

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

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

TO: Office of the President
Group Health Plan, Inc.
550 Maryville Centre Drive
Suite 300
St. Louis, MO 63141-5818

RE: Missouri Market Conduct Examination 0612-58-TGT
Group Health Plan, Inc. (NAIC #96377)

**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 Group Health Plan, Inc., (hereafter referred to as "GHP"), 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, GHP has been granted a certificate of authority to transact the business of insurance in the State of Missouri; and

WHEREAS, the Department conducted a Market Conduct Examination of GHP and prepared report number 0612-58-TGT; and

WHEREAS, the report of the Market Conduct Examination stated that:

1. In some instances, GHP used the verbiage “Sole and Absolute Discretion” in its policy forms to describe its contractual rights under its policies, in violation of §375.936(16), RSMo.
2. In some instances, GHP allowed small group employers to establish the number of hours required to be eligible for group health benefits at more than 30 hours per week, rather than including all employees who work 30 hours or more per week to be eligible, as required by §§379.930.2(15) and 379.940, RSMo, and DIFP Bulletin 07-07.
3. In some instances, GHP allowed small group employers to include coverage for Domestic Partners as a familial relationship and added a 1% charge in its premium for that coverage, in violation of §§375.936(11)(e), 375.995.4(11), and 376.820, RSMo.
4. In some instances, GHP improperly denied chiropractic claims, required the submission of a Treatment Plan in advance of treatment rather than basing the determination of coverage on medical necessity, and failed to pay the correct amount on claims. GHP’s actions violated §§375.1007(3) and (4), 376.1230, and 376.1350, RSMo, and GHPs Provider Agreement and Manuals.
5. In some instances, GHP improperly denied childhood immunization claims, in violation of §§375.1007(3) and (6), 376.383, 376.384, RSMo, and 20 CSR 100-1.030(3).
6. In some instances, GHP failed to assist claimants in the claim process and required a “clean claim” before it would process any request for payment, thereby violating §§375.1007(3), (4), and (6), and 376.383, RSMo, and 20 CSR 100-1.030.
7. In some instances, GHP improperly calculated the amount of interest due on electronically submitted claims, in violation of §§376.383 and 376.384, RSMo.
8. In some instances, GHP improperly rejected and denied claims, in violation of §§375.1007(3), (4), and (6), 376.383, 376.384, and 376.1350(35), RSMo, 20 CSR 100-1.010(1)(B)1. And (G), 20 CSR 100-1.020(1)(B), 20 CSR 100-1.030, and 20 CSR 400-2.030(2)(C).
9. In some instances, GHP’s claims handling procedures included confusing and contradictory language in its manuals and handbooks, required additional actions that go beyond what is required by statute, and failed to provide clear and specific instructions to its members so that they can understand their policy benefits and claim submission requirements. These practices violated §§354.430.3, 354.442.1, 376.1215, 376.1350(12), and 376.1367, RSMo.
10. In some instances, GHP had certain requirements relating to laboratory vendors that it failed to disseminate to referring medical providers or members so that all parties understood their responsibilities and to assure the congruity of services, thereby violating §375.1007(3) and (4), RSMo.
11. In some instances, GHP failed to properly investigate claims before denying them, in violation of §375.1007(3), RSMo.

12. GHP had a practice of using members of its affiliated company as members of GHP's second level appeal committee, in violation of §§354.442 and 376.1385, RSMo, and GHP's filed and used Certificate of Coverage.

WHEREAS, GHP 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. GHP agrees to take corrective action to assure that the errors noted in the above-referenced market conduct examination reports do not recur; and

2. GHP 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 60 days of the entry of a final Order closing this examination;

3. GHP agrees to reopen and pay the full amount of the improperly denied or rejected claims noted by the examiners, including all applicable interest due through the date of payment. Evidence shall be provided to the Department that such payments have been made within 60 days after a final Order concluding this exam is entered by the Director; and

4. GHP agrees to review all denied childhood immunization submitted to the Company dated January 1, 2005, through the date that an Order is entered by the Director finalizing this exam, to make a determination of liability. If the claim should have been paid, the Company must issue all payments that are due to the claimants, bearing in mind that an additional payment of one per cent (1%) interest is due from the 46th day after receipt of the claim to the date of payment, as required by §376.383.5, RSMo, and at nine per cent (9%) on all paper claims submitted by individual claimants pursuant to §408.020, RSMo. A letter must be included with the refund payments or on the remittance documentation indicating that the payments are made "as a result of a Missouri Market Conduct examination." Evidence shall be provided to the Department that such payments have been made within 120 days after a final Order concluding this exam is entered by the Director.

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

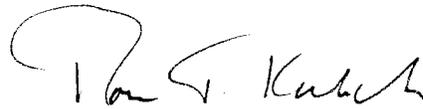
WHEREAS, GHP is of the position that this Stipulation of Settlement and Voluntary Forfeiture is a compromise of disputed factual and legal allegations, and that payment of a forfeiture is merely to resolve the disputes and avoid litigation; and

WHEREAS, GHP, 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

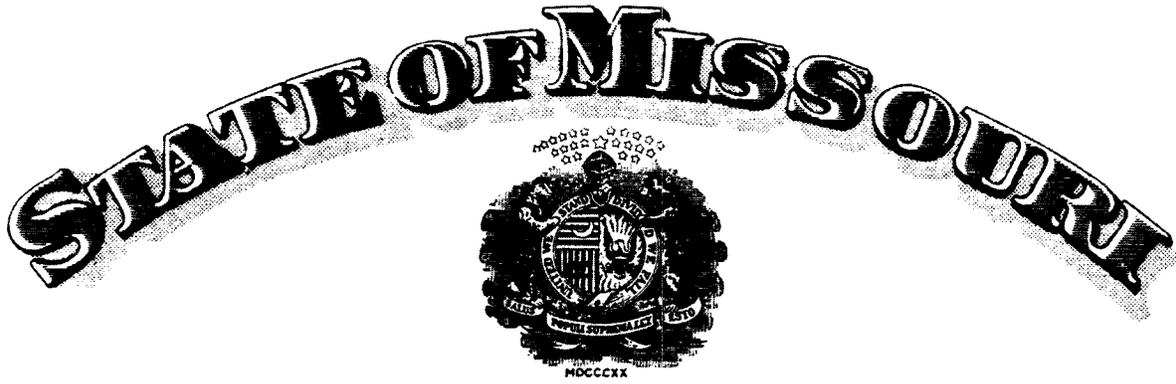
WHEREAS, GHP hereby agrees to the imposition of the ORDER of the Director and as a result of Market Conduct Examination #0612-58-TGT further agrees, voluntarily and knowingly to surrender and forfeit the sum of \$77,635.00.

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 GHP to transact the business of insurance in the State of Missouri or the imposition of other sanctions, GHP 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 \$77,635.00, such sum payable to the Missouri State School Fund, in accordance with §374.280, RSMo.

DATED: 12/1/2009



President
Group Health Plan, Inc.



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

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

In re:)
) Examination No. 0612-58-TGT
Group Health Plan, Inc. (NAIC #96377))

ORDER OF THE DIRECTOR

NOW, on this 30th day of December, 2009, Director John M. Huff, after consideration and review of the market conduct examination report of Group Health Plan, Inc. (NAIC #96377), (hereafter referred to as "GHP") report numbered 0612-58-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.

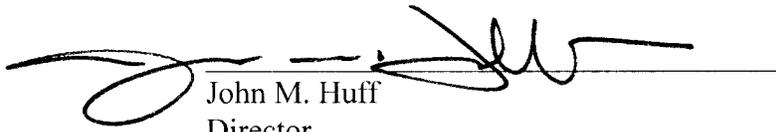
IT IS THEREFORE ORDERED that GHP and the Division of Insurance Market Regulation have agreed to the Stipulation and the Director does hereby approve and agree to the Stipulation.

IT IS FURTHER ORDERED that GHP shall not engage in any of the violations of law and regulations set forth in the Stipulation and shall implement procedures to place GHP 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 GHP shall pay, and the Department of Insurance, Financial Institutions and Professional Registration, State of Missouri, shall accept, the Voluntary Forfeiture of \$77,635.00, 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

MARKET CONDUCT

FINAL EXAMINATION REPORT

OF THE

HMO BUSINESS

OF

GROUP HEALTH PLAN, INC.

NAIC NUMBER: 96377

STATE OF DOMICILE:

MISSOURI

550 MARYVILLE CENTRE DRIVE, STE 300

ST LOUIS, MO 63141-5818

October 16, 2009

REPORT NUMBER: 0612-58-TGT

TABLE OF CONTENTS

FOREWORD	3
SCOPE OF THE EXAMINATION	4
EXECUTIVE SUMMARY	5
I. UNDERWRITING AND RATING PRACTICES	8
A. Policy Forms	8
B. Underwriting and Rating	9
II. CLAIM PRACTICES	11
A. Unfair Settlement and General Handling Practices	11
III. COMPLAINTS.....	27
A. Missouri Department of Insurance, Financial Institutions and Professional Registration Complaints.....	27
B. Consumer Complaints	28
C. Appeals.....	28
IV. CRITICISM & FORMAL REQUEST TIME STUDY.....	30
V. EXAMINATION SUBMISSION.....	31
ATTACHMENTS:	
Appendix A	
Appendix B	
Appendix C	
Appendix D	

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 portion of the Company's operations for its 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 Company's response, and administrative actions based on the findings of the Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration.

Wherever used in the report:

“Company,” “GHP,” or “the Company” refers to Group Health Plan, Inc.;

“DIFP” refers to the Department of Insurance, Financial Institutions and Professional Registration;

“NAIC” refers to the National Association of Insurance Commissioners;

“RSMo” refers to the Revised Statutes of Missouri;

“CSR” refers to Code of State Regulation;

“COC” refers to Certificate of Coverage; and

“EOB” refers to Explanation of Benefits.

SCOPE OF THE EXAMINATION

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

The Company reviewed was Group Health Plan, Inc.

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

Prior to this examination, the State of Missouri conducted the most recent Market Conduct examination of Group Health Plan, Inc. that ended August 1, 2003. The State of Illinois performed a Market Conduct examination in 2002.

While the examiners reported on the errors found in individual files, the examination also focused upon the general business practices of the Company. The DIFP has adopted the error tolerance guidelines established by the NAIC. Unless otherwise noted, the examiners applied a ten percent (10%) error tolerance ratio to all operations of the Company with the exception of claims handling. The error tolerance ratio applied to claims matters was seven percent (7%). Any operation with an error ratio exceeding these criteria indicates a general business practice.

The examination included, but was not limited to, a review of the following lines of business: Accident & Health. The examination included, unless otherwise noted, a review of the following areas of the Company's operations for the lines of business reviewed: Policy Forms and Filings, Underwriting and Rating, Claims, and Complaints.

EXECUTIVE SUMMARY

This examination revealed the following principal areas of concern.

- ❖ The Company's Certificate of Coverage includes the words "Sole and Absolute Discretion" in regard to the determination of policy provisions. This language is not allowed in Missouri.
- ❖ During the application process, the Company allowed 94 of 138 small employer group applicants to select more than 30 hours as the required minimum number of hours to qualify for health benefits.
- ❖ The Company allows employers to include coverage for Domestic Partners as a familial relationship. The Company did not provide actuarial proof that additional premium is necessary to cover this type relationship, yet it charged an additional 1% of premium charge.
- ❖ GHP requires providers to submit claims on specific forms without omission or error – a "clean claim." GHP does not consider anything less than a "clean claim" to be a claim and rejects it. A rejected submission may have to be re-submitted more than once before it qualifies as a "clean claim," it may be delayed past the 90-day submission requirement mandated by the Provider's Contract. Also, there is no such requirement for "clean claim" under Missouri law.
- ❖ Contracts between GHP and laboratory facilities require that they will provide services for members who reside in specific counties. If a lab provides service for a member who does not reside in one of the specified counties, it will not receive payment and cannot bill the member. GHP does not advise members of the resident county requirement in the COC, and it does not inform providers of the county of residence information of the members.
- ❖ GHP's certificates of coverage, provider contracts, member handbook and claim processing provisions include requirements that may be confusing to the general public, resulting in claim submission issues, rejected claims, and denials.
- ❖ The Company allows individual providers to ignore its contract, accept payment from third party carriers and return GHP's payment. Missouri does not allow companies to include benefits paid from a liability claim to coordinate medical claim payments.
- ❖ The Company requires chiropractors to submit a treatment plan prior to providing treatments. This allows GHP to pre-authorize future treatments, which is not allowed until after the 26th visit.

- ❖ The Company does not follow required second level appeal procedures. The examiners found that GHP sometimes includes members of other plans to serve on the committees making second level appeal decisions.

EXAMINATION FINDINGS

For

Group Health Plan, Inc
NAIC NUMBER: 96377

I. UNDERWRITING AND RATING PRACTICES

In this section of the report, the examiners reviewed the Company's underwriting and rating practices. These practices included use of policy forms, adherence to underwriting guidelines, assessment of premiums and procedures to decline or terminate coverage. Because there were a large number of policy files, examining each and every policy file was not appropriate. To reduce the duration of the examination, while still achieving an accurate evaluation of the Company's practices, the examiners employed a statistical sampling of the Company's policy files. A policy file as a sampling unit is one complete premium unit representing the coverage provided or restricted by the riders attached to the policy. The most appropriate statistic to measure the Company's compliance with the law is the percent of files in error. An error can include but is not limited to any miscalculation of the premium based on the information in the file or any improper acceptance or rejection of applications, misapplication of the Company's underwriting guidelines and any other activity violating Missouri laws.

A. Policy Forms

The examiners reviewed the Company's policy forms to determine their compliance with filing, approval and content requirements to ensure that the contract language is not ambiguous and is adequate to protect those insured. The examiners conducted a review of the forms used by the Company. The examiners noted the following errors:

1. The Company included the verbiage “Sole and Absolute Discretion” in its policy forms to describe its contractual rights under its policies. The use of this wording can only be interpreted to expand on what is explicit in an insurance contract - that the insurer will make coverage and benefit decisions. This interpretation leads the insured or any one else to believe that no action on the part of the insured or anyone else is able to modify the insurer’s decision. This conflicts with several provisions of law. This interpretation eliminates the insured’s right to seek legal action, to enforce the contract, and makes any required right to appeal the decision, file a grievance or seek relief through the DIFP meaningless. Using this language tends to confuse and mislead insured persons.

Reference: Section 375.936(16), RSMo

B. Underwriting and Rating

The examiners reviewed policies already issued by the Company to determine the accuracy of rating and adherence to prescribed and acceptable underwriting criteria. The following are the results of the reviews.

1. Underwriting and Rating

a. Small Employer Group Underwriting

Field Size:	138
Sample Size:	138
Type of Sample:	Census
Number of Errors:	94
Error Rate:	68.1%
Within Dept. Guidelines:	No

The examiners noted the following errors in this review.

- i. The Company allowed employers to establish the number of hours required to be eligible for group health benefits. Employers for 94 of the 138 small employer group applications reviewed required

employees to work more than 30 hours per week to be eligible for group health benefits. Missouri requires small employer groups to include employees who work 30 hours or more per week. By allowing employers to set the qualifying limit over 30 hours, the Company fails to include all employees whom Missouri law requires to be eligible.

References: Sections 379.930.2(15) & 379.940, RSMo, and DIFP Bulletin 07-07

Appendix A lists the 94 employer group numbers.

- ii. The Company allows employers to include coverage for Domestic Partners as a familial relationship. This coverage does not add to or extend coverage for any person in the household. Although the Company does not have actuarial proof that additional premium is necessary to cover this type relationship, it charges an additional 1% of premium. An additional 1% charge is not placed on a household with married parents. Since premium is charged per person for group policies, the addition of the premium appears to be unwarranted.

References: Sections 376.820, 375.936(11)(e), and 375.995.4(11), RSMo

b. Small Employer Group Underwriting Nonrenewals

The records provided by the Company included a list of policies that were non-renewed during the period under reviewed. The examiners reviewed the information to determine the actual reason for the non-renewal. The examiners asked the Company to provide the actual reason why each of the 50 selected policies were non-renewed.

The examiners found no problems with the information provided.

II. CLAIM PRACTICES

In this section, the examiners reviewed the claim practices of the Company to determine its accuracy of payment, efficiency in handling, adherence to contract provisions and compliance with Missouri law. Because there were a large number of claim files, examining each and every file was inappropriate. The examiners conducted a statistical sampling of the Company's claim files. A claim file as a sampling unit is an individual demand/request for payment under an insurance contract for benefits that may or may not be payable. The most appropriate statistic to measure a company's compliance with the law is the percent of files in error. An error can include, but is not limited to, any unreasonable delay in the acknowledgment, investigation or payment/denial of a claim, the failure to calculate the claim benefits correctly, or the failure to comply with Missouri law on claim settlement practices.

A. Unfair Settlement and General Handling Practices

The examiners reviewed paid and denied claims for adherence to claim handling requirements and contract provisions.

The following are the results of the reviews.

1. Paid Chiropractic Claims

Field Size:	119,214
Type of Sample:	Census by Printout
Number of Errors:	0
Within Dept. Guidelines:	Yes

The examiners noted no concerns with the information provided.

2. Denied Chiropractic Claims

Field Size: 3,389
Type of Sample: Census by Printout
Number of Errors: 1,372
Error Ratio: 40.5%
Within Dept. Guidelines: No

The examiners noted the following errors in this review.

- a. The Company denied 482 chiropractic claims for reason code 218 “ Rej-Member not effective on date of service,” the date of service was outside of the term of coverage under the policy. However, the members incurred the following three claims during a period of active coverage – which should have been covered and paid.

References: Section 375.1007(3) & (4), RSMo

<u>Member Number</u>	<u>Claim Number</u>	<u>DOS</u>	<u>Issue Date</u>	<u>Term Date</u>
900837323*01	1508801712	3/2/05	8/1/03	5/31/05
900837323*01	1510124842	3/30/05	8/1/03	5/31/05
901059680*02	2520117973	7/15/05	7/13/04	3/31/07

- b. The Company allows the initial visit to any chiropractor for assessment. Then, unless there is a chiropractic rider attached to the policy or the out-of-network provider obtains an authorization, all visits after the first visit must be with an in-network chiropractor. The Company’s Provider Agreement refers to the Provider Manual to incorporate the wording that the Plan does not interfere with the professional medical judgment of the provider.

Additionally, the Company requires the Chiropractor to submit a Treatment Plan before it will consider any treatment medically necessary and payable. Although the Company requires providers to submit a plan to confirm that the treatment is medically necessary, a treatment plan in itself does not prove medical necessity. The Company has a contractual right to process already incurred claims, determine medical necessity, and make an appropriate payment or denial. The Company’s

requirement for a Treatment Plan in advance of treatment amounts to a method to allow the Company to pre-authorize future treatments which according to law is not allowed until after the 26th visit.

The Company provided the examiners lists of denied claims. The list of denied chiropractic claims included 865 claims that the Company denied with denial code 1104 “Reject-No Notification/Treatment Plan on File” because the provider failed to submit a Treatment Plan in advance. The Company also uses the Treatment Plan requirement to limit the number of treatments the provider can perform to correct the condition presented. The Company uses it to control the quantity of the provider’s care for the member even though it states that it does not interfere with the professional judgment of the provider.

References: Sections 376.1230, and 376.1350, RSMo, & GHP’s Provider Agreement and Provider Manual

Appendix B is a list of claims that the Company denied because the provider did not submit the required Treatment Plan prior to treatment.

- c. Provider number 33736 submitted claims during the review period. The analysis of the claims to this provider found that additional payments totaling \$655.13 were due to the provider for two members with the following 54 claims.

Reference: Section 375.1007, RSMo

Member Number 900849434*05

<u>Claim Numbers</u>	<u>Claim Numbers</u>	<u>Claim Numbers</u>
19828766	19828767	19828802
19828803	19828820	19828821
19828825	19828826	19828827
19828828	19828831	19828832
19828836	19828837	19828848
19828831	19828831	19828849
19828851	19828852	19828856
19828857	19828859	19828860

Member Number 900849434*04

<u>Claim Numbers</u>	<u>Claim Numbers</u>	<u>Claim Numbers</u>
19828658	19828673	19828744
19828750	19828776	19828804
19828866	19828867	19828868
19828871	19828872	19828875
19828878	19828880	19828883
19828884	19828963	19828970
19828679	19828693	19828698
19828706	19828714	19828718
19828757	19828759	19828784
19828788	19828811	19828813

- d. The Company’s claim list included 196 claims that it denied for reason code 208 “Reject – Services Exceed Authorized Limit.” This code implies that prior authorization is required before the Company considers the treatments incurred for payment.

Missouri law requires a health carrier to provide up to 26 chiropractic visits per policy period for any condition requiring chiropractic treatment. The Company, as a health carrier, has an inherent right to adjudicate claims according to the medical necessity of the condition presented. After 26 visits in a policy period, a health carrier may require the member to obtain prior approval for additional visits.

References: Section 376.1230, RSMo

Appendix C lists the 196 claims for 89 members that the Company denied because the provider provided more treatments than the Treatment Plan authorized.

- e. The Company provided a list of denied chiropractic claims that included disposition code 229 “Reject - Services not Authorized” and/or reason 356 for “Reject – Services were not Authorized.”

Members were receiving chiropractic care during the year 2005 and were denied coverage for one or more treatments for the disposition codes 229 and/or 356. There were 109 members with 506 claims including claims that did not identify the member number.

The Company’s claim procedures do not conform to the specifications of Section 376.1230, RSMo, which allows up to 26 chiropractic visits before the Company may require prior authorization for further visits.

Reference: Section 376.1230, RSMo

Appendix D lists the 506 claims the Company denied because it did not authorize the services rendered.

3. Paid Childhood Immunization Claims Deductible and Copay

Field Size:	2
Type of Sample:	Census
Number of Errors:	0
Within Dept. Guidelines:	Yes

The examiners noted no errors in this review.

4. Denied Childhood Immunization Claims

Field Size:	4,035
Sample:	100
Type of Sample:	Systematic
Number of Errors:	11
Error Ratio:	11%
Within Dept. Guidelines:	No

The examiners noted the following errors in this review.

The Company denied benefits for the following 11 claims because box 31 on the HCFA 1500 claim form did not contain the exact information required. The Company failed to investigate and assist the claimant in the settlement of the claim submitted. GHP procedure is to reject the claim and advise that provider information was not provided in the box stipulated. In some instances, the information was included in a different box on the same form but the Company ignored it.

References: Sections 375.1007(3) & (6), 376.383, 376.384, RSMo, and 20 CSR 100-1.030(3)

<u>Claim Number</u>	<u>Claim Number</u>	<u>Claim Number</u>
1505246054	1506022692	1508445762
1510125287	1512224448	1526523351
2504014432	2514012818	4507423037
4523646382	4530146419	

5. Denied ER and Ambulance Claims

Field Size:	64,845
Sample Size:	100
Type of Sample:	Systematic
Number of Errors:	1
Error Ratio:	1%
Within Dept. Guidelines:	Yes

The examiners noted one error in this review.

On 06/20/05, member 900749622*1 was admitted through the emergency room for a urinary obstruction. The condition required the provider to perform an immediate surgery to remove the blockage. The provider submitted claim #14119490 covering both the emergent and surgical services. The amount of the claim was \$5,575.94 of which \$381.60 was paid on 07/11/05. On 09/14/05, the provider requested additional payment of \$1,754.00 per its contract with GHP. The documentation provided did not indicate that GHP paid any additional benefit. The examiners asked the Company to explain the basis of the lesser payment. Upon review of the claim, the Company stated that it had procedures in place to respond to such inquiries, but had failed to do so in this case. GHP found that it had not paid the claim in full and issued an additional payment of \$1,781.84 plus \$404.65 interest.

References: Section 375.1007(3)&(4), RSMo, and 20 CSR 100-1.040(1)(A)

6. Denied PSA Test Claims

Field Size: 226
Type of Sample: 10
Number of Errors: 0
Within Dept. Guidelines: Yes

The examiners noted no errors in this review.

7. Denied PAP Smear Test Claims

Field Size: 616
Type of Sample: 25
Number of Errors: 1
Error Ratio: 4.0%
Within Dept. Guidelines: Yes

The examiners noted the following errors in this review.

The Company failed to pay benefits for a mandated benefit for a PAP Smear in the following claim. The Company initially denied the claim because the provider included an incorrect CPT code. When the claim was resubmitted with the correct code, the Company again denied coverage for the PAP Smear because the service was not authorized. The Company paid charges for the office visit and lab pathology but denied the charge for the mandated benefit of a PAP Smear. The EOB advised that the PAP Smear was the member's responsibility. This is not an appropriate practice for a mandated benefit.

Reference: Section 376.1250.1 RSMo

<u>Member Number</u>	<u>Claim Number</u>
0881344*01	1434445940 for first filing 15012455659 for second filing 1506845223 for third filing

8. Denied Cancer Screening Tests Claims

Field Size:	401
Sample:	17
Type of Sample:	Systematic
Number of Errors:	0
Within Dept. Guidelines:	Yes

The examiners noted no errors in this review.

9. Denied Mammogram Test Claims

Field Size:	1,087
Sample:	47
Type of Sample:	Systematic
Number of Errors:	0
Within Dept. Guidelines:	Yes

The examiners noted no errors in this review.

10. General Claim Handling

- a. The following subsections involve some of the general claim handling practices of the Company. They reflect that GHP incorporates practices that do not conform to Missouri laws concerning claim processing.
 - i. The Company requires each submission from a provider to be complete and without error, a “clean claim,” before it considers it for payment. The Provider Manual specifies that one of two forms must be completed for submission; either a CMS 1500 or a UB92. The CMS 1500 requires over 40 items of data plus any coordination of benefits information, and the UB92 has 86 elements of data that a provider must include without error before GHP will consider it a “clean claim.”

If the provider submits a claim without all the stated elements, the Company rejects it by way of denial codes that indicate a lack of or including incorrect information. GHP rejects any responsibility to

investigate such a filing. GHP treats this scenario as if the provider did not submit the claim at all.

When the provider re-submits the claim with all information in the specified spaces, the Company assigns a new claim number and processes it as a new submission using the current date as the received date. In some instances, a claim was submitted several times over a period of time and was assigned multiple claim numbers before it was considered a “clean claim.” Then, GHP processed it under yet another claim number. Since the Company does not consider a claim submitted until it meets its definition of a “clean claim,” it can be delayed past the provider’s contract requirement for claim submission within 90 days after treatment.

The Company processes electronic claims in much the same way. A third party vendor who receives claims from providers, manipulates the data into a specific format then forwards it to GHP. The vendor will return to the provider for correction any submission that is not complete according to its standards. Even when a form appears to be complete and correct, the Company may not accept it from the vendor because of a technical error or exclusion. This will also delay the submission. The Company does not attempt to assist the claimant or to begin an investigation to obtain or clarify needed information.

Missouri requires companies to assist claimants in the claim process. There is no requirement for “clean claims” in any Missouri claim statutes. Therefore, GHP has the responsibility to begin investigating and request additional information to process incomplete claims.

References: Sections 375.1007(3),(4) & (6), and 376.383, RSMo, and 20 CSR 100-1.030

ii. The Provider Manual states that:

Electronic claims require the same information as paper claims. Special arrangements need to be made for submission of claims with attachments. GHP accepts initial claims submissions electronically through Gateway EDI or WEB MD. For more information, contact your Provider Relations Representative.

Claims filed electronically are NOT considered “received” unless they have passed our system edits and have been accepted into our system. For every claim filed electronically the provider should receive two (2) reports back: (1.) A report that the clearinghouse

accepted the claim. (2.) A file stating the action taken by GHP (Second Level Acceptance Report).

The provider does not control the creation or the distribution of these reports. The clearing house controls the first report, and GHP controls the second report. Yet, GHP has made the provider responsible for maintaining and providing copies of both of these reports. The Company does not maintain proof of delivery.

For example:

The examiners reviewed denied ER and ambulance claims. The remittance advice for the following claims stated the denial reason as failing to file the claim within 90 days of the date of service. The provider advised that it did file each claim in a timely manner and provided supporting documentation. Since the supporting documents were not generated by the provider, they could not be altered or changed by the provider. Upon review by GHP, all of the claims were again denied, stating that the earlier submission would require a “second level acceptance report” to substantiate a timely filing date. These denials were not substantiated by documentation; but rather, assumed by the Company. The chart below shows the details for each claim.

References: Sections 376.383, 376.384, 376.1007, RSMo, and 20 CSR 100-1.030

Date of Service	Claim Number	Date Co. Recorded Received	Related Claim Number	Date of Original Filing	Days DOS Rec'd
09/06/04	4508800724	03/29/05	None Filed	10/01/04	25
12/15/04	1519345508	07/12/05	1519345102	01/07/05	23
12/07/04	4526523693	09/22/05	No # given	12/22/04	15
09/08/04	4506223214	03/03/05	1508000556	10/01/04	23
12/09/04	4510203806	04/12/05	2508416996	01/14/05	36
12/20/04	4518000523	06/29/05	1515100687	01/06/05	17
07/14/04	11449569	01/18/05	2435715925	07/29/04	15
08/28/04	4507346302	03/14/05	1508000537	10/01/04	34
12/04/04	4518246853	07/01/05	1515201324	12/31/04	27
12/04/04	4517945385	06/28/05	1515100756	12/16/04	12
12/03/04	4510202091	04/12/05	1521622597	12/27/04	24
11/26/04	4527900157	10/06/05	1508000527	12/18/04	22

- iii. Missouri requires a submission to be paid, denied or pending for investigation. GHP claim processing does not pending claims for investigational purposes. A claim is either paid, denied or rejected. The Company does not investigate claims. Rather it requires the

claimant submitting the claim to determine exactly what information is missing or incorrect and provide it. Although the Company may ultimately receive a “clean claim” with sufficient documentation to support the claim and it is filed timely, GHP may still refuse to pay claims submitted after the 90-day limitation.

No Missouri statute or regulation indicates that a “clean claim” or acceptance of a claim is required before the commencement of the time to acknowledge, investigate, or adjudicate.

References: Sections 375.1007(3)&(4), 376.383, RSMo, and 20 CSR 100-1.010(1)(B)&(G)

With regard to paper claims the Company’s position directly contravenes 20 CSR 100-1.010(1)(B), which defines the following terms as follows:

Claim means --

A request or demand for payment of a loss which may be included within the terms of coverage of an insurance policy; . . .

Investigation means --

All activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy;

Notification of claim means --

Any notification, whether in writing or by other means acceptable under the terms of an insurance policy to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim;

Third-party claimant means --

Any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy;

The intent of these provisions is clear. A request for payment can be less than perfect and still be a claim. GHP makes no attempt to coordinate or otherwise correlate prior submissions with subsequently received documentation. When a prior filing is referred to by the provider and noted by the Company, GHP will use a

subsequent submission to pay the claim except, when it is received after the 90-day limitation.

- iv. Providers are encouraged to file electronic claims (pursuant to Section 376.383, RSMo). In the case of electronic claims, the original date of receipt starts the clock for determining when payment is due. The Company circumvents the 45 day payment requirement as well as the calculation and payment of interest with its “clean claim” requirement. Nothing in Sections 376.383 or 376.384, RSMo, sets forth any requirement for a “clean claim” before action is required by the carrier.

References: Sections 376.383, and 376.384, RSMo

- v. GHP was a secondary insurer on the following claim. As such, the provider had one year in which to file the claim. GHP’s original receipt of this claim was 03/04/05. The claim was originally rejected on 03/17/05, as being the liability of the primary carrier. On 03/23/05, the provider was informed that the EOB submitted could not be read. However, there was a letter in the file from a collection agency stating the amount paid. The amount stated as being paid by the primary could be confirmed by looking closely at the copy of the invoice submitted with the letter. As the date of receipt was within the time allowed by statute, this claim appeared to be payable.

References: Sections 375.1007(3) & (4), RSMo

Claim 1506346416 DOS 08/24/04 Amount at issue: \$1,234.90

- vi. Multiple HCFA 1500 forms were submitted to GHP with the typed name of an Advanced Practice Nurse instead of a physician’s name. Claims denied multiple times code 0761 “Rebill with physician’s name and credential in box 31.” The submitting provider was a county health department.

Later, the county health department submitted a HCFA 1500 with a physician’s name but the claim was then denied for code 1055, “Untimely Filing,” and 212, “Time Limit for Filing has Expired.”

The provider included the attending provider correctly on the form because a non-physician is permitted to administer injections. This claim was rejected for an administrative requirement that could have been rectified with some assistance from the Company’s Claim Department.

The Company acknowledges that the claim had been filed nine times previously, yet the claim was denied for “Untimely Filing.” The Company maintained no correlation between the time of the first filing and the time of the last (10th) filing when the “required” information was provided and then denied. There was no investigation; only a rejection. Other than rejecting the claim, no effort was made to contact the provider for the information or to assist them in providing the desired information.

References: Section 375.1007(3), (4) & (6), RSMo, and 20 CSR 100-1.010(1)(B)1., and 20 CSR 100-1.020(1)(B)

Claim 2514012818 DOS 02/01/05

- vii. Box 31 of HCFA form 1500 requests the signature and credentials of the physician or supplier. A computer generated signature or stamp is acceptable in lieu of a signature. The Company accepts the name of a non-physician for various claims. The claims below have the name of either a physician or other medical professional, including credentials.

The Company rejected the following claims under Disposition Code 761 – claim lacked information needed for adjudication. They were rejected even though names and professional designations were furnished in box 31 of HCFA 1500.

References: Sections 375.1007(3), and 376.1350(25), RSMo

<u>Claim No.</u>	<u>DOS</u>
1436345292	07/12/04
1505223272	10/27/04
4521324683	06/21/05
4526500357	07/29/05 & 08/04/05
4526500366	05/06/05 & 06/17/05
4526500367	6/17/05; 07/08/05; 07/14/05; & 07/29/05
4527300081	08/19/05
4535323203	11/10/05

- viii. GHP had secondary coverage on this claim. Under Missouri law, in the event of a secondary carrier, the provider has up to 12 months in which to file a claim with the secondary carrier. The provider filed the claim with the primary on a timely basis. However, the documentation needed for a secondary filing was not received within the 90-day period required by GHP in the Provider

Manual. Once received, the provider submitted the claim within two calendar days.

The claim was received from the provider on 6-16-05 and denied per code 212 “time limit for filing has expired.” This claim was filed previously. However, it was rejected because it did not contain all of the required documentation. The provider had no control over when he would receive the needed information and promptly submitted it when it did become available.

Reference: 20 CSR 400-2.030(2)(C)

Claim 2530809184 DOS 12-27-04 Amount at issue: \$1,685.28

- ix. The following additional elements of GHP’s claim procedures are of concern as well:

Prior authorization of certain services is required of the provider. Those services are identified in the Provider Manual.

Page 40 of the 2005 Provider Manual states: “member may be financially penalized if the provider fails to notify of an ER admission or visit instructed by the provider.”

The Manual states on page 21 “failure by the provider to authorize imposes penalty on the provider, not the member.” Elsewhere it states, “physician obtains authorization, member held harmless.”

Section 2.8 of the COC states: “Plan members are responsible for verifying...and the required prior authorization has been granted before receiving the Health Services.”

Section 6 of the COC states: “for some services prior authorization is required, for other services prior authorization may be required and for other services prior authorization is not required.”

The member’s COC and the Member Handbook indicates that it is the responsibility of the member to ensure services provided by non-participating providers were authorized.

The language in the Company’s contracts and Member Handbooks do not provide information about the conditions and requirements for claim processing. The above excerpts result in the following concerns:

(1) Communications in the form of manuals, Certificates of Coverage and Member Handbooks extend contradictory and confusing requirements for obtaining authorizations for treatment.

(2) The member has no leverage in ensuring that a non-participating provider will obtain any needed authorization.

(3) With the many options and alternatives concerning the requirement for authorization, it is difficult for a member to have a clear understanding of what specific services require pre-authorization.

(4) A member should not be penalized for an emergency room service or admittance if the provider fails to notify the Company of said emergency service. There is a statutory standard that determines the need for emergent care services. Notification and authorization requirements are not conditions in the legal definition of emergent care.

(5) The notice requirement for chiropractic services has no benefit except to burden the service process. According to Section 376.1215, RSMo, prior authorization of chiropractic services is not required for the first 26 treatment visits during each policy or certificate year. The initial chiropractic visit is always paid, whether participating or non-participating provider.

(6) The Company's forms and manuals fail to provide instructions and requirements that are clear and specific so the insured member can understand the policy benefits and requirements necessary for claim adjudication.

References: Sections 354.430.3, 354.442.1, 376.1215, 376.1350(12), and 376.1367, RSMo.

- b. The Company requires laboratory vendors to provide services for members based on the member's county of residence. This requirement is made known to the lab but is not disseminated to referring medical providers or the members. The procedures do not require medical providers to record the member's county of residence for referral purposes nor does the COC include notice to the member that s/he must select a lab based on her/his county of residence. Without disseminating the information and correlating the terms of the contracts and handbooks, the Company has placed the lab vendors in a disparaging financial situation. It is impossible for members and the various health

care providers to follow the requirements and rules within contracts when the Company does not correlate procedures and disseminate information to assure their congruity.

References: Section 375.1007(3) & (4), RSMo

III. COMPLAINTS

A. Missouri Department of Insurance, Financial Institutions, and Professional Registration Complaints

As part of the examination process, the examiners reviewed the Company's handling of complaints that it received from the DIFP dated January 1, 2005, through December 31, 2005.

The examiners noted the following exceptions during this review.

1. Complaint 06J001649 dealt with a request for a special type of MRI. The member's Medical records reflected that the member qualified for that MRI. The Company denied the provider's request for approval twice on the same date. During the handling of the complaint, the Company's precertification department provided a document that indicated the member's condition met the prerequisites for the requested procedure. File documentation did not include any new medical record or information between the denial date and the approval date. The Company did not investigate the original claim adequately to make the appropriate determination.

Reference: Section 375.1007(3), RSMo

Member Number 900731228*01

Claim Numbers

15258142
2616403649

2. The Company's file 07DOI413401MO for DIFP complaint 04S000389 contained medical records that reflected that the condition of the member was emergent and required immediate medical treatment. After the original submission, the Company paid benefits at the out-of-network level even when its policy is to pay out-of-network providers at an in-network level when the claim involves an emergent situation. The Company did not correct this until it received a complaint from the DIFP. Without obtaining additional information, the Company paid the claims three months after it received the original claim submission. The Company stated that it did not re-open and pay the claim correctly because there was no further contact from the member or the provider until the complaint.

Reference: Section 375.1007(3), RSMo

Member Number 49150544*01

<u>Claim Numbers</u>	<u>Claim Numbers</u>	<u>Claim Numbers</u>
10000903	10001278	10001455
10001642	10001760	10002079

B. Consumer Complaints

The examiners reviewed the Company's handling of consumer complaints dated January 1, 2005, through December 31, 2005.

The examiners noted no exceptions in this review.

C. Appeals

The examiners reviewed the Company's handling of appeals submitted by and for the consumer dated January 1, 2005 through December 31, 2005.

The examiners noted the following concern during this review.

1. One element of the examination process includes reviewing the manner in which the Company handles "appeals." The Company uses a two-step claim appeal process. The first step is a review by company personnel in the Company's utilization review section under the direction of or with the assistance of the Company Medical Director. In the second step, a committee reviews the appeal and makes a decision. Missouri law requires the committee to include an insured member, who is not an employee of the Company.

The examiners asked the Company to provide the names of those individual members who served on each second level appeal committee involved with the second level appeals during the time frame of the examination. Some of the individuals who served in this capacity were not insured by GHP HMO but rather by an affiliated company. The fact that the Company used members of another company's plan does not meet the Missouri appeal process requirements.

References: Sections 354.442, and 376.1385, RSMo, and the Company's filed and used COC provided to its members.

<u>Initials</u>	<u>Plan</u>	<u>Company</u>
F. K.	Advantra Plan	Coventry Health and Life Ins. Co
L. J. S.	Group Health Plan	Group Health Plan, Inc

IV. FORMAL REQUESTS AND CRITICISMS TIME STUDY

This study is based upon the Company’s ability to provide the examiners with requested material or to respond to criticisms within the 10 calendar day time limit required by Section 374.205.2(2), RSMo, and 20 CSR 300-2.200(5)&(6).

A. Criticism Time Study

<u>Calendar Days</u>	<u>Number of Criticisms</u>	<u>Percentage</u>
0 to 10	24	100.0%
Total	24	100.0%

B. Formal Request Time Study

<u>Calendar Days</u>	<u>Number of Requests</u>	<u>Percentage</u>
0 to 10	74	100.0%
Total	74	100.0%

V. EXAMINATION SUBMISSION

Attached hereto is the Division of Insurance Market Regulation's Final Report of the examination of Group Health Plan, Inc. (NAIC #96377), Examination Number 0612-58-TGT. This examination was conducted by Michael Gibbons, Gary Land, and Walter Guller. The findings in the Final Report were extracted from the Market Conduct Examiner's Draft Report, dated March 24, 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.

Michael W. Woolbright
Chief Market Conduct Examiner

Date



GROUP HEALTH PLAN, INC.

RESPONSE TO

MARKET CONDUCT

EXAMINATION

REPORT NUMBER: 0612-58-TGT

I. UNDERWRITING AND RATING PRACTICES

A. Policy Forms

1. **MDI Finding:** The Company included the verbiage “Sole and Absolute Discretion” in its policy forms to describe its contractual rights under its policies. The use of this wording can only be interpreted to expand on what is explicit in an insurance contract - that the insurer will make coverage and benefit decisions. This interpretation leads the insured or any one else to believe that no action on the part of the insured or anyone else is able to modify the insurer’s decision. This conflicts with several provisions of law. This interpretation eliminates the insured’s right to seek legal action, to enforce the contract, and makes any required right to appeal the decision, file a grievance or seek relief through the DIFP meaningless. Using this language tends to confuse and mislead insured persons.

Reference: Section 375.936(16), RSMo

GHP Response: GHP respectfully disagrees with Finding. The Certificates of Coverage (“COCs”) referenced above do not misrepresent the coverage terms of the policy. GHP makes it clear to its members numerous times throughout the claims and appeals processes that a member may in fact question or challenge GHP as follows:

1. Each COC contains an entire section entitled “Resolving Complaints and Grievances”. In this section, the various avenues a member could use to challenge GHP’s determinations – complaints, appeals, contacting the MO-DOI – is explained complete with timeframes.
2. In “Utilization Review Policy and Procedures” section of each COC, GHP’s members are specifically informed of their right to request a reconsideration of various adverse benefit determinations and their right to appeal.
3. A document entitled “Your Right to Review the Plan’s Determination” is included with every EOB. This document provides detail on the process provided to its members to challenge the adverse determinations and how to utilize the MDI to affect such a challenge. This document is also sent as an attachment to member denial letters for adverse determinations.
4. “Appeal and Grievance Process and Member Rights” is provided to members at the conclusion of the first level and second level appeals processes.

5. The Member Handbook also informs the member of their right to file a complaint or grievance.
6. If a member calls the Customer Service Organization (CSO) with a complaint or grievance, a representative of the CSO will explain to the member the process for filing such complaint or grievance.

See Exhibit -01.

In light of the information above, it is difficult to understand that the COCs one-time use of the words “sole and absolute discretion” gives the impression that “no action on the part of the insured or anyone else is contractually available to modify the insurer’s decision”.

Notwithstanding GHP’s disagreement with this Finding, GHP has already removed references to its “sole and absolute discretion” from all COCs.

B. Underwriting and Rating

1. Underwriting and Rating

a. Small Employer Group Underwriting

- i. **MDI Finding:** The Company allowed employers to establish the number of hours required to be eligible for group health benefits. Employers for 94 of the 138 small employer group applications reviewed required employees to work more than 30 hours per week to be eligible for group health benefits. Missouri requires small employer groups to include employees who work 30 hours or more per week. By allowing employers to set the qualifying limit over 30 hours, the Company fails to include all employees whom Missouri law requires to be eligible.

References: Sections 379.930.2(15) & 379.940, RSMo, and DIFP Bulletin 07-07

Appendix A lists the 94 employer group numbers.

GHP Response: GHP agrees with this Finding. GHP has already revised, filed, and received MDI approval of its Application for Benefit Offering form addressing this issue. Attached is the revised form and evidence of the MDI’s approval. **See Exhibit -02.**

- ii. **MDI Finding:** The Company allows employers to include coverage for Domestic Partners as a familial relationship. This coverage does not add to or extend coverage for any person in the household.

Although the Company does not have actuarial proof that additional premium is necessary to cover this type relationship, it charges an additional 1% of premium. An additional 1% charge is not placed on a household with married parents. Since premium is charged per person for group policies, the addition of the premium appears to be unwarranted.

References: Sections 376.820, 375.936(11)(e), and 375.995.4(11), RSMo.

GHP Response: GHP agrees with this Finding. In 2006, GHP ceased charging an additional rate associated with domestic partner coverage and started use of a domestic partner rider.

b. Small Employer Group Underwriting Nonrenewals

The examiners noted no concerns with the information provided.

II. CLAIM PRACTICES

A. Unfair Settlement and General Handling Practices

1. Paid Chiropractic Claims

The examiners noted no concerns with the information provided.

2. Denied Chiropractic Claims

- a. **MDI Finding:** The Company denied 482 chiropractic claims for reason code 218 “Rej-Member not effective on date of service,” the date of service was outside of the term of coverage under the policy. However, the members incurred the following three claims during a period of active coverage – which should have been covered and paid.

References: Section 375.1007(3) & (4), RSMo

<u>Member Number</u>	<u>Claim Number</u>	<u>DOS</u>	<u>Issue Date</u>	<u>Term Date</u>
900837323*01	1508801712	3/2/05	8/1/03	5/31/05
900837323*01	1510124842	3/30/05	8/1/03	5/31/05
901059680*02	2520117973	7/15/05	7/13/04	3/31/07

GHP Response: GHP agrees with this Finding. Each member at issue, at a point in time prior to the date of service, terminated and then reinstated their membership with GHP coverage. GHP’s claims processing system failed recognize that these members were again eligible for coverage with regard to these claims, and, thus denied them.

GHP has taken corrective action regarding this issue; specifically, it has changed its internal processes so that a list of terminated/reinstated members is reviewed monthly to help avoid situations such as these. **See Exhibit-03.**

- b. **MDI Finding:** The Company allows the initial visit to any chiropractor for assessment. Then, unless there is a chiropractic rider attached to the policy or the out-of-network provider obtains an authorization, all visits after the first visit must be with an in-network chiropractor. The Company’s Provider Agreement refers to the Provider Manual to incorporate the wording that the Plan does not interfere with the professional medical judgment of the provider.

Additionally, the Company requires the Chiropractor to submit a Treatment Plan before it will consider any treatment medically necessary

and payable. Although the Company requires providers to submit a plan to confirm that the treatment is medically necessary, a treatment plan in itself does not prove medical necessity. The Company has a contractual right to process already incurred claims, determine medical necessity, and make an appropriate payment or denial. The Company's requirement for a Treatment Plan in advance of treatment amounts to a method to allow the Company to pre-authorize future treatments which according to law is not allowed until after the 26th visit.

The Company provided the examiners lists of denied claims. The list of denied chiropractic claims included 865 claims that the Company denied with denial code 1104 "Reject-No Notification/Treatment Plan on File" because the provider failed to submit a Treatment Plan in advance. The Company also uses the Treatment Plan requirement to limit the number of treatments the provider can perform to correct the condition presented. The Company uses it to control the quantity of the provider's care for the member even though it states that it does not interfere with the professional judgment of the provider.

References: Sections 376.1230, and 376.1350, RSMo, & GHP's Provider Agreement and Provider Manual

Appendix B is a list of claims that the Company denied because the provider did not submit the required Treatment Plan prior to treatment.

GHP Response: GHP respectfully disagrees that its treatment plan requirement constitutes a prior authorization requirement and that it used this requirement to "limit the number of treatments a provider can perform" or control the quantity of the provider's care".

First, GHP did not impose prior authorization requirements on any in-network chiropractor claim listed in Appendix B. Section 376.1230.1 RSMo requires that that GHP's chiropractic coverage should be "clinically appropriate and medically necessary."

For the period examined by the MDI, GHP's contracts with in-network chiropractors required submission of a treatment plan so that it could determine medical necessity, not so that GHP could impose a prior authorization barrier to coverage. Under this process, in the event an in-network chiropractor failed to submit any treatment plan prior to rendering a service, or did submit a treatment plan prior to rendering a service that did not establish medical necessity, GHP would deny claims for such services. However, as further evidence that GHP did not use the treatment plan requirement as a prior authorization barrier to coverage, GHP would reprocess and pay any claims previously denied for lack of a treatment plan establishing medical necessity upon

submission of a treatment plan establishing such medical necessity, even if such submission occurred after services were already rendered. GHP, of course, would not require any treatment plan for a member's initial visit to in-network chiropractor's evaluation; GHP covered all claims for such initial visits in accordance with the terms of the member's policy.

Although GHP did impose prior authorization requirements on non-network chiropractor claims listed in Appendix B, section 376.1230.1 specifically permits it. In particular, section 376.1230.1 RSMo., states "nor shall a carrier be required to reimburse for services rendered by a nonnetwork chiropractor unless prior approval has been obtained from the carrier by the enrollee."

Second, GHP did not use the treatment plan requirement to "limit the number of treatments a provider can perform" or control the quantity of the provider's care", as alleged in this Finding. As stated above, GHP used the treatment plan to establish medical necessity of an in-network chiropractor's care. The MDI has not provided any clinical evidence that the number of visits deemed medically necessary by GHP in response to a submitted treatment plan was unsupported by medical literature. And certainly, a provider was free to provide treatment beyond that deemed medically necessary by GHP; GHP did not prevent how much care an in-network chiropractor provided. GHP's treatment plan requirement merely set forth what treatments would be considered medically necessary under the member's policy.

Finally, it is important to note that in 2008 GHP eliminated the treatment plan requirement that in-network chiropractors submit a treatment plan so that it could determine medical necessity.

- c. **MDI Finding:** Provider number 33736 submitted claims during the review period. The analysis of the claims to this provider found that additional payments totaling \$655.13 were due to the provider for two members with the following 54 claims.

Reference: Section 375.1007, RSMo

Member Number 900849434*05

<u>Claim Numbers</u>	<u>Claim Numbers</u>	<u>Claim Numbers</u>
19828766	19828767	19828802
19828803	19828820	19828821
19828825	19828826	19828827
19828828	19828831	19828832
19828836	19828837	19828848

19828831	19828831	19828849
19828851	19828852	19828856
19828857	19828859	19828860

Member Number 900849434*04

<u>Claim Numbers</u>	<u>Claim Numbers</u>	<u>Claim Numbers</u>
19828658	19828673	19828744
19828750	19828776	19828804
19828866	19828867	19828868
19828871	19828872	19828875
19828878	19828880	19828883
19828884	19828963	19828970
19828679	19828693	19828698
19828706	19828714	19828718
19828757	19828759	19828784
19828788	19828811	19828813

GHP Response: GHP agrees with this Finding. GHP’s enrollment process for newborns addresses those situations such as this where duplicate member numbers are reconciled so that all claims are processed under the correct member number. Unfortunately, GHP believes the above event was due to human error. GHP has since reprocessed all claims above. **See Exhibit-04.**

- d. **MDI Finding:** The Company’s claim list included 196 claims that it denied for reason code 208 “Reject – Services Exceed Authorized Limit.” This code implies that prior authorization is required before the Company considers the treatments incurred for payment.

Missouri law requires a health carrier to provide up to 26 chiropractic visits per policy period for any condition requiring chiropractic treatment. The Company, as a health carrier, has an inherent right to adjudicate claims according to the medical necessity of the condition presented. After 26 visits in a policy period, a health carrier may require the member to obtain prior approval for additional visits.

References: Section 376.1230, RSMo

Appendix C lists the 196 claims for 89 members that the Company denied because the provider provided more treatments than the Treatment Plan authorized.

GHP Response: The Company respectfully disagrees that it is has violated section 376.1230 RSMo. for two reasons.

First, GHP did not impose prior authorization requirements on any in-network chiropractor claim listed in Appendix C. As stated above by the MDI in this Finding, GHP has “an inherent right to adjudicate claims according to the medical necessity of the condition presented”. Section 376.1230.1 RSMo requires that that GHP’s chiropractic coverage should be “clinically appropriate and medically necessary.”

For the period examined by the MDI, GHP’s contracts with in-network chiropractors required submission of a treatment plan so that it could determine medical necessity, not so that GHP could impose a prior authorization barrier to coverage. Under this process, in the event an in-network chiropractor failed to submit any treatment plan prior to rendering a service, or did submit a treatment plan prior to rendering a service that did not establish medical necessity, GHP would deny claims for such services. However, as further evidence that GHP did not use the treatment plan requirement as a prior authorization barrier to coverage, GHP would reprocess and pay any claims previously denied for lack of a treatment plan establishing medical necessity upon submission of a treatment plan establishing such medical necessity, even if such submission occurred after services were already rendered. GHP, of course, would not require any treatment plan for a member’s initial visit to in-network chiropractor’s evaluation; GHP covered all claims for such initial visits in accordance with the terms of the member’s policy.

Although the Company concedes that the use of the word “authorized” in reason code 208 may not been the most appropriate choice of words, it is incorrect that the Company required prior authorization for in-network chiropractic providers.

Second, although GHP did impose prior authorization requirements on non-network chiropractor claims listed in Appendix C, section 376.1230.1 specifically permits it. In particular, section 376.1230.1 RSMo., states “nor shall a carrier be required to reimburse for services rendered by a nonnetwork chiropractor unless prior approval has been obtained from the carrier by the enrollee.” As a result, GHP disagrees that it violated section 376.1230.1 RSMo.

Finally, it is important to note that in 2008 GHP eliminated the treatment plan requirement that in-network chiropractors submit a treatment plan so that it could determine medical necessity.

- e. **MDI Finding:** The Company provided a list of denied chiropractic claims that included disposition code 229 “Reject - Services not

Authorized” and/or reason 356 for “Reject – Services were not Authorized.”

Members were receiving chiropractic care during the year 2005 and were denied coverage for one or more treatments for the disposition codes 229 and/or 356. There were 109 members with 506 claims including claims that did not identify the member number.

The Company’s claim procedures do not conform to the specifications of Section 376.1230, RSMo, which allows up to 26 chiropractic visits before the Company may require prior authorization for further visits.

Reference: Section 376.1230, RSMo

Appendix D lists the 506 claims the Company denied because it did not authorize the services rendered.

GHP Response: GHP respectfully disagrees that it violated section 376.1230.1 RSMo. when it denied the 490 of the 506 claims listed in Appendix D. Although

Non-Network Chiropractor Claims (486 Claims) – Although GHP imposed prior authorization requirements on non-network chiropractors, section 376.1230.1 RSMo. permitted this action. In particular, section 376.1230.1 RSMo., states “nor shall a carrier be required to reimburse for services rendered by a nonnetwork chiropractor unless prior approval has been obtained from the carrier by the enrollee.” Of the 506 claims listed in Appendix D, 486 claims were for services rendered by a non-network chiropractor. GHP’s denial of these claims for lack of prior authorization did not violate section 376.1230.1 RSMo.

However, GHP did not impose prior authorization requirements on any in-network chiropractor claim listed in Appendix D. Section 376.1230.1 RSMo requires that that GHP’s chiropractic coverage should be “clinically appropriate and medically necessary.”

In-Network Chiropractor Claims (4 Claims) For the period examined by the MDI, GHP’s contracts with in-network chiropractors required submission of a treatment plan so that it could determine medical necessity, not so that GHP could impose a prior authorization barrier to coverage. Under this process, in the event an in-network chiropractor failed to submit any treatment plan prior to rendering a service, or did submit a treatment plan prior to rendering a service that did not establish medical necessity, GHP would deny claims for such services. However, as further evidence that GHP did not use the treatment plan requirement as a prior authorization barrier to coverage, GHP would reprocess and

pay any claims previously denied for lack of a treatment plan establishing medical necessity upon submission of a treatment plan establishing such medical necessity, even if such submission occurred after services were already rendered. GHP, of course, would not require any treatment plan for a member's initial visit to in-network chiropractor's evaluation; GHP covered all claims for such initial visits in accordance with the terms of the member's policy. Of the 506 claims listed in Appendix D, 4 claims were for services rendered by an in-network chiropractor who did not submit a treatment plan that established medical necessity. As a result, GHP's denial of these claims did not violate section 376.1230.1 RSMo.

Incorrectly Denied (16 Claims) – With respect to a total of 16 claims associated with 2 members – member numbers 900580770-06 and 900816229-01 – through further review, GHP has determined that the provider did, in fact, submit a treatment plan that established medical necessity for all services rendered. GHP denied these 16 claims in error but is in the process of reprocessing them to pay with interest.

Finally, it is important to note that in 2008 GHP eliminated the treatment plan requirement that in-network chiropractors submit a treatment plan so that it could determine medical necessity.

3. Paid Childhood Immunization Claims Deductible and Copay

The examiners noted no errors in this review.

4. Denied Childhood Immunization Claims

MDI Finding: The Company denied benefits for the following 11 claims because box 31 on the HCFA 1500 claim form did not contain the exact information required. The Company failed to investigate and assist the claimant in the settlement of the claim submitted. GHP procedure is to reject the claim and advise that provider information was not provided in the box stipulated. In some instances, the information was included in a different box on the same form but the Company ignored it.

References: Sections 375.1007(3) & (6), 376.383, 376.384, RSMo, and 20 CSR 100-1.030(3)

<u>Claim Number</u>	<u>Claim Number</u>	<u>Claim Number</u>
1505246054	1506022692	1508445762
1510125287	1512224448	1526523351
2504014432	2514012818	4507423037

GHP Response: GHP disagrees that it violated sections 375.1007 (3) & (6), RSMo. The 2005 Provider Manual in the Section entitled “Claims Information” informs providers on how to complete the HCFA 1500. With regard to Box 31, the Provider Manual instructs providers that a “Signature of Physician or Supplier” is required along with the physician’s credentials. **See Exhibit-05.** The participating provider that submitted the above claims never provided such rendering/attending physician’s signature and credentials. Rather, it repeatedly submitted claims for the same service with listing the nurse practitioner. Upon learning this through its investigation on each claim, GHP instructed the provider to “Resubmit with rendering/attending physician’s signature”. **See Exhibit-06.**

GHP also disagrees that it is in violation of 376.383, 376.384 RSMo or 20 CSR 100-1.030. Each claim above was processed within the timeframe specified in these regulations. **See Exhibit-07.** In addition, each Provider Remittance Advice communicated to the provider that the information needed to process the claim was the “rendering/attending physician’s signature”.

GHP notes for the MDI that at the time these claims were processed GHP did not contract with Nurse Practitioners (NP) or Physician’s Assistants (PA). However, since that time, GHP has begun a process to contract with NPs and PAs. As such, in such cases, future claims submissions stating NP or PA signature/credentials in Box 31 will not face the situation described above.

5. Denied ER and Ambulance Claims

MDI Finding: On 06/20/05, member 900749622*1 was admitted through the emergency room for a urinary obstruction. The condition required the provider to perform an immediate surgery to remove the blockage. The provider submitted claim #14119490 covering both the emergent and surgical services. The amount of the claim was \$5,575.94 of which \$381.60 was paid on 07/11/05. On 09/14/05, the provider requested additional payment of \$1,754.00 per its contract with GHP. The documentation provided did not indicate that GHP paid any additional benefit. The examiners asked the Company to explain the basis of the lesser payment. Upon review of the claim, the Company stated that it had procedures in place to respond to such inquiries, but had failed to do so in this case. GHP found that it had not paid the claim in full and issued an additional payment of \$1,781.84 plus \$404.65 interest.

References: Section 375.1007(3)&(4), RSMo, and 20 CSR 100-1.040(1)(A)

GHP Response: GHP agrees with this response.

6. Denied PSA Test Claims

The examiners noted no errors in this review.

7. Denied PAP Smear Test Claims

MDI Finding: The Company failed to pay benefits for a mandated benefit for a PAP Smear in the following claim. The Company initially denied the claim because the provider included an incorrect CPT code. When the claim was resubmitted with the correct code, the Company again denied coverage for the PAP Smear because the service was not authorized. The Company paid charges for the office visit and lab pathology but denied the charge for the mandated benefit of a PAP Smear. The EOB advised that the PAP Smear was the member's responsibility. This is not an appropriate practice for a mandated benefit.

Reference: Section 376.1250.1 RSMo

<u>Member Number</u>	<u>Claim Number</u>
0881344*01	1434445940 for first filing 15012455659 for second filing 1506845223 for third filing

GHP Response: GHP respectfully disagrees with this Finding. Although section 376.1250 RSMo. requires HMO policies to cover pap smears, it does not require that such policies offer out-of-network coverage for pap smears when out-of-network coverage is not provided for any other benefit.

The member at issue in this Finding had a GHP policy that had a benefit plan that did not include out-of-network coverage except for emergent services, urgent services, or medically necessary services for which no in-network provider is available and prior authorization is obtained. This policy did in fact cover pap smears on an in-network basis in compliance with section 376.1250 RSMo.

Regarding the claim at issue, the provider rendering the service to the member was an out-of-network provider. In addition, the pap smear were not rendered on an emergent or urgent basis, and they was not obtained with prior authorization because no in-network provider was available. As a result, GHP disagrees with this Finding.

8. Denied Cancer Screening Tests Claims

The examiners noted no errors in this review.

9. Denied Mammogram Test Claims

The examiners noted no errors in this review.

10. General Claim Handling

- a. The following subsections involve some of the general claim handling practices of the Company. They reflect that GHP incorporates practices that do not conform to Missouri laws concerning claim processing.
 - i. **MDI Finding:** The Company requires each submission from a provider to be complete and without error, a “clean claim,” before it considers it for payment. The Provider Manual specifies that one of two forms must be completed for submission; either a CMS 1500 or a UB92. The CMS 1500 requires over 40 items of data plus any coordination of benefits information, and the UB92 has 86 elements of data that a provider must include without error before GHP will consider it a “clean claim.”

If the provider submits a claim without all the stated elements, the Company rejects it by way of denial codes that indicate a lack of or including incorrect information. GHP rejects any responsibility to investigate such a filing. GHP treats this scenario as if the provider did not submit the claim at all.

When the provider re-submits the claim with all information in the specified spaces, the Company assigns a new claim number and processes it as a new submission using the current date as the received date. In some instances, a claim was submitted several times over a period of time and was assigned multiple claim numbers before it was considered a “clean claim.” Then, GHP processed it under yet another claim number. Since the Company does not consider a claim submitted until it meets its definition of a “clean claim,” it can be delayed past the provider’s contract requirement for claim submission within 90 days after treatment.

The Company processes electronic claims in much the same way. A third party vendor who receives claims from providers, manipulates the data into a specific format then forwards it to GHP. The vendor will return to the provider for correction any submission that is not complete according to its standards. Even when a form appears to be complete and correct, the Company may not accept it from the vendor because of a technical error or exclusion. This will also delay

the submission. The Company does not attempt to assist the claimant or to begin an investigation to obtain or clarify needed information.

Missouri requires companies to assist claimants in the claim process. There is no requirement for “clean claims” in any Missouri claim statutes. Therefore, GHP has the responsibility to begin investigating and request additional information to process incomplete claims.

References: Sections 375.1007(3),(4) & (6), and 376.383, RSMo, and 20 CSR 100-1.030

GHP Response: GHP respectfully disagrees with this Finding.

GHP acknowledges that it has the responsibility, as stated in the final sentence of this Finding, “to begin investigating and request additional information to process incomplete claims”. GHP’s claims process does just this. In fact, the second paragraph of this Finding states as much, stating that GHP rejects claims without all necessary information by way of denial codes that indicate a lack of information or the additional information needed. GHP’s denial codes request the particular information needed, such medical records. It is this additional requested information that constitutes the beginning of GHP’s investigation of incomplete claims.

The third paragraph of this Finding alleges that, in some instances, claims submitted several times were assigned multiple claim numbers, that GHP would process a claim submission only after it provides all information, resulting in a delay that would cause such claims to be rejected for violating a provider contract requirement that claims must be submitted within 90 days of treatment. Although GHP strives to process each claim in good faith, mistakes do occur. However, even with such mistakes, GHP disagrees that these instances constitute GHP’s standard claims practice. In order to respond squarely to this Finding, GHP requests the claim numbers that constitute these instances.

Nonetheless, even without these specific claim numbers, GHP’s general claims practice is not engineered to reject claims so that claims can be delayed to after 90 days of treatment. Rather, GHP’s Provider Manual instructs that providers have an additional 90 days from the date of their remittance advice to submit additional information requested. **See Exhibit-08.** As a result, where a provider submits an initial claim within 90 days of treatment and GHP requests additional information, so long as a follow-up claim providing such additional information is submitted within 90 days after GHP requested it (this request would be communicated through

a remittance advice), GHP will process the follow-up claim even if its submission date is more than 90 days after the date of treatment. The fact that GHP's claims system assigns of a new claim number to the follow-up claim has no bearing on this result.

ii. **MDI Finding**: The Provider Manual states that:

Electronic claims require the same information as paper claims. Special arrangements need to be made for submission of claims with attachments. GHP accepts initial claims submissions electronically through Gateway EDI or WEB MD. For more information, contact your Provider Relations Representative.

Claims filed electronically are NOT considered "received" unless they have passed our system edits and have been accepted into our system. For every claim filed electronically the provider should receive two (2) reports back: (1.) A report that the clearinghouse accepted the claim. (2.) A file stating the action taken by GHP (Second Level Acceptance Report).

The provider does not control the creation or the distribution of these reports. The clearing house controls the first report, and GHP controls the second report. Yet, GHP has made the provider responsible for maintaining and providing copies of both of these reports. The Company does not maintain proof of delivery.

For example:

The examiners reviewed denied ER and ambulance claims. The remittance advice for the following claims stated the denial reason as failing to file the claim within 90 days of the date of service. The provider advised that it did file each claim in a timely manner and provided supporting documentation. Since the supporting documents were not generated by the provider, they could not be altered or changed by the provider. Upon review by GHP, all of the claims were again denied, stating that the earlier submission would require a "second level acceptance report" to substantiate a timely filing date. These denials were not substantiated by documentation; but rather, assumed by the Company. The chart below shows the details for each claim.

References: Sections 376.383, 376.384, 376.1007, RSMo, and 20 CSR 100-1.030

Date of Service	Claim Number	Date Co. Recorded Received	Related Claim Number	Date of Original Filing	Days DOS Rec'd
09/06/04	4508800724	03/29/05	None Filed	10/01/04	25
12/15/04	1519345508	07/12/05	1519345102	01/07/05	23
12/07/04	4526523693	09/22/05	No # given	12/22/04	15
09/08/04	4506223214	03/03/05	1508000556	10/01/04	23
12/09/04	4510203806	04/12/05	2508416996	01/14/05	36
12/20/04	4518000523	06/29/05	1515100687	01/06/05	17
07/14/04	11449569	01/18/05	2435715925	07/29/04	15
08/28/04	4507346302	03/14/05	1508000537	10/01/04	34
12/04/04	4518246853	07/01/05	1515201324	12/31/04	27
12/04/04	4517945385	06/28/05	1515100756	12/16/04	12
12/03/04	4510202091	04/12/05	1521622597	12/27/04	24
11/26/04	4527900157	10/06/05	1508000527	12/18/04	22

GHP Response: GHP respectfully disagrees with this Finding.

It is important to clarify a few things about GHP's claims process. During the time period covered by this examination, GHP used Emdeon as its clearinghouse. Providers, however, may have used any one of many clearinghouses as their agent to submit their claims to Emdeon. When a provider attempted to submit a claim to GHP, the provider's clearinghouse would communicate back to the provider a report listing those claims accepted and not accepted by Emdeon (the "First Level Acceptance Report"). After Emdeon received such accepted claims and attempted to submit them to GHP, Emdeon would then provide a report to the provider's clearinghouse listing those claims accepted and not accepted by GHP. It would be the provider clearinghouse's responsibility and standard practice to then communicate this listing back to the provider (the "Second Level Acceptance Report").

As a result, GHP did not control the Second Level Acceptance Report, despite the MDI's assertion to the contrary in the second paragraph of this Finding. Although it is correct that the provider did not control the creation or distribution of the First or Second Level Acceptance Reports, the provider was in fact able to control its access to the Reports – both Reports are distributed to them directly from their own clearinghouse.

During the period covered by this examination, GHP's Provider Manuals clearly instructed providers that it was the provider's obligation to provide these two reports as proof of timely filing. In each of the cases listed above, the provider did not provide this proof– that is, the Second Level Acceptance Report – that was made available to them by their own clearinghouses and required by the

GHP Provider Manual. What is more, GHP timely investigated and processed each claim in compliance with the statutes/regulation cited above. **See Exhibit-09.**

- iii. **MDI Finding:** Missouri requires a submission to be paid, denied or pended for investigation. GHP claim processing does not pend claims for investigational purposes. A claim is either paid, denied or rejected. The Company does not investigate claims. Rather it requires the claimant submitting the claim to determine exactly what information is missing or incorrect and provide it. Although the Company may ultimately receive a “clean claim” with sufficient documentation to support the claim and it is filed timely, GHP may still refuse to pay claims submitted after the 90-day limitation.

No Missouri statute or regulation indicates that a “clean claim” or acceptance of a claim is required before the commencement of the time to acknowledge, investigate, or adjudicate.

References: Sections 375.1007(3)&(4), 376.383, RSMo, and 20 CSR 100-1.010(1)(B)&(G)

With regard to paper claims the Company’s position directly contravenes 20 CSR 100-1.010(1)(B), which defines the following terms as follows:

Claim means --

A request or demand for payment of a loss which may be included within the terms of coverage of an insurance policy; . . .

Investigation means --

All activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy;

Notification of claim means --

Any notification, whether in writing or by other means acceptable under the terms of an insurance policy to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim;

Third-party claimant means --

Any individual, corporation, association, partnership or other legal entity asserting a claim against any

individual, corporation, association, partnership or other legal entity insured under an insurance policy;

The intent of these provisions is clear. A request for payment can be less than perfect and still be a claim. GHP makes no attempt to coordinate or otherwise correlate prior submissions with subsequently received documentation. When a prior filing is referred to by the provider and noted by the Company, GHP will use a subsequent submission to pay the claim except, when it is received after the 90-day limitation.

GHP Response: GHP respectfully disagrees with this Finding. Please see its response to the above Finding in section II.2.A.10.a.i.

- iv. **MDI Finding:** Providers are encouraged to file electronic claims (pursuant to Section 376.383, RSMo). In the case of electronic claims, the original date of receipt starts the clock for determining when payment is due. The Company circumvents the 45 day payment requirement as well as the calculation and payment of interest with its “clean claim” requirement. Nothing in Sections 376.383 or 376.384, RSMo, sets forth any requirement for a “clean claim” before action is required by the carrier.

References: Sections 376.383, and 376.384, RSMo

GHP Response: GHP agrees with this Finding.

- v. **MDI Finding:** GHP was a secondary insurer on the following claim. As such, the provider had one year in which to file the claim. GHP’s original receipt of this claim was 03/04/05. The claim was originally rejected on 03/17/05, as being the liability of the primary carrier. On 03/23/05, the provider was informed that the EOB submitted could not be read. However, there was a letter in the file from a collection agency stating the amount paid. The amount stated as being paid by the primary could be confirmed by looking closely at the copy of the invoice submitted with the letter. As the date of receipt was within the time allowed by statute, this claim appeared to be payable.

References: Sections 375.1007(3) & (4), RSMo

Claim 1506346416 DOS 08/24/04 Amount at issue: \$1,234.90

GHP Response: GHP respectfully disagrees that the Company failed “...to adopt and implement reasonable standards for the prompt investigation and settlement of claims...” and did not attempt

“...in good faith to effectuate prompt, fair and equitable settlement of claims...”

Although the provider did in fact provide a collection agency letter stating the amount paid, this letter, the letter did not confirm that it was regarding the member in question. In particular, this letter was illegible with respect the critical information needed for GHP to confirm it applied to the member in question, namely the member’s identification number, date of service, total amount of the claim, primary carrier allowed amount, primary carrier’s member responsibility and payments made by the primary carrier. As a result, upon reading this letter as part of its investigation into this claim, could still not confirm accuracy so as to process the claim in question. **See Exhibit-10.**

As a result, GHP did in fact comply with sections 375.1007(3) & (4), RSMo.

- vi. **MDI Finding:** Multiple HCFA 1500 forms were submitted to GHP with the typed name of an Advanced Practice Nurse instead of a physician’s name. Claims denied multiple times code 0761 “Rebill with physician’s name and credential in box 31.” The submitting provider was a county health department.

Later, the county health department submitted a HCFA 1500 with a physician’s name but the claim was then denied for code 1055, “Untimely Filing,” and 212, “Time Limit for Filing has Expired.”

The provider included the attending provider correctly on the form because a non-physician is permitted to administer injections. This claim was rejected for an administrative requirement that could have been rectified with some assistance from the Company’s Claim Department.

The Company acknowledges that the claim had been filed nine times previously, yet the claim was denied for “Untimely Filing.” The Company maintained no correlation between the time of the first filing and the time of the last (10th) filing when the “required” information was provided and then denied. There was no investigation; only a rejection. Other than rejecting the claim, no effort was made to contact the provider for the information or to assist them in providing the desired information.

References: Section 375.1007(3), (4) & (6), RSMo, and 20 CSR 100-1.010(B)(1), and 20 CSR 100-1.020(1)(B)

GHP Response: GHP respectfully disagrees with this Finding because the provider in question did not fulfill its contractual obligation to comply with the GHP Provider Manual. GHP's contract with the provider required it to comply with GHP's Provider Manual.

The Provider Manual provided to this provider set forth two requirements: (1) any submitted claim must provide the name of rendering or attending physician associated with the service, and (2) information requested regarding a claim must be provided within 90 days of such request. This provider failed to comply with both requirements. **See Exhibit-11.**

On 2/8/05 GHP received the original claim for the DOS of 2/1/05. The claim listed the name of the nurse who administered the injection, not the name of rendering or attending physician associated with the service as is required by the claim and the Provider Manual. As a result, this original claim submission and the provider's subsequent submission providing the same information were denied. Despite rejection codes explaining that the rendering/attending physician name and credentials should be provided in box #31 of the claim form, this provider sent in this claim an additional eight times without changing the claim submission. **See Exhibit-12.**

By the time the provider did make the requested change to the claim – 9/22/05 – over seven months had passed since GHP's initial request for this information on 2/23/05. **See Exhibit-13.** As a result, as set forth in GHP's Provider Manual, GHP correctly denied this claim for untimely submission of requested information.

It should be noted that although this Finding correctly states that it is permissible for a non-physician to administer injections, this does not mean that the claim for such a service need not comply with the Provider Manual with which the provider is contractually bound to comply. In this case, the provider did not comply with Provider Manual requirements to (1) the name of rendering or attending physician and (2) provide requested information within 90 days. As a result, GHP disagrees that it violated the statutes/regulations cited above and that it should readjudicate this claim.

- vii. **MDI Finding:** Box 31 of HCFA form 1500 requests the signature and credentials of the physician or supplier. A computer generated signature or stamp is acceptable in lieu of a signature. The Company

accepts the name of a non-physician for various claims. The claims below have the name of either a physician or other medical professional, including credentials.

The Company rejected the following claims under Disposition Code 761 – claim lacked information needed for adjudication. They were rejected even though names and professional designations were furnished in box 31 of HCFA 1500.

References: Sections 375.1007(3), and 376.1350(25), RSMo.

<u>Claim No.</u>	<u>DOS</u>
1436345292	07/12/04
1505223272	10/27/04
4521324683	06/21/05
4526500357	07/29/05 & 08/04/05
4526500366	05/06/05 & 06/17/05
4526500367	6/17/05; 07/08/05; 07/14/05; & 07/29/05
4527300081	08/19/05
4535323203	11/10/05

GHP Response: GHP disagrees that it violated sections 375.1007 (3) & (6), RSMo. The 2005 Provider Manual in the Section entitled “Claims Information” informs providers on how to complete the HCFA 1500. With regard to Box 31, the Provider Manual instructs providers that a “Signature of Physician or Supplier” is required along with the physician’s credentials. **See Exhibit-14.** The participating providers that submitted the above claims never provided such rendering/attending physician’s signature and credentials. Rather, they repeatedly submitted claims for the same service with listing the nurse practitioner. Upon learning this through its investigation on each claim, GHP instructed the providers to “Resubmit with rendering/attending physician’s signature”. **See Exhibit-15.**

GHP’s practices are compliant with 376.1350(25) RSMo, to the extent that one can be compliant with a definition. The definition of "Participating provider" is “a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than coinsurance, co-payments or deductibles, directly or indirectly from the health carrier.” The participating providers related to the claims in this Finding did have an expectation of receiving payment for services rendered, when

proper procedures were followed. The providers in these claims did not follow proper claims submission procedures set forth in the Provider Manual.

GHP notes for the MDI that at the time these claims were processed GHP did not contract with Nurse Practitioners (NP) or Physician's Assistants (PA). However, since that time, GHP has begun a process to contract with NPs and PAs. As such, in such cases, future claims submissions stating NP or PA signature/credentials in Box 31 will not face the situation described above.

- viii. **MDI Finding:** GHP had secondary coverage on this claim. Under Missouri law, in the event of a secondary carrier, the provider has up to 12 months in which to file a claim with the secondary carrier. The provider filed the claim with the primary on a timely basis. However, the documentation needed for a secondary filing was not received within the 90-day period required by GHP in the Provider Manual. Once received, the provider submitted the claim within two calendar days.

The claim was received from the provider on 6-16-05 and denied per code 212 "time limit for filing has expired." This claim was filed previously. However, it was rejected because it did not contain all of the required documentation. The provider had no control over when he would receive the needed information and promptly submitted it when it did become available.

Reference: 20 CSR 400-2.030(2)(C)

Claim 2530809184 DOS 12-27-04 Amount at issue: \$1,685.28

GHP Response: GHP respectfully disagrees with this Finding because it appears that this Finding is based on a faulty premise – namely, that the claim in question involves coordination of benefits. It does not. GHP did not have at the time in question, and does not currently have, any information indicating that the member had other insurance. As a result, the 12 month submission timeframe cited in 20 CSR 400-2.030(2)(C) does not apply to this claim, and as explained in GHP's response to Criticism #3, GHP was correct to apply the 90-day period set forth in this provider's Provider Manual.

- ix. **MDI Finding:** The following additional elements of GHP's claim procedures are of concern as well:

Prior authorization of certain services is required of the provider. Those services are identified in the Provider Manual.

Page 40 of the 2005 Provider Manual states: “member may be financially penalized if the provider fails to notify of an ER admission or visit instructed by the provider.”

The Manual states on page 21 “failure by the provider to authorize imposes penalty on the provider, not the member.” Elsewhere it states, “physician obtains authorization, member held harmless.”

Section 2.8 of the COC states: “Plan members are responsible for verifying...and the required prior authorization has been granted before receiving the Health Services.”

Section 6 of the COC states: “for some services prior authorization is required, for other services prior authorization may be required and for other services prior authorization is not required.”

The member’s COC and the Member Handbook indicates that it is the responsibility of the member to ensure services provided by non-participating providers were authorized.

The language in the Company’s contracts and Member Handbooks do not provide information about the conditions and requirements for claim processing. The above excerpts result in the following concerns:

- (1) Communications in the form of manuals, Certificates of Coverage and Member Handbooks extend contradictory and confusing requirements for obtaining authorizations for treatment.
- (2) The member has no leverage in ensuring that a non-participating provider will obtain any needed authorization.
- (3) With the many options and alternatives concerning the requirement for authorization, it is difficult for a member to have a clear understanding of what specific services require pre-authorization.
- (4) A member should not be penalized for an emergency room service or admittance if the provider fails to notify the Company of said emergency service. There is a statutory standard that determines the need for emergent care services.

Notification and authorization requirements are not conditions in the legal definition of emergent care.

(5) The notice requirement for chiropractic services has no benefit except to burden the service process. According to Section 376.1215, RSMo, prior authorization of chiropractic services is not required for the first 26 treatment visits during each policy or certificate year. The initial chiropractic visit is always paid, whether participating or non-participating provider.

(6) The Company's forms and manuals fail to provide instructions and requirements that are clear and specific so the insured member can understand the policy benefits and requirements necessary for claim adjudication.

References: Sections 354.430.3, 354.442.1, 376.1215, 376.1350(12), and 376.1367, RSMo.

GHP Response: GHP respectfully disagrees with this Finding and will respond to the six allegations stated above.

First, GHP disagrees that the Provider Manual, Certificates of Coverage and Member Handbook extend contradictory and confusing requirements. These documents are intended for different audiences. The Provider Manual is for the use of participating providers only, while the COC and Member Handbooks are for the use of the members. Moreover, the requirements contained in each are complementary, rather than contradictory, and are in no way confusing.

- With respect to this Finding's statement regarding Page 40 of the Provider Manual, the statement actually reads, "Please remember that failure to notify GHP of an emergency room visit or emergency hospital admission may result in financial penalties and/or a reduction in benefits to the member." The information prior to this statement describes an emergency. If a member goes to the Emergency Room for a non-emergent condition when sent by the provider, the member could be held responsible for the charges if GHP was not informed by the provider that the member had been instructed, specifically, to go to the Emergency Room. This complements Section 7 of the COC as described further in this Response. **See Exhibit-16.**
- With respect to this Finding's statement regarding Page 21 of the 2005 Provider Manual, the statement actually reads, "Please remember that failure to comply with our authorization process may impose financial liability on the provider as outlined in GHP's

Providers Sanction Policy in this manual. In this case, the member must be held harmless.” This statement is regarding authorization of services in general. Members were not held responsible for charges resulting from services in which the participating provider failed to obtain authorization, unless the service rendered was not a covered benefit. This Finding appears to indicate that this statement contradicts Section 2.8 of the COC. GHP disagrees. Section 2.8 does caution the member to ensure that authorization has been obtained. This is so that if a member called to verify that authorization had been obtained and learned it had been denied, the member would then have complete information as to the denial. **See Exhibit-17.**

These documents do provide a lot of information to their intended audiences. However, the statements cited by this Finding as being contradictory were not so, but rather were each designed to capture a nuance or specific set of circumstances, as is explained in each section. For instance, as described above, there is a procedure that should be followed by participating providers when instructing members to go to the emergency room, so that even if the condition with which they present would not otherwise qualify as a qualified medical emergency under the COC, GHP would pay as an emergency, anyway. Again, GHP disagrees that this information is contradictory in any way, or confusing.

Second, GHP disagrees that a member does not have any leverage with non-participating providers in this regard. As this Finding has indicated elsewhere, a non-participating provider stands to lose the member as a customer if the provider does not satisfy the member’s expectations of service (not only medical, but presumably cooperation with administrative requirements, such as obtaining pre-certification where required by the member’s insurance coverage). In this respect, the member does have leverage with an out of network provider in that if the out-of-network provider does not cooperate with the member’s request that the provider seek authorizations, the member can choose not to see said provider for those particular services, or any future services. Moreover, GHP has even less leverage with a non-participating provider than the member, so in cases where the member has a plan with out-of-network benefits, it is appropriate that the member be given the responsibility for confirming that the provider called in for authorization, where required.

Third, GHP disagrees that it is confusing and would be difficult for members to have an understanding as to what services require prior authorization or notification. This Finding appears to have gathered language from various paragraphs of Section 6 and represented them, together, as a quotation. Again, there is a lot of information presented in the COCs. GHP agrees that had members been provided with a quote

such as that the one that this Finding has strung together above, there may have been a risk of confusion. To the contrary, though, the COCs first present a list of covered services in section 6, and state whether prior authorization is required always, in some instances, or not required, for each. Section 2 separately offers a non-exhaustive list of services requiring authorization or notification. This list is included in the COCs and the Provider Manual. In both documents it is made clear that the list is non-exhaustive. As medical technology evolves and industry standards shift, the list of services which may require authorization in order to be covered may change. This is why Members are encouraged in numerous sections of their COCs to contact GHP's Member Services Department to verify benefits, the status of any authorizations, and participation status of providers. Providers are also encouraged to verify benefits and inquire as to whether particular benefits require prior authorization before rendering services. Therefore, GHP disagrees that it is confusing and would be difficult for members to have an understanding as to what services require prior authorization or notification.

Fourth, GHP disagrees with this Finding's assertion that the member is penalized when seeking qualified emergency room services without obtaining prior authorization. Section 7 of the COCs informs members of the obligation to notify GHP within 48 hours (or within a reasonable period of time) of their visit to the Emergency Room. This section does not tell the member that penalties are imposed if GHP is not notified. In fact, there are no penalties if the member goes to the Emergency Room for a qualified medical emergency as per 354.400(5) RSMo, and as defined in the COC. Therefore GHP disagrees that the member is penalized.

Fifth, GHP does not agree that requirement of notification for chiropractic coverage is a burdensome process. Notification and provision of treatment plans by the chiropractor allows GHP to determine if the visits are medically necessary and clinically appropriate as allowed by 376.1215 RSMo. GHP would like to note that in 2008 GHP eliminated the treatment plan requirement that in-network chiropractors submit a treatment plan so that it could determine medical necessity.

As a result, GHP disagrees that the forms and manuals are ambiguous, contradictory and/or confusing. Further, the COCs and other forms addressed to members were reviewed and approved by the DOI prior to their use.

- b. **MDI Finding**: The Company requires laboratory vendors to provide services for members based on the member's county of residence. This

requirement is made known to the lab but is not disseminated to referring medical providers or the members. The procedures do not require medical providers to record the member's county of residence for referral purposes nor does the COC include notice to the member that s/he must select a lab based on her/his county of residence. Without disseminating the information and correlating the terms of the contracts and handbooks, the Company has placed the lab vendors in a disparaging financial situation. It is impossible for members and the various health care providers to follow the requirements and rules within contracts when the Company does not correlate procedures and disseminate information to assure their congruity.

References: Section 375.1007(3)&(4), RSMo

GHP Response: GHP respectfully disagrees with this Finding. Contrary to this first sentence of this Finding, GHP does not require laboratory vendors to provide services for members based on the member's county of residence. Rather, GHP's contracts with certain laboratory vendors explicitly limit what services will be reimbursed based on the member's county of residence.

As GHP stated in its response to Criticism #12, on which this Finding is based, GHP disagrees with this Finding that the member-of-county provision has placed the lab vendors in a disparaging financial situation. To the contrary, the lab providers themselves agreed to this provision in order to gain access to GHP membership in rural markets, as evidenced by negotiation of the provision and execution of the provider contract.

Finally, it is important to note that, as acknowledged by the Examiner in Criticism #12, neither the members nor the physicians referring the member to a lab at issue in Criticism #12 were held accountable for charges.

III. COMPLAINTS

A. Missouri Department of Insurance, Financial Institutions, and Professional Registration Complaints

1. **MDI Finding:** Complaint 06J001649 dealt with a request for a special type of MRI. The member's Medical records reflected that the member qualified for that MRI. The Company denied the provider's request for approval twice on the same date. During the handling of the complaint, the Company's precertification department provided a document that indicated the member's condition met the prerequisites for the requested procedure. File documentation did not include any new medical record or information between the denial date and the approval date. The Company did not investigate the original claim adequately to make the appropriate determination.

Reference: Section 376.1007(3), RSMo

Member Number 900731228*01

Claim Numbers

15258142
2616403649

GHP Response: GHP respectfully disagrees that it did not properly investigate these claims before denying them on both 6/5/06 and 6/6/06.

On 6/05/06, GHP received a telephone request for prior authorization for a Thallium Nuclear Stress Test ("Nuclear Stress Test"), not an MRI as stated in this Finding. GHP's medical director, Dr. Yenchick, reviewed the information included with the request. Dr. Yenchick used the Cardiac Stress Test Algorithm ("Algorithm"), which is based on Interqual criteria and the American College of Cardiology's criteria for a Nuclear Stress Test, to determine with the Nuclear Stress Test should be approved or denied. Dr. Yenchick appropriately denied the request for the Nuclear Stress Test based on the entire Algorithm, which includes review of (i) the presenting risk factors, (ii) the patient's symptoms, and (iii) the history of prior use of less invasive, equally effective diagnostic tests such as echocardiograms and EKGs. The request was denied for the following reasons: (a) there were no symptoms documented, such as chest pain, that necessitated use of the Nuclear Stress Test and (b) there was no documentation showing prior results of a stress echocardiogram or EKG, which are tests that, in the normal course, are performed before the more invasive Nuclear Stress Test is considered. Therefore, GHP properly investigated this claim before

denying it, and a denial letter was sent to the member and requesting physician on 6/6/06. **See Exhibit-18.**

On 6/06/06, after the original denial letter had been sent, GHP received additional information regarding the previous day's request, specifically, ST segment abnormalities on an EKG test without any documentation of acute changes or comparison to other EKG tests done in the past. The member received two pure scans in the last two years and both were abnormal. During a peer-to-peer discussion, Dr. Yenchick and Dr. Murphy, another GHP medical director, reviewed and discussed this new information and determined that this new information did not have any impact on GHP 6/6/06 denial because such scans are not of any clinical value in the Algorithm. As a result, GHP upheld the previous day's denial on reconsideration based on the entire Algorithm because the documentation showed no contraindications to a stress echocardiogram in lieu of the Nuclear Stress Test. Therefore, GHP did in fact properly investigate this claim before upholding its denial as set forth in the 6/6/06 denial letter.

On 6/22/06, GHP received a DOI complaint with a copy of the member's letter to the DOI regarding this matter attached. No additional information was included with the DOI complaint. In responding to the DOI complaint, GHP's Appeal Manager reviewed the member's medical documentation with the Precertification Director. Unfortunately, the Appeals Manager and Precertification Director incorrectly reversed the initial denial of the request for prior authorization because she mistakenly applied only part of the Algorithm. Based on this error, GHP reversed the decision on the original request with the rationale – incorrect, of course – was that the member met requirements regarding presenting risk factors under the Algorithm. Needless to say, this rationale failed to consider a separate, necessary component of the Algorithm, namely, that the member had not exhausted less invasive, equally effective echocardiogram tests. As a result, although GHP's 6/5/06 and 6/6/06 denials were overturned, GHP adequately investigated the claim on these dates and the overturn was a result of the incomplete application of the Algorithm.

Finally, Section 376.1007(3), RSMo requires a multiple employer self-insured health plan to make certain filings and does not contain a subsection (3). As this statute is not applicable to this Finding, GHP has not in violated this law.

2. **MDI Finding:** The Company's file 07DOI413401MO for DIFP complaint 04S000389 contained medical records that reflected that the condition of the member was emergent and required immediate medical treatment. After the original submission, the Company paid benefits at the out-of-network level even when its policy is to pay out-of-network providers at an in-network level when the claim involves an emergent situation. The Company did not

correct this until it received a complaint from the DIFP. Without obtaining additional information, the Company paid the claims three months after it received the original claim submission. The Company stated that it did not re-open and pay the claim correctly because there was no further contact from the member or the provider until the complaint.

Reference: Section 376.1007(3), RSMo

Member Number 49150544*01

<u>Claim Numbers</u>	<u>Claim Numbers</u>	<u>Claim Numbers</u>
10000903	10001278	10001455
10001642	10001760	10002079

GHP Response: GHP agrees with this Finding. The member was admitted on 2/16/04 to an out-of-area facility as an emergent admission. On 2/16/04, the facility contacted GHP to request authorization for services. GHP incorrectly authorized the admission at the out-of-network level of benefits. On 5/13/04, GHP subsequently received a DOI complaint alleging that GHP should have covered the admission at the in-network benefit level. GHP reviewed the complaint, corrected the error, and reprocessed the claim on 5/24/04.

Please be advised the neither the member nor the provider contacted GHP from the date of admission through the date on which GHP received the DOI complaint. Therefore, GHP did not discover this error until 5/13/04. . In GHP’s response to the 5/13/04 DOI complaint, it acknowledged its error in the handling of this claim and GHP reprocessed the claim accordingly.

Finally, Section 376.1007(3), RSMo requires a multiple employer self-insured health plan to make certain filings and does not contain a subsection (3). Therefore, this statute is not applicable to this Finding and GHP is not in violation of this law.

B. Consumer Complaints

The examiners noted no exceptions in this review.

C. Appeals

1. **MDI Finding:** One element of the examination process includes reviewing the manner in which the Company handles “appeals.” The Company uses a two-step claim appeal process. The first step is a review by company personnel in the Company’s utilization review section under the direction of or with the assistance of the Company Medical Director.

In the second step, a committee reviews the appeal and makes a decision. Missouri law requires the committee to include an insured member, who is not an employee of the Company.

The examiners asked the Company to provide the names of those individual members who served on each second level appeal committee involved with the second level appeals during the time frame of the examination. Some of the individuals who served in this capacity were not insured by GHP HMO but rather by an affiliated company. The fact that the Company used members of another company's plan does not meet the Missouri appeal process requirements.

References: Sections 354.442, and 376.1385, RSMo, and the Company's filed and used COC provided to its members.

<u>Initials</u>	<u>Plan</u>	<u>Company</u>
F. K.	Advantra Plan	Coventry Health and Life Ins. Co
L. J. S.	Group Health Plan	Group Health Plan, Inc.

GHP Response: GHP respectfully disagrees with the Finding that 376.1385 and 354.442 RSMo have been violated.

With respect to the specific members listed in this Finding, Frances Kuhlman was, in fact, a Group Health Plan, Inc. ("GHP") member, and thus was clearly an appropriate member for the 2nd level appeal committees. With respect to the second member listed in this Finding, Linda J Siebold was in fact a Coventry Health and Life Insurance Company ("CHL") member appointed to sit on GHP appeal committees. GHP serves as the administrative services organization for CHL. Given the relationship between GHP and CHL, the participation of a CHL member on a GHP appeal committee does not violate 376.1385 and 354.442 RSMo.

Further, although GHP has made efforts in the past to recruit GHP members for the GHP 2nd level appeal committee, so as to not use the same members repeatedly or to rely upon CHL members to serve on the appeals' committees, those efforts often have proven fruitless. Such efforts have included a notice in the member newsletter, letters sent directly to GHP members, and the Customer Service Department attempting to recruit members when a member called the Department.

Finally, 376.1385, RSMo sets forth the information GHP must provide to its enrollees. This Finding does not address the requirements of this statute and GHP is not in violation of this law.

IV. FORMAL REQUESTS AND CRITICISMS TIME STUDY

This study is based upon the Company’s ability to provide the examiners with requested material or to respond to criticisms within the 10 calendar day time limit required by Section 374.205.2(2), RSMo, and 20 CSR 300-2.200(5)&(6).

A. Criticism Time Study

<u>Calendar Days</u>	<u>Number of Criticisms</u>	<u>Percentage</u>
0 to 10	24	100.0%
Total	24	100.0%

B. Formal Request Time Study

<u>Calendar Days</u>	<u>Number of Requests</u>	<u>Percentage</u>
0 to 10	74	100.0%
Total	74	100.0%