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**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 0612-48-TGT
Blue Cross & Blue Shield of Kansas City, d/b/a Blue-Advantage, Inc. (NAIC #47171)

**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 Blue Cross & Blue Shield of Kansas City, d/b/a Blue-Advantage, Inc., (hereafter referred to as "Blue-Advantage"), 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, Blue-Advantage 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 Blue-Advantage and prepared report number 0612-48-TGT; and

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

1. Blue-Advantage 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. Blue-Advantage allowed an enrollee to make aggregate copayments that exceeded 20% of the total cost of providing all basic health care services, in violation of 20 CSR 400-7.100.

3. In some instances, Blue-Advantage failed to conduct a reasonable investigation prior to denying certain claims, thereby violating §375.1007(3), (4), and (6), RSMo.

4. In some instances, Blue-Advantage 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, Blue-Advantage 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. Blue-Advantage agrees to take corrective action to reasonably assure that the errors noted in the above-referenced market conduct examination reports do not recur;

2. Blue-Advantage 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. Blue-Advantage 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, Blue-Advantage neither admits nor denies the findings or violations set forth above and enumerated in the examination report; and

WHEREAS, Blue-Advantage 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, Blue-Advantage, 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, Blue-Advantage hereby agrees to the imposition of the ORDER of the Director and as a result of Market Conduct Examination #0612-48-TGT further agrees, voluntarily and knowingly to surrender and forfeit the sum of \$9,309.00.

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 Blue-Advantage to transact the business of insurance in the State of Missouri or the imposition of other sanctions, Blue-Advantage 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 \$9,309.00, such sum payable to the Missouri State School Fund, in accordance with §374.280, RSMo.

DATED: 12-24-09



President and CEO - Elect
Blue Cross & Blue Shield of Kansas City,
d/b/a Blue-Advantage, Inc.



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

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

In re:)
) Examination No. 0612-48-TGT
Blue Cross & Blue Shield of Kansas City,)
d/b/a Blue-Advantage, Inc. (NAIC #47171))

ORDER OF THE DIRECTOR

NOW, on this 30th 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 Cross & Blue Shield of Kansas City, d/b/a Blue-Advantage, Inc. (NAIC #47171), (hereafter referred to as "the Company") report numbered 0612-48-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 \$9,309.00, 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 30th 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

BLUE CROSS AND BLUE SHIELD OF KANSAS CITY
d/b/a BLUE-ADVANTAGE
NAIC # 0537-47171

MISSOURI EXAMINATION #0612-48-TGT

NAIC EXAM TRACKING SYSTEM #MO268-M29

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.
- “Blue-Advantage” or “Company” refers to Blue Cross and Blue Shield of Kansas City d/b/a Blue-Advantage.
- “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 Blue Cross and Blue Shield of Kansas City d/b/a Blue-Advantage. The examination only encompassed the Blue Advantage HMO business and not the other, non-HMO business of the Company. The examination was conducted in conjunction with an examination of the Company's HMO subsidiary, Good Health HMO, Inc. d/b/a Blue-Care, Inc.

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 statute. 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).

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

On November 25, 1991, Blue Cross and Blue Shield of Kansas City incorporated a subsidiary named HealthSource, Inc. On December 3, 1991, HealthSource, Inc. registered the fictitious name of "Blue-Advantage." A certificate of authority to conduct business as a health maintenance organization (HMO) was subsequently issued to HealthSource, Inc. d/b/a Blue-Advantage on February 26, 1992. HealthSource, Inc. amended its articles of incorporation to change its name to "TriSource HealthCare, Inc." on November 9, 1994. TriSource HealthCare, Inc. d/b/a Blue-Advantage was subsequently merged into Blue Cross and Blue Shield of Kansas City via the following series of events described in Blue Cross and Blue Shield of Kansas City's 2001 Annual Statement:

All of the following events occurred on April 2, 2001 as a whole and simultaneously, with approval of the Missouri Department of Insurance:

- *The Company made a capital contribution of \$51,472,000 to BMA Selectcare, Inc. (BMA), a wholly owned subsidiary of the Company.*
- *BMA merged with TriSource HealthCare, Inc. (TriSource), a 52% owned subsidiary of TriLink HealthCare, Inc. (TriLink), a wholly owned subsidiary of the Company, with BMA surviving. In consideration, BMA paid TriLink \$24,472,000, and BMA paid the minority owners of TriSource a total of \$27,000,000. Additionally, TriLink received a note from BMA for \$2,128,000, and the minority owners of TriSource received notes from BMA totaling \$2,400,000. All notes are non-interest bearing and payable in five installments over 30 months. As a result of this transaction, BMA assumed the net assets and liabilities of TriSource, and TriSource ceased to exist.*
- *BMA merged with the Company, with the Company surviving. Notes previously issued by BMA were re-issued by the Company with the same terms described above.*
- *TriLink paid a dividend to the Company in the amount of \$24,472,000.*

Also on this same date, the Blue-Advantage fictitious name registration was cancelled for TriSource and registered for Blue Cross and Blue Shield of Kansas City. Blue Cross and Blue Shield of Kansas City, which has been licensed as an HMO since 1995, then began operating the Blue-Advantage HMO as a line of business.

The Company is licensed as an HMO in the states of Missouri and Kansas, and conducts business in a 12 county service area consisting of the Missouri counties of Buchanan, Cass, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Ray and St. Clair, and the Kansas counties of Johnson and Wyandotte. The Company was offering this individual practice association HMO product in the individual market, the small employer market and the large employer market in Missouri through December 31, 2006, but the Company is currently in the process of phasing it out. During the course of the exam, the Company

indicated that all individual Blue-Advantage contracts were converted to Good Health HMO's Blue-Care product as of January 1, 2007, and that most groups were being converted to Blue-Care as they renewed in 2007. Some groups, however, are expected to remain in the Blue-Advantage product into 2009. With the phase-out of the Company's Blue-Advantage product, the 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 seven of 21 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 10-13.*)
- 2. Small Employer Group Health Insurance Underwriting and Rating Manual**
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 one case, a member paid 27.85% of the allowable charges in copayments, contrary to the “twenty percent (20%) of the total cost of providing all basic health services” limitation in 20 CSR 400-7.100. The Company issued a refund of \$447.19 to the member after the examiners brought this overpayment to the attention of the Company. (*Page 15.*)

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 17.*)
- 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’s subsidiary, Good Health HMO, Inc., d/b/a Blue-Care, was criticized in a previous market conduct exam for denying such claims without investigation, contrary to §375.1007(3), (4) and (6), RSMo. (*Page 18.*)
- 3. Emergency Services – Denied Claims:** Out of 173 denied claim lines, three were denied as being out-of-network. (*Pages 18-19.*)
- 4. Mammography – Denied Claims:** Out of 25 denied claim lines, 11 were denied as being out-of-network (“prior authorization”). (*Page 19.*)
- 5. Colon Cancer Screenings – Denied Claims:** Out of 23 denied claim lines, 10 were denied as being out-of-network (of which, eight were lab claims). (*Pages 19-20.*)
- 6. Pap Smear Cancer Screenings – Denied Claims:** Out of 44 denied claim lines, all were denied as being out-of-network. (*Page 20.*)

7. **PSA Cancer Screenings – Denied Claims:** Out of seven denied claim lines, three were denied as being out-of-network. (*Page 20.*)

B. Claim Handling – Out-of-Network

1. **Denied Pathology/Laboratory Claims:** Out of 4,351 denied claim lines, 604 were denied as being out-of-network. Of the 50 out-of-network claims sample reviewed by the examiners, the Company indicated seven were eventually paid after the initial denial either because of a management exception or because a referral was documented to have been made by a network provider. (*Pages 20-22.*)

2. **Denied Anesthesiology Claims:** Out of 66 denied claim lines, 12 were denied as being out-of-network. (*Pages 22-23.*)

3. **Denied Radiology Claims:** The examiners noted 13 claims (out of 58 claims reviewed) in which the Company denied the claim, even though the member's PCP or a network specialist had either sent the radiology test results to be interpreted by an out-of-network provider or referred the member out-of-network for radiology services. The examiners felt that a reasonable investigation of such claims by the Company (pursuant to §375.1007(3) and (6), RSMo) would have allowed the claims to be paid initially under the Company's policies and procedures for claim exceptions in such circumstances. (*Pages 23-27.*)

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. (*Page 27.*)

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. (*Page 28.*)

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. (*Page 28.*)

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 28-29.*)

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 law 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

Field Size:	273
Sample Size:	21
Type of Sample:	Random
Number of Errors:	7
Error Rate:	33%
Within DIFP Guidelines:	No

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 273, the examiners chose a random sample of 21 for review of the Company's policy files. Appearing in many of these underwriting files were one of the following application forms:

BCBSKC –GrpApp (Under 100) MetLife -4/03
BCBSKC –GrpApp (Under 100) Life -1/04
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 considers as "full-time" for the purposes of plan eligibility. This blank included an instruction that it could not be less than 30 hours.

In addition, the employer in one of the files (Group #24701000) that had an application that did not contain such a blank (Form #BCBSKC-GRP(Under 100)-APP-LIFE-11/01) was still able to designate something other than 30 hours as "full-time." This was accomplished by checking the "Other" box and writing in "35 Hrs per wk" next to it.

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 35 or 40 hours per week. In the following seven cases, the Company issued plans that limit eligibility to employees working a greater number of hours per week than 30:

GROUP #	# EEs Shown on App.	Group Application Information
25615000	17 FT, 0 PT	full time = 40 hrs. per week
26219000	5 FT, 0 PT	full time = 40 hrs. per week
26466000	6 FT, 0 PT	full time = 40 hrs per week
24701000	8 FT, 1 PT	full time = 35 hrs. per week
25539000	3 FT, 0 PT	full time = 35 hrs. per week
26326000	4 FT, 0 PT	full time = 40 hrs. per week
27477000	9 FT, 2 PT	full time = 35 hrs. per week

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

In response to Criticism #4, which was propounded as part of the concurrent examination of Good Health HMO, Inc., the Company disagreed with the Department’s interpretation stating, in part, that:

BCBSKC 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.

Presumably, this position represented a change in the Company’s interpretation of the law given that earlier versions of the “Group Application (Groups of 2-99 Full Time Employees)” that appear in the underwriting files do not appear to give the employer the flexibility to

designate a greater number of hours per week than 30 as constituting “full-time” status (see Form #BCBSKC-GRP-APP-99).

2. Small Employer Group Health Insurance Underwriting and Rating Manual

The examiners reviewed the underwriting guidelines in the manual and noted that 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, and 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-Advantage product and Good Health HMO, Inc.'s Blue-Care 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, 822 were appeals involving the Company's Blue-Advantage 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	136	16.55%
Claims Adjudication	494	60.1%
Customer Service-Access/Service	5	0.61%
Medical Necessity	116	14.11%
Membership	13	1.58%
Other	6	0.73%
Provider Access	52	6.33%
Totals	822	100%

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:

“Claims Adjudication” Subtype	Count
Accuracy	9
Denial	29
Medical Necessity	9
No Claim	1
Non-Covered	2
Out of Network	27
Prior Authorization	23
Total	100

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

Formal Request #11, Appeal #05001587: In reviewing this “upheld” appeal, the examiners were concerned that the member’s aggregate copayments may have exceeded the “twenty percent (20%) of the total cost of providing all basic health services” limitation in 20 CSR 400-7.100. They asked the Company to provide justification of the amount of copayments assessed during the benefit period in question. After reviewing the costs of services and the copayments that had been assessed, the Company concluded that the member paid 27.85% of the allowable charges in copayments. As a result, the Company issued a refund of \$447.19 to the member.

Reference: Regulation 20 CSR 400-7.100

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) 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 46 claim numbers and asked to explain why they had been denied. The explanations given can be categorized as follows:

Denial Explanation	Number
Diagnosis	1
No referral/authorization	1
Paid	10
Provider returned payment	4
Provider write-off	5
Redundant procedure	1
Wrong PCP	23
Wrong provider	1
Total	46

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 Blue-Advantage childhood immunization claim lines denied for this reason (121 out of 433 or 27.94%) was even higher than the percentage of Blue-Care claim lines denied for this same reason (78 out of 607 or 12.85%) noted in the Good Health HMO, Inc., d/b/a Blue-Care examination report. When questioned about the high percentage of childhood immunization claim denials for being the wrong PCP in regard to Blue-Care claims, the response was 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 response further 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 Blue-Care response, however, only seven of the 28 Blue-Care claim numbers represented by the 78 Blue-Care claim lines had been readjudicated. This would also be an issue for Blue-Advantage claims since they are processed by the same people on the same system.

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. Six 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. Three of these six claims were paid upon resubmission with a corrected code, but three of the claims were unclear as to the processing. The Company indicated that these three 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.

The same issue of denying without further investigation claims that had an incorrect age-related CPT code arose in the Good Health HMO, Inc. examination conducted in conjunction with this examination as well as the 2001 Good Health HMO, Inc. examination (exam #0040-11-HMO).

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

3. Emergency Services – Denied Claims

A list of 173 denied claim lines was given to the Company requesting an explanation for their denial. The following explanations were given:

(See next page)

Denial Explanation	Number
Blue Card	3
Dental	80
Diagnosis	2
Exclusion	7
Not medically necessary	4
Other – mismatched claim	1
Paid	32
Prior authorization	3
Primary paid	1
Provider error	4
Provider number wrong/missing	5
Provider refund	8
Provider write-off	3
Redundant procedure	6
Workers’ compensation	14
Total	173

“Prior authorization” in the above table means the member went out-of-network.

4. Mammography – Denied Claims

A list of 25 denied claim lines was given to the Company requesting an explanation for their denial. The following explanations were given:

Denial Explanation	Number
No authorization	1
Not eligible	1
Out-of-network	11
Paid	9
Provider write-off	3
Total	25

5. Colon Cancer Screenings – Denied Claims

A list of 23 denied claim lines was given to the Company requesting an explanation for their denial. The following explanations were given:

(See next page)

Denial Explanation	Number
No authorization/referral	5
Out-of-network (of which, 8 were lab claims)	10
Paid	4
Wrong PCP	1
Wrong provider (provider write-off)	3
Total	23

6. Pap Smear Cancer Screenings – Denied Claims

A list of 44 denied claim lines was given to the Company requesting an explanation for their denial. The Company indicated that all 44 were denied as being out-of-network.

7. PSA Cancer Screenings – Denied Claims

A list of 7 denied claim lines was given to the Company requesting an explanation for their denial. The following explanations were given:

Denial Explanation	Number
Exclusions	3
Out-of-network	3
Utilization review denial	1
Total	7

B. Claim Handling – Out-of-Network

Of the 822 first level appeals/grievances listed as being for the Blue-Advantage product, 16.9% (139 out of 822) were described as concerning denials for out-of-network care. Due to the significant number of such appeals, the examiners decided to look at such denied claims in greater detail.

1. Denied Pathology/Laboratory Claims

Of the claim lines in the “Denied Claims” database supplied by the Company, 4,351 were determined to involve pathology/laboratory services. Of these, 604 (13.9%) were denied as being out-of-network by the Company. 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			PAR – In Service Area Provider			OUT – Out of Service Area Provider			OUT – In Service Area Provider		
		PLACE OF SERVICE											
		Outpatient Hospital	Independent Lab	Facility	Office	Independent Lab	Facility	Office	Independent Lab	Public Health Clinic	Facility	Office	Independent Lab
P R O V I D E R T Y P E	Family Practice											3	
	Obstetrics & Gynecology				2								
	Urology											1	
	Oral Pathology												1
	Public Health or Welfare Agency											3	
	Independent Lab					5							7
	Mixed Specialty Group	2	13					2	6	1			
	Facility			1			2				1		
	TOTALS	2	13	1	2	5	2	2	6	1	1	7	8

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.

“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.

According to the Company, seven of the 50 claims in the sample were eventually paid after the initial denial either because of a management exception or because a referral was documented to have been made by a network provider.

2. Denied Anesthesiology Claims

Of the claim lines in the “Denied Claims” database supplied by the Company, 66 claim lines were determined to involve anesthesiology services. Twelve of these were coded as being out-of-network. The characteristics of these twelve claim lines were as follows:

		IN – Out of Service Area Provider			IN – In Service Area Provider	OUT – Out of Service Area Provider	OUT – In Service Area Provider	
		PLACE OF SERVICE						
		Inpatient Hospital	Outpatient Hospital	Facility	Outpatient Hospital	Outpatient Hospital	Outpatient Hospital	Ambulatory Surgical Center
P R O V I D E R T Y P E	Anesthesiology	1			5			
	Mixed Specialty Group						1	
	Certified Registered Nurse Anesthetist		1			1		1
	Facility			2				
	TOTALS	1	1	2	5	1	1	1

In reviewing the claim documentation supplied by the Company, the examiners noted the following:

Claim #05096H343700: This claim was initially denied although prior authorization had been obtained. The claim was paid when the member brought this to the attention of a customer service representative.

Claim #05179F021600 (two claim lines): The examiners were confused as to why this claim was denied when the provider billing for the service appeared to be in the Blue-Advantage network at the time of service according to the provider directories supplied. This confusion was compounded by the fact that three other claims for this member that had the same CPT code and were initially denied as being out-of-network (05179F068E00, 05179F069000, and 05179F071F00) were eventually paid.

Claim #05194H102001: This claim was denied although the member indicated that he had been referred by his PCP. The claim was appealed (#05003803) and upheld due to the Company not having received requested medical records. The first level grievance/appeal listing provided by the Company indicates that a follow-up appeal (#06000165) resolved the claim, but it is not clear from the information provided whether or not the claim was ultimately paid.

Claim #052000148900: This Medicaid reimbursement claim was initially denied even though the services were performed by a network provider. The claim was paid after the member received a bill from Medicaid and called the Company's customer service unit.

Claim #05293H234000: It was unclear to the examiners why this out-of-area claim was denied when it appeared that the member's network PCP had referred them.

Claim #05332H375600 and Claim #05334H269100: These two claims were initially denied even though prior authorization had been obtained. Both were subsequently paid.

3. Denied Radiology Claims

Of the claim lines in the "Denied Claims" database supplied by the Company, 1,640 claim lines involved radiology services. Of these, 99 claim lines (65 claim numbers) were coded as being out-of-network radiology claims. The examiners chose 58 claim numbers to review in greater detail. The breakdown of these 58 claims is as follows:

		IN – Out of Service Area Provider				PAR – Out of Service Area Provider			OUT – Out of Service Area Provider		OUT – In Service Area Provider					
		PLACE OF SERVICE														
		Office	Inpat. Hosp.	Outpat. Hosp.	Facility	Office	Outpat. Hosp.	Facility	Office	Outpat. Hosp.	Office	Outpat. Hosp.	ER-Hosp.	Skilled Nursing Facility	Nursing Facility	Indep. Lab
P R O V I D E R T Y P E	Allergy and Immunology									1						
	Anesthesiology							1	1							
	Cardiovascular Disease					1										
	Family Practice					1				1						
	Obstetrics and Gynecology						3									
	Orthopedic Surgery									3						
	Chiropractor	1							1	4						
	General Dentistry														1	
	Podiatry									2						
	Radiation Oncology										1					
	Portable X-Ray Supplier												5	1		
	Mixed Specialty Group	4	1	9					1	1	1	1				
	Freestanding Radiology Facility									4						
	Facility				7		1									
	TOTALS	5	1	9	7	2	3	1	2	2	16	2	1	5	1	1

In Criticism #1, the examiners noted 13 radiology claims that the Company denied even though the member's PCP or a network specialist had either sent the radiology test results to be interpreted by an out-of-network provider or referred the member out-of-network for radiology services. The examiners felt it was reasonable for a member to believe that radiology services conducted at the instruction of a Blue-Advantage network provider or in a Blue-Advantage network facility should be covered. Although the Company has policies and procedures in place to make exceptions in such circumstances, a member must make an inquiry to the Company's customer service unit and/or file an appeal/grievance in order to take advantage of these exceptions. Those members who are not proactive will end up paying the bill out-of-pocket. The examiners felt that a reasonable investigation of such claims by the Company initially would have allowed the claims to be paid without further action by the member.

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

The Company disagreed, explaining as follows:

BCBSKC does conduct a reasonable investigation of claims, including out of network claims. These claims are processed based on the information available to BCBSKC when the claim is submitted, including, but not limited to, information submitted with the claim.

Except for emergency services or prior authorized services, the Blue Advantage HMO Product does not provide benefits for out of network claims. The contract states "Services from Non-HMO Providers are not covered except as described in the Emergency Services provision or if Approved in Advance by Us." BCBSKC performed an adequate investigation to determine if the claims were in or out of network. And, if out of network, determined if the services were related to Emergency Service or Approved in Advance by BCBSKC.

As noted by the examiner, BCBSKC does have a Benefit Exception Policy to consider payment of benefits that are not covered under a member's contract, in order to consider extenuating circumstances. Specifically mentioned in the Policy is a process for considering services provided by in area non-network providers if the Primary Care Physician provided a referral on a BCBSKC Referral Form in advance of the services being performed.

Although the Comments above indicate that "Network MD referred OON," no claims referenced in this criticism were submitted with a BCBSKC Referral Form from the PCP. Four of the claim forms indicated that there was a referring physician (05012X025400, 052130154800, 05293F062300, and 05314X086200). However, no Referral Form accompanied the claim submissions and two

(05012X025400, 05314X086200) of the four physicians noted on the claims were not the member's PCP. One claim (05229F18F500) was subsequently paid on an appeal when the member provided the BCBSKC Referral Form from their PCP during the appeal process. However, this claim did not note a referring physician on the claim, nor did it include a BCBSKC Referral Form with the claim submission.

All thirteen of the claims were initially denied correctly based on the information submitted with the claim.

It was noted in reviewing the claims referenced, that three claims were originally submitted with the wrong provider number, making the claims appear to be out of network. Claim 05256H188100 was subsequently paid when the claim was resubmitted with the correct provider information. Claim 05200015240 was paid upon research performed by BCBSKC. This claim was actually received from Medicaid, with Medicaid indicated as the provider, since they had already paid for the services. Claim 052130154800, originally submitted with the wrong provider number, was later resubmitted by the network provider with the correct provider number. The subsequent claim was denied as a duplicate because the provider failed to follow claim filing procedures. The subsequent claim should have been denied for timely filing and the member would be held harmless. These three claims were not actually out of network claims.

Also mentioned in the Benefit Exception Policy is consideration for radiology services provided as part of an inpatient admission to a network facility 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. None of the claims in this criticism appear to fall into this category:

- The three claims noted above (05256H188100, 05200015240, and 052130154800) were in network radiologists at in network facility. The provider billing errors made them appear to be out of network but they were not.*
- Three other claims indicate that the place of service was a Skilled Nursing Facility (SNF). However, the services on claims 05189F08F200 and 05280F079600 were performed at an out of network SNF by an out of network radiologist. Even though claim 05343F223000 indicates the place of services as SNF, it does not appear to have been performed at a SNF. Per claim history, this member was discharged from a SNF on 10/28/05, prior to their radiology date of service, 12/7/05. They were not readmitted to a SNF until 12/21/05. Thus, these three claims do not meet the*

potential Benefit Exception criteria of out of network radiologist at an in network facility.

- *Claim 05293F062300 indicates that it was provided in an outpatient setting but no facility claim has been received. So, it is not possible to determine if the services were rendered in a network facility, which could then be considered for Benefit Exception.*
- *The six remaining claims indicate that the place of service was the radiologist's office, leading one to believe that the members were in control of their provider selection.*

In summary, these claims were not emergency claims and were submitted without prior authorization or a BCBSKC Referral Form from the PCP for the services rendered. A reasonable investigation of these claims was conducted using the information that had been provided to BCBSKC at the time of claim submission and all were properly denied based on that information and their contractual benefits. Although BCBSKC does occasionally make Benefit Exceptions for extenuating circumstances, only the claim that was appealed falls into a category that BCBSKC considers for Benefit Exceptions. A reasonable investigation at the time of claim adjudication could not have determined it was eligible for a Benefit Exception since the BCBSKC Referral Form was not provided until the appeal was received.

4. Access Plan

The examiners reviewed the 2005 and 2007 access plans filed by the Company for its Blue-Advantage product. These access plans are substantially the same as the access plans filed for Good Health HMO, Inc.'s Blue-Care product, which were reviewed as part of the Good Health HMO, Inc. examination conducted in conjunction with this examination. As with the Blue-Care access plan, 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. The reader is directed to the Good Health HMO, Inc. examination report (#0612-57-TGT) for a detailed discussion of this issue. Due to the confusion, the Company should also amend the Blue-Advantage access plan to clarify which hospital-based providers would be paid without prior authorization and which would not.

Reference: §354.603.2, RSMo.

5. Out-of-Network Claims Generally

Since the same BCBSKC claim processing unit handles both the Blue-Care and Blue-Advantage claims, the issues with regard to the handling of out-of-network claims noted in the Good Health HMO, Inc. examination report are equally applicable here. To summarize, 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.

The reader is directed to the Good Health HMO, Inc. examination report (#0612-57-TGT) for a detailed discussion of this issue.

C. Refunds of Excessive Copayments

As indicated in the Good Health HMO, Inc. examination report, the Company relies upon providers to make the required refunds to members when the provider has collected a copayment that exceeds the 50% of any single service limitation in 20 CSR 400-7.100. Since it is the Company's obligation to assure compliance with this regulation, 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.

The reader is directed to the Good Health HMO, Inc. examination report (#0612-57-TGT) for a detailed discussion of this issue.

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 (received in connection with the Good Health HMO, Inc., examination) that the Company may regard this event as a new "received" date in many instances.

As indicated in the Good Health HMO, Inc. examination report, the Company appears to be applying a “clean claim” standard from Kansas law to determine when interest is payable on a claim. 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 at length with this assessment of its claim process. The reader is directed to the Good Health HMO, Inc. examination report (#0612-57-TGT) for the Company’s explanation of its disagreement and a detailed discussion of this issue.

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

Number of Calendar Days to Respond	Number of Criticisms	Percentage of Total
0 to 10 days	1	100%
Over 10 days with extension	None	None
Over 10 days without extension	None	None
Totals	1	100%

B. Formal Request Time Study

Number of Calendar Days to Respond	Number of Requests	Percentage of Total
0 to 10 days	18	95%
Over 10 days with extension	1	5%
Over 10 days without extension	None	None
Totals	19	100%

EXAMINATION REPORT SUBMISSION

Attached hereto is the Division of Insurance Market Regulation's Final Report of the examination of Blue Cross & Blue Shield of Kansas City d/b/a Blue-Advantage (NAIC #47171), Examination Number 0612-48-TGT. This examination was conducted by James W. Casey and Kevin R. Jones. 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.

Jim Mealer
Chief Market Conduct Examiner

Date



**BlueCross BlueShield
of Kansas City**

An Independent Licensee of the
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 #0612-48-TGT,
Blue Cross and Blue Shield of Kansas City, d/b/a Blue-Advantage, 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 seven of 21 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.

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:

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.

Company’s Response:

The Company agrees with this finding. The Company’s manual has been updated to reflect current information. 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 §379.396, RS Mo, were noted.

Company's Response:

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

II. Complaints and Grievances

DIFP stated in the Executive Summary:

In one case, a member paid 27.85% of the allowable charges in copayments, contrary to the “twenty percent (20%) of the total cost of providing all basic health services” limitation in 20 CSR 400-7.100. The Company issued a refund of \$447.19 to the member after the examiners brought this overpayment to the attention of the Company.

Company's Response:

The Company agrees with the comment regarding one grievance file. One member did exceed the 20% of total cost of providing all basic health services. A check was issued to the member after this was brought to our attention during the Missouri Market Conduct Examination. In July of 2007, the Company revised its process for reimbursing members whose co-pays exceed twenty percent of the total cost of providing all basic health services to better ensure compliance with the regulation.

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.

During the exam period of 2003-2005, approximately 1,354,100 Blue-Advantage 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 identify and correct errors. 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 Primary Care Physician ("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 immunizations 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 *twenty-three* claims referenced by DIFP were denied as being the "wrong PCP." These claims 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 referring to the Blue-Care HMO Market Conduct Examination, on seven out of twenty-eight Blue-Care 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 discussed above. 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's subsidiary, Good Health HMO, Inc., d/b/a/ Blue Care, 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 correctly 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 industry standard 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 on the claim. Prohibiting employees from changing claim information also 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.

DIFP noted in the Examination Findings section of the report:

Three of these six claims were paid upon resubmission with a corrected code, but three of the claims were unclear as to the processing. The Company indicated that these three were never corrected and resubmitted.

Specifically related to the three claims that were never corrected and resubmitted:

- One claim for procedure 90732, a code for an adult pneumococcal vaccine, correctly denied due to “age > extreme range for procedure.” This procedure is defined as “adult patient dosage, when administered to 2 years or older.” The HMO member was less than two years old at the time of service. It appears that the incorrect CPT code was submitted by the provider or the claim may have been submitted to us in error. This claim was not resubmitted by the provider.
- One claim with four lines correctly denied. The claim was for an influenza virus vaccine, the administration of that vaccine, and the associated office visit charges for date of service 11/11/2005. The services were rendered by a provider other than the member's PCP. The member had the same assigned PCP for over two years (05/01/2004 through 02/01/2007), and the member requested their assigned PCP to be changed to another PCP (i.e., not the PCP who rendered the services on this claim) on 02/01/2007.
- One claim containing procedure code 90656 (Influenza Virus Vaccine, for Use In Individuals 3 Years of Age and Above) correctly denied, as stated, for “age > extreme range for procedure”. The child was fifteen months of age at the date of service of 11/16/2005. This claim was not resubmitted by the provider.

3. Emergency Services – Denied Claims:

DIFP stated in the Executive Summary:

Out of 173 claims denied claim lines, three were denied as being out-of-network.

Company's Response:

The Company agrees that the *three* claims referenced were denied. *Two* of the three claims were correctly denied during initial processing for services received at a non-HMO facility. The remaining *one* of three claims was correctly denied, as the facility did not obtain the required authorization for the inpatient stay.

- Regarding claim 05158F043400. Services were rendered by a non-HMO provider and were correctly denied during initial processing. The diagnosis from the emergency room physician claim was “Alcohol abuse, unspecified drinking behavior.” The claim and related information was carefully reviewed and it was determined the claim was *not* emergent. Services from non-HMO providers are not covered except as described in the emergency services provision, if approved in advance by the Company, or if they are performed, prescribed, ordered or arranged by the member's PCP.
- Regarding claim 05362G005200. Services were rendered by a non-HMO provider and correctly denied during initial processing on 01/03/2006. Subsequently, additional clinical information was received from the facility resulting in a determination that the services were related to an emergent condition. The claim was re-adjudicated and paid on 05/15/2006, prior to the DIFP examination.
- Regarding claim 05298Y005800. Services were rendered by an HMO facility related to an inpatient admission following an emergency room visit. Although the member was admitted to an HMO facility, the claim was correctly denied as the facility did not obtain the required authorization for the inpatient stay. 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.*” Obtaining authorization was the responsibility of the facility. As a result, the provider was held responsible for the charges and there was no member liability for the charges.

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 25 denied claims lines, 11 were denied as being out-of-network (“prior authorization”).

Company’s Response:

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

- Eight claims referenced by DIFP 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, if approved in advance by the Company, or if they are performed, prescribed, ordered or arranged by the member’s PCP.
- Three claims correctly denied. The providers who rendered the services were held responsible for the charges contractually prohibited from billing the HMO members for these services. As a result, there was no member liability for the charges. HMO members do not have benefits outside the service area except as described in the emergency services provision, if approved in advance by the Company, or if they are performed, prescribed, ordered or arranged by the member’s PCP.

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 23 denied claim lines, 10 were denied as being out-of-network (of which, eight were lab claims).

Company’s Response:

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

- Eight claims were correctly denied because the HMO physician 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.

- Two claims were correctly denied because the services were rendered by a non-HMO provider. Coverage would have been provided for these services if the member had obtained these services from 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, if approved in advance by the Company, or if they are performed, prescribed, ordered or arranged by the member's PCP.

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 44 denied claim lines, all were denied as being out-of-network.

Company's Response:

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

- Forty-four claims 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, if approved in advance by the Company, or if they are performed, prescribed, ordered or arranged by the member's PCP.

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.

7. PSA Cancer Screenings – Denied Claims

DIFP stated in the Executive Summary:

Out of seven denied claim lines, three were denied as being out-of-network.

Company's Response:

The Company agrees that the *three* claims referenced by DIFP were denied as being out-of-network as discussed below:

- *Three* claims 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 HMO Health Benefits Certificate. Services from non-HMO providers are not covered except as described in the emergency services provision, if approved in advance by the Company, or if they are performed, prescribed, ordered or arranged by the member's PCP.

Provider remittances and member EOB are sent to the provider and member, respectively, informing them of the status 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 *1,354,100* Blue-Advantage 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 in place 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 4,351 denied claim lines, 604 were denied as being out-of-network. Of the 50 out-of-network claims sample reviewed by the examiners, the Company indicated seven were

eventually paid after the initial denial either because of a management exception or because a referral was documented to have been made by a network provider.

Company's Response:

The Company agrees that the 604 claims referenced by DIFP were denied as being out-of-network, and the seven claims were paid subsequent to the initial denial as indicated.

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-Advantage 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, if approved in advance by the Company, or if they are performed, prescribed, ordered or arranged by the member's PCP.

Of the fifty claims referenced in the table within the Examination Findings section, based on the information provided with the initial claim, the member would be responsible for the services. These services were provided by non-HMO provider, were not emergency services, and were submitted without prior authorization or a Company Referral Form from the PCP for the services rendered. 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:

Out of 66 denied claim lines, 12 were denied as being out-of-network.

Company's Response:

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

The seven claims referenced in the Examination Findings section are discussed below:

- Regarding claim 05096H343700. The claim was denied during initial processing due to a manual error matching the inpatient prior authorization to the claim. The issue was identified as the result of a customer service call from the member indicating an authorization had been obtained. The claim was re-adjudicated and paid when the error was discovered.
- Regarding claim 05179F021600. This claim was denied during initial processing due to a manual clerical error. The claim was paid under claim number 05200F009A00 on 07/25/2005, within twenty days of the initial denial.
- Regarding claim 05194H102001. This claim was correctly denied for no prior authorization for services received from a non-HMO provider. In both appeals referenced in the Examination Findings section, the claim denial was upheld. Documentation showed that this was an elective, routine surgery for chronic tonsillitis. There was no indication that the services were due to an emergency. The HMO Health Benefits Certificate states that services from non-HMO providers are not covered except as described in the emergency services provision, if approved in advance by the Company, or if they are performed, prescribed, ordered or arranged by the member's PCP.
- Regarding claim 052000148900. This claim was correctly denied as being out of network with no authorization received. In the Examination Findings section, DIFP indicated that this claim was paid after the member received a bill from Medicaid and called the Company's customer service unit. The claim was not paid, as discussed below.

The Company received this claim from the Medicaid Reclamation vendor requesting reimbursement of the Medicaid payment made on the member's behalf. The services in question were to correct a congenital condition. There was no indication that the services were due to an emergency. The HMO Health Benefits Certificate states that services from non-HMO providers are not covered except as described in the emergency services provision, if approved in advance by the Company, or if they are performed, prescribed, ordered or arranged by the member's PCP.

- Regarding claim 05293H234000. This claim was correctly denied as being out-of-network with no authorization received. A prior authorization for this surgery was

requested before the surgery was performed, and the request was denied. The services in question were to correct a strabismus. There was no indication that the services were due to an emergency. The HMO Health Benefits Certificate states that services from non-HMO providers are not covered except as described in the emergency services provision, if approved in advance by the Company, or if they are performed, prescribed, ordered or arranged by the member's PCP.

- Regarding claims 05332H375600 and 05334H269100. The claims were incorrectly denied during initial processing due to a manual error matching the authorization to the claim. Claim 05332H375600 was for the facility portion of the outpatient wrist arthroscopic surgery, and claim 05334H269100 was for related anesthesiology services. The member called the Company's customer service and indicated an authorization was approved for these out-of-network services. The claims were re-adjudicated and paid.

Blue-Advantage 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. In three of the cases above, coverage could have been provided if the member had used an HMO provider. Services from non-HMO providers are not covered except as described in the emergency services provision, if approved in advance by the Company, or if they are performed, prescribed, ordered or arranged by the member's PCP. In the remaining four cases above, the Company paid the claims when related errors were identified.

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.

3. Denied Radiology Claims:

DIFP stated in the Executive Summary:

The examiners noted 13 claims (out of 58 claims reviewed) in which the Company denied the claim, even though the member's PCP or a network specialist had either sent the radiology test results to be interpreted by an out-of-network provider or referred the member out-of-network for radiology services. The examiners felt that a reasonable investigation of such claims by the Company (pursuant to §375.1007(3) and (6), RSMo) would have allowed the claims to be paid initially under the Company's policies and procedures for claim exceptions in such circumstances.

Company's Response:

The Company respectfully disagrees that a reasonable investigation was not conducted on the thirteen claims referenced. These claims were not for emergency services and were submitted without prior authorization or a Company Referral Form from the PCP for the services rendered. 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.

The *thirteen* claims referenced are discussed below:

- Regarding claims 05256H188100, 05200015240, and 052130154800. These claims contained provider billing errors that made the services appear to be rendered by non-HMO Providers. Upon resubmission of the claims they were re-adjudicated and paid.
- Regarding claims 05189F08F200, 05280F079600, 05343F223000. The services were performed at a non-HMO facility by a non-HMO radiologist. These claims were not for emergency services and were submitted without prior authorization or a Company Referral Form from the PCP and were correctly denied.
- Regarding claim 05293F062300. The radiology claim received by the Company indicated that services were rendered in an outpatient facility; however, no facility claim was received. It was not possible to determine if the services were rendered in an HMO facility and the claim was correctly denied.
- The *six* remaining claims (05012X025400, 05195F27DA00, 05229F18F500, 05279F022500, 05313X166000, 05314X086200) were not for emergency services, were submitted without prior authorization or a Company Referral Form from the PCP, and were correctly denied.

Blue-Advantage 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, if approved in advance by the Company, or if they are performed, prescribed, ordered or arranged by the member's PCP.

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.

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 agrees to amend its access plan to clarify that non-HMO "hospital-based physician or physician group" covered services provided in either an inpatient or outpatient setting at an HMO 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 noted 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 co-payments.

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 HIPAA¹. Any claim submitted by a healthcare provider not in compliance with these standards is not subject to the prompt pay statute.

¹“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

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 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-Advantage 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 \$101.06 in additional interest payments made on 08/27/2007 related to 26 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.