transaction Acknowledgement Report, the 997 Report, and/or the Claims Confirmation Report).

If the claim is rejected (which may be due to file, batch or claim errors) the claim is not transmitted to the Company. It must be corrected and resubmitted to ASK. If the claim is accepted, ASK will then transmit the claim to the Company. Upon receipt, the Company issues an acknowledgement (a 997 Report) to ASK. It is only at this point that the Company considers the claim to be “received” for the purposes of the prompt payment law.

Once the Company determines that it has “received” the claim from ASK, it begins its own review and determination as to whether the claim should be paid or denied. If the Company determines that the claim should be denied in whole or in part, it will communicate this information to the provider and the member. If the provider and/or member should subsequently furnish additional information, make an inquiry or file an appeal regarding the denied claim, it appeared from standard operational procedure documents supplied in response to formal requests that the Company may regard this event as a new “received” date in many instances. For example:

- The “Claim Receipt Date for Adjustments” chart supplied in response to Formal Request #58 shows the following:

<b>Adjustment Reason</b>	<b>Receipt Date</b>
Inquiry / Written Correspondence	Received date found in the Customer Service End Call page or the earliest / oldest date of correspondence
Corrected claim, not inquiry related	Date the corrected claim was first in house

- The document supplied in response to Formal Request #64 entitled “Warning Message – Possible Interest Payment – Medical and Dental- Adjusted Prior to 12/15/05” contains a chart showing the following:

If Medical Adjustment	then
<ul style="list-style-type: none"> <li>• is for additional information or</li> <li>• is a Grievance when additional information has been received to reverse the decision</li> </ul>	<ul style="list-style-type: none"> <li>• the <b>Receipt Date</b> for the adjustment is the date the information is received;</li> <li>• the <b>Interest Clean Date</b> is the Receipt Date of the adjustment.</li> </ul>

The standard operational procedure documents appeared to also apply to the processing of paper claims submitted by one of the Company’s members.

In Criticism #7, the examiners noted the processes described above and how the Company appeared to be following the “clean claim” methodology of Kansas law to determine when a claim should be considered “received” for the purposes of calculating when interest becomes due under the Missouri prompt payment law. The criticism noted that this was inconsistent with Missouri law since the 45 days in which a claim must be paid in order to escape the payment of interest begins on one of following days rather than some later date when the Company considers it to be a “clean claim”:

- An electronic claim would be considered “received” by the Company when it is first transmitted to ASK, regardless of any rejection.
- A paper claim would be considered “received” by the Company when it receives the form from the member, regardless of whether or not additional information is needed.
- A readjudicated claim would be considered “received” when originally received, not on the date additional information is provided, an inquiry is made, or an appeal is filed.

By choosing to follow the “clean claim” timeframes of Kansas law for Missouri claims, the Company will fail to pay (or underpay) interest on many claims that are paid more than 45 days after the date of receipt under Missouri law. As a result, the Company does not appear to be in compliance with Missouri law in its payment of interest on claims.

Reference: §§376.383 to 376.384, RSMo.

The Company disagreed with the criticism, stating as follows:

*ASK performs two distinct roles in regard to electronically submitted claims:*

1. *ASK contracts with providers and clearinghouses to submit electronic claims to payers. These entities contract with ASK as “Trading Partners” as defined in the HIPAA Transactions Rule. As required by both their contract with ASK and the Transactions Rule, Trading Partners must submit data in*

*ANSI/X12 compliant format. ASK performs edits on the data to determine whether it conforms to the X12 standards including validation of the format, syntax and structure. If there are errors, the entire file is rejected back to the submitter for correction.*

2. *BCBSKC contracts with ASK as a “Participating Payor.” Under this contract ASK: accepts and translates EDI from Trading Partners; validates syntax, Implementation Guide (IG)<sup>1</sup> compliance, and external code sets as defined under HIPAA for each transaction; and transmits such EDI to the payer for adjudication. Per HIPAA Title II regulations the Company is not required to accept non-compliant electronic claims (45 CFR §162.925 – “covered entities” under HIPAA must conduct transactions as HIPAA-compliant standard transactions. RSMo 376.384.2 also requires HIPAA standard transactions – “On or after January 1, 2003, all claims for reimbursement for a health care service provided in this shall be submitted in an electronic format consistent with federal administrative simplification standards adopted pursuant to the Health Insurance Portability and Accountability Act of 1996”).*

*Claims that pass the initial ASK X12 edits can be rejected based on “all payer” or “payer specific” edits. These are edits which assure the claim can be processed in an individual payer’s system. Without these correct elements, the claim is essentially non-processable. If the claim is submitted and accepted with errors in these data elements, the claim would still be stopped and returned for correction, but the process is much slower and would lead to less timely payment to the provider, which is contrary to the purpose of the prompt payment laws. Accepting such a non-processable claim as received for interest calculation purposes could also give the provider an incentive to delay responding with additional data needed to process the claim in order to increase interest payments.*

*Claims that are rejected at this point by ASK are not transmitted to the Company; we do not know they were submitted to ASK, and we cannot track them. The claim is not transmitted because it lacks the minimum required X12 elements needed to pass ASK’s initial edits and so cannot be processed. In order for an electronic claim to be considered “received” it must appear on the ASK Claim Confirmation Report as an accepted claim. Claims that reject due to*

<sup>1</sup> *The Implementation Guide (IG) is a document explaining the proper use of a standard for a specific business purpose. The X12N HIPAA IGs are the primary reference documents used by those implementing the associated transactions, and are incorporated into the HIPAA regulations by reference.*

*edits on the ASK Claim Confirmation Report are not received by BCBSKC.*

*The relevant SOP has been corrected, removing the “Clean Claim” terminology.*

*In practice, during adjudication the Company may determine that the claim should be denied in whole or in part. If it does so, it will communicate this information to the provider and the member. If the provider and/or member should furnish additional information, make an inquiry or file an appeal regarding the denied claim, the Company uses the original received date (received by BCBSKC from ASK) for the purposes of interest payment. The Company does not regard this event as a new “received” date for the purposes of the prompt payment law as stated in Criticism #7, so that the provider is not penalized by the Company’s request for additional information.*

*As discussed above, if a data file is rejected by ASK it is because it does not meet X12 format requirements. The Company is not obligated to accept non-compliant claims (45 CFR §162.923, §162.925).*

*Because the processing at ASK is so rapid, for practical purposes, those claims that are received by the Company do use the date the claim is first transmitted to ASK because claims are submitted, edited, and transmitted to the Company within hours. We receive our production files from ASK every business day around noon.*

*As noted, the “clean claim” language has been corrected in the relevant SOP. In practice, the Company uses the original received date (from ASK) for interest calculations even when additional information is requested. We believe that using the date BCBSKC receives the claim from ASK (i.e., the date the claim passes ASK’s edits for required X12 elements) is the proper “received date” to begin the calculation of the statutory time to pay the claim without incurring interest. The Company also wishes to point out that, because of the time saved by electronic transactions, and because during the period covered by this exam we were applying a 30-day standard to both Kansas and Missouri claims (instead of the 45-day timeframe of RSMo 376.383.5) we do not believe that we “will fail to pay (or underpay) interest on many claims that are paid more than forty-five days after the date of receipt”. The Company was likely overpaying interest on a number of claims each month. The Company also believes its claims processing procedures meet the Department’s goal of properly processing 95% of all claims as set forth in RSMo 376.384.3.*

#### **IV. CRITICISM & FORMAL REQUEST TIME STUDY**

This study reflects the amount of time taken by the Company to respond to criticisms and requests submitted by the examiners. The Company did an outstanding job responding in a timely manner.

##### **A. Criticism Time Study**

<b>Number of Calendar Days to Respond</b>	<b>Number of Criticisms</b>	<b>Percentage of Total</b>
0 to 10 days	5	71%
Over 10 days with extension	2	29%
Over 10 days without extension	None	None
<b>Totals</b>	<b>7</b>	<b>100%</b>

##### **B. Formal Request Time Study**

<b>Number of Calendar Days to Respond</b>	<b>Number of Requests</b>	<b>Percentage of Total</b>
0 to 10 days	74	99%
Over 10 days with extension	1	1%
Over 10 days without extension	None	None
<b>Totals</b>	<b>75</b>	<b>100%</b>

## **EXAMINATION REPORT SUBMISSION**

Attached hereto is the Division of Insurance Market Regulation's Final Report of the examination of Good Health HMO, Inc., d/b/a Blue-Care, Inc. (NAIC #95315), Examination Number 0612-57-TGT. This examination was conducted by James W. Casey, Kevin R. Jones, and James E. Mealer. The findings in the Final Report were extracted from the Market Conduct Examiner's Draft Report, dated May 19, 2009. Any changes from the text of the Market Conduct Examiner's Draft Report reflected in this Final Report were made by the Chief Market Conduct Examiner or with the Chief Market Conduct Examiner's approval. This Final Report has been reviewed and approved by the undersigned.

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Jim Mealer  
Chief Market Conduct Examiner

Date



**BlueCross BlueShield  
of Kansas City**

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Blue Cross and Blue Shield Association

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July 30, 2009

Carolyn Kerr  
Senior Counsel, Market Conduct Section  
301 West High Street, Room 530  
P.O. Box 690  
Jefferson City, MO 65102-0690

RE: Missouri Market Conduct Examination #0612-57-TGT,  
Good Health HMO, Inc., d/b/a/ Blue-Care, Inc.

Dear Ms. Kerr:

Attached please find the Company's response to the items noted in the Missouri Department of Insurance, Financial Institutions and Professional Registration ("DIFP") draft Market Conduct Examination report received by the Company on June 1, 2009. As requested in your correspondence dated May 27, 2009, you will receive an electronic copy of the Company's response via e-mail, as well as a hard copy.

Upon review of the draft report, we noted several items that had not been previously communicated to us through the formal criticism process during the examination. As this is the Company's first opportunity to formally respond to these items, we would appreciate the opportunity to answer any further questions the Department has regarding the Company's responses, prior to the report being finalized.

We look forward to working with the Department to resolve any outstanding questions and to concluding this exam.

Sincerely,

A handwritten signature in black ink that reads "Brian R. Schatz".

Brian R. Schatz  
Director of Audit Services and Compliance Officer

## **I. Small Employer Group Underwriting and Rating Practices**

### **A. Small Employer Group Health Insurance Underwriting**

#### **1. Small Employer Group Health Insurance Policy Files**

DIFP stated in the Executive Summary:

*In 12 of 28 files, Company allowed small employers to define a full-time employee for eligibility purposes as requiring more than 30 hours per week, contrary to §379.930(15), RSMo. This resulted in the Company not offering coverage to all “eligible employees” as required by §379.940 (5), RSMo.*

#### **Company’s Response:**

The Company agrees with this finding. In response to the clarification provided in Missouri DIFP Bulletin 07-07, dated 12/23/2007, the group application for employers with between two and fifty employees was changed to specify a thirty hour work week as full time. Prior to the DIFP Bulletin, the Company allowed several employers to determine who would be eligible under their health plans, as requested by the employers.

#### **2. Small Employer Group Health Insurance Underwriting and Rating Manual**

DIFP stated in the Executive Summary:

(a.) *Basic and Standard Plans: The Company’s manual stated that only Missouri Valley Life and Health Insurance Company would issue the Basic and Standard Plans. This was contrary to the Company’s agreement pursuant to a prior market conduct exam. Although the Company indicated this statement was an oversight and would be corrected, documentation provided by the Company indicated that it did not begin offering the Basic and Standard Plans until at least four and one-half months after the Department had approved the Company’s forms, contrary to §§379.940.1(1) and 379.940.2(5)(a), RSMo.*

(b.) *Definition of “full-time” employee for small employer eligibility purposes: The Company’s manual states in two places that an employer may define “full-time” as working some greater number of hours per week than 30 for purposes of being eligible for coverage under a small employee group health plan contrary to §§379.930.2(15) and 379.940.2 (5)(a), RSMo.*

#### **Company’s Response:**

(a.) The Company respectfully disagrees with this finding. As of 01/01/2003, the date the Company’s Basic and Standard plans were approved by DIFP, the Basic and Standard Plans were available to issue if requests for these plans had been received. The “Contracts and Compliance State Approval Bulletin” dated 05/16/2003 referenced in the DIFP report was an internal notification which did occur approximately four and one-half months after DIFP’s formal approval of the Company’s forms on 01/01/2003.

The internal notification would not have prevented the issuance of the basic and standard certificates had a request for such coverage been received during the timeframe between 01/01/2003 and 05/16/2003. It is not unusual for an internal notification to be released some time following DIFP's approval of forms, as coding new products takes time.

- (b.) The Company agrees with this finding. In response to the clarification provided in Missouri DIFP Bulletin 07-07, dated 12/23/2007, the group application for employers with between two and fifty employees was changed to specify a thirty hour work week as full time. Prior to the DIFP Bulletin, the Company allowed several employers to determine who would be eligible under their health plans, as requested by the employers.

## **B. Small Employer Group Health Insurance Rating**

DIFP stated in the Executive Summary:

*Other than some referencing errors noted in the manual, no exceptions to the rating requirements of §379.936, RSMo, were noted.*

### **Company's Response:**

The Company has corrected the referencing errors in its manual noted by DIFP.

## **II. Complaints and Grievances**

### **Company's Response:**

In general response to all of the three areas where DIFP noted issues in this section of the Executive Summary, the Company has business practices and procedures in place to ensure all claims are processed accurately based on the information received at the time the claim is submitted.

During the exam period of 2003-2005, approximately 1,952,500 Blue-Care claims were processed by the Company. Given the complexity of the healthcare delivery and reimbursement system, as acknowledged by DIFP in this report, and the volume of claims processed by the Company, some minimal number of processing errors is inevitable. The Company has in place ongoing Quality Assurance and claim auditing processes to proactively ensure claims are paid appropriately. A complaints and grievances appeal process is also available to members and providers. This process is communicated to members clearly on each Explanation of Benefits ("EOB"), in the HMO Health Benefits Certificate, and in an annual member mailing.

Provider remittances and member EOBs are sent to the provider and member, respectively, informing them of the status and adjudication of the claim. If either party provides additional information timely to the Company, the claim, along with the additional information, is reviewed to determine if payment is appropriate.

The specific issues raised by DIFP in the three bulleted statements within the Complaints and Grievances section of the Executive Summary report are responded to individually below for the twenty-four appeals referenced. The number of appeals associated with each bullet in the Executive Summary is as follows:

- First Bullet: Seven appeals  
Second Bullet: Three appeals  
Third Bullet: Fourteen appeals. Note that that three of the fourteen appeals are the same appeals referenced in the second bullet, resulting in eleven unique appeals.

## II.1 DIFP stated in the Executive Summary (first bullet):

*In seven cases, the Company incorrectly denied claims even though prior authorization had been received, contrary to §376.1361, RSMo, and 20 CSR 400-10.200.*

The Company is in compliance with §376.1361, RSMo, and 20 CSR 400-10.200 with its utilization review programs. The prior authorizations were made in a timely manner and by the appropriate personnel. No authorization was withdrawn after the services were provided. Either clerical mistakes were made when adjudicating the claim associated with the prior authorizations or no prior authorizations had been requested for the services denied.

Clerical mistakes were made on five of the seven appeals referenced. When the claims were received the Company was unable to locate an authorization that matched the services described on the claim. Provider billing differences or variations from the Company's prior authorization documentation can result in a determination that the services provided to the member were not prior authorized.

- Regarding appeal 03002063. This was a manual data entry error by the Company. The claim related to this appeal was denied as a non-HMO claim. There was a prior authorization for the non-HMO service, but it was mistakenly entered under the requesting HMO provider and not under the non-HMO facility that would provide the service. Upon appeal, the Company determined the prior authorization was entered incorrectly and the claim was re-adjudicated and paid.
- Regarding appeal 03002569. This appeal was the result of an interpretation error by the Claims Examiner. The prior authorization note indicated the claims should pay \$136.00 per day to this non-HMO provider. When the claims were processed, the Claims Examiner paid only one unit on each of the three claims that were submitted. Upon receipt of the appeal, the Company discovered the claims processing error and re-adjudicated the claims for additional payment.
- Regarding appeal 03003481. This appeal was the result of an oversight by the Claims Examiner. The claim was for the purchase of a CPAP machine. There was a prior authorization for the rental of the machine and also a prior authorization for the

purchase of the machine. The Claims Examiner denied the claim for purchase of the CPAP indicating there was only a prior authorization for the rental. Upon appeal, the Company discovered the second authorization and the claim was re-adjudicated and paid.

- Regarding appeal 04002351. This appeal was related to follow-up care with a non-HMO provider. This member had emergency surgery performed by the non-HMO physician at a non-HMO facility. The non-HMO physician called the Company and requested two follow-up visits with the member at the non-HMO facility. The follow-up visits were approved, but only the physician prior authorization was documented, prior authorization related to the facility was mistakenly not documented. As a result, when the facility claim was received, it was denied for no prior authorization. Upon appeal, the Company determined the non-HMO facility was also approved and the claim was re-adjudicated and paid.
- Regarding appeal 05002746. This appeal was the result of an error by the Claims Examiner. The claim was for ophthalmologic testing services due to the member's medical condition. The specialized testing was not available by an HMO provider. Prior authorization was received for the non-HMO provider for the specialized ophthalmologic services. However, when the claim was received, one of the services on the claim was denied because the diagnosis on the claim was a routine diagnosis instead of for a medical condition. The prior authorization covered this specific procedure, but the Claims Examiner did not process the claim correctly. Upon appeal, the Company determined this procedure had been previously approved and the claim was re-adjudicated and paid.

Note, in each of these appeals, the Company corrected and adjudicated the claims correctly demonstrating its processes are effective.

The Company respectfully disagrees with this finding for claims related to two of the seven appeals referenced. No prior authorization had been requested when the related claims were denied.

- Regarding appeal 04001820. This appeal concerned the denial of a non-HMO provider office visit. The Company received a prior authorization request from an HMO provider. The HMO provider requested authorization for the dental appliance to be supplied by a non-HMO provider. Prior authorization was given for the dental appliance since the appliance was not available by an HMO provider. Upon receipt of claim, the Claims Examiner correctly approved the claim for the appliance and denied the non-HMO office visit. The non-HMO provider contacted the Company to explain that an office visit was necessary prior to creating the appliance. The authorization was modified to include an office visit for the non-HMO provider. The claim was adjusted to pay after the member submitted the appeal but prior to appeal investigation. Therefore, the appeal response documented that this claim had already been re-adjudicated and paid.

- Regarding appeal 04000916. This appeal was related to a denial of a nursing facility visit by a non-HMO provider. The HMO facility stay was approved. However, a non-HMO provider saw the member while the member was at the facility. These claims were correctly denied as non-covered, non-HMO services. This provider contacted the Company and submitted an appeal. While investigating the appeal, the Company determined that the services of the non-HMO provider should be approved because the member's Primary Care Physician ("PCP") did not have privileges at the skilled nursing facility. The claim was re-adjudicated and paid.

**II.2** DIFP stated in the Executive Summary (second bullet):

*In three cases, the Company incorrectly denied claims for services that were actually covered, contrary to §375.1007(6), RSMo.*

The Company is in compliance with §375.1007(6), RSMo. The Company has effective processes in place to conduct reasonable investigations that result in accurate processing of claims based upon the information available at the time each claim is submitted. In order to provide timely claim adjudication, it would not have been appropriate to request additional information prior to the processing of the claims related to these appeals. If the provider or member provides additional information timely to the Company, the claim, along with the additional information, is reviewed to determine if payment is appropriate.

The Company agrees there was an initial processing error for one of the three appeals referenced.

- Regarding appeal 05002074. This appeal was related to a claim that was denied incorrectly due to an oversight in documentation surrounding prior authorization. Upon review during the appeal process, the Company determined that information had been received and reviewed, but the approval was not correctly documented by the Company. The claim was re-adjudicated and paid.

The Company respectfully disagrees with this finding for two of the three appeals referenced. Claims referenced by DIFP related to appeal numbers 03001631 and 03003612 were denied correctly when initially processed.

- Regarding appeal 03001631. The claim related to this appeal was correctly denied when submitted. The item in question, a Jobst stocking, was covered under this member's HMO Health Benefits Certificate when medically necessary. The stocking did not require prior authorization; however, did require a letter of medical necessity from the member's physician which the Company had not received when the claim was initially processed. The member submitted an appeal indicating the provider had been told the services would be covered. Upon review during the appeal process, the Company determined that the provider was correctly informed that the service would be covered with a letter of medical necessity. After receiving a letter of medical necessity from the provider, the claim was re-adjudicated and paid.

- Regarding appeal 03003612. This appeal was related to a claim that denied because contraceptive services were not a covered benefit under the member's HMO Health Benefits Certificate. The diagnosis submitted by the provider on the original claim was for general counseling and advice on contraceptive management. Except for elective sterilization, contraceptive services are not a covered benefit and therefore the claim was correctly denied. Upon appeal, medical records were obtained and reviewed. The Company determined that, contrary to the provider's coding on the original claim, the visit was related to a consultation for elective sterilization, which is a covered benefit, and the claim was re-adjudicated and paid.

**II.3** DIFP stated in the Executive Summary (third bullet):

*In 14 cases, the Company incorrectly denied claims without conducting a reasonable investigation, contrary to §375.1007(6), RSMo.*

The Company is in compliance with §375.1007(6), RSMo. The Company has effective processes in place to conduct reasonable investigations that result in accurate processing of claims based upon the information available at the time each claim is submitted. In order to provide timely claim adjudication, it would not have been appropriate to request additional information prior to the processing of the claims related to these appeals. If the provider or member provides additional information timely to the Company, the claim, along with the additional information, is reviewed to determine if payment is appropriate.

The Company agrees there was an initial processing error for the one of the fourteen appeals referenced by DIFP:

- Regarding appeal 03001436. The Company agrees that a manual processing error occurred and that this claim should not have been denied. This member had an approval to see the non-HMO specialist for six months due to transition of care issues. The non-HMO x-ray from this provider should not have denied. Upon appeal, the Company determined a manual processing error by the Claims Examiner caused the out-of-network x-ray from this provider to be denied. Claim 03051X363601 was re-adjudicated and paid on 05/19/2003, prior to this DIFP exam.

The Company respectfully disagrees with this finding for thirteen of the fourteen appeals referenced by DIFP:

- Regarding appeal 03001960. When this claim was received by the Company, it was determined that the services were for a dental procedure and not covered under the medical HMO Health Benefits Certificate. The claim was correctly denied as a non-covered service. Upon appeal, the provider indicated they had been informed the procedure code in question would be covered at 100%. The Company reviewed the customer service history and determined the provider was erroneously informed the procedure code would be covered. That procedure code is a covered service if necessary due to certain medical conditions, but not for a dental procedure. However,

because the provider relied upon information provided by the Company, the claim was re-adjudicated and paid.

- Regarding appeal 03001205. This claim was for outpatient, observation and laboratory charges from a non-HMO facility. Under the member's HMO Health Benefits Certificate, the member does not have benefits for non-HMO services unless they are approved in advance by the Company or in the case of an emergency. In the case of an emergency, the certificate indicates as follows: "You must notify Us of any emergency Admission within 48 hours of the time of the Admission or as soon as is reasonably possible." There was no indication on this claim the services were due to an emergency and there was no communication from the member or provider prior to receipt of the appeal. Upon appeal, additional clinical information about the outpatient services was obtained and reviewed. Based on this additional information, the Company determined the services were emergent and the claim was re-adjudicated and paid.
- Regarding appeal 03001531. This claim for counseling services correctly denied based on the procedure code and diagnosis submitted on the claim. The diagnosis on the initial claim was "Other Specified Counseling." Upon receipt of the denial, the member submitted an appeal and the provider submitted medical records to the Company. The medical records were reviewed and it was determined there was appropriate clinical documentation to support payment of the procedure based on the additional diagnosis of diabetes documented in the medical records but not submitted on the claim. The claim was re-adjudicated and paid.
- Regarding appeal 03002362. This member sought care from a non-HMO physician on 06/20/2003 and then followed up with the non-HMO physician on 06/24/2003. On 06/24/2003, the non-HMO physician admitted the member to a non-HMO facility, where the member stayed until 06/27/2003. There was no indication that the services were due to an emergency. The facility Utilization Review nurse advised the Company that the member was aware she was out-of-network and her mother was willing to pay the bill. When the claim was received by the Company, it was correctly denied as no prior authorization had been issued. The facility then appealed on behalf of the member. Medical records were ordered and reviewed. Based on the additional information provided during the appeal process, the Company determined the services were emergent and the claim was re-adjudicated and paid. Under the member's HMO Health Benefits Certificate, the member does not have benefits for non-HMO services unless they are approved in advance by the Company or in the case of an emergency. In the case of an emergency, the certificate indicates as follows: "You must notify Us of any emergency Admission within 48 hours of the time of the Admission or as soon as is reasonably possible."
- Regarding appeal 03003793. This claim was correctly denied as a non-covered out-of-network service. The claim included both emergency room charges and inpatient charges. The emergency room charges were paid for related services rendered on

05/23/2003. The inpatient services were correctly denied because they were not authorized.

On 05/30/2003, the Company was notified by the non-HMO facility that the member was an inpatient and was out-of-network. There was no additional clinical information provided by the non-HMO facility until the claim denied. Under the member's HMO Health Benefits Certificate, the member does not have benefits for non-HMO services unless they are approved in advance by the Company or in the case of an emergency. In the case of an emergency, the certificate indicates as follows: "You must notify Us of any emergency Admission within 48 hours of the time of the Admission or as soon as is reasonably possible." There was no indication on this claim the services were due to an emergency and there was no communication from the member or provider prior to receipt of the appeal. The facility submitted an appeal for the non-HMO inpatient admission. Upon review of the medical records during the appeal process, the Company determined that the member had been turned away from an HMO facility because it was full. The claim was re-adjudicated and paid.

- Regarding appeal 04002365. The Company was notified of this admission when the member arrived at a non-HMO facility in Arizona. No clinical information was given at the time of the admission, but was requested by the Company on two separate occasions. Because there was no information provided regarding the reason for the admission, prior authorization was not given. When the claim was received, the claim was correctly denied as a non-covered out-of-network service. The member's Health Benefits Certificate does not cover out-of-network services except in the case of an emergency. If there is an out-of-network admission for an emergency, the member's certificate states as follows: "You must notify Us of any emergency Admission within 48 hours of the time of the Admission or as soon as is reasonably possible." Upon receipt of the denial, the facility appealed the denial and supplied medical records. Based on this additional information, the Company determined the services were emergent and the claim was re-adjudicated and paid.
- Regarding appeal 05001168. This claim was correctly denied as a non-HMO claim. The Company received a claim from a non-HMO physician for the interpretation of a stress-test administered in a physician's office. There was no indication that the services were due to an emergency. Upon appeal, the member provided information that the stress-test was actually performed in an emergency room. The Company reviewed the additional information and determined the services performed by the non-HMO physician were related to the emergency room visit. The claim was re-adjudicated and paid.
- Regarding appeals 03000947 and 03001867. These claims were not denied by the Company and therefore were not incorrectly denied as referenced in §375.1007(6), RSMo. The claims were paid upon initial receipt; however, the amount allowed on the claims was inaccurate. Upon appeal, the Company discovered the claims payment error and the claims were re-adjudicated to pay the proper amounts.

- Regarding appeal 04002063. This claim was correctly denied during initial processing as a non-HMO claim. The claim was for follow-up care due to an accident. The services related to the accident were received within the HMO network, however the follow-up services were received from a non-HMO provider and were not emergent. Services from non-HMO providers are not covered except as described in the emergency services provision or if approved in advance by the Company. During the appeal process, it was erroneously determined that the services should be covered and the claim was paid. While the claim was paid incorrectly, due to its error the Company did not reverse its appeal decision.

*As noted above at the beginning of the Company's response, it appears that the three appeals below are the same three appeals referenced in the second bullet within the Executive Summary.*

- Regarding appeals 03001631, 03003612, and 05002074. A reasonable investigation was conducted in processing the claim related to appeal 05002074; however, a manual documentation error did occur when recording the prior authorization related to the claim. The error resulted in an incorrect denial upon initial processing. The claims related to these three appeals were re-adjudicated and paid as discussed in section II.2 above.

### **III. Claim Practices**

#### **A. Claim Handling – Mandated Benefits**

##### **Company's Response:**

In general response to all of the seven areas where DIFP noted issues in this section of the Executive Summary, the Company has business practices and procedures in place to ensure all claims are processed accurately based on the information received at the time the claim is submitted. The Company has in place ongoing Quality Assurance and claim auditing processes to proactively ensure claims are paid appropriately. A complaints and grievances appeal process is also available to members and providers. This process is communicated to members clearly on each EOB, in the HMO Health Benefits Certificate, and in an annual member mailing.

Provider remittances and member EOBs are sent to the provider and member, respectively, informing them of the status and adjudication of the claim. If either party provides additional information timely to the Company, the claim, along with the additional information, is reviewed to determine if payment is appropriate.

This Market Conduct examination is in regard to an HMO product that is designed to provide greater benefits with lower premiums for the member. These benefits and lower costs come with conditions and limitations as specified in the HMO Health Benefits Certificate, which are reviewed and approved by DIFP. Services must be received in accordance with the

requirements of the HMO Health Benefits Certificate. It is stated in the HMO Health Benefits Certificate that specified services and supplies will be covered only if they are performed, prescribed, ordered or arranged by the member's PCP. Services from non-HMO providers are not covered except as described in the emergency services provision or if approved in advance by the Company.

#### 1. Childhood Immunizations – Denied Claims:

DIFP stated in the Executive Summary:

*Many immunization claims were denied as being the “wrong PCP” due to the Company’s process of automatically assigning the mother’s PCP to a newborn.*

##### **Company’s Response:**

The Company agrees that the *ten* claims referenced by DIFP were denied as being the “wrong PCP.” These claims were correctly denied because the HMO Health Benefits Certificate requires that the immunization be provided by the member's PCP. These services were rendered by an HMO provider, but not the member's PCP. In each case, the member sought and received services from a provider who was not the member's PCP. Each member has the responsibility to select an HMO PCP and notify the Company of the selection. If member fails to notify the Company of their selected HMO PCP, an HMO PCP is assigned to the member. Members also have the right and opportunity to change their PCP. Coverage would have been available if the members had received service from their PCP.

In response to the report's comments regarding PCP selection for newborns, as described in the HMO Health Benefits Certificate, all HMO members are required to have a PCP. The contract holder has responsibility to notify the Company that a PCP has been selected for a newborn. If the contract holder fails to notify the Company, the mother's PCP is assigned to the newborn. If the contract holder contacts the Company within 90 days of the newborn's date of birth with a PCP selection and requests the PCP become effective on the date of birth, the PCP change is made (changed from the mother's PCP to the selected PCP for the newborn) and claims are then reviewed to determine if claims adjustments are needed. If a child's PCP is requested to be changed retroactive to a date prior to the immunization, claims will be adjusted.

Regarding the notation in the Examination Findings report section on seven out of twenty-eight claims (seventy-eight claim lines) being re-adjudicated, those seven claims were adjusted to pay when the member requested a retro-active PCP change. The remaining twenty-one claims were non-covered services because the member did not receive immunizations from their assigned PCP as required by the HMO Health Benefits Certificate. None of these twenty-one claims were related to newborn immunizations.

Provider remittances and member EOBs are sent to the provider and member, respectively, informing them of the status and adjudication of the claim. If either party provides

additional information timely to the Company, the claim, along with the additional information, is reviewed to determine if payment is appropriate.

## 2. Childhood Immunizations – Paid Claims:

DIFP stated in the Executive Summary:

*Immunization claims were initially denied due to the CPT code used being inconsistent with the age of the child even though the actual service is covered. The Company was criticized in a previous market conduct exam for denying such claims without investigation, contrary to §375.1007(3), (4) and (6), RSMo.*

### Company's Response:

The Company agrees that the immunization claims referenced by DIFP were initially denied due to the CPT code used being inconsistent with the age of the child. These claims were correctly denied as it is expected that claims will be coded and submitted to the Company using appropriate CPT codes. These national coding standards and definitions (i.e., ICD-9 and CPT-IV) are required by the HIPAA implementation guide for 837 transactions and are used universally by providers and insurance companies to process claims uniformly. Mandated childhood immunization benefits services are eligible for coverage if the provider submits an appropriate CPT code for the services provided to the member. The Company is in compliance with §375.1007(3), (4) and (6), RSMo.

The Company processes claims with the information as it is submitted on the claim. Therefore, if a claim (or claim line) is filed without complete or valid information, the claim (or claim line) may be denied with an explanation for the denial. When the provider submits a corrected claim, the original claim is adjusted to reflect the corrected information.

Providers are required to submit claims that reflect the services rendered and that are consistent with the provider's medical record for that patient. The Company does not allow its employees to change procedure codes or other information filed by the provider or member. This activity is prohibited in order to avoid an allegation that the Company changed the information in the claim. Prohibiting employees from changing claim information assists in the detection of provider or member fraud. If a claim is received on a member indicating a procedure code that incorrectly describes the age of the member, it is possible the ID card is fraudulently being used by someone other than the member.

In addition, the Company has received claims that were incorrectly submitted to the Company for the wrong member when there was no intent to commit fraud. Changing procedure codes to retrofit member information could cause the Company to pay for claims that are not for our members. Our denial of the claim allows the provider to correct the provider's error and bill the appropriate party.

Provider remittances and member EOBs are sent to the provider and member, respectively, informing them of the status and adjudication of the claim. If either party provides

additional information timely to the Company, the claim, along with the additional information, is reviewed to determine if payment is appropriate.

Specifically related to the four claims that had not been corrected and resubmitted prior to the DIFP examination:

- Two claims were submitted on one member. One claim paid and one claim denied. The claim that paid was submitted with an appropriate procedure code and paid on original submission to the Company. The denied claim was correctly denied based on the procedure code submitted by the provider on the claim. The procedure code 90732, a code for an adult pneumococcal vaccine, was not “age appropriate” for the member for whom the claim was submitted. This claim was not resubmitted with an appropriate procedure code. Similarly, the procedure code 90723, a code for a child vaccine, denied on the original claim due to “age > extreme range for procedure.” The provider contacted the Company’s customer service and it was determined that the Company had the incorrect date of birth for this member. The date of birth was corrected and the denied claim was re-adjudicated and paid prior to the DIFP examination.
- One claim related to a 04/07/2005 date of service and was correctly denied. The procedure code 90732, a code for an adult pneumococcal vaccine, was not “age appropriate” for the member for whom the claim was submitted, as the member was less than two years old at the time of service. Another claim submitted for the same member related to a 07/19/2005 date of service with procedure code 90472, for additional vaccine, was correctly paid. The two claims were unrelated.
- One claim for procedure code 90658, a code for an influenza vaccine for 3+ years, correctly denied due to “age > extreme range for procedure.” This claim was not resubmitted by the provider with an appropriate procedure code.

### 3. Emergency Services – Denied Claims:

DIFP stated in the Executive Summary:

*Claims for emergency services were initially denied and subsequently paid when the examiners asked for explanations as to why they were denied. The Company was criticized in a previous market conduct exam for denying such claims without investigation, contrary to §375.1007(3) (4) and (6), RSMo.*

#### **Company’s Response:**

The Company agrees that the five claims referenced were denied when initially processed. These claims correctly denied based upon the information that had been provided to the Company at the time of claim adjudication. The Company is in compliance with §375.1007(3) (4) and (6), RSMo. The Company has effective processes in place to conduct

reasonable investigations that result in accurate processing of those claims based upon the information available at the time each claim is submitted.

Per the HMO Health Benefits Certificate, *“All admissions, except maternity and emergency admissions must be approved in advance by us. We require notification of emergency and maternity admissions within 48 hours of the admission or as soon as reasonably possible.”*

For each of these claims, there was no authorization on file and the diagnoses submitted on the claims did not indicate an emergency. As noted in the examination findings, these claims were paid upon review of additional information that was provided to the Company following initial processing. Information regarding initial processing and subsequent payment is provided below for each of the five claims:

- Regarding claim 04363V026000. The claim was originally denied due to the non-specific diagnosis of 959.19, other injury of other sites of trunk, submitted on the ambulance claim which did not support the medical necessity for ambulance transport. After the ambulance claim was denied, the Company received an emergency room claim for the same date of service with a diagnosis of 922.0, contusion of breast. Based on the diagnosis submitted on the emergency room claim, it was determined that the ambulance claim should be paid. The claim was re-adjudicated and paid.
- Regarding claim 05273H160800. The claim was not paid initially due to the group membership being terminated for non-payment of premium and the member was not eligible for covered services on the date of the claim. When the claim was submitted for payment, it denied correctly. Subsequent to the initial adjudication of the claim, the group membership was reinstated. Related claims were re-adjudicated and paid, however this claim was missed due to manual error.
- Regarding claim 05285Y020500. The claim was correctly denied due to a lack of inpatient prior authorization as required by the HMO Health Benefits Certificate. The facility contacted the Company and indicated they did not request an authorization because they thought Medicare was primary. The claim payment delay was due to the facility’s misunderstanding of the member’s health insurance coverage. The clinical information was provided to the Company and a retroactive prior authorization was approved. The claim was re-adjudicated and paid prior to the DIFP examination.
- Regarding claim 053140291500. The claim was correctly denied as it was not a benefit under the member’s Kansas contract. This member is a part of a Kansas group, University of Kansas Hospital Authority. Under this Kansas group’s contract, dependent daughter maternity is not covered. When the claim was subsequently reviewed, it was determined that the services were actually related

to a complication of pregnancy which is considered. The claim was re-adjudicated and paid.

- Regarding claim 05347F0AC900. The claim was correctly denied as a duplicate, the original claim had already been paid prior to the DIFP examination. The provider filed the claim three times using two different provider names even though the original payment was made within four days of receipt of the claim.

Please note that the Company has implemented an additional process to further ensure that emergency claims are processed accurately. Monthly reports that contain claim information on all denied emergency room claims are analyzed. Claims are reviewed to ensure accuracy in the initial processing. Through this review, if it is determined the emergency room claim is covered, related claims are reprocessed also. This does not change the fact that the Company can only process claims based on the information that it has at the time of adjudication. However, it may result in reconsideration of claims based on information that is received at a later date, after the initial timely adjudication.

Provider remittances and member EOBs are sent to the provider and member, respectively, informing them of the status and adjudication of the claim. If either party provides additional information timely to the Company, the claim, along with the additional information, is reviewed to determine if payment is appropriate.

#### 4. Mammography – Denied Claims

DIFP stated in the Executive Summary:

*Out of 18 denied claim lines, 14 were denied as being out-of-network.*

##### **Company's Response:**

The Company agrees that the *fourteen* claims referenced by DIFP were denied as being out-of-network. The claims were correctly denied because the services were rendered by a non-HMO provider. Coverage would have been provided if the member had obtained services from an HMO provider. Services must be received in accordance with the requirements of the HMO Health Benefits Certificate. Services from non-HMO providers are not covered except as described in the emergency services provision or if approved in advance by the Company.

Provider remittances and member EOBs are sent to the provider and member, respectively, informing them of the status and adjudication of the claim. If either party provides additional information timely to the Company, the claim, along with the additional information, is reviewed to determine if payment is appropriate.

#### 5. Colon Cancer Screenings – Denied Claims

DIFP stated in the Executive Summary:

*Out of 34 denied claim lines, 26 were denied as being out-of-network (of which, 20 were lab claims).*

**Company's Response:**

The Company agrees that the twenty-six claims referenced by DIFP were denied as being out-of-network. The claims were correctly denied as discussed below:

- Twenty claims were correctly denied because the HMO provider was not contracted to provide these lab services. These claims denied as provider responsibility with no member liability. The HMO provider has agreed to refer certain lab services, including the services provided on these claims, to the Company's designated HMO lab provider (Quest Labs). If the HMO provider fails to refer these services to the designated lab provider, there is no member liability for the charges. The members were not required to pay for the services due to the HMO providers' errors.
- Six claims were correctly denied because the services were rendered by a non-HMO provider. Coverage would have been provided if the member had used an HMO provider. The HMO Health Benefits Certificate states that services from non-HMO providers are not covered except as described in the emergency services provision or if approved in advance by the Company.

Provider remittances and member EOBs are sent to the provider and member, respectively, informing them of the status and adjudication of the claim. If either party provides additional information timely to the Company, the claim, along with the additional information, is reviewed to determine if payment is appropriate.

**6. Pap Smear Cancer Screenings – Denied Claims**

DIFP stated in the Executive Summary:

*Out of 78 denied claim lines, 67 were denied as being out-of-network (of which, 5 were lab claims).*

**Company's Response:**

The Company agrees that the sixty-seven claims referenced by DIFP were denied as being out-of-network. The claims were correctly denied as discussed below:

- Fifty-eight claims were correctly denied because the services were rendered by a non-HMO provider. Coverage would have been provided if the member had obtained services from an HMO provider. Services must be received in accordance with the requirements of the HMO Health Benefits Certificate. Services from non-

HMO providers are not covered except as described in the emergency services provision or if approved in advance by the Company.

- Five claims were correctly denied because the HMO provider was not contracted to provide these lab services. These claims denied as provider responsibility with no member liability. The HMO provider has agreed to refer certain lab services, including the services provided on these claims, to the Company's designated HMO lab provider (Quest Labs). If the HMO provider fails to refer these services to the designated lab provider, there is no member liability for the charges. The members were not required to pay for the services due to the HMO providers' errors.
- Three claims were correctly denied as part of a primary procedure (i.e., not payable separately). These claims denied as provider responsibility with no member liability.
- One claim was correctly denied because the member did not use the Blue-Care laboratory vendor. In addition, this member has Medicare as their primary carrier. Medicare denied this claim and required the provider to write off the claim and hold the member harmless.

Provider remittances and member EOBs are sent to the provider and member, respectively, informing them of the status and adjudication of their claim. If either party provides additional information timely to the Company, the claim, along with the additional information, is reviewed to determine if payment is appropriate.

## 7. PSA Cancer Screenings – Denied Claims

DIFP stated in the Executive Summary:

*Out of 38 denied claim lines, 24 were denied as being out-of-network (of which, 5 were lab claims).*

### **Company's Response:**

The Company agrees that the twenty-four claims referenced by DIFP were denied as being out-of-network. The claims were correctly denied as discussed below:

- Nineteen claims were correctly denied because the services were rendered by a non-HMO provider. Coverage would have been provided if the member had obtained services from an HMO provider. Services must be received in accordance with the requirements of the HMO Health Benefits Certificate. Services from non-HMO providers are not covered except as described in the emergency services provision or if approved in advance by the Company.
- Five claims were correctly denied because the HMO provider was not contracted to provide these lab services. These claims denied as provider responsibility with no

member liability. The HMO provider has agreed to refer certain lab services, including the services provided on these claims, to the Company's designated HMO lab provider (Quest Labs). If the HMO provider fails to refer these services to the designated lab provider, there is no member liability for the charges. The members were not required to pay for the services due to the HMO providers' errors.

Provider remittances and member EOBs are sent to the provider and member, respectively, informing them of the status and adjudication of the claim. If either party provides additional information timely to the Company, the claim, along with the additional information, is reviewed to determine if payment is appropriate.

## **B. Claim Handling – Out-of-Network**

In general response to all of the five areas where DIFP noted issues in this section of the Executive Summary, the Company has business practices and procedures in place to ensure all claims are processed accurately based on the information received at the time the claim is submitted.

During the exam period of 2003-2005, approximately *1,952,500* Blue-Care claims were processed by the Company. Given the complexity of the healthcare delivery and reimbursement system, as acknowledged by DIFP in this report, and the volume of claims processed by the Company, some minimal number of processing errors is inevitable. The Company has in place ongoing Quality Assurance and claim auditing processes to proactively ensure claims are paid appropriately. A complaints and grievances appeal process is also available to members and providers. This process is communicated to members clearly on each EOB, in the HMO Health Benefits Certificate, and in an annual member mailing.

Provider remittances and member EOBs are sent to the provider and member, respectively, informing them of the status and adjudication of the claim. If either party provides additional information timely to the Company, the claim, along with the additional information, is reviewed to determine if payment is appropriate.

### **1. Denied Pathology/Laboratory Claims**

DIFP stated in the Executive Summary:

*Out of 6,659 denied claim lines, 1,211 were denied as being out-of-network.*

#### **Company's Response:**

The Company agrees that the 1,211 claims referenced by DIFP were denied as being out-of-network.

As is common with HMO plans, certain laboratory services would be covered only if provided by a specified laboratory provider. The Company contracted with Quest Labs to provide such services.

Blue-Care is an HMO product with a defined service-area and a defined network that members are required use as outlined in their HMO Health Benefits Certificate. Services from non-HMO providers are not covered except as described in the emergency services provision or if approved in advance by the Company.

Of the *fifty* claims referenced in the table within the Examination Findings section, based on the information provided with the initial claim, the provider would be responsible in the *eighteen* cases noted by DIFP in the “IN – In Service Area Provider” column (i.e., the provider delivering the service was both in the Company’s service area and in the Company’s network). The members did not have to pay for these services.

In the remaining *thirty-two* case, these services were provided by non-HMO provider, were not emergency services, and were submitted without prior authorization. A reasonable investigation of these claims was conducted using the information that had been provided to the Company at the time of claim submission and all were correctly denied based on that information and the member’s benefits.

Many avenues are available to both members and providers to inquire if a specific provider is in the HMO network (e.g., provider directory, the Company website, customer service). The Company emphasizes member education to ensure a thorough understanding of their HMO Health Benefits Certificate (e.g., the Company’s website, open enrollment materials, customer service contacts). Additionally, the Company’s provider services staff works to specifically educate providers that they must utilize the contracted laboratory provider for HMO members.

Provider remittances and member EOBs are sent to the provider and member, respectively, informing them of the status and adjudication of the claim. If either party provides additional information timely to the Company, the claim, along with the additional information, is reviewed to determine if payment is appropriate.

## 2. Denied Anesthesiology Claims

DIFP stated in the Executive Summary:

*A secondary COB claim, which was determined by the Company to be emergent and paid upon questioning by the examiners, was initially denied without further investigation, contrary to §§375.1007(6) and 376.1367, RSMo.*

### **Company’s Response:**

The Company agrees that the *one* secondary COB claim referenced by DIFP was denied incorrectly during initial processing due to a manual error.

Claim 052060418400 was incorrectly denied for no prior authorization. After subsequently reviewing, the Company has determined the member went to the emergency room and was admitted to the facility through the emergency room. Because these services were for emergent care, the claim was re-adjudicated under claim number 072420062600, and the Company paid as secondary to Medicare. All other claims related to this admission were paid prior to the DIFP examination.

The Company is in compliance with §§375.1007(6) and 376.1367, RSMo. The Company has effective processes in place to conduct reasonable investigations that result in accurate processing of those claims based upon the information available at the time each claim is submitted. This claim was incorrectly denied due to a manual error.

### 3. Denied Radiology Claims

#### Company's Response:

Blue-Care is an HMO product with a defined service-area and a defined network that members are required use as outlined in their HMO Health Benefits Certificate. Services from non-HMO providers are not covered except as described in the emergency services provision or if approved in advance by the Company.

Many avenues are available to both members and providers to inquire if a specific provider is in the HMO network (e.g., provider directory, the Company website, customer service). The Company emphasizes member education to ensure a thorough understanding of their HMO Health Benefits Certificate (e.g., the Company's website, open enrollment materials, customer service contacts).

Provider remittances and member EOBs are sent to the provider and member, respectively, informing them of the status and adjudication of the claim. If either party provides additional information timely to the Company, the claim, along with the additional information, is reviewed to determine if payment is appropriate.

The specific issues raised by DIFP in the four bulleted statements within the Denied Radiology Claims section of the Executive Summary report are responded to individually below.

#### 3.1 DIFP stated in the Executive Summary (first bullet):

*In two claims where members with debilitating illnesses were confined to network skilled nursing facilities and under the care of network physicians, the Company denied claims for portable x-ray services provided in the facility because the provider was out-of-network.*

The Company agrees that the *two* claims referenced by DIFP were denied as being out-of-network. These claims correctly denied based upon the information that had been provided to the Company at the time of claim adjudication.

Regarding claims 05216F069000 and 05270F0B1500 . Non-HMO providers performed portable x-rays in an HMO skilled nursing facility. Coverage would have been provided if the member, or the HMO skilled nursing facility, HMO attending physician, or the member had used an HMO provider for these portable x-rays. The HMO contract states that services from non-HMO providers are not covered except as described in the emergency services provision or if approved in advance by the Company. There was no indication on these claims that the services were due to an emergency and the services had not been approved in advance by the Company.

**3.2** DIFP stated in the Executive Summary (second bullet):

*A “Medicaid Reclamation” claim that was both in-network and emergent was denied as being out-of-network without further investigation, contrary to §375.1007(6), RSMo, and 20 CSR 400-2.030(2)(F)4.F.*

The Company respectfully disagrees with this finding for the *one* claim referenced. The Company is in compliance with §375.1007(6), RSMo, and 20 CSR 400-2.030(2)(F)4. The Company has effective processes in place to conduct reasonable investigations that result in accurate processing of those claims based upon the information available at the time each claim is submitted.

Regarding claim 052000048300. This claim was a Medicaid Reclamation claim filed by Missouri Medicaid for reimbursement of the Medicaid payment since the Company was the primary carrier. The non-HMO facility rendering the services did not bill the Company for the claim. The initial denial of the Medicaid Reclamation claim was due to the lack of an emergency room charge on the claim. The claim was re-filed by Missouri Medicaid to include the emergency room charges. The claim was then paid under the emergency services provisions of the HMO Health Benefits Certificate.

**3.3** DIFP stated in the Executive Summary (third bullet):

*A claim related to an inpatient stay was denied without further investigation due to a date of service error, contrary to §375.1007(6), RSMo. The Company readjudicated and paid the claim during the course of the examination.*

The Company respectfully disagrees with this finding for the *one* claim referenced. The Company is in compliance with §375.1007(6), RSMo. The Company has effective processes in place to conduct reasonable investigations that result in accurate processing of those claims based upon the information available at the time each claim is submitted.

Regarding claim 05241P164000. This claim was denied due to a manual keying error. The claim, for radiology services, related to an inpatient admission for dates of service 09/30/2003 through 10/03/2003. The date of service was keyed (i.e., manual data entry) in error by the Company as 10/12/2003. The actual date of service was 10/01/2003, which was during the approved admission. Neither the provider nor member contacted the Company regarding this error on the EOB. The review by the examiners brought this to the attention of the Company and the claim was then corrected.

**3.4** DIFP stated in the Executive Summary (fourth bullet):

*A radiology claim that was emergent in nature was denied without further investigation, contrary to §375.1007(6), RSMo. The Company readjudicated and paid the claim during the course of the examination.*

The Company respectfully disagrees with this finding for the *one* claim referenced. The Company is in compliance with §375.1007(6), RSMo. The Company has effective processes in place to conduct reasonable investigations that result in accurate processing of those claims based upon the information available at the time each claim is submitted.

Regarding claim 05034F025500. There was several radiology claims submitted for the same date of service because the technical components (i.e., x-ray machine, technician time) were billed separately from the professional (i.e., radiologist) components. The claim was manually reviewed by a Claims Examiner who failed to allow for both professional and technical components of the radiology services. A reasonable investigation was performed; however, the claim was denied incorrectly due to a Claim Examiner error. The claim was re-adjudicated and paid during the course of the examination.

**4. Access Plan:**

DIFP stated in the Executive Summary:

*The Company's access plan appears to indicate that any services provided in a network hospital by a "hospital-based provider" will be covered; however, the Company's definition of what constitutes a hospital-based provider is much narrower than the Company's access plan response would seem to indicate. The Company should amend its access plan filing to more accurately reflect its processes pursuant to §354.603.2, RSMo.*

**Company's Response:**

The Company respectfully disagrees with this finding. While "hospital-based providers" were not specifically defined, this is not specifically required by §354.603.2, RSMo, referenced above.

The Company agrees to amend its access plan to clarify that non-HMO "hospital-based physician or physician group" claims for services provided in either an inpatient or outpatient setting at a network hospital will be paid. "Hospital-based physician or physician group" claims include the following specialties: emergency medicine, radiology, anesthesiology, and pathology (including laboratory services).

## 5. Out-of-Network Claims Generally:

DIFP stated in the Executive Summary:

*There appears to be confusion among the Company's members as to when they are out-of-network and when out-of-network claims are payable. To alleviate such problems the Company needs to be proactive in educating its members as to the differences between "Par" and "network" providers, and the circumstances under which the Company would pay claims that are initially denied as being out-of-network. The Company should also work on improving claim processes so that claims payable as exceptions are identified and investigated rather than automatically denied.*

### Company's Response:

There are several resources available to educate members regarding who is an HMO provider (i.e., provider directory, the Company website, customer service contacts). The Company emphasizes member education to ensure a thorough understanding of their HMO Health Benefits Certificate (i.e., the Company's website, open enrollment materials, customer service contacts). Additionally, the Company works to educate providers that there is limited coverage for services rendered by non-HMO providers and when such services would be covered.

Members have no responsibility to understand if a provider is a "par" (i.e., a provider that has a contract with the Company but is not an HMO provider) provider. Members are required to ensure that services are rendered by an HMO provider. To the extent an HMO provider renders services that the provider has agreed to refer to a designated HMO provider (i.e., lab) the HMO provider is not allowed to bill the member.

## C. Refunds of Excessive Copayments

DIFP stated in the Executive Summary:

*The Company does not have any process in place to monitor whether or not providers make refunds of copayments that exceed 50% of a single service in compliance with 20 CSR 400-7.100.*

### Company's Response:

The Company respectfully disagrees with this finding. While 20 CSR 400-7.100 does not require that we monitor whether providers make refunds of copayments that exceed 50%, the Company does have a process that assists members who believe the provider owes them money; as well as processes to educate providers to avoid collecting excess copayments.

20 CSR 400-7.100 and §354.485, RSMo, prohibit an HMO from imposing copayment charges that exceed fifty percent (50%) of the total cost of providing any single service to its enrollees.

Upon receipt of a claim from an HMO provider, we adjudicate the claim and determine whether the applicable copayment should be reduced due to the billed charge or our negotiated discounts. If the copayment should be reduced, both the member and the provider are notified of the correct co-pay amount on the EOB and provider remittance advice, respectively.

If a provider has collected the copayment at the time of service, upon receipt of the remittance advice indicating that the copayment has been reduced, the provider is to refund the member the amount that exceeds 50% of the cost of providing the service.

To minimize the frequency of situations resulting in copayment refunds, the Company's Provider Relations staff educates providers on an ongoing basis concerning the 50% rule. We encourage providers to only collect no more than 50% of the allowable charges (i.e., billed charges less any negotiated discounts) at the time of service.

Members who believe they are due a refund may contact us as indicated on the member's EOB. We then contact the provider's office to determine if the provider has applied the amount to a previous balance due or if the amount should be refunded to the member.

While 20 CSR 400-7.100 does not require that we monitor whether providers that collect copayments in excess of 50% of any single service make the necessary refunds to members, our process allows us to thoroughly investigate whether a member is owed money due to the 50% rule.

In the event money is owed to the member we follow up with the provider. The Company is in compliance with the requirements of 20 CSR 400-7.100.

#### **D. Prompt Payment of Claims**

DIFP stated in the Executive Summary:

*The Company is not correctly calculating the 45-day period for the payment of interest required by §§376.383 to 376.384, RSMo, because:*

- *The Company does not regard an electronic claim as being received until it receives it from its contracted electronic claim vendor.*

- *If a claim is denied in whole or in part and the provider and/or member subsequently furnishes additional information, makes an inquiry or files an appeal regarding the denied claim, it appeared from standard operational procedure documents that the Company may regard this event as a new “received” date in many instances.*

**Company’s Response:**

The Company contracted with Administrative Services of Kansas, Inc. (“ASK”) to act as a clearinghouse for the receipt of the electronic claims from providers. Providers are required to submit electronic claims that are in compliance with HIPAA. ASK was accountable for accepting and translating Electronic Data Interchange transmissions from providers and validating that related electronic files and claims complied with the HIPAA Implementation Guide (“HIPAA IG”) and external code sets (i.e., ICD-9 and CPT-4) as defined under HIPAA. After passing relevant HIPAA IG edits, claims were transmitted to the Company for adjudication.

Below are the Company’s responses for each of the two bullets referenced by DIFP in the Executive Summary. In both instances, it is important to note that during the period covered by this exam the Company was paying interest after a thirty day period for all claims (versus the forty-five day timeframe allowed by RSMo. 376.383.5). Consequently, it appears the Company was actually overpaying interest on a number of claims each month.

**D.1** DIFP made the following comment with the first bullet in the Executive Summary:

*The Company does not regard an electronic claim as being received until it receives it from its contracted electronic claim vendor.”*

There are two distinct components to consider, discussed separately below:

**a.** *Claims Rejected by ASK*

The Company respectfully disagrees that claims rejected by ASK were subject to prompt pay statutes. In order for the prompt pay statutes to apply under RSMo 376.384.2, all claims must be submitted by a healthcare provider in an electronic format consistent with federal administrative simplification standards adopted pursuant to HIPAA<sup>1</sup>. Any claim submitted by a healthcare provider not in compliance with these standards is not subject to the prompt pay statute.

The file and claim-level edits used by ASK are used to review a claim for compliance with HIPAA IG requirements. To the extent the claim is not consistent with HIPAA standards, it is rejected by ASK. The Company is not

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<sup>1</sup>“On or after January 1, 2003, all claims for reimbursement for a health care service provided in this shall be submitted in an electronic format consistent with federal administrative simplification standards adopted pursuant to the Health Insurance Portability and Accountability Act of 1996”.

required to consider such claims as being received if the healthcare provider fails to submit claims that meet the minimum requirements contained in RSMo 376.384.2.

For example, the top 35 ASK edits from the first six months of 2009 accounted for over ninety-seven percent of the total claims rejected by ASK. As a result, over ninety-seven percent of claims rejected were due to the provider failing to comply with HIPAA standards. Each edit corresponds to a specific HIPAA IG requirement. While historical statistics for the period of time covered by this exam (2003-2005) are not available, the Company believes the 2009 statistics to be representative of ASK edit activity during the exam period.

In addition to RSMo 376.384.2, HIPAA (45 CFR §162.923; §162.925) prohibits the Company from accepting non-compliant electronic claims. The Company as a “covered entity” under HIPAA must utilize HIPAA-compliant standard transactions. It was appropriate for these claims to be rejected in order to comply with these laws.

**b. Claim Receipt Date**

The Company agrees that for some HIPAA compliant claims that were sent to the Company from ASK, the receipt date used in calculating the period for the payment of interest required by §§376.383 to 376.384, RSMo, reflected the date claims were received by the Company, and not the date received by ASK.

Claims received by ASK prior to 10:00 a.m. on the transmission date are included within the same day’s file, and claims transmissions to the Company occur each weekday at approximately 12:00 p.m. The timing of claim receipt at ASK and transmission of those claims to the Company (i.e., time of day and day of week) sometimes resulted in no more than a three day difference between the receipt date recorded by the Company and the actual date received by ASK, as outlined below.

- *The Company received date was the same as the ASK received date* for claims received by ASK on weekdays between 12:00 a.m. and 10:00 a.m., and transmitted to the Company the same day (e.g., ASK received claim at 6:00 a.m. Monday, the Company received claim at 12:00 p.m. Monday). This scenario, not taking into account possible variances in claim submission volume, applied approximately 41.7% of the time.
- *The Company received date was one day later than the ASK received date* for claims received by ASK on weekdays between 10:00 a.m. and 12:00 a.m. the following day, and transmitted to the Company the following day (e.g., ASK received claim at 2:00 p.m. Monday, the Company received claim at 12:00 p.m. Tuesday). This scenario, not taking into account possible variances in claim submission volume, applied approximately 46.7% of the time.

- *The Company received date was three days later than the ASK received date for claims received by ASK on Fridays between 10:00 a.m. and 12:00 a.m. the following day, and transmitted to the Company the following Monday (e.g., ASK received claim at 2:00 p.m. Friday, the Company received claim at 12:00 p.m. the following Monday). This scenario, not taking into account possible variances in claim submission volume, applied approximately 11.7% of the time.*

**D.2** DIFP made the following comment with the second bullet in the Executive Summary:

*If a claim is denied in whole or in part and the provider and/or member subsequently furnishes additional information, makes an inquiry or files an appeal regarding the denied claim, it appeared from standard operational procedure documents that the Company may regard this event as a new “received” date in many instances.*

The Company agrees that the Standard Operating Procedures and claim processing practices between 2003 and 2005 treated the receipt of additional information as a new “received” date. This approach was based on the Company’s interpretation of prompt pay statutes §§376.383 to 376.384, RSMo, which was different from DIFP’s interpretation. Through subsequent discussions with DIFP, the Company modified its claim processing practices to calculate interest as of the original receipt date.

In 2007, the Company reviewed Blue-Care claims paid between 2003 and 2005 and recalculated the interest due using the original received date (i.e., versus the new “received” date that may have been considered when the claims were initially processed). This resulted in approximately \$2,259.39 in additional interest payments made on 08/27/2007 related to 386 claims.

In 2007, the Company’s Standard Operating Procedure for interest payments was revised to reflect that the original claim receipt date is to be used to calculate interest.