



DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

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

TO: Office of the President
Mercy Health Plans
14528 South Outer Forty Rd.
Suite 300
Chesterfield, MO 63017-5702

RECEIVED
JUN 21 2010
DEPT. OF INSURANCE,
FINANCIAL INSTITUTIONS &
PROFESSIONAL REGISTRATION

RE: Missouri Market Conduct Examination 0903-11-TGT
Mercy Health Plans of Missouri, Inc. (NAIC #95309)

**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 Mercy Health Plans of Missouri, Inc., 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, Mercy Health Plans of Missouri, Inc., 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 Mercy Health Plans of Missouri, Inc., and prepared report number 0903-11-LAH; and

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

1. In some instances, Mercy Health Plans of Missouri, Inc., improperly denied claims, thereby violating §§160.900, 208.144, and 376.1218.4 and .5, RSMo, and 20 CSR 400-2.170(3)(B), (4)(B), (C)3.C. and (E).

2. In some instances Mercy Health Plans of Missouri, Inc., failed to properly communicate to the claimants the specific reason for its claim denials, in violation of §376.383.9, RSMo.

WHEREAS, Mercy Health Plans of Missouri, Inc., 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. Mercy Health Plans of Missouri, Inc., agrees to take corrective action to assure that the errors noted in the above-referenced market conduct examination reports do not recur;

2. Mercy Health Plans of Missouri, Inc., agrees to review all denied claims dated January 1, 2006, to the date a final Order is entered closing this examination, to assure that the denial of the claim was properly communicated to the claimant, in accordance with §376.383.9, RSMo. If the denial was not properly communicated to the claimant, Mercy Health Plans of Missouri, Inc., agrees to send proper notification of the denial to the claimant with a letter stating that the notice is being sent "as a result of findings from a market conduct examination performed by the Missouri Department of Insurance, Financial Institutions, and Professional Registration." Additionally, evidence should be provided to the Department within 90 days of the date a final Order is entered closing this examination that such notice has been sent to the claimants.

3. Mercy Health Plans of Missouri, Inc., agrees to review all denied claims dated January 1, 2006, to the date a final Order is entered closing this examination, to assure that the claim was properly adjudicated, in accordance with §376.1218, RSMo. If the claim was not properly adjudicated, Mercy Health Plans of Missouri, Inc., agrees to reopen and reprocess the claim. If the claim should have been paid, the Company will issue any payments that are due to the claimant, bearing in mind that an additional payment of one per cent (1%) interest is also required, per §376.384, RSMo, for any delayed payments from the date the claim was first received with a letter stating that the payments are being made "as a result of a Missouri Market Conduct examination." Additionally, evidence should be provided to the Department within 90 days of the date a final Order is entered closing this examination that such notice has been sent to the claimants.

4. Mercy Health Plans of Missouri, Inc., agrees to file documentation of all remedial

actions taken by it to implement compliance with the terms of this Stipulation of Settlement and Voluntary Forfeiture 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 90 days of the entry of a final Order closing this examination.

WHEREAS, Mercy Health Plans of Missouri, Inc., neither admits nor denies the findings or violations set forth above and enumerated in the examination report; and

WHEREAS, Mercy Health Plans of Missouri, Inc., 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, Mercy Health Plans of Missouri, Inc., 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, Mercy Health Plans of Missouri, Inc., hereby agrees to the imposition of an ORDER of the Director as a result of Market Conduct Examination #0903-10-TGT further agrees, voluntarily and knowingly to surrender and forfeit the sum of \$9,700.

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 Mercy Health Plans of Missouri, Inc., to transact the business of insurance in the State of Missouri or the imposition of other sanctions, Mercy Health Plans of Missouri, Inc., does hereby voluntarily and knowingly waive all rights to any hearing, does consent to the ORDER of the Director and does surrender and forfeit the sum of \$9,700, such sum payable to the Missouri State School Fund, in accordance with §374.280, RSMo.

DATED: 7-20-2010



President
Mercy Health Plans



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

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

In re:)
) Examination No. 0903-11-TGT
Mercy Health Plans of Missouri, Inc. (NAIC #95309))

ORDER OF THE DIRECTOR

NOW, on this 30TH day of AUGUST, 2010, Director John M. Huff, after consideration and review of the market conduct examination report of Mercy Health Plans of Missouri, Inc. (NAIC #95309), (hereafter referred to as "the Company") report numbered 0903-11-TGT, prepared and submitted by the Division of Insurance Market Regulation pursuant to §374.205.3(3)(a), RSMo, and the Stipulation of Settlement ("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. 2009), is in the public interest.

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

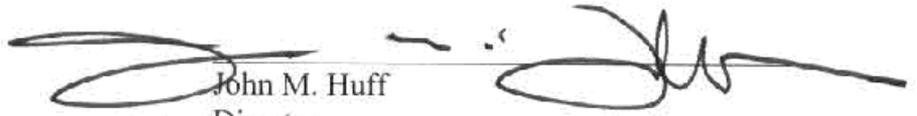
IT IS FURTHER ORDERED that the Company shall not engage in any of the violations of law and regulations set forth in the Stipulation and shall implement procedures to place the Company in full compliance with the requirements in the Stipulation and the statutes and regulations of the State of Missouri and to maintain those corrective actions at all times.

of Missouri and to maintain those corrective actions at all times.

IT IS FURTHER ORDERED that the Company shall pay, and the Department of Insurance, Financial Institutions and Professional Registration, State of Missouri, shall accept, the Voluntary Forfeiture of \$9,700, 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 AUGUST, 2010.


John M. Huff
Director



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



FINAL MARKET CONDUCT EXAMINATION REPORT
Of the Life and Health Business of

Mercy Health Plans of Missouri, Inc
NAIC # 95309

MISSOURI EXAMINATION # 0903-11-TGT

NAIC EXAM TRACKING SYSTEM # MO268-109

August 20, 2010

Home Office
14528 S OUTER 40 RD., SUITE 300
CHESTERFIELD, MO 63017-5705

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VERIFICATION OF WRITTEN REPORT OF EXAMINATION

FOREWORD

This is a targeted market conduct examination report of Mercy Health Plans of Missouri, Inc (NAIC Code # 95309). This examination was conducted at the offices of the Missouri Department of Insurance, Financial Institutions and Professional Registration.

This examination report is generally a report by exception. However, failure to criticize specific practices, procedures, products or files does not constitute approval thereof by the DIFP. During this examination, the examiners cited errors made by the Company. Statutory citations were as of the examination period unless otherwise noted.

When used in this report:

- “Company” refers to Mercy Health Plans of Missouri, Inc;
- “Covansys” refers to Covansys (CSC - Computer Sciences Corporation), the claim designee for the Missouri Department of Elementary and Secondary Education (DESE) as described in 20 CSR 400-2.170(4) (C);
- “CPT” refers to the Current Procedural Terminology codes as published by the American Medical Association and used for standardized billing purposes to describe the services and procedures provided by healthcare professionals;
- “CSR” refers to the Missouri Code of State Regulation;
- “HCPCS” refers to the Healthcare Common Procedure Coding System as published by the federal Centers for Medicare & Medicaid Services (CMS) and is used for standardized billing purposes for of medical services, supplies and equipment;
- “DESE” refers to the Missouri Department of Elementary and Secondary Education;

- “DIFP” refers to the Missouri Department of Insurance, Financial Institutions and Professional Registration;
- “Director” refers to the Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration;
- “First Steps” refers to Missouri’s early intervention system as eligible for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431, et seq and §376.1218 RSMo;
- “NAIC” refers to the National Association of Insurance Commissioners; and
- “RSMo” refers to the Revised Statutes of Missouri.

SCOPE OF EXAMINATION

The DIFP has authority to conduct this examination pursuant to, but not limited to, §§374.110, 374.190, 374.205, 375.445, 375.938, 375.1009, RSMo.

The purpose of this examination was to determine if the Company complied with Missouri statutes and DIFP regulations pursuant to Missouri's First Steps program. The primary period covered by this review is January 1, 2006, through December 31, 2008, unless otherwise noted. Errors outside of this time period discovered during the course of the examination, however, may also be included in the report.

The examination was a targeted examination involving the following business functions and lines of business: Equitable claim payments for Early Childhood Intervention Services, "First Steps."

The examination was conducted in accordance with the standards in the NAIC's *Market Regulation Handbook*. As such, the examiners utilized the benchmark error rate guidelines from the *Market Regulation Handbook* when conducting reviews that applied a general business practice standard. The NAIC benchmark error rate for claims practices is seven percent (7%), for electronically submitted health claims is five percent (5%), and ten percent (10%) for other trade practices. Error rates exceeding these benchmarks are presumed to indicate a general business practice contrary to the law. The benchmark error rates were not utilized, however, for reviews not applying the general business practice standard.

In performing this examination, the examiners only reviewed a sample of the Company's practices, procedures, products and files related to First Steps claims. Therefore, some noncompliant practices, procedures, products and files may not have been discovered. As such, this report may not fully reflect all of the practices and procedures of the Company. As indicated previously, failure to identify or criticize improper or noncompliant business practices in this state or other jurisdictions does not constitute acceptance of such practices.

COMPANY PROFILE

The Company is licensed by the DIFP under Chapter 354, RSMo, to write Health Maintenance Organization (HMO) business as set forth in its Certificate of Authority. The following information was obtained by the examiners from the Company's web site at:

<http://www.mercyhealthplans.com/about/default.aspx>

“Rooted in the mission of Jesus and the healing ministry of the Church, and faithful to Catherine McAuley's service tradition marked by justice, excellence, stewardship and respect for the dignity of each person, Mercy Health Plans, a member of the Sisters of Mercy Health System, implements and advocates for innovative health and social services to improve the health and quality of life of the communities served, with particular concern for persons who are economically poor. In doing so, we make a difference by touching the lives of those we serve with compassion and exceptional Mercy service.

As part of the Mercy Health Ministry, we honor our Catholic identity and remain faithful to the Church's moral and religious teachings.”

EXECUTIVE SUMMARY

The DIFP conducted a targeted market conduct examination of 14 insurance companies providing First Steps benefits. For Mercy Health Plans of Missouri, the examiners found the following principal areas of concern:

- The Company improperly denied 169 First Steps claims.
- The overall error ratio was 12%.

The insurance coverage mandate for First Steps began on January 1, 2006. This is the first examination targeting First Steps benefits and claim payments.

Examiners requested that the Company make refunds concerning claim underpayments found for amounts greater than \$5.00 during the examination. The Company is directed to take immediate corrective action to demonstrate its ability and intention to conduct business according to the Missouri insurance laws and regulations. When applicable, corrective action for other jurisdictions should be addressed.

This market conduct examination was performed as a desk audit at the DIFP offices:

HST State Office Building
301 W. High Street
Jefferson City, MO 65101

EXAMINATION FINDINGS

I. UNDERWRITING AND RATING PRACTICES

The examiners reviewed the Company's forms filed by or on behalf of the Company with the DIFP.

An error can include, but is not limited to, any miscalculation of the premium based on the information in the file, an improper acceptance or rejection of an application, the misapplication of the Company's underwriting guidelines, incomplete file information preventing the examiners from readily ascertaining the Company's rating and underwriting practices, and any other activity indicating a failure to comply with Missouri statutes and regulations.

A. Forms and Filings

The examiners reviewed the Company's policy and contract forms to determine its compliance with filing, approval, and content requirements to ensure that the contract language is not ambiguous or misleading and is adequate to protect those insured.

The examiners discovered no issues or concerns.

II. CLAIMS PRACTICES

This section of the report is designed to provide a review of the Company's claims handling practices. Examiners reviewed how the Company handled claims to determine the timeliness of handling, accuracy of payment, adherence to contract provisions, and compliance with Missouri statutes and regulations.

To minimize the duration of the examination, while still achieving an accurate evaluation of claim practices, the examiners reviewed a sampling of the claims processed. The examiners requested a listing of claims paid and claims closed without payment during the examination period for the line of business under review. The review consisted of claims from First Steps providers with a date of closing from January 1, 2006, through December 31, 2008.

A. Unfair Settlement and General Handling Practices

Examiners reviewed the Company's claim handling processes to determine compliance with contract provisions, adherence to unfair claims statutes and regulations and compliance with First Steps statutes and regulations. Whenever a claim file reflected that the Company failed to meet these standards, the examiners cited the Company for noncompliance.

The examiners reviewed denied claims for adherence to Missouri's First Steps mandated benefit. For the following reviews the examiners eliminated claims that were subsequently paid and those that did not involved the parameters specified. They reviewed records to determine that the Company's claims process is fair, reasonable, prompt and equitable according to the laws and regulations of Missouri.

The examiners asked for the computer processing specifications that control the requirements and payment levels for handling claims. The Company provided information and contracts related to claims clearinghouses and claim processing procedures.

Field Size:	1,091 total 706 claims incurred pre-8/28/2007 385 claims incurred post-8/28/2007
Number of Errors:	133 total 97 claims incurred pre-8/28/2007 36 claims incurred pre-8/28/2007
Percent of Errors:	12% overall 13% of claims incurred pre-8/28/2007 9% of claims incurred pre-8/28/2007
Within Dept. Guidelines:	No

The examiners noted the following exceptions during their review:

1. Improperly Denied Claims

A. Files indicate that the Company wrongfully denied claims that, according to reasons provided by Company, were improperly coded. These claims contained a denial code of “AA030,” “XSERV,” and “NPOS.” The codes represent “Separate procedure-payment included with major service”, “Possible excluded service. Requires review” and “After med review no medical necessity indicated.” Such codes represent a determination of medical necessity or diagnosis.

Reference: §376.1218.4, RSMo, and 20 CSR 400-2.170(4)(C)3.C

The 62 claims applicable to this error are found in Appendix A. The claims containing these denial codes have been re-processed and paid by the Company

B. Files indicate that the Company wrongfully denied claims that, according to reasons provided by Company, were improperly coded. These claims contained a denial code of “OONC.” This code represents “Out-of-network services must be prior authorized.” Such a code represents a participating provider other than First Steps.

Reference: §376.1218.4, RSMo, and 20 CSR 400-2.170(3).

The 36 claims applicable to this error are found in Appendix A. The claims containing these denial codes have been re-processed and paid by the Company. and are not counted in the error ratio.

- C. The Company underwent a change in their claims system during the examination period. Files indicate that the Company denied claims because of “claims check edits: 801, 828, 826, 829, 809” and 203. The Company indicates that “claim check edits” are not specific to any denial of service or benefit. The Company stated “these edits will be disabled and the claims will be reprocessed and paid.”

Reference: §§ 376.383.9, 376.1218.5, RSMo, and 20 CSR 400-2.170(4)(B)

The 64 claims applicable to this error are found in Appendix B. The Company has re-adjudicated the claims as stated.

- D. Examiners discovered that payments for seven claim files were wrongfully denied because the Company felt the charges exceeded the First Steps provider Medicaid rate published by DESE or because the CPT or HCPCS code was not disclosed or priced by DESE. The Company initially denied such claims with a code of 809, 150 or CODES to describe the non-payment of CPT “E1399” or certain HCPCS “L” codes. Therefore, the Company did not pay these claims at the applicable Medicaid Rate.

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

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

The seven claims applicable to this error are found in Appendix C. These claims have been re-processed and paid by the Company.

III. CRITICISMS AND FORMAL REQUESTS TIME STUDY

This study is based upon the time required by the Company to provide the examiners with the requested material or to respond to criticisms. Missouri law requires companies to respond to criticisms and formal requests within 10 calendar days. Please note that in the event an extension was requested by the Company and granted by the examiners, the response was deemed timely if it was received within the time frame granted by the examiners. If the response was not received within that time period, the response was not considered timely.

A. Criticism Time Study

<u>Calendar Days</u>	<u>Number of Criticisms</u>	<u>Percentage</u>
Received w/in time-limit, incl. any extensions	1	100%
Received outside time-limit, incl. any extensions	0	0 %
<u>No Response</u>	<u>0</u>	<u>0%</u>
Total	1	100 %

Reference: §374.205.2(2), RSMo, and 20 CSR 100-8.040

B. Formal Request Time Study

<u>Calendar Days</u>	<u>Number of Requests</u>	<u>Percentage</u>
Received w/in time-limit, incl. any extensions	7	100%
Received outside time-limit, incl. any extensions	0	0 %
<u>No Response</u>	<u>0</u>	<u>0%</u>
Total	7	100 %

Reference: §374.205.2(2), RSMo, and 20 CSR 100-8.040

EXAMINATION REPORT SUBMISSION

Attached hereto is the Division of Insurance Market Regulation's Final Report of the examination of Mercy Health Plans of Missouri, Inc. (NAIC #95309), Examination Number 0903-10-TGT. This examination was conducted by John S. Korte, E. Jack Baldwin, John T. Clubb, Mike Woolbright, and David Pierce. The findings in the Final Report were extracted from the Market Conduct Examiner's Draft Report, dated May 27, 2010. Any changes from the text of the Market Conduct Examiner's Draft Report reflected in this Final Report were made by the Chief Market Conduct Examiner or with the Chief Market Conduct Examiner's approval. This Final Report has been reviewed and approved by the undersigned.

Jim Mealer	Date
Chief Market Conduct Examiner	



June 17, 2010

Carolyn H. Kerr
Senior Counsel
Market Conduct Section
Missouri Department of Insurance
301 West High Street, Room 530
Jefferson City, MO 65102-0690

RE: Missouri Market Conduct Examination #0903-11-TGT
Mercy Health Plans of Missouri, Inc. (NAIC #95309)

Dear Ms. Kerr:

This letter is Mercy Health Plans of Missouri's (MHP) formal response to the draft market conduct examination report dated May 27, 2010 submitted by Jim Mealer. I will respond to the findings in that draft market conduct examination report in the order presented in the report.

I. UNDERWRITING AND RATING PRACTICES

A. Forms and Filings

MHP acknowledges that the examiners found no issues or concerns with MHP's policy and contract forms in regard to compliance with filing, approval and content requirements.

II. CLAIMS PRACTICES

A. Unfair Settlement and General Handling Practices

1. Improperly Denied Claims

A. MHP acknowledges that the percentage of errors at 12% were outside of department guidelines. Also, MHP recognizes the 62 claims found to be in error by the examiners have been re-processed and paid.

B. MHP acknowledges that the 36 denied claims found by the examiners to be in error regarding the denial code of “OONC” (representing out-of-network claims) have been re-processed and paid.

C. MHP acknowledges that the 64 claims denied due to claim check edits 801, 828, 826, 829, 809 and 203 have been re-processed and paid and that MHP has disabled the claims check edits to ensure similar denials will not occur in the future.

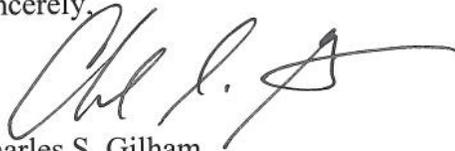
D. MHP recognizes that the 7 claims found to be in error by the examiners have been re-processed and paid. However, the company reiterates its objection to the examiner’s findings that the claims or services that were not listed or priced by DESE constituted an error on part of MHP. When there is no applicable CPT, HCPCS code or fee per unit of service published by DESE, or Medicaid rate in existence, it seems reasonable that MHP would interpret these as not covered by DESE and not covered per 376.1218 RSMo. Despite MHP’s objection, MHP did reprocess and pay these claims at issue.

III. CRITICISMS AND FORMAL REQUESTS TIME STUDY

MHP recognizes that 100% of MHP responses were within the statutory time frames for both the Criticisms Time Study and Formal Request Time Study.

Finally, MHP acknowledges and appreciates the comment by Mr. Korte that he appreciated the “courteous cooperation” of the officers and employees of MHP during this audit.

Sincerely,



Charles S. Gilham
Vice President – Counsel
Mercy Health Plans

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