



**BlueCross BlueShield
of Kansas City**

An Independent Licensee of the
Blue Cross and Blue Shield Association

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July 07, 2010

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 #0903-04-TGT,
Blue Cross Blue Shield of Kansas City (NAIC #47171)

Dear Ms. Kerr:

Attached please find the Company's initial 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 9, 2010.

A meeting is scheduled between the Company and DIFP on July 15, 2010, to discuss the examiner's comments related to paying First Steps claims at the applicable Medicaid rate. Subsequent to that meeting, the Company will respond to related items in this report (i.e., section II.A.2).

As requested in your correspondence dated June 4, 2010, you will receive an electronic copy of the Company's response via e-mail, as well as a hard copy. 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

Enclosures: Company Response, Supporting Documentation

II. Claims Practices

A. Unfair Settlement and General Handling Practices

1. Improperly Denied Claims

A. DIFP Stated in the Report:

Thirty-nine claims were wrongfully denied, in that they were a part of a system edit and improperly coded. These claims contained a denial code of N59 or N01 which stated “line items that denied as a subset of another service.” Although these claims were re-adjudicated as a result of this examination, it should be noted that these claims were paid by the Company at a rate less than the amount billed.

Reference: §3761218.5, RSMo, and 20 CSR 400-2.170(4)(C)3.C

The 39 claims applicable to this error may be found in Appendix A.

Company’s Response:

The Company agrees with this finding. These claims were re-adjudicated and paid.

For most claims processed by the Company, the processing system is configured to identify instances where reimbursement for a particular procedure code (i.e., service received by the member) is already included within another procedure code on the same claim – a “subset.” This is an industry-standard claims processing approach to ensure the Company does not overpay for effectively the same service. The claims noted were then manually processed by claims examiners and denied. This would have been correct treatment for most claims the Company processes; however, the First Steps program has unique processing requirements.

B. DIFP Stated in the Report:

Examiners discovered that payments for 79 claim files were wrongfully denied because the Company felt the charges exceeded the First Steps provider Medicaid rate published by DESE. To distinguish that a file was being paid at a reduced rate, these claim files contained Remittance Advice codes of PS and PSS, indicating that a “charge has been processed based upon the provider’s participation status” with the Company. The reasons for the reduced payment given to the examination staff were that the Company did not consider the Place of Service (POS) code as billed by DESE. As stated the Company’s response, dated October 18, 2009, to an examiner criticism, “The Company based its payment to DESE/Covansys on the Medicaid published fee schedule.”

As advised by DESE and Mo HealthNet, the applicable Medicaid rate and applicable provider manuals are related to the HCY/EPST program and discussed in 13 CSR 70-70.010. Subsection (5) of this regulation states “Reimbursement. Payment will be made in accordance with the fee per unit of service as defined and determined by the MO

HealthNet Division.” The Mo HealthNet Therapy Manual indicated that POS codes may “have a higher...maximum allowable amount.”

Reference: §§160.900, 208.144, 376.1218.4 and .5, RSMo, and 20 CSR 400-2.170(3)(B) and (4)(E)

The 79 claims applicable to this error may be found in Appendix B

Company’s Response:

The Company agrees that 22 of the 79 claims were incorrectly denied when initially processed. However, because the claims were denied (i.e., versus paid at a discounted rate), the Medicaid published fee schedule referenced by examiners was not a factor. They were denied as a result of manual errors made during initial processing. The claims were re-adjudicated and paid.

The Company respectfully disagrees that 57 of the 79 claims noted were incorrectly denied, as discussed below.

- The 3 claims listed below were not denied; they were processed and allowable charges were applied to deductible, as noted by examiners in Appendix B. A meeting is scheduled between the Company and DIFP on July 15, 2010, to discuss the examiner’s comments related to paying First Steps claims at the applicable Medicaid rate.

Claims:

07061F4C7900, 07061F4C7A00, 08164F4AED00

- The 54 claims listed below were denied correctly, as the 3 members associated with these claims were covered under a self-insured Administrative Services Only (ASO) employer group contract. Per §376.1218 (3), RSMo, First Steps coverage does not extend to policies subject to ERISA.

Supporting documentation is provided in a separate attachment so as not to include the member’s personal information in a public document.

1 Claim: 08164F4A9B00

12 Claims:

08203F545700, 08203F545900, 08252F4A9A00, 08252F4A9B00,
08252F4A9C00, 08259F59FF00, 08259F5A0000, 08259F5A0100,
08296F5D7200, 08296F5D7300, 08296F5D7400, 08354F4FAF00

41 Claims:

08252F4B7100, 08252F4B7200, 08259F5A9500, 08259F5A9600,
08296F5E1F00, 08296F5E2000, 08329F4E4700, 08329F4E4800,
08329F4E5E00, 08329F4E5F00, 08329F4E6000, 08329F4E6100,

08329F4E6200, 08329F4E6300, 08329F4E6400, 08329F4E6500,
08329F4E6600, 08329F4E6700, 08329F4DCE00, 08354F4FB000,
08354F4FEE00, 08354F4FEF00, 08354F4FF000, 09021F519100,
09021F519200, 09021F519300, 09021F519400, 09021F519500, 09021F519600,
09021F519700, 09021F519800, 09021F519900, 09021F519A00, 09021F519B00,
09021F519C00, 09021F519D00, 09048FACE300, 09048FACE400,
09048FACE500, 09078F4DAF00, 09078F4DB000

C. DIFP Stated in the Report:

The Company wrongfully denied claims because they did not receive information about Coordination of Benefits (COB). 20 CSR 400-2.170(4)4 references the Company's obligations related to COB. According to that regulation, DESE will notify a primary plan or secondary plan about payment obligations under COB. Although these claims were re-adjudicated as a result of this examination, it should be noted that these claims were paid by the Company at a rate less than the amount billed.

Reference: §376.1218.1 RSMo.

The 25 claims applicable to this error may be found in Appendix C.

Company's Response:

The Company agrees that the 25 claims noted were denied because COB information was not received. These claims were re-adjudicated and paid, and process changes were implemented so that COB information request letters are not generated for future First Steps claims.

For most claims processed by the Company, COB review is performed to determine if other coverage exists. Benefits are then coordinated if the member has other coverage to ensure appropriate payments are made by the insurer with primary and secondary responsibility. However, First Steps claims have unique processing requirements and COB information is not required.

A meeting is scheduled between the Company and DIFP on July 15, 2010, to discuss the examiner's comments related to paying First Steps claims at the applicable Medicaid rate.

D. DIFP Stated in the Report:

The Company wrongfully denied five claims because they did not receive additional information as requested. 20 CSR 100-1.060(2)(L)1 states that a request for additional information "shall describe with specificity" the information needed. Neither the file nor the X17 claim denial code specifies the needed information. As a result of this examination, these claims were re-adjudicated and paid.

Reference: §376.383, RSMo.

<u>Claim Number</u>	<u>Reason Code</u>	<u>Amount Billed</u>	<u>Claim Status</u>
08164F4AC900	X17	\$40.00	Denied
08105F5D3B00	X17	\$40.00	Denied
08105F5D3C00	X17	\$40.00	Denied
08046F45F800	X17	\$40.00	Denied
08046F45F900	X17	\$40.00	Denied

Company’s Response:

The Company agrees that the 5 claims noted were incorrectly denied when initially processed. These claims were re-adjudicated and paid.

E. DIFP Stated in the Report:

The Company improperly denied four claims because they did not receive a “valid rendering provider: name or number. The information requested duplicates the information set forth in 20 CSR 400-2.170(3) and does not pertain to the Company’s determination of liability. Additionally, the Company adjudicated claims for over a year prior to the submission of these specific claims. Although these claims were re-adjudicated as a result of this examination, it should be noted that these claims were paid by the Company at a rate less than the amount billed.

Reference: §376.1218.4 RSMo.

<u>Claim Number</u>	<u>Reason Code</u>	<u>Amount Billed</u>	<u>Claim Status</u>
07061F4BE000	XB3	\$50.00	Denied
07061F4BE300	XB3	\$50.00	Denied
07061F4BE400	XB3	\$50.00	Denied
07061F4B7F00	XB3	\$62.50	Denied

Company’s Response:

The Company agrees with this finding. These claims were re-adjudicated and paid.

For most claims processed by the Company, rendering provider information is necessary to correctly process the claim. If claims do not contain this, additional information is requested from the provider. First Steps claims are unique in that the rendering provider number is not necessary. The claims examiners made a manual error by requesting that information for these claims.

A meeting is scheduled between the Company and DIFP on July 15, 2010, to discuss the examiner’s comments related to paying First Steps claims at the applicable Medicaid rate.

2. Improperly Reduced Claim Payments

A. DIFP Stated in the Report:

The aforementioned Appendix A claims were reprocessed as a course of this examination. The Company did not pay claims at the applicable Medicaid Rate. Although these claims were re-adjudicated as a result of this examination, it should be noted that these claims were paid by the Company at a rate less than the amount billed.

Reference: §376.1218.5, RSMo, and 20 CSR 400-2.170(4)(E)

The 34 claims applicable to this error may be found in Appendix D and are not counted in the error ratio.

Company's Response:

A meeting is scheduled between the Company and DIFP on July 15, 2010, to discuss the examiner's comments related to paying First Steps claims at the applicable Medicaid rate.

B. DIFP Stated in the Report:

Examiners discovered that payments for 790 claim files were wrongfully underpaid because the Company felt the charges exceeded the First Steps provider Medicaid rate published by DESE. To distinguish that a files was being paid at a reduced rate, these claim files contained remittance advice code of PS and PSS indicating that a "charge has been processed base upon the provider's participation status" with the Company. The reduced payment reasons given to the examination staff were that the Company did not consider the Place of Service (POS) code as billed by DESE. As stated in the Company's response, dated October 18, 2009, to an examiner criticism, "The Company based its payment to DESE/Covansys on the Medicaid published fee schedule."

As advised by DESE and Mo HealthNet, the applicable Medicaid rate and applicable provider manuals are related to the HCY/EPSTDT program and discussed in 13 CSR 70-70.010. Subsection (5) of this regulation states "Reimbursement. Payment will be made in accordance with the fee per unit of service as defined and determined by the MO HealthNet Division." The Mo HealthNet Therapy Manual indicated that POS codes may "have a higher...maximum allowable amount."

Reference: §§160.900, 208.144, 376.1218.4 and .5, RSMo, and 20 CSR 400-2.170(3)(B) and (4)(E)

The 790 claims applicable to this error may be found in Appendix E and are counted in the error ratio.

Company’s Response:

A meeting is scheduled between the Company and DIFP on July 15, 2010, to discuss the examiner’s comments related to paying First Steps claims at the applicable Medicaid rate.

3. Unreasonable delay in the payment or denial of a claim

DIFP Stated in the Report:

The Company issued letters which requested additional information about certain First Steps claims. Because §376.1218, RSMo and 20 CSR 400-2.170 set forth situations for the unconditional acceptance of diagnosis, provider status, and COB, letters requesting additional information delayed the payment of a First Steps claim.

Files indicate that the Company delayed payment to the provider by issuing a letter requesting additional information. The letter requested information about diagnoses and rendering provider name and address. Since the information requested duplicates the rules set forth in 20 CSR 400-2.170, the request does not pertain to the Company’s “determination of liability” and is a duplication of information and verification.”

Reference §§ 374.205.2(2), 375.1007(11), 376.383.10, 376.1218 RSMo, 20CSR 400-2.170(3) and (4)(C)3.

<u>Claim Number</u>	<u>CoCode</u>	<u>Date of Letter</u>
08046F45F900	47171	2/21/2008

The Company response to an Examiner inquiry revealed that there were similar letters sent in 2009. Examiners requested that the Company take corrective action so that such letters are not generated for future First Steps claims.

Company’s Response:

The Company agrees with this finding; however, claim number 08046F45F900 was also cited by examiners under item II.A.1.D. in this report for what appears to be the same issue. The claim noted was re-adjudicated and applied to the member’s deductible. Process changes were implemented so that such letters are not generated for future First Steps claims.

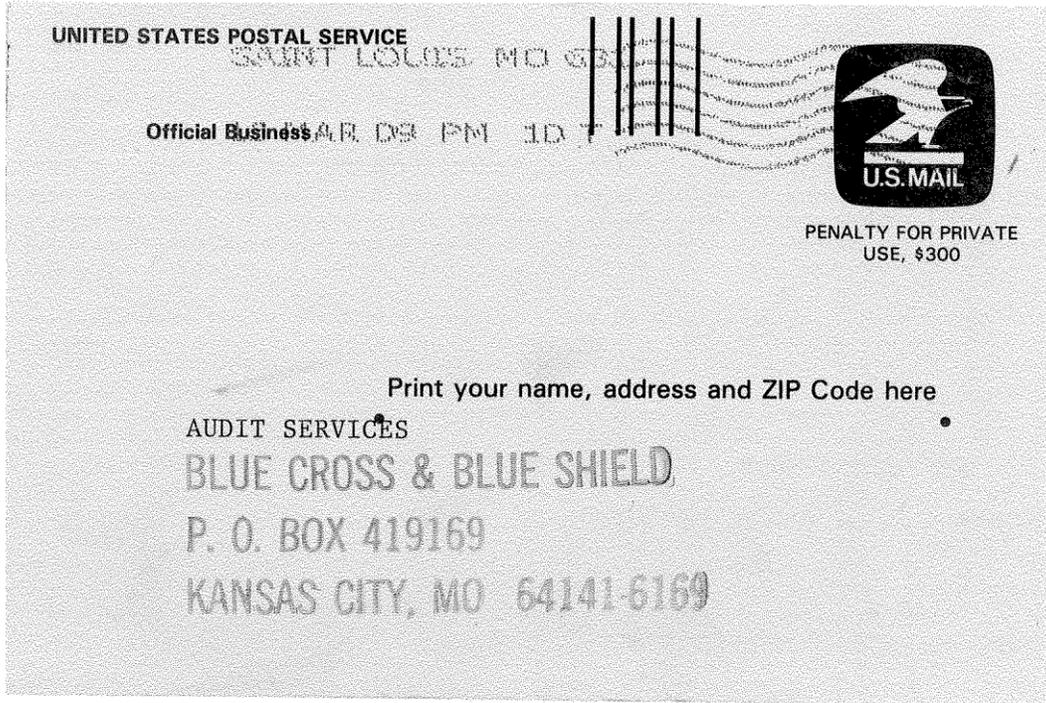
III. Criticisms and Formal Requests Time Study

B. Formal Request Time Study

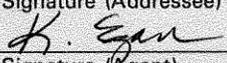
The examiner’s draft report indicates the Company’s response to *I* request was received outside the time limit, including any extensions. Per an e-mail from Carolyn Kerr, Senior Counsel, Market Conduct Section, DIFP believed the Company failed to respond to the Examination Notification Letter within the required ten working days.

**Missouri Market Conduct Examination #0903-04-TGT
Blue Cross Blue Shield of Kansas City (NAIC #47171)
Company Response – Draft Report Dated 05/27/2010**

The Company received the Examination Notification Letter on March 4, 2009, and sent the required response to DIFP on March 9, 2009, via certified U.S. Mail. The return receipt (images of front/back below) indicates it was received by DIFP on March 16, 2009, and signed for by what appears to be “K. Egan.” DIFP received the Company’s response on the eighth working day following receipt of the Notification Letter, within the required ten working day timeframe.



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SENDER: • Complete items 1 and/or 2 for additional services. • Complete items 3, and 4a & b. • Print your name and address on the reverse of this form so that we can return this card to you. • Attach this form to the front of the mailpiece, or on the back if space does not permit. • Write "Return Receipt Requested" on the mailpiece below the article number. • The Return Receipt Fee will provide you the signature of the person delivered to and the date of delivery.		I also wish to receive the following services (for an extra fee): 1. <input type="checkbox"/> Addressee's Address 2. <input type="checkbox"/> Restricted Delivery Consult postmaster for fee.	
3. Article Addressed to: Mr. Jim Mealer, Audit Manager MISSOURI DEPARTMENT OF INSURANCE 111 North Seventh Street, Room 229 St. Louis, Missouri 63101		4a. Article Number P 691 918 621	
		4b. Service Type <input type="checkbox"/> Registered <input type="checkbox"/> Insured <input checked="" type="checkbox"/> Certified <input type="checkbox"/> COD <input type="checkbox"/> Express Mail <input checked="" type="checkbox"/> Return Receipt for Merchandise	
		7. Date of Delivery 3/16/09	
5. Signature (Addressee) 		8. Addressee's Address (Only if requested and fee is paid)	
6. Signature (Agent)			
PS Form 3811, November 1990 ☆ U.S. GPO: 1991-287-066		DOMESTIC RETURN RECEIPT	