MARKET CONDUCT EXAMINATION

OF THE

PHYSICIANS HEALTH SERVICES OF NEW JERSEY, INC.

LOCATED IN

NEPTUNE, NEW JERSEY

AS OF

NOVEMBER 9, 2000

BY EXAMINERS OF

OF THE

STATE OF NEW JERSEY

DEPARTMENT OF BANKING AND INSURANCE

DIVISION OF ENFORCEMENT AND CONSUMER PROTECTION

MARKET CONDUCT EXAMINATION UNIT

DATE REPORT ADOPTED:

JANUARY 2, 2003

PHYSICIANS HEALTH SERVICES OF NEW JERSEY, INC.

MARKET CONDUCT EXAMINATION REPORT

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I. INTRODUCTION

This is a report of the Market Conduct activities of Physicians Health Services of New Jersey, Inc. (hereinafter referred to as PHS or the Company). In this report, examiners of the New Jersey Department of Banking and Insurance (NJDBI) present their findings, conclusions and recommendations as a result of their market conduct examination. The Market Conduct Examiners were Marleen Sheridan, Examiner-in-Charge, Dean Turner, Judy Suarez and Thomas Goehrig.

A. SCOPE OF EXAMINATION

The scope of the examination included HMO coverage sold in New Jersey. The examiners evaluated the Company's compliance with certain market conduct-related provisions of the Health Maintenance Organization's laws and regulations. The review period for the examination was July 1, 1999 to November 9, 2000. The examiners completed their field work at the Company's Neptune, New Jersey office on various dates between August 14, 2000 and November 9, 2000. On various dates thereafter, the examiners completed additional review work and the writing of the report.

The examiners randomly selected files and records from computer listings and documents provided by the Company. The random selection process is in accordance with the National Association of Insurance Commissioner's Market Conduct Examiners' Handbook. In addition, the examiners used the NAIC Handbook, Chapter VIII-Conducting the Health Examination as a guide to write this report.

B. ERROR RATIOS

Error ratios are the percentage of files which the examiners found to be handled in error. Each file either mishandled or not handled in accordance with applicable state statutes or regulations is an error. Even though a file may contain multiple errors, the examiners counted the file only once in calculating the error ratios; however, any file that contains more than one error will be cited more than once in the report. In the event that the Company corrected an error as a result of a consumer complaint or due to the examiners' findings, the error is included in the error ratio. If the Company corrects an error independent of a complaint or NJDBI intervention, the error is not included in the error ratios.

For the purpose of the computer analyses conducted, the examiners define an exception as a file or record in a database that does not meet specified criteria as set forth in computer queries. The file or record has not been reviewed in depth by an examiner.

Many of the statutes and/or regulations cited in this report define unfair practices or practices in general as specific acts that a carrier commits so frequently that it constitutes an improper general business practice. Whenever the examiners found that the errors cited constitute an improper general business practice, they have stated this in the report that follows.

The examiners sometimes find improper general business practices or errors that may be technical in nature or which did not have an impact on a consumer. Even though such errors or practices would not be in compliance with law, the examiners do not count each of these files as an error in determining error ratios. Whenever such business practices or errors do have an impact on an enrollee or provider, each of the files in error will be counted in the error ratio. The examiners indicate in the report that follows whenever they did not count particular files in the error ratio.

The examiners submitted written inquiries to Company representatives on the errors cited in this report. This provided PHS with the opportunity to respond to the examiners' findings and to provide exception to the statutory and/or regulatory errors or mishandling of files reported herein. In response to these inquiries, PHS agreed with some of the errors cited in this report. On those errors with which the Company disagreed, the examiners evaluated the individual merits of each response and gave due consideration to all comments. In some instances, the examiners did not cite the files due to the Company's explanatory responses. In others, the errors remained as cited in the examiners' inquiries. The examiners also reviewed PHS' response to the draft report and either retained, removed or amended errors as warranted. For the most part, this is a report by exception.

C. COMPANY PROFILE

First Option Health Plan of New Jersey formed in May 1993 and received its Certificate of Authority (COA) to operate as a health maintenance organization in New Jersey in June 1994. Physicians Health Services of New Jersey, Inc. (PHS) received its COA to operate as an HMO in New Jersey in January 1996. On January 1, 1999, PHS merged with First Option Health Plans of New Jersey (FOHP). In connection with the merger, First Option changed its name to Physicians Health Services of New Jersey, Inc. Subsequently, PHS changed its name to HealthNet of New Jersey, Inc., effective November 29, 2001. The company's managed care products include group and individual policies, offering various levels of benefits.

PHS has contracted with The Guardian Life Insurance Company of America to reinsure the out-of-network benefit of PHS's point of service products. In addition, the company cedes 50% of HMO/POS in-network business to Guardian. Since Guardian is an admitted insurer for the out-of-network portion of the business, PHS is allowed to offer point of service products to its members under this arrangement. In addition to its in-house claims processing system, PHS utilized two vendors (MHN and Landmark) to process claims.

II. COMPLAINT AND UTILIZATION APPEAL REVIEW

A. INTRODUCTION

The examiners evaluated PHS' complaint handling and utilization management appeals procedures and checked for compliance with applicable laws such as N.J.S.A. 26:2J-1 et seq., N.J.S.A. 26:2S-1 et seq., N.J.S.A. 17B:30-13.1 et seq., and N.J.A.C. 8:38-1 et seq. These laws set forth requirements for the proper recording of appeals and complaints, their resolution, and timeliness in responding.

During the period July 1, 1999 through June 30, 2000, PHS received 389 utilization management appeal files, 273 complaints from the Department of Banking and Insurance (DOBI) and 2,446 non-DOBI complaints. The examiners excluded from their examination complaints that were not subject to DOBI's jurisdiction or were outside of the review period. From the remaining population, they reviewed 92 complaints and 47 utilization appeal files that they randomly selected from records maintained by the company.

B. ERROR RATIOS

The examiners calculated the error ratios by applying the procedure outlined in the introduction of this report. The following chart is a breakdown of complaint and utilization files found in error:

Type of Review	Files Reviewed	Files in Error	Error Ratio
Utilization Management Appeals	47	31	66%
Non-DOBI Complaints	55	41	75%
DOBI Complaints	37	19	51%
Total	139	91	65%

Database Reviews	Records Reviewed	Exceptions	Error Ratio
Non-DOBI Complaints	2,412	1,490	62%
DOBI Complaints	255	179	70%

C. COMPLAINT HANDLING ERRORS

1. Failure to Respond to Non-DOBI Complaints in a Timely Manner – 29 random errors – 67 register errors – 1,490 Database Exceptions - Improper General Business Practice

N.J.S.A. 26:2J-12a(1) requires companies to establish and maintain a complaint system to provide reasonable procedures for the resolution of written complaints initiated by enrollees concerning health care services. N.J.S.A. 17B:30-13.1(b) requires responses to claim-related communications to be reasonably prompt. In addition, N.J.A.C. 8:38-3.7(a)4 requires a 30-day turnaround for complaint responses. This is related to the NAIC Handbook standard four for complaint handling, which reads "the time frame within which the company responds to complaints (should be) in accordance with the applicable statutes, rules and regulations." Contrary to these laws, PHS did not provide its response within the required timeframe on 29 complaints.

PLEASE SEE APPENDIX A1 FOR FILES IN ERROR

In addition, PHS' non-DOBI complaint register did not contain the date of its response for 67 subscriber complaints. PHS responded to an inquiry that these complaints were not resolved as of July 26, 2000, the date it produced the log in response to the examination call letter. The examiners found delays ranging in error from 11 days to 328 days beyond the allowed 30-day time frame. In response to examiners' inquiries, the company agreed with these findings.

The examiners conducted a database review of all 2,412 non-DOBI complaints received by PHS to determine its compliance with the aforementioned statutes and regulation. On 1,490 of these complaints, the examiners found that PHS did not respond within the required 30 days allowed by law. Therefore, the company's delay in responding to complaints constitutes an improper general business practice due to the high exception ratio of 62% and the high random error ratio of 53%.

2. Delayed Response to Department of Banking and Insurance Complaints – 18 random errors (16 Claim and 2 Non-Claim) – 17 register errors – 179 Database Exceptions - Improper General Business Practice

N.J.A.C. 8:38-13.5(a) states that "HMO's shall be subject to all of the provisions of the Trade Practice Act, N.J.S.A. 17B:30-1 et seq., any amendments thereto, and all rules promulgated thereunder, except to the extent that HMO's have been specifically excluded by reference from a provision of the applicable statutes or rules." N.J.A.C. 11:2-17.6(d) was promulgated under the Trade Practice Act and made applicable to HMO's under N.J.A.C. 8:38-13.5(a). This regulation requires companies to provide complete and accurate responses within 15 working days to claim related inquiries from the NJDBI. In addition, N.J.S.A. 17:23-1 specifies that the Commissioner may address any inquiries to a company on any matter, and that a prompt reply shall be made in writing. The 15 working day response period outlined in N.J.A.C. 11:2-17.6(d) sets a reasonable response standard for complaints that are not claim related. Also, Standard four in the complaint handling section of the NAIC Market Conduct Handbook states that

"the time frame within which the company responds to complaints should be in accordance with applicable statutes, rules and regulations." Contrary to N.J.A.C. 11:2-17.6(d), PHS failed to respond to the Department within the required timeframe on 16 claim complaints. Contrary to N.J.S.A. 17:23-1, PHS failed to respond to the Department within a reasonably prompt time frame of 15 working days on two non-claim complaints.

PLEASE SEE APPENDIX A2 FOR FILES IN ERROR

Additionally, PHS' DOBI complaint registers failed to contain the date of the company's response for 17 complaints. The company advised the examiners that as of July 26, 2000, it had not resolved these inquiries from the Department. PHS produced the logs in response to the examination call letter on that date. The delays ranged in error from 5 working days to 222 working days beyond the 15-days allowed by regulation. In response to examiners' inquiries, the company agreed with these findings.

The examiners conducted a database review of all 255 DOBI complaints and found that 179 of these complaints were not in compliance with N.J.A.C. 11:2-17.6(d) and N.J.S.A. 17:23-1, which require a 15 day turnaround. Seventy percent of the files and records reviewed revealed that PHS failed to respond promptly to NJDOBI complaints. The examiners found this error to be an improper general business practice on Department of Banking and Insurance complaints due to the high exception/error ratios.

3. Failure to Respond to Stage 1 Utilization Management Appeals within Required Time Frame – 22 random errors – Improper General Business Practice

Pursuant to N.J.A.C. 8:38-8.5, an HMO shall establish and maintain an informal internal appeal process (stage 1 appeal) whereby any member, or any provider acting on the behalf of a member, who is dissatisfied with an adverse medical necessity determination, shall have the opportunity to discuss and appeal that determination. All Stage 1 appeals shall be concluded within 72 hours with regard to urgent or emergency care, or five business days in the case of all other appeals. PHS handled 22 Stage 1 appeals, requiring a five-business day turnaround time, contrary to N.J.A.C. 8:38-8.5. The delayed responses ranged in error from 1 day to 157 days, averaging a 20-day turnaround. The examiners' findings constitute an improper general business practice due to the high error ratio of 47%. The company agreed with the examiners' findings during the field examination. In response to the draft report, however, PHS disagreed with several of these same errors but, did not provide any documentation to support its position.

PLEASE SEE APPENDIX A3 FOR FILES IN ERROR

4. Failure to Effectively Communicate to Members their Right to Proceed to a Stage 2 Appeal – 9 random errors – Improper General Business Practice

The examiners review of nine stage 1 denial letters, noted below, revealed the content of these letters to be generic in nature and do not effectively advise members of their right to proceed to a stage 2 utilization management appeal, pursuant to N.J.A.C.

8:38-8.5. This regulation states that, "if the (stage 1) appeal is not resolved to the satisfaction of the member at this level, the HMO shall provide the member and/or the provider with a written explanation of his or her right to proceed to a stage 2 appeal. The denial letter does not mention the term "stage 2," therefore failing to bring to the attention of the member his or her rights under this appeal which are enunciated in this section.

In addition, PHS' stage 1 denial letter requires the submission of pertinent medical records with a further appeal, but N.J.A.C. 8:38-8.5 does not require the submission of same in order to file a stage 2 utilization management appeal. The company's request for medical records at this stage may be construed as a deterrent to keep the member from pursuing the next level. The examiners cited this error as an improper general business practice as it occurred on all of the company's denial letters for stage 1 appeals. In response to an inquiry, PHS agreed with these findings and provided the examiners with a revised appeal response letter, which conforms to N.J.A.C. 8:38-8.5. The files in error are as follows:

File Number	File Number	File Number
6428	15250	2793
31711	32207	16151
34791	5752	7523

5. Failure to Maintain an Accurate and Complete Complaint Log – 65 random errors – 24 Register errors

N.J.S.A. 17B:30-13.2 requires the complaint record to indicate the nature of each complaint, the disposition of these complaints, and the time it took to process each complaint. The statute defines complaint as any written communication primarily expressing a grievance; hence complaints include utilization management appeals. Also, this statute is relative to Standard one of the complaint handling section of the NAIC Handbook, which reads "all complaints are recorded in the required format on the company complaint register. In addition, Standard two of the grievance procedures section of the Handbook which states that the "health carrier documents grievances and establishes and maintains grievance procedures…" is applicable to appeals. Contrary to N.J.S.A. 17B:30-13.2, PHS neither recorded the nature of the complaint for one file nor accurate dates for 41 complaints and 14 stage 1 appeal files reviewed by the examiners. In addition, the examiners' review of seven stage 2 appeal files revealed that the company's utilization management appeal log does not contain columns to record the stage 2 appeals process. PHS' inaccurate recording of the receipt and /or response date and its failure to include columns for stage 2 appeals precludes the ability to measure the time taken to process these matters.

The examiners also found that the company erroneously recorded the date of the Department of Banking and Insurance's complaint inquiry to the company as the receipt date. The dates of these letters may not reflect the actual receipt date. The utilization

appeal log does not record the actual receipt date of the stage 1 appeal. These inaccurate recordings caused the record to reflect incorrectly the time taken to process each complaint or appeal.

PLEASE SEE APPENDIX A4 FOR FILES IN ERROR

In addition, the company's complaint and utilization registers contained 24 errors. The examiners' review of PHS' DOBI registers found the following deficiencies on 24 complaints: its year 1999 log did not contain the nature of one complaint and the disposition was not noted on two complaints. The year 2000 log did not provide the nature of the complaint on 17 DOBI complaints, the disposition on two and the receipt date of two. PHS disagreed with this finding, stating that "it is not unreasonable or contrary to the above cite [N.J.S.A. 17B:30-13.2] to utilize solely the complaint date"… [instead of the receipt date]. The company's failure to record the complaint receipt date invalidates the complaint register because the correct or actual complaint processing time cannot be established. The examiners also found deficiencies in the company's complaint log design. For example, the utilization management appeals register does not contain designated columns to record the stage 2 appeals process. In response to an inquiry, PHS stated that, "the database used by the Plan does in fact track the Stage 2 appeals process. The database includes a field that identifies the stage of any particular appeal." PHS supplied the examiners with two utilization management databases for review. The examiners noted that neither database contained a column that identifies stage 2 appeals, let alone the status of the appeal. The examiners did not count the log design errors in the error ratio.

6. Failure to Provide an Appropriate Response to a Written Complaint – 16 random errors

N.J.S.A. 26:2J-12a(1) requires a company to provide reasonable procedures for the resolution of written complaints. N.J.A.C. 8:38-3.7(a)6 requires follow-up action to inform the complainant of the resolution of the complaint. This is relative to Standard number three of the complaint handling section of the NAIC Market Conduct Handbook which states, "the company should take adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules, regulations and contract language." In addition, Standard number two of the NAIC Handbook states that the examiners should verify that the company has adequate complaint handling procedures in place and communicates such procedures to policyholders. Furthermore, the company's own procedure manual requires all responses to be in writing. The examiners found that PHS responded to 16 written claim complaints by telephone, rather than in writing. The company advised the examiners that, "if, through a grievance, a PHS coverage decision is overturned, the member is notified telephonically (such notification is documented), the claim is paid and the member receives a written Explanation of Benefits indicating such."

Since it is PHS' position that the Explanation of Benefits (EOB) forms the basis of the complaint response in cases where an adjusted payment is made, the examiners requested that the company provide them with the EOB's. The examiners clarified that the Explanation of Benefits must be clear on its terms that it is part of the complaint process. However, PHS did not provide the examiners with copies of these 16 EOB's for

review stating that "it is very difficult to reproduce copies…" The examiners believe an EOB does not adequately respond to a grievance as its purpose is to define benefits, deductibles, and the application of co-payments, if applicable. A better practice would have been for PHS to provide a written response to each of the 16 written complaints instead of replying by telephone.

PLEASE SEE APPENDIX A5 FOR FILES IN ERROR

7. Failure to Maintain Pertinent Communication – 5 random errors

N.J.A.C. 8:38-2.12(a) states that documents required in the complaint and appeal system, N.J.A.C. 8:38-3.7, are subject to examination. N.J.A.C. 8:38-3.7(a)2 requires every HMO to establish and maintain a system to record and document the status of all complaints, which shall be maintained for at least three years. In addition, N.J.A.C. 11:2-17.12(c) requires that every carrier shall maintain records of all pertinent communication relating to a claim. This is related to Standard three in the complaint handling section of the NAIC Market Conduct Handbook which requires the company to take adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations. PHS' inability to provide the examiners with pertinent file documentation on the following five complaints prevented the examiners from reviewing the file to determine whether the company handled it properly and whether its record of complaints was accurate. The company agreed with this finding, stating, "we are about to switch to a digital imaging system which will allow documents to be scanned. This will greatly increase our ability to locate old files in the future."

File/DBI#	Missing Documentation
21129 (c)	Complete file
16657	Complete file
00-30437(c)	Company response
33412 (c)	Company response
17566	Subscriber's complaint letter

(c) denotes a claim complaint

8. Failure to Advise Provider of Right to Pursue Stage 2 Appeal – 2 random errors

In subscriber files 18872 and 41730, the examiners found two stage 1 denial letters to providers that did not advise them of their right to proceed to a stage 2 appeal. PHS informed the examiners that, "at the time these letters were written, the company did not interpret N.J.A.C. 8:38-8.5 as pertaining to provider grievances when the services had already been rendered and there was no member liability." Although providers in order to continue an appeal must be acting on behalf of the member with the member's consent, N.J.A.C. 8:38-8.4(a) clearly states that "…providers shall be provided with a written explanation of the appeal process…upon the conclusion of each stage in the process as

described in N.J.A.C. 8:38-8.5 through 8.7." Pursuant to N.J.A.C. 8:38-8.4(b), "nothing in the HMO's policies, procedures or provider agreement shall prohibit a member or provider (on behalf of a member) from …exercising the right to an appeal available under N.J.A.C. 8:38-8.5 through 8.7." Whether there is or is not a financial obligation of the member is irrelevant to this process. Therefore, PHS' denial letter to the provider must state that the provider has the right to the Utilization Management appeal process as outlined in N.J.A.C. 8:38-8 if they are acting on behalf of the member with the member's consent. As a result of recommendations from the Department of Banking and Insurance, PHS informed the examiners that it revised its procedure and began offering stage 2 appeals as of June 26, 2000.

9. Miscellaneous Errors – 4 random errors

a. N.J.A.C. 8:38-8.6(c) states that "all such stage 2 appeals shall be acknowledged by the HMO, in writing, to the member or provider filing the appeal within 10 business days of receipt." The review of the file for subscriber 19163 revealed that PHS failed to acknowledge in writing the stage 2 appeal, contrary to N.J.A.C. 8:38-8.6(c).

b. N.J.S.A. 26:2J-18b requires HMO's to submit its records for examinations. N.J.A.C. 8:38-2.12(a) states that an examination may include the review of documents and patient records. In addition, N.J.S.A. 17B:30-16 enables the examiners to investigate the affairs of any individual to determine whether they are engaged in unfair trade practices. On utilization management appeal file 2793, PHS altered pertinent clinical documents by blacking out areas and obscuring data. This file was not handled in conformity with the statutes and regulation cited because the company provided the examiners with censored documents. PHS stated that the nurse processing this case erred in blinding the original documents sent to an external consultant for review instead of a copy.

c. Pursuant to N.J.A.C. 8:38-3.7(a)7, every HMO's general complaint systems must, at a minimum, incorporate procedures for notifying the continuous quality improvement program of all valid complaints related to quality of care. This regulation is relative to Standard two of the complaint handling section of the Market Conduct Handbook, which reads "the company has adequate complaint handling procedures in place and communicates such procedures to policyholders. PHS received a claim complaint from subscriber 6643 regarding ambulance transportation from one hospital to another. Although the subscriber complained about the denial of this claim, his letter brought up the issue of quality of care. PHS' Appeals and Grievances Department failed to notify its Quality Improvement Unit as required by the aforementioned regulation.

d. N.J.S.A. 26:2J-12a(1) requires every health maintenance organization to establish and maintain a complaint system that provides reasonable procedures for the resolution of written complaints initiated by enrollees concerning health care services. This statute is relative to Standard two of the complaint handling section of the NAIC Handbook, which states that, "the company (should have) adequate complaint handling procedures in place." PHS received a complaint from a provider on behalf of subscriber

17426 with the member's consent, regarding a denied claim. The company responded to the member only. PHS' lack of communication with the complainant caused the complainant to write twice to the President of the company. In neither case did PHS respond to the complainant with a copy of its response. The company did not use reasonable procedures in resolving this complaint, contrary to the aforementioned statute. In reply to an inquiry, PHS stated that it responded to the member because the provider was out of network. The company agreed with this finding, and advised the examiners that its "current policy …(will be) … to respond to the complainant and to copy the member on the response."

D. Other Findings

1. Complaint System

N.J.A.C. 8:38-3.7(a) 2 requires an HMO to establish a system to record and document the status of all complaints, which shall be maintained for a least three years. PHS provided the examiners with a computer run of its complaint system which recorded the status of all complaints for the past three years.

E. Summary

The examiners reviewed 92 complaint files and 47 utilization appeal files and found 91 files in error for an error ratio of 65%. The examiners found four Improper General Business Practices: failure to respond to direct complaints timely, delayed response to DOBI complaints, failure to respond to stage 1 utilization management appeals timely and failure to effectively communicate to members of their right to proceed to a stage 2 appeal. Additional findings included: failure to maintain an accurate and complete complaint log and failure to provide an appropriate response to a written complaint.

III. CLAIM HANDLING

A. INTRODUCTION

The examiners manually reviewed 287 claims submitted under health insurance policies during the period July 1, 1999 through June 30, 2000. In that time frame, PHS processed 3,756,751 claims; this number included 2,393,825 paid and 1,362,926 denied claims. In arriving at these populations, the examiners excluded Medicare and Medicaid claims, and self-funded plans organized under ERISA. The examiners selected random samples from computer runs supplied by the Company. The distribution of errors from these samples is reflected in the chart below.

The examiners also performed a computer analysis of the claim population to verify compliance with statutory and regulatory guidelines. This analysis also reflects totals from July 1, 1999 to June 30, 2000.

In reviewing claims, the examiners checked for compliance with statutes and regulations which govern the handling of claims, particularly N.J.S.A. 26:2J-1 et seq. (the Health Maintenance Organization Act), N.J.S.A. 17B:30-13.1 (the Unfair Claim Settlement Practices Act), N.J.A.C. 11:2-17 et. seq. (Unfair Claim Settlement Practices), N.J.A.C. 8:38-1 et seq. (Health Maintenance Organizations) and N.J.A.C. 11:4-28 (coordination of benefits).

B. ERROR RATIOS

The examiners calculated the error ratios by applying the procedure outlined in the introduction of this report. The following charts outline the examiners' findings based on several different review types. The first and second charts (identified as Random Sample Review – Paid and Denied by Year and Random Sample Review – Delayed Paid and Retroactive Denials by Year) summarize errors that reflect the entire scope of this review, including prompt pay, interest payments where applicable, improper denials, etc. These errors are discussed in detail in sections C and D of this report. The remaining charts in the error ratio section, numbered 3 through 6, itemize the examiners' findings based solely on prompt pay reviews conducted on the entire population of clean claims that the company processed during the review period. These charts itemize settlement time frames for in-house and vendor claims submitted electronically and by regular mail.

1. RANDOM SAMPLE REVIEW – PAID AND DENIED BY YEAR

	Files Reviewed	Files In Error	Error Ratio
2000 Paid Claims	84	0	--
1999 Paid Claims	14	1	7%
Paid Subtotal	98	1	1%
2000 Denied Claims	90	21	23%
1999 Denied Claims	7	1	14%
Denied Subtotal	97	22	23%
Random Totals	195	23	12%

As itemized in the chart above, the examiners found a total of 23 claims in error, for an error ratio of 12%. The results of this review indicate a denied error ratio of 23% for claims denied in 2000 and 14% for claims denied in 1999, for a combined overall denial error ratio of 23%. The examiners found no errors for claims paid in 2000, and a 7% error ratio for claims paid in 1999, for a combined overall paid error ratio of 1%. The combined error ratio disparity of 23% for denied claims and 1% for paid claims indicates a significant disparity in PHS' claim settlement methodology for paid and denied claims. The files in error are identified in sections C and D of the report that follow.

2. SELECT SAMPLE REVIEW – DELAYED PAID AND RETROACTIVE DENIALS BY YEAR

	Files Reviewed	Number of Errors	Error Ratio
Select Reviews:			
2000 Delayed Paid Claims	30	13	43%
1999 Delayed Paid Claims	25	13	52%
2000 Retroactive Denials	21	5	24%
1999 Retroactive Denials	16	7	44%
	92	38	41%

For this review, the examiners selected claims that the company paid beyond the required timeframes to determine if PHS pays interest on overdue claims. In addition, they selected claims that appeared to be denied retroactively. These claims involved covered services that PHS authorized prior to the provider administering the service, but then later denied the claim when the provider submitted the charges for payment. As the above chart indicates, the examiners found 38 claims in error for an error ratio of 41% from this select sample. This review shows a 43% error ratio for delayed paid claims in 2000 and 52% for delayed claim payments in 1999. This 9% difference indicates that PHS improved somewhat in the handling of delayed claim payments from 1999 to 2000. In addition, the examiners found a 24% error ratio for claims denied retroactively in 2000

and a 44% error ratio for claims retroactively denied in 1999. This 20% difference shows that PHS has improved significantly in its treatment of retroactively denied claims. The errors are identified in section III.C of this report.

3. POPULATION REVIEW, ELECTRONIC PAID CLAIMS (PROMPT PAY)

Claims System	Claim Population	Number Exceptions	Exception Ratio
In-house	672,751	17,243	3%
Vendors:			
MHN	133	1	<1%
Landmark	209	2	<1%
Vendor subtotals	342	3	<1%
Overall Totals	673,093	17,246	3%

The examiners queried the entire population of electronically submitted paid claims that PHS and its vendors processed during the examination period (July 1, 1999 through June 30, 2000). As noted above, the exception rate on PHS's in-house claim processing system was 3%. The examiners discovered an exception rate of less than 1% on those claims processed by PHS's two vendors, MHN and Landmark. The exception rate for each vendor was also less than 1%. Including both in-house and vendor data, the overall exception rate was 3%.

Notably, PHS' in-house staff processed 99.95% (672,751 claims) of the entire paid electronic claim population (673,093), and accounted for 99.98% (17,243/17,246) of all exceptions. The vendors processed only 0.05% (342) of all electronic claims, and accounted for only 0.02% (3/17,246) of all exceptions noted in this dataset review. This review did not reveal any significant disparity in the handling of in-house versus vendor claims.

4. POPULATION REVIEW, MAILED PAID CLAIMS (PROMPT PAY)

Claims System	Claim Population	Number Exceptions	Exception Ratio
In-house	1,710,500	30,062	2%
Vendors:			
MHN	1,074	9	<1%
Landmark	9,158	90	<1%
Vendor subtotals	10,232	99	<1%
Overall Totals	1,720,732	30,161	2%

The examiners queried the entire population of paid claims submitted by mail that PHS and its vendors processed during the examination period (July 1, 1999 through June 30, 2000). As noted above, the exception rate on PHS' in-house claim processing system

was 2%. The examiners discovered an exception rate of less than 1% on those claims processed by PHS' two vendors, MHN and Landmark. The exception rate for each vendor was also less than 1%. Including both in-house and vendor data, the overall exception rate was 2%.

Notably, PHS's in-house staff processed 99.40% (1,710,500) of the entire paid claim population of 1,720,732 mailed claims, and accounted for 99.67% (30,062/30,161) of all exceptions. The vendors processed only 0.6% (10,232/1,720,732) of all mailed claims, and accounted for only 0.33% (99/30,161) of all exceptions noted in this dataset review. This review did not reveal any significant disparity in the handling of in-house versus vendor claims.

Summary of Mailed and Electronic Paid Claim Population Review

The results of this analysis indicate very similar performance between paid claims that were submitted electronically and those submitted by regular mail. As outlined above, the examiners cited a 2% exception rate on paid mailed claims and a 3% exception rate on electronically submitted paid claims. In addition, the examiners discovered a relatively minor prompt pay exception rate disparity between those claims handled by PHS' in-house processors (2% for mailed claims and 3% for electronic claims) and its vendors (1% on both mailed and electronic claims). The underlying errors are discussed in sections III.C and III.D of this report.

5. POPULATION REVIEW, ELECTRONIC DENIED CLAIMS (PROMPT PAY)

Claims System	Claim Population	Number File Exceptions	Exception Ratio
In-house	274,121	6,096	2%
Vendors:			
MHN	559	1	<1%
Landmark	280	2	<1%
Vendor subtotals	839	3	<1%
Overall Totals	274,960	6,099	2%

The examiners queried the entire population of denied claims submitted electronically that PHS and its vendors processed during the examination period (July 1, 1999 through June 30, 2000). As noted above, the exception rate on PHS's in-house claim processing system was 2%. The examiners discovered exception rates of less than 1% on those claims processed by PHS's two vendors, MHN and Landmark. Including both in-house and vendor data, the overall exception rate was 2%.

Notably, PHS's in-house staff processed 99.69% (274,121) of the entire denied claim population of 274,960 electronically submitted claims, and accounted for 99.95% (6,096/6,099) of all exceptions. The vendors processed only 0.31% (839/274,960) of all mailed claims, and accounted for only 0.05% (3/6,099) of all exceptions noted in this

dataset review. This review did not reveal any significant disparity in the handling of in-house versus vendor claims.

6. POPULATION REVIEW, MAILED DENIED CLAIMS (PROMPT PAY)

Claims System	Claim Population	Number File Exceptions	Exception Ratio
In-house	1,044,939	62,283	6%
Vendors:			
MHN	26,047	580	2%
Landmark	16,980	59	<1%
Vendor subtotals	43,027	639	1.5%
Overall Totals	1,087,966	62,922	6%

The examiners queried the entire population of denied claims submitted by mail that PHS and its vendors processed during the examination period (July 1, 1999 through June 30, 2000). As noted above, the exception rate on PHS's in-house claim processing system was 6%. The examiners discovered an exception rate of 1.5% on those claims processed by PHS's two vendors, MHN and Landmark. The exception rate for each vendor was no greater than 2%. Including both in-house and vendor data, the overall exception rate was 6%.

Notably, PHS's in-house staff processed 96% (1,044,939) of the entire paid claim population of 1,087,966 mailed claims, and accounted for 98.98% (62,283/62,922) of all exceptions. The vendors processed only 4% (43,027/1,087,966) of all mailed claims, and accounted for only 1.02% (639/62,922) of all exceptions noted in this dataset review. This review did not reveal any significant disparity in the handling of in-house versus vendor claims.

Summary of Mailed and Electronic Denied Claim Population Review

The results of this analysis indicate very similar performance between denied claims that were submitted electronically and those submitted by regular mail. As outlined above, the examiners cited a 6% exception rate on denied mailed claims, and a 2% exception rate on electronically submitted denied claims. This variance of 4% does not represent a significant disparity between mailed and electronic claims. In addition, the examiners discovered a relatively minor exception rate disparity between those claims handled by PHS's in-house processors (6% for mailed claims and 2% for electronic claims) and its vendors (1.5% on mailed denied claims and 1% on electronic denied claims). The underlying errors are discussed in sections III.C and III.D of this report.

C. CLAIM HANDLING ERRORS

1. Failure to Pay Claims Within Required Time Frames – 33 Errors

N.J.S.A. 26:2J-8.1d(1) requires a company to pay clean 2000 mailed claims within 40 days and 2000 electronically submitted claims within 30 days. In addition, N.J.A.C. 8:38-16.4(b) requires a Company to pay clean 1999 claims within 60 days. N.J.S.A. 26:2J-8.1(d)1(a) through (e) defines a clean claim as one which must be free of coding errors, missing information, suspected fraud, and other disputes. Additionally, the NAIC Market Conduct Examiners' Handbook Claims Section contains Standard 3, which states that examiners should verify whether a company settles claims in a timely manner.

The examiners reviewed the random sample and the general population for claims paid within required time frames. In the random sample of 98 files, PHS failed to pay one claim in a timely fashion. In addition, the examiners found five claims paid in error in the denied random sample. The examiners queried claim databases spanning the period July 1, 1999 to June 30, 2000 and found that the company failed to pay 47,407 claims timely out of a population of 2,393,825 paid claims for an exception ratio of 2%.

The examiners also conducted a Select Sample of claims paid beyond the required time frames for the purpose of determining whether PHS pays interest on overdue claims. The examiners report the results of that review in item number two, below. But that sample also produced a high ratio of claims improperly paid outside of time frames. From a select sample of 55 claims, the Company failed to pay 26 in a timely fashion. Additionally, the examiners found one paid claim from the retroactive denial sample that was not a denial and was not paid timely. In response to the examiners' inquiries, PHS agreed that 26 of the 33 claims cited were not paid timely. The company stated that the remaining seven claims were paid within the required timeframes. However, at the time of the examination, PHS did not provide documentation to support this position. In response to the draft report, PHS again disagreed with these errors, but did not provide documentation to support its position.

PLEASE SEE APPENDICES B1 AND B2 FOR A LIST OF THE 33 CLAIMS IN ERROR

2. Failure to Pay Interest – 26 Errors – Improper General Business Practice

N.J.S.A. 26:2J-8.1d(7) requires a company to pay interest on year 2000 mailed claims not paid within 40 days and on year 2000 electronically submitted claims not paid within 30 days. N.J.A.C. 8:38-16.4(a) requires a company to pay interest on both types of year 1999 claims not paid within 60 days. Also, the NAIC handbook contains Standard 10, which states that canceled company benefit checks and drafts should be examined to determine whether they reflect appropriate claim-handling practices. In addition, Standard 6 of the handbook states examiners should verify whether companies handle claim files in accordance with policy provisions and state law.

The examiners conducted an extensive review with respect to interest payments, covering random samples of paid and denied claims, select samples of claims paid outside of applicable time frames, and select samples of retroactively denied claims. They found that the company failed to pay interest on all five claims in the random sample in which interest was due, and that PHS failed to pay interest on both of the two partially paid claims in which interest was due in the Retroactive Denial sample. From the select Delayed Payment sample, the examiners found 26 claims to be improperly delayed; the Company failed to pay interest on 19 of these claims, which was an error ratio of 73%. The examiners also conducted a computer study of the delayed claims population of 47,407 delayed claims for the period July 1, 1999 to June 30, 2000 and found 19,915 exceptions in which PHS failed to pay interest on these claims. This represents an exception ratio of 42%. Based on the high error ratio and large number of exceptions, the examiners found that PHS' failure to pay interest on overdue claims was an Improper General Business Practice on delayed claims. In response to an inquiry, the Company did not comment on this finding and did not disagree.

PLEASE SEE APPENDIX B3 FOR A LIST OF 26 CLAIMS IN ERROR

3. Failure to Fully Explain Claim Denials – 23 Errors -Improper General Business Practice

N.J.S.A. 26:2J-8.1d(2)e requires a company to notify a claimant of all the reasons for a denial, and to provide a statement explaining what additional documentation it needs to adjudicate the claim. N.J.S.A. 17B:30-13.1(n) requires a company to provide a reasonable explanation of the basis in the policy for a denial. Also, N.J.A.C. 11:2-17.8(a) requires a carrier to provide specific reference to policy language when denying a claim. Additionally, the NAIC Market Conduct handbook contains Standard 9 in the Health Insurance Claims section, which calls for examiners to verify whether companies handle denied claims in accordance with policy provisions and state law.

The Company has a total of 206 denial codes that it may draw upon in denying each claim. These codes may appear either on partially paid or denied claims, and they generate messages on Explanations of Benefits to members. The examiners found that 15 of the messages did not adequately explain the denial.

PLEASE SEE APPENDIX B4 FOR THE 15 DENIAL CODES IN ERROR

The examiners found that PHS failed to provide a reasonable explanation for denial in 23 files by using processing codes that did not fully explain the denials. For this reason, the examiners found that the Company engaged in an improper general business practice whenever it utilized the codes.

In a study of the denied claim population for the period July 1, 1999 to June 30, 2000 the examiners found that PHS used these inadequate codes in 118,966 claims. The denied claim population for that period was 1,362,926, which constitutes an exception ratio of 9%. In response to several inquiries, PHS provided the definition of each denial

code but failed to support how or why this language complies with the aforementioned statutes and regulations. In addition, the company admitted that the wording of one of the codes (LV) "is currently under review as it was previously questioned in an inquiry by one of the auditors."

PLEASE SEE APPENDIX B5 FOR A LIST OF THE 23 CLAIMS IN ERROR

4. Improper Claim Denials – 4 Errors - Improper General Business Practice (System Error)

New Jersey statutes address improper denials at N.J.S.A. 17B:30-13.1(f) and N.J.A.C. 11:2-17.8(i), which require a company to settle a claim in which liability is reasonably clear.Also, N.J.A.C. 11:2-17.8(i) prohibits a company from denying a claim when it is reasonably clear that benefits are payable. Standard 9 of the NAIC Market Conduct Examiners' Handbook Health Insurance Claims section also applies to improper denials.

In the Retroactive Denial sample, PHS improperly denied claim numbers 893870-001 and H79787-002. In these files the Company failed to enter pre-authorization data into the processing system. This oversight caused the improper denial of claims that had been pre-authorized, contrary to the aforementioned statute. The examiners found the same error in one claim from the Denied Claim random sample. PHS improperly denied claim number BL7291-035 when a clerical error resulted in failure to enter pre-authorization data.

However, one of the four improper denials resulted from a malfunction of the Company's scanning software (called "MACESS"). In claim number DA7322-022, the examiners found that the software temporarily stopped reading critical data in some mailed claims. Specifically, it could not scan the figure "1" in the "Days or Units" section of some HCFA 1500 forms, which is the billing form that doctors use most often. Instead, the system erroneously split the charge in half and denied one of the charges as a duplicate of the other. This was not in conformity with N.J.S.A. 17B:30-13.1(f) because it was an erroneous denial.

The examiners found only one of these errors in the samples, and sent an inquiry asking the Company to produce a report outlining the extent of the problem. PHS reported that the software made the error on mailed claims from October 1, 1999 to April 24, 2000 and that it could have occurred to any number of approximately 1.2 million claims. The examiners tested the system to determine whether the error had in fact been corrected, and found no errors after April 24, 2000. When the examiners asked how many claims had been affected, the Company wrote, "There is no way to know which claims were affected. The only claims adjusted at this point are the claims brought to our attention via phone call or resubmission from the physicians." The examiners find this to be an improper general business practice for certain mailed claims erroneously denied as duplicate that were submitted from October 1, 1999 to April 24, 2000.

5. Failure to Deny Year 2000 Claims Within 30 Days and 1999 Claims within 60 Days – 7 Errors

N.J.S.A. 17B:30-13.1(e) requires a company to issue a claim denial within a reasonable time after the company receives the claim. N.J.S.A. 26:2J-8.1d(2)e defines that period of time as 30 days for claims received in 2000. For claims received in 1999, N.J.A.C. 8:38-16.1(f) defines the period as 60 days. Standard 9 of the NAIC Market Conduct Examiner's Handbook Claims Section requires examiners to verify that companies deny claims in accordance with state law. Contrary to these provisions, PHS failed to deny seven ineligible claims within the required time frame. All seven errors occurred in the 2000 Denied claim sample. In response to several inquiries, PHS disagreed that it denied five of the seven claims untimely. However, when PHS calculates turnaround time, it uses the date the computer system processes the claim instead of the date the denial notification was actually sent to the member and provider. This procedure does not allow 30-day notification of the denial to the member and the provider as required by law. The examiners also reviewed the general claim population databases to determine the extent of PHS' compliance with the statutes and the regulation. In the period July 1, 1999 to June 30, 2000 the Company denied 1,362,926 claims. It failed to deny 69,021 of those claims within the required time frames, for a 5% exception ratio.

PLEASE SEE APPENDIX B6 FOR A LIST OF THE 7 CLAIMS IN ERROR

D. GENERAL CLAIM FINDINGS

1. Mandated Benefits

The state of New Jersey requires health carriers to provide coverage for certain medical services that were once the subject of common policy exclusions. For example, N.J.S.A. 26:2J-4.11 requires companies to provide benefits for diabetic supplies, N.J.S.A. 26:2J-4.4 requires companies to cover Mammograms in the absence of an existing diagnosis, and N.J.S.A. 26:2J-4.13 requires coverage for prostate cancer screening. In addition to those, the examiners chose four other mandated benefits with which to review PHS's compliance with the mandates. To the above list, they added Wilm's Tumor (N.J.S.A. 26:2J-4.1 and N.J.A.C. 8:38-5.6), PAP Smears (N.J.S.A. 26:2J-4.12), Restoration of Breast Symmetry Following Mastectomy (N.J.S.A. 26:2J-4.14) and Biological Mental Disorders (such as Autism) (N.J.S.A. 26:2J-4.20).

The database of the general claim population contained claim diagnoses and procedure codes, so the examiners used these codes to filter subsets of claims for each mandated benefit. For example, they filtered out claims for Restoration of Breast Symmetry Following Mastectomy by using CPT Codes 19318 and 19324. The examiners then queried the resultant subset for denied claims, and proceeded to review the denial codes. The examiners found only a trace number of exceptions in the seven subsets. Almost all of the denial codes used were proper, and included such reasons as eligibility, improper submitted code, incorrect date of service, and services performed by non-plan

provider. Based on their review, the examiners concluded that PHS was in conformity with those mandated benefits

2. Acknowledging Claims Within Two Days

N.J.S.A. 26:2J-8.1d(4) requires an HMO to acknowledge receipt of an electronically submitted claim within two days. The examiners reviewed such claims for the period July 1, 1999 to June 30, 2000, finding that the Company received them through two different clearinghouses. These were Envoy-NEIC and Equifax-NDC. Once the claim arrived in the PHS system, a "Functional Acknowledgement" was automatically sent to either of the clearinghouses, which in turn sent daily acceptance/rejection reports to the provider. The examiners found that these acknowledgements were within required time frames, and that the Company was in compliance with N.J.S.A. 26:2J-8.1d(4).

E. Summary

The examiners reviewed 287 claim files and found 61 claims in error for an error ratio of 21%. They discovered three Improper General Business Practices: failure to pay interest on overdue claims, denial codes that did not fully explain claim denials and improper denials related to a system malfunction. Other errors included failure to pay or deny claims within the required timeframes. Additionally, the examiners verified that PHS paid mandated benefit claims and acknowledged all electronic claims within two days.

IV. TERMINATIONS

A. INTRODUCTION

Physicians Health Services provided computer runs indicating that during the review period of July 1, 1999 to June 30, 2000 there were 1,702 terminated providers and hospitals, 730 terminated groups and 136,044 terminated members. The examiners randomly selected and reviewed 110 termination files for compliance with N.J.S.A. 26:2J-15c and N.J.A.C. 8:38-3.4 (member contract terminations), N.J.S.A. 26:2S-8b, N.J.A.C. 8:38-3.5, N.J.S.A. 26:2J-11.1 (provider & hospital terminations), N.J.A.C. 11:2-13.3 & 4 (notice of discontinuance of contract), and N.J.A.C. 8:38-3.2(a) (nondiscriminatory enrollment practices)

B. ERROR RATIO

The examiners calculated the error ratios by applying the procedure outlined in the introduction of this report. The following chart is a breakdown of errors that the examiners found:

Type of Termination	Files Reviewed	Files in Error	Error Ratio
Provider	20	3	15 %
Group	34	0	0
Member	51	1	2 %
Hospital	5	1	20 %
Totals	110	5	5 %

C. EXAMINERS' FINDINGS

1. Failure to Provide 90 Days Prior Written Notice of Termination (2 Errors)

N.J.S.A.26:2S-8 b requires an HMO carrier to provide a health care professional with 90 days written notice of termination, and notice of a right to a hearing. Standard eleven: Chapter VIII of the underwriting and rating section of the NAIC handbook states, cancellation practices must comply with policy provisions and state laws. Contrary to the statute, PHS provided only 30 days notice rather than the 90 days required to provider files F12198 and FO4197. The company sent letters on September 1, 1999 to both providers with an effective termination date of October 1, 1999. In addition, the notices did not contain a statement regarding the providers right to a hearing. The company stated that these providers did not sign a new Participating Physician Agreement and failure to comply resulted in their termination. Although PHS can terminate a provider

for the stated reason, it is required to give 90 days notice and advise the provider of the right to a hearing.

2. Miscellaneous Errors

a. Failure to Provide Written Notices of Hospital Termination Timely (1 Error)

According to N.J.A.C. 8:38-3.5(e) and N.J.S.A. 26:2J-11.1, if a hospital's contract is terminated, both the hospital and HMO shall continue to abide to the terms of the contract for four months from the termination date. In addition, an HMO is to provide written notification of the hospital termination within the first 15 business days of the four month extension to all health care providers it has contracted with and members who reside in the adjacent county and HMO service area. The notice to members must also advise them of available options to health care coverages. This is related to Standard ten: Chapter VIII of the underwriting and rating section of the NAIC Handbook which states that, "cancellation / non- renewal notices comply with policy provisions and state laws, including the amount of advance notice provided to the insured and other parties to the contract." Contrary to N.J.A.C. 8:38-3.5(e) and N.J.S.A. 26:2J-11, PHS failed to provide written notification within the first 15 business days after the termination of file number 1L5026-15037. The four-month extension period began May 15, 2000 and PHS did not send notification until June 9, 2000, which was 3 days beyond the first 15-business days requirement. PHS agreed that it sent notification to members on June 9, 2000.

b. Failure to Notify Members of Provider's Termination (1 Error)

N.J.A.C. 8:38-3.5(b) requires that written notice be given to each member within 30 days prior to a provider's termination. Standard ten, Chapter VIII of the underwriting and rating section of the NAIC Handbook states that, "cancellation/non-renewal notices comply with policy provisions and state laws, including the amount of advanced notice provided to the insured and other parties to the contract." In response to an inquiry, PHS stated that it notified members by telephone of the termination of provider number OK1000 and this is "sufficient notification." However, to comply with regulation, the Company should have issued written notification to members on the same date the notice was sent to the physician.

c. Failure to Timely Notify Provider of Termination (1 Error)

N.J.A.C. 8:38-3.5(a)1 requires an HMO to give notice to the provider of a termination in the time and manner specified in the contract. In addition, section ten of the underwriting/rating section of the NAIC handbook reads, cancellation/non-renewal notices must comply with policy provisions and state laws, including the amount of advance notice provided to the insured and other parties to the contract. PHS issued a notice of termination that gave 30 days notice instead of the 60 days notice, which was required in provider contract OK1000 with PHS.

d. Failure to Give Member Opportunity to Pay Premium before Termination (1Error)

N.J.A.C. 8:38-3.4(b) requires that before a member's coverage can be terminated for nonpayment of premiums, the member shall be given written notice and the opportunity to come into compliance. Following any decision to terminate a member's coverage, the HMO shall notify the member of his or her right to appeal such decision. Chapter VIII, standard eleven of the underwriting/rating section of the NAIC Handbook states that cancellation practices must comply with policy provisions and state laws. PHS did not send the required notification letter to member with file number FP1919 before terminating the policy. Instead the company sent the member a letter on June 28, 2000 informing her of the termination of her policy effective April 30, 2000, which is 59 days after the policy cancelled for nonpayment. In addition, the letter did not include a statement notifying the member of her right to appeal the decision, contrary to N.J.A.C 8:38-3.4(b).

Other Findings

N.J.S.A. 26:2S-9.1a requires a carrier which offers a managed care plan to provide that if a covered person is receiving post-operative follow-up care, oncological treatment, psychiatric treatment or obstetrical care by a physician who is employed by or under contract with a carrier at the time the treatment is initiated, the covered person may continue to be treated by that physician for the duration of the treatment in the event that the physician is no longer employed by or under contract with the carrier. Standard 15 of the NAIC Handbook states that company complies with the provisions of continuation of benefits procedures contained in policy forms, statutes, rules and regulations. During a review of terminated provider files, the examiners read termination letters from PHS that indicated the provider must treat patients with the above mentioned conditions after the provider's date of termination. In addition, the examiners did not find any claims denied because of a terminated provider.

E. SUMMARY

The examiners found an overall error ratio of 5% for the termination review. Errors included PHS' failure to provide the proper termination notification to members and health care professionals in a timely manner and failure to give member opportunity to pay premium before terminating policy.

V. UNDERWRITING AND RATING

A. INTRODUCTION

PHS provided databases to the examiners indicating that the company had 1,134 individual contracts and 9,466 group contracts in force during the review period. The examiners randomly selected and reviewed 20 individual contracts and 19 group contracts for compliance with applicable statutes and regulations, including N.J.S.A. 26:2J-4.1 et seq., (Mandated Benefits). N.J.S.A. 26:2S-1 et seq. (Health Care Quality Act), N.J.S.A. 17B:27-54 through 67 (Group Health Insurance Portability), N.J.A.C. 8:38-2.7 (Notice of Changes in HMO Operations), N.J.A.C. 11:4-40.5 (Form Approval Procedures). In addition, PHS provided the examiners with a list of 20 specimen, policy forms that they are currently issuing. The examiners verified that the Company filed the forms with the New Jersey Department of Banking and Insurance.

B. ERROR RATIOS

The examiners calculated the error ratios by applying the procedure outlined in the introduction of this report. The following chart is a breakdown of errors that the examiners found:

Type of Review	No. Reviewed	No. in Error	Error Ratio
Large Group Contracts	5	0	0
Small Group Contracts	14	0	0
Individual Contracts	20	0	0
Policy Forms	21	3	14%
Total	60	3	5%

C. EXAMINERS' FINDINGS

1. Failure to Include Required Contract Language in Policy Forms – Improper General Business Practice

N.J.A.C. 11:21-4.1(c) requires a carrier that issues health benefits plans to small employers to use the standard policy form for HMO-POS plan as set forth in the Appendix to chapter 21 (Small Employer Health Benefits Program). N.J.A.C. 11:21-4.2(a) requires a carrier to certify that its health benefits plans are in compliance with the small employer health benefits plans and all provisions of N.J.A.C. 11:21-4. Although PHS submitted the required certification form to the DOBI for policy form NJPOSGROUP.DOC 5/00, the examiners determined that the company failed to include the section for Continuity of Coverage; the company issued this form to 3,174 groups.

PHS submitted the required certification form to the DOBI for policy form NJ SmGRP FBG000 EOC/REV 11/00. However, the examiners determined that PHS included supplementary text ("$5 copayment Plan"), in an area on the form that is inconsistent with the standard HMO form format. This change does not comply with N.J.A.C. 11:21-4.1(a) which states that carriers may use only those standard policy forms which are specified in the appendix to this regulation. Moreover, N.J.A.C. 11:21-4.1(a) does not allow carriers to make any changes to the text of the standard policy except as permitted by brackets in the standard policy form template. Reference to the "$5 copayment Plan" appeared in an area of the form that was not bracketed and therefore not subject to variable language or change.

According to N.J.A.C. 8:38-8.4(b), nothing in the HMO policies, procedures or provider agreement shall prohibit a member or a provider from discussing or exercising the right to an appeal. The Grievance (reconsideration) Process section of form, NJ SmGRP FBG000 EOC/REV 11/00, allows up to six months to file a grievance regarding decisions that are not based on medical necessity. PHS' placement of a six-month time constraint is contrary to N.J.A.C. 8:38-8.4(b), which neither contains nor allows for a specific timeframe in which a member may file a grievance. The six-month deadline constitutes a limitation or time constraint that is prohibited by this regulation, which states that nothing shall preclude a member's right to file a grievance. The company issued this form to 5,849 members.

N.J.A.C. 11:20-3.2(b) requires a carrier choosing to offer a standard individual health benefits plan through a managed care network to use the appropriate standard language set forth in the appendix to chapter 20 (Individual Health Coverage Program). N.J.A.C. 11:20-3.2(c) requires a carrier to file a certification form before marketing, issuing or renewing any standard policy form. PHS failed to include a section regarding a schedule of premium rates and provisions in policy form NJINDIVHMO 1/99; the company issued this form to 6,715 members.

During the review, PHS agreed that these forms did not include the required language. The company stated that it downloaded the forms from the Department's web-site "where there may have been an error in the downloading process. We will update the form accordingly." The examiners cited this error as an improper general business practice since it occurred on all policies issued on these forms. However, in response to the report draft, PHS disagreed with these findings, stating that the referenced regulation does not specify timeframes for filing a grievance. For the reasons stated above, the examiners cited the company's six-month period as a limitation, which is prohibited by N.J.A.C. 8:38-8.4(b).

2. Other Findings

The examiners reviewed individual and group contracts to test for compliance with HMO laws and verified whether the Commissioner approved the policy forms used by PHS. This review included a comparison of language in the approved forms with that which appears in the forms PHS used. With the exception of the three policy forms cited

earlier in this section, the examiners found no errors. The examiners also found no instance of non-compliance with the following requirements:

a. N.J.S.A. 26:2S-4 requires a carrier to disclose in writing to a subscriber the terms and conditions of its health benefits plan, and shall promptly provide the subscriber with written notification of any change in the terms and conditions prior to the effective date of the change. Standard 2 of the underwriting and rating section of the NAIC Handbook references that all mandated disclosures are documented and in accordance with applicable statutes, rules and regulations. The examiners obtained copies of letters and brochures that were sent to subscribers that disclosed the terms and conditions of the health plan. In addition, the examiners reviewed notification to subscribers of changes in the terms of their health plan and found that the company complied with this regulation.

b. According to N.J.S.A. 26:2S-5, a carrier which offers a managed care plan shall disclose to a subscriber, in writing, at the time of enrollment and annually thereafter, a provider directory, information about financial incentives and percentage of board certified physicians. In addition, Standard 2 of the underwriting and rating section of the NAIC handbook references that all mandated disclosures are documented and in accordance with applicable statutes, rules and regulations. The examiners reviewed five letters that informed subscribers of financial incentives between participating physicians under contract with the carrier and the number of board certified physicians. They also reviewed the current provider directory on the web-site and in paper form and determined that the directory provided information on a covered person's access to primary care physicians and specialists, including the number of available participating physicians, by provider category or specialty and by county. In addition, the directory included the professional office address of primary care physicians and their hospital affiliation as well as a list of participating hospitals.

c. N.J.S.A. 17B:27-60a requires a health carrier, which offers a group health plan to provide a written certification of creditable coverage at the time an individual ceases coverage. N.J.S.A. 17B:27-60b states the written certification of creditable coverage shall include the period of creditable coverage. During a review of member termination files, the examiners determined that PHS issues written certifications of creditable coverage when a member's policy terminates. The certifications indicate the names of all family members on the policy, all the policy periods in which they had health coverage and the termination date of the coverage.

d. According to N.J.S.A. 17B:27-62, a health carrier which offers a group health plan shall permit an employee or dependent who is eligible, but not enrolled, for coverage under the terms of the plan, to enroll for coverage if they had health insurance coverage at the time coverage was previously offered to the employee or dependent, the previous coverage was terminated and the employee requests enrollment not later than 30 days after exhaustion of prior coverage. The examiners reviewed policy contracts and determined that PHS allowed employees and their dependents to enroll for coverage that they previously declined.

e. N.J.S.A. 17B:27-63 states if a group health plan makes coverage available with respect to a dependent of an individual who is a participant under the plan and a person becomes a dependent of the individual through marriage, birth, adoption or placement for adoption, the group health plan shall provide for a dependent special enrollment period during which the dependent may be enrolled. The dependent special enrollment period shall be for a period of not less than 30 days. During a review of policy contracts, the examiners found that PHS has a dependent special enrollment period of 30 days after the date of marriage, birth, adoption or placement for adoption.

f. According to N.J.S.A. 17B:27-64, a health carrier which offers a group health plan may not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the plan based on health status-related factors in relation to the individual or a dependent of the individual. There was no indication in the policy contracts that PHS had rules for eligibility based on health status-related factors. In addition, the computer runs provided by the company indicated that PHS did not decline any applicants due to health status-related factors.

g. N.J.S.A. 26:2S-10a states "a carrier which offers a managed care plan shall offer a point-of-service plan to every contract holder which would allow a covered person to receive covered services from out-of-network health care providers without having to obtain a referral or prior authorization from the carrier." PHS offers two plans called Charter Point-of-Service plans (NJCHPOSEOC.998 & NJHCSCHPOSEOC.998) which are in-network and out-of-network open access plans that comply with the statute. The examiners verified that PHS filed these plans with the DOBI. The DOBI issued its approval on June 15, 2000 for both plans.

h. According to N.J.A.C. 11:4-40.5, no carrier shall deliver or issue for delivery any form unless the Commissioner has approved the form. Standard four of the underwriting and rating section of the NAIC Handbook states "all forms, including contracts, riders, endorsement forms and certificates, are filed with the department of insurance, if applicable." PHS provided the examiners with a list of policies and forms that they are currently issuing. The examiners confirmed that the company filed the large group policy contracts, riders and other forms with the Department as required by N.J.A.C. 11:4-40.5.

i. According to N.J.S.A. 26:2J-4.3e a health maintenance organization shall file all rates and supplementary rate information and all changes and amendments thereof for the coverages required to be offered for approval with the Commissioner of Insurance at least 60 days prior to becoming effective. Standard number one in the NAIC Handbook states the rates charged for the policy coverage are in accordance with filed rates. Based on the review of files and the company's rate schedules, the examiners found that PHS was using filed rates on 20 individual policies. In addition, the examiners rated 5 large group and 14 small group contracts and found no errors--the company utilized filed group rates.

j. N.J.S.A. 26:2J-8a requires an HMO to provide enrollees with evidence of coverage and evidence of the total amount of payment which the enrollee is obligated to prepay for health care services. The examiners verified that PHS complies with this statute by issuing an evidence of coverage along with a schedule that indicates the total premium due for a health care contract.

k. N.J.S.A. 26:2J-10.1a states a health maintenance organization contract or certificate in which dependent coverage is available shall not deny coverage for an enrollee's child for health care services on the grounds that the child was born out of wedlock. Standard two of the NAIC handbook states "All mandated disclosures are documented and in accordance with applicable statutes, rules and regulations." The examiners reviewed PHS's HMO contracts and determined that they define a dependent as a child who is "your own issue" --those born to you. In addition, the examiners did not find any denied claims or terminated coverage for these dependents. Therefore, PHS offers coverage to children born out of wedlock.

D. SUMMARY

The examiners reviewed individual and group contracts for compliance with mandated offer requirements and the use of filed rates. The examiners found that PHS is using policy contracts that do not contain the required contract language. However, the examiners also found PHS was compliant in many other areas with respect to its contracts, such as including special enrollment period for employees and dependents who previously declined coverage and dependent special enrollment period of 30 days following date of marriage, birth or adoption and in using filed evidence of coverage forms and issuing written certifications of creditable coverage.

VI. LICENSING AND ADVERTISING; GENERAL FINDINGS

A. AGENT LICENSING

According to N.J.A.C. 8:38-13.1, no HMO shall employ, directly or indirectly, any person to solicit, negotiate or bind contracts for the delivery of health care services to subscribers or members unless such person is licensed as an insurance producer in New Jersey in accordance with N.J.A.C. 11:17. Standard one of the producer licensing section of the NAIC Handbook states "company records of licensed and appointed (if applicable) producers agree with department of insurance records." During the review period, 396 producers negotiated contracts for PHS; the company did not terminate any agent contracts during the same period. The examiners randomly selected and reviewed 35 agent files for compliance with licensing requirements. In addition, throughout the examination process, the examiners randomly crosschecked agents to the master licensing records of the New Jersey Department of Banking and Insurance to assure that all agents were properly licensed. The examiners found no unlicensed agents.

N.J.A.C. 11:17-2.9(a)2 requires a company contracting with a licensed producer to advise the Department of the relationship by filing a notice within 15 days after execution of the contract. The examiners randomly reviewed 35 agent files and determined that PHS notified the Department of each agent relationship.

B. ADVERTISING

The examiners reviewed PHS's Internet site and 14 pieces of advertising materials, which consisted of newsletters, pamphlets, magazine publications, and promotional give-away articles for compliance with all statutory requirements as they relate to advertising. The examiners placed particular emphasis on N.J.S.A. 26:2J-15a(2) and N.J.S.A. 17B: 30-4, (which prohibit untrue or misleading advertising materials); N.J.S.A. 17B: 30-3 (prohibits misrepresentations and false advertising of policies) and N.J.A.C. 11:2-11.1 et seq. (rules governing health insurance advertising).

The examiners found neither the printed material nor the content of the Internet site to be contrary to the aforementioned statutes. This is relative to Standard number one of the marketing and sales section of the NAIC Handbook, which states "All advertising and sales materials are in compliance with applicable statutes, rules and regulations."

C. GENERAL FINDINGS

1. Failure To Respond Promptly To Examiners' Inquiries

N.J.S.A. 17: 23-1 requires a company to respond promptly in writing to all inquiries from the Department of Banking and Insurance. The examiners wrote a total of 226 inquiries during the examination. Contrary to N.J.S.A. 17: 23-1, PHS failed to respond to 40 of the 226 inquiries promptly; these 40 responses exceeded 10 working days. The Company disagreed that it responded to all 40 inquiries beyond ten business days. PHS indicated that it responded timely to 18 of the 40 inquiries. The company's records show that they replied to the examiners at an earlier date than the actual response date. However, the examiners received these inquiry responses several days after the date on the inquiries.

PLEASE SEE APPENDIX C FOR THE LIST OF ERRORS

VII. RECOMMENDATIONS

PHS should inform all responsible personnel and third party entities who handle the files and records cited as errors in this report of the remedial measures which follow in the report sections indicated. The examiners also recommend that the Company establish procedures to monitor compliance with these measures.

Throughout this report, the examiners cite all errors found. If the report cites a single error, the examiners often include a "reminder" recommendation because if a single error is found, more errors may have occurred.

The examiners acknowledge that during the examination, the Company had agreed and had already complied with, either in whole or in part, some of the recommendations. For the purpose of obtaining proof of compliance and for the Company to provide its personnel with a document they can use for future reference, the examiners have listed all recommendations below.

A. GENERAL INSTRUCTIONS

All items requested for the Commissioner and copies of all written instructions, procedures, recommended forms, etc. should be sent to the Commissioner, c/o Clifton J. Day, Manager of Market Conduct Examinations and Anti-Fraud Compliance, 20 West State Street, PO Box 329, Trenton, NJ 08625, within thirty (30) days of the date of the adopted report.

On claims reopened as recommended, the claim payment should be sent to the insured with an accompanying cover letter containing the following first paragraph (variable language is include in parentheses):

"During a recent review of our claim files by market conduct examiners of the New Jersey Department of Banking and Insurance, they found that we failed to pay interest on your claim in the amount of (insert amount). Enclosed is our check for that amount to correct the error."

B. COMPLIANCE MATTERS

1. For each recommendation listed in the Market Conduct Report where we request that the Company issue written instructions, the Company should provide the number of employees and the titles of the personnel to whom it issued these instructions.

2. The Company should also advise us whether it has a designated compliance unit or persons whose sole responsibility is monitoring and assuring that the Company is complying with New Jersey statutes and regulations. If the Company does not have such a unit, then we strongly suggest that the Company create a compliance unit to address compliance issues on a continuing basis in light of the findings and recommendations stated in this report.

C. COMPLAINT AND UTILIZATION MANAGEMENT REVIEW

1. In order to comply with N.J.S.A. 17B:30-13.2, PHS must issue written instructions to all appropriate personnel that the complaint log must contain the nature of each complaint, the disposition of these complaints and the receipt and response dates must be accurately recorded to indicate the time it took to process each complaint. Also, company staff must use the actual date of receipt, not the date of the letter to assure its compliance.

2. PHS is to revise its Utilization Management Appeal Log to incorporate the columns necessary for stage 2 recordings, pursuant to N.J.S.A. 17B:30-13.2. In addition, the company must amend the heading titled "Date complete information received" to read receipt date. The actual receipt date is essential in determining the total number of days to resolve appeals.

3. The company must issue written instructions to the complaint handling staff that:

    a. pursuant to N.J.S.A. 26:2J-12a(1), N.J.S.A.17B:30-13.1(b) and N.J.A.C. 8:38-3.6(a)4 a 30-day turnaround is required for complaint responses;
    b. N.J.A.C. 11:2-17.6(d) requires companies to provide complete and accurate responses to claim complaints within 15 working days to the DOBI; and
    c. they must respond to written complaints in writing.

4. PHS must remind the appropriate personnel that they must maintain all complaint handling records. These instructions should include a statement that failure to maintain complaint correspondence constitutes a failure to keep necessary documentation and records of its complaints, contrary to N.J.A.C. 8:38-2.12(a).

5. The company's Appeals and Grievances Department must be reminded to forward to its Quality Improvement Unit all valid complaints related to quality of care, pursuant to N.J.A.C. 8:38-3.6(a)7. PHS must implement a system for monitoring and following up on complaints submitted to its Quality Improvement Unit, pursuant to N.J.A.C. 8:38-7.1(f).

6. PHS should inform the appropriate personnel that a complaint brought by a provider on behalf of a subscriber and with the subscriber's consent should be responded to the provider not the subscriber.

7. Pursuant to N.J.A.C. 8:38-8.5, the company must issue written instructions to its complaint handling staff that all stage 1 appeals other than urgent or emergency care are to be concluded within five business days.

8. To assure compliance with N.J.A.C. 8:38-8.5, PHS must forward to the Commissioner a copy of the revised appeal letter that advises members of their right to proceed to a stage 2 utilization management appeal prior to its use. In addition, the company should destroy its supply of the generic denial letter.

9. The company must remind appropriate personnel that, pursuant to N.J.A.C. 8:38-8.5, its denial letter to the provider must state that the provider has the right to the utilization management appeal process if they are acting on behalf of the member with the member's consent. To assure compliance with this regulation, a copy of the revised provider stage 1 denial letter should be forwarded to the Commissioner.

10. PHS should remind its Appeals and Grievances Department that:

    a. all stage 2 appeals must be acknowledged in writing within ten business days, as required by N.J.A.C. 8:38-8.6(c) and:

    b. file documentation should not be obscured so that a review of these documents can be concluded pursuant to N.J.S.A. 26:2J-18b, N.J.A.C. 8:38-2.12(a) and N.J.S.A. 17B:30-16.

D. CLAIMS

11. PHS must advise all claims handling personnel in writing that N.J.S.A. 26:2J-8.1d(6) requires a company to pay clean mailed claims within 40 days and electronically submitted claims within 30 days.

12. PHS must inform all claims handling personnel in writing that N.J.S.A. 26:2J-8.1d(7) requires a company to pay simple interest of 10% on mailed claims not paid within 40 days and on electronically submitted claims not paid within 30 days.

13. Since the claims in Appendix B3 did not include the interest payments required by N.J.S.A. 26:2J-8.1d(7), the Company must re-open each claim and pay any interest due. It must also re-open its entire population of 1999 and 2000 claims that were overdue on payment, and pay interest on any claim in which interest was not paid. See General Instructions for the appropriate cover letter to be sent with any payment issued.

14. PHS must issue written instructions to its claim personnel responsible for claim denial messages that N.J.S.A. 26:2J-8.1d(2)e requires a company to notify a claimant of all the reasons for a denial, and to provide a statement explaining what additional documentation it may need to adjudicate a claim. The Company must also advise such personnel that N.J.S.A. 17B:30-13.1(n) requires a company to provide a reasonable explanation of the basis in the policy for a denial. In addition, PHS must also advise such personnel that N.J.A.C. 11:2-17.8(a) requires it to provide a specific reference to policy language when denying a claim. Since the denial codes located in Appendix B4 do not conform to these rules, PHS must re-write them so that their meaning is clear and conforms to these requirements.

15. The Company must inform all claims handling personnel in writing that N.J.S.A. 17B:30-13.1(f), in requiring a company to settle a claim in which liability is reasonably clear, requires PHS to pay for claims in which a pre-authorization has been issued. PHS must inform claim-handling personnel that N.J.A.C. 11:2-17.8(i) requires

payment when it is reasonably clear that benefits are due. The Company must instruct in writing all claims handling personnel that pre-authorization data must be entered into the Company's claims processing system without error.

16. PHS should incorporate safeguards to monitor all claim-scanning procedures. The Company should reopen all claim submittals that were scanned from October 1, 1999 to April 24, 2000 and issue refunds on those that were partially denied due to the scanning systems error. PHS should submit a computer run showing all such claims, including member's name, claim number, date paid, amount paid and payee's name. See General Instructions for the appropriate cover letter to be sent with any payment issued.

17. The Company must advise all claims handling personnel in writing that N.J.S.A. 17B:30-13.1(e) requires a company to issue a claim denial within a reasonable time after receipt, and N.J.S.A. 26:2J-8.1d(2)e defines that period of time as 30 days.

E. TERMINATIONS

18. PHS should issue a reminder to appropriate personnel that:

a. N.J.S.A. 26:2S-8b requires an HMO to provide a health care professional 90 days written notice of termination, and notification of a right to a hearing.

b. N.J.A.C.8:38-3.5(e) and N.J.S.A. 26:2J-11.1 requires an HMO to provide written notification of the hospital termination within the first 15 business days of the four month extension to all health care providers it has contracted with and members who reside in the adjacent county and HMO service area.

c. N.J.A.C. 8:38-3.5(a)3 requires that written notice be given to each member within 30 days prior to a provider's termination.

d. N.J.A.C.8:38-3.5(a)1 requires an HMO to give notice to the provider of a termination in the time and manner specified in the contract.

e. N.J.A.C. 8:38-3.4(b) requires that before a member's coverage can be terminated for nonpayment of premiums, the member shall be given written notice and the opportunity to come into compliance. Following any decision to terminate a member's coverage, the HMO shall notify the member of his or her right to appeal such decision.

F. UNDERWRITING AND RATING

19. PHS must revise their policy form, NJPOSGROUP.DOC 5/00, to conform to the language and format required by N.J.A.C. 11:21-4.1(c) and the Appendix to chapter 21 (Small Employer Health Benefits Program). An amended copy of the policy form should be submitted to the Department for forms approval in the usual manner and a

copy of the submittal letter forwarded to the Commissioner in accordance with the instructions in section A of this recommendation section of the report.

20. PHS must revise their policy form, NJ SmGRP FBG000 EOC/REV 11/00 to conform to the language and format required by N.J.A.C. 11:21-4.1(b) and the Appendix to chapter 21 (Small Employer Health Benefits Program). An amended copy of the policy form should be submitted to the Department for forms approval in the usual manner and a copy of the submittal letter forwarded to the Commissioner in accordance with the instructions in section A of this recommendation section of the report.

21. PHS must revise their policy form, NJINDIVHMO 1/99 to conform to the format required by N.J.A.C. 11:20-3.2(b) and the appendix to chapter 20 (Individual Health Coverage Program). An amended copy of the policy form should be submitted to the Department for forms approval in the usual manner and a copy of the submittal letter forwarded to the Commissioner in accordance with the instructions in section A of this recommendation section of the report.

G. GENERAL FINDINGS

22. The company must issue written instructions to all appropriate personnel that they must respond promptly to all correspondence from the NJDBI, including inquiries from examiners, as required by N.J.S.A. 17:23-1.

APPENDIX A – COMPLAINT HANDLING ERRORS

1. Failure to respond to non-DOBI complaints in a timely manner

PHS File Number	Receipt Date	Response Date	Calendar Days Beyond 30
17288	08/12/99	10/07/99	26
7564*	08/10/99	10/01/99	22
32192*	01/27/00	05/05/00	68
24963*	11/24/99	02/01/00	39
35285	07/06/99	03/21/00	229
18335	09/15/99	07/13/00	272
3870*	07/19/99	09/07/99	20
18403	07/19/99	11/09/99	83
21213	11/16/99	01/07/00	22
37697	10/05/99	12/21/99	47
15408	07/06/99	09/20/99	46
16209	10/13/99	12/20/99	38
24870	11/12/99	01/24/00	43
25307	03/04/99	06/14/99	72
31887	12/08/99	02/07/00	31
32658	01/15/00	05/01/00	76
37304	03/27/00	07/18/00	83
30626	10/26/99	01/28/00	64
41203	02/21/00	03/28/00	6
18959	09/17/99	10/27/00	10
22199	10/25/99	01/23/00	60
40287	03/17/00	05/25/00	39
28686	12/13/99	03/21/00	69
30743	12/22/99	02/07/00	17
34634	02/25/00	07/12/00	108
31049	10/08/99	01/28/00	81
28922	12/29/99	02/08/00	11
34253	02/21/00	05/18/00	57
24601	11/01/99	06/05/00	155

* indicates non-claim complaint

2. Delayed response to DBI complaints

DBI Number	Receipt Date	Response Date	Working Days Beyond 15
99-27328	12/13/99	01/12/00	5
99-27665	12/21/99	08/30/00	162

DBI Number	Receipt Date	Response Date	Working Days Beyond 15
99-25493	10/09/99	12/23/99	37
00-29692	04/03/00	08/30/00	90
00-29966	03/14/00	05/03/00	21
00-28032	01/11/00	02/08/00	5
00-33454	06/30/00	08/15/00	16
00-29508	03/13/00	08/26/00	102
99-26707	11/22/99	02/03/00	13
99-27270	12/09/99	04/11/00	71
00-34097*	07/20/00	08/17/00	5
00-28414*	04/10/00	05/03/00	2
99-22370	08/18/99	11/02/99	37
99-25723	10/20/99	11/22/99	9
00-29678	03/13/00	04/17/00	10
00-32787	06/06/00	08/30/00	45
00-33148	06/15/00	08/17/00	29
00-28612	01/29/00	03/28/00	27

* indicates non-claim complaint

3. Failure to respond to stage 1 appeals within required time frame

PHS File Number	Receipt Date	Response Date	Business Days Beyond 5
2793	11/22/99	12/13/99	9
38163	09/14/99	10/26/99	25
43316	05/30/00	06/12/00	4
19644	09/28/99	11/01/99	19
19933	11/01/99	11/23/99	11
7523	08/19/99	09/01/99	4
19833	11/03/99	11/15/99	3
5752	07/08/99	07/26/99	7
18341	09/28/99	12/09/99	46
40522	05/01/00	06/29/00	37
6760	07/06/99	08/11/99	21
4114	06/09/99	07/09/00	16
38119	04/03/00	05/09/00	21
6358	07/28/99	08/05/99	1
6312	07/16/99	08/02/99	6
42181	05/18/00	05/31/00	3
5687	07/15/99	07/23/99	1

PHS File Number	Receipt Date	Response Date	Business Days Beyond 5
7610	09/01/99	09/21/99	8
18872	10/26/99	06/15/00	157
17004	10/04/99	11/02/99	15
6190	06/17/99	07/30/99	25
41652	05/12/00	06/01/00	8

4. Failure to maintain an accurate complaint log.

a. Inaccurate log dates

File Number	Log Receipt Date	Actual Receipt Date	Days in Error	Log Response Date	Actual Response Date	Days in Error
99-27328	12/08/99	12/10/99	2	1/12/00	3/29/00	77
99-27665	12/16/99	12/21/99	5	n/a	n/a	0
99-25493	n/a	n/a	0	11/23/99	12/23/99	30
00-29304	02/22/00	02/25/00	3	n/a	n/a	0
00-29673	06/02/00	02/12/00	111	n/a	n/a	0
00-29692	02/28/00	04/03/00	35	n/a	n/a	0
00-33313	06/16/00	06/20/00	4	06/29/00	07/05/00	6
00-30117	03/10/00	03/20/00	10	n/a	n/a	0
7564	n/a	n/a	0	08/19/99	10/01/99	43
00-32192	05/12/00	05/16/00	4	05/19/00	06/08/00	20
00-29861	04/10/00	04/17/00	7	n/a	n/a	0
00-30283	03/15/00	03/20/00	5	n/a	n/a	0
00-29508	not logged	03/13/00	n/a	n/a	n/a	0
99-26707	11/18/99	11/22/99	4	n/a	n/a	0
99-27270	12/07/99	12/09/99	2	n/a	n/a	0
18335	09/27/99	09/15/99	12	n/a	n/a	0
00-33243	06/14/00	06/19/00	5	n/a	n/a	0
00-28467	02/23/00	02/28/00	5	n/a	n/a	0
DH5502020	02/12/00	02/22/00	10	n/a	n/a	0
DA9874020	05/15/00	05/18/00	3	n/a	n/a	0
00-30243	03/15/00	03/20/00	5	n/a	n/a	0
18403	09/07/99	09/03/99	4	n/a	n/a	0
22157	10/19/99	10/05/99	14	n/a	n/a	0
15408	07/14/99	07/06/99	8	n/a	n/a	0

File Number	Log Receipt Date	Actual Receipt Date	Days in Error	Log Response Date	Actual Response Date	Days in Error
00-28414	01/14/00	04/10/00	87	n/a	n/a	0
21870	11/16/99	08/18/99	90	11/29/99	11/02/99	27
25307	12/28/99	03/04/99	299	03/22/00	06/14/99	282
00-30437	03/21/00	03/23/00	2	04/18/00	04/25/00	7
40287	04/27/00	03/17/00	41	n/a	n/a	0
00-29678	02/28/00	03/13/00	14	n/a	n/a	0
32658	01/31/00	01/15/00	16	n/a	n/a	0
00-32782	06/02/00	06/06/00	4	n/a	n/a	0
00-30075	03/10/00	03/15/00	5	n/a	n/a	0
00-33148	06/13/00	06/15/00	2	n/a	n/a	0
31300	01/28/00	01/24/00	4	n/a	n/a	0
00-32093	05/09/00	05/12/00	3	n/a	n/a	0
00-32306	05/16/00	05/18/00	2	n/a	n/a	0
00-28612	03/27/00	01/29/00	58	n/a	n/a	0
41203	05/08/00	02/21/00	77	06/20/00	03/28/00	84
19644	10/13/99	09/28/99	15	n/a	n/a	0
7260	11/22/99	11/19/99	3	n/a	n/a	0
19833	n/a	n/a	0	11/11/99	11/15/99	4
18341	10/22/99	09/28/99	24	11/04/99	12/09/99	35
6760	08/04/99	07/06/99	29	n/a	n/a	0
4114	07/01/99	06/09/99	22	n/a	n/a	0
6312	07/27/99	07/16/99	11	n/a	n/a	0
42181	05/30/00	05/18/00	12	n/a	n/a	0
17004	10/06/99	10/04/99	2	n/a	n/a	0
6190	07/26/99	06/17/99	39	n/a	n/a	0
19933	11/05/99	11/01/99	4	n/a	n/a	0
5752	07/08/99	07/19/99	11	n/a	n/a	0
17158	9/30/99	10/08/99	8	n/a	n/a	0
41899	5/18/00	05/16/00	2	n/a	n/a	0
41652	05/25/00	05/12/00	13	n/a	n/a	0

b. Log fails to indicate nature of the complaint

File Number

18163
00-29508
00-29678
00-28612

c. Log fails to contain stage 2 appeals

PHS File Number	PHS File Number	PHS File Number	PHS File Number
7260	32207	23601	19163
15250	4644	21368	

5. Failure to provide an appropriate response to a written complaint

PHS File Number	PHS File Number	PHE File Number	PHS File Number
44955	26943	30743	28922
18959	41452	34634	37745
22199	40287	33315	17019
24601	28686	31049	34253

APPENDIX B – CLAIM ERRORS

1. N.J.S.A. 26:2J-8.1d(6), failure to pay clean 2000 Claims in a timely fashion, electronic claims not paid within 30 days and mailed claims not paid within 40 days:

Claim Number	Received	Paid	Days In Excess of 30 or 40
AW0208-949	04/07/2000	06/06/2000	20
DB1937-021	03/13/2000	05/23/2000	31
DE6899-008	05/09/2000	06/20/2000	2
DA1474-010	02/24/2000	04/21/2000	17
AW0208-934	03/30/2000	06/06/2000	28
DB5470-019	03/20/2000	05/09/2000	10
BX6632-019	01/07/2000	02/22/2000	6
DG3634-004	06/05/2000	07/18/2000	3
DA7205-033	03/06/2000	04/20/2000	5
89387O-001	08/29/2000	10/24/2000	26
BZ0303-006	02/03/2000	03/24/2000	10
DA8381-044	03/07/2000	05/02/2000	16
DC4262-006	04/03/2000	08/01/2000	80
DD2952-017	04/17/2000	07/11/2000	45
DF3042-004	05/18/2000	08/01/2000	35
DA7322-022	03/06/2000	10/12/2000	180
H79787-001	04/21/2000	10/06/2000	128
S22119-008	02/14/2000	05/09/2000	55
DA4842-009	03/01/2000	07/25/2000	106

2. N.J.A.C. 8:38-16.4(a), failure to pay clean 1999 claims within 60 days:

Claim Number	Received	Paid	Days In Excess of 60
BL7291-035	06/14/1999	04/25/2000	256
BO7257-008	08/02/1999	01/04/2000	95
BW7815-009	12/20/1999	02/29/2000	11
BR9493-008	09/27/1999	05/02/2000	158
BS7889-010	10/11/1999	01/25/2000	46
BX1730-003	12/28/1999	03/28/2000	31
BX1134-008	12/23/1999	04/18/2000	57
BX0694-002	12/27/1999	03/07/2000	11

Claim Number	Received	Paid	Days in Excess of 60
BV9820-039	12/06/1999	07/04/2000	151
BY8259-018	12/03/1998	10/30/2000	637
BU4511-002	11/08/1999	04/11/2000	95
L85156-005	03/27/1999	04/04/2000	314
BL1321-002	06/04/1999	04/11/2000	252
BL2139-005	06/07/1999	04/11/2000	249

3. Failure to Pay Interest

a. N.J.A.C. 8:38-16.4(b), failure to pay interest on 1999 claims not paid within 60 days:

Claim Number	Received	Paid	Days In Excess of 60
BO7257-008	08/02/1999	01/04/2000	95
BW7815-009	12/20/1999	02/29/2000	11
BR9493-008	09/27/1999	05/02/2000	158
BS7889-010	10/11/1999	01/25/2000	46
BX1730-003	12/28/1999	03/28/2000	31
BX1134-008	12/23/1999	04/18/2000	57
BX0694-002	12/27/1999	03/07/2000	11
BV9820-039	12/06/1999	07/04/2000	151
BL7291-035	06/14/1999	04/25/2000	256
BY8259-018	12/03/1998	10/30/2000	637
BU4511-002	11/08/1999	04/11/2000	95
L85156-005	03/27/1999	04/04/2000	314
BL1321-002	06/04/1999	04/11/2000	252

b. N.J.S.A. 26:2J-8.1d(7), failure to pay interest on 2000 Claims, electronic claims not paid within 30 days and mailed claims not paid within 40 days:

Claim Number	Received	Paid	Days In Excess of 30 or 40
AW0208-949	04/07/2000	06/06/2000	20
DB1937-021	03/13/2000	05/23/2000	31
DE6899-008	05/09/2000	06/20/2000	2
DA1474-010	02/24/2000	04/21/2000	17
H79787-001	04/21/2000	10/06/2000	128

DB5470-019	03/20/2000	05/09/2000	10
BX6632-019	01/07/2000	02/22/2000	6
DG3634-004	06/05/2000	07/18/2000	3
DA7205-033	03/06/2000	04/20/2000	5
89387O-001	08/29/2000	10/24/2000	26
DA7322-022	03/06/2000	10/12/2000	180
DA4842-009	03/01/2000	07/25/2000	106
AW0208-934	03/30/2000	06/06/2000	28

4. Improper Denial Codes

N.J.S.A. 26:2J-8.1d(2), and N.J.S.A. 17B:30-13.1(n), Denial Codes that fail to fully explain a denial:

Code	Message	Deficiency
A6	Prior Approval Not Obtained or Services are Non-Emergent.	Generally, emergent services do not require prior approval; however, non-emergent services may very well require such prior approval. The reason stated in the message may result in confusion to the member because the message incorrectly intimates that prior approval is a requirement not associated with non-emergent services.
AX	Charges exceed the dollar maximum per provider contract.	It is not clear what type of dollar maximum is applicable (daily, weekly, etc.), the amount of the maximum, or where the exclusion appears in the provider contract.
KP	Charges disallowed per reimbursement rules.	The message must provide a specific reference to a rule.
KR	Claim illegible – unable to identify specific information on claim and/ or attached documents – please resubmit.	The illegibility must be pinpointed so the claimant will not resubmit the claim with the same error.

Code	Message	Deficiency
LA	Prior authorization required and not obtained or service was reviewed and deemed not medically necessary.	The message must state which of the two reasons is applicable.
LB	Services rejected – Prior authorization required and not obtained or service was reviewed and deemed not medically necessary.	The message must state which of the two reasons is applicable.
LV	Prior authorization requirements have not been met. Charges related to Behavioral Health admissions should be communicated to the PHS provider Services Department.	The reference to Behavioral Health admissions should not be paired with a denial for failure to obtain prior authorization, as this denial may be issued for services other than Behavioral Health admissions.
MO	Procedure code does or does not require a modifier.	The message must state which of two conditions is applicable and must explain what a “modifier” is.
PA	Prior authorization not obtained or exceeds the prior authorization visit limit – Member responsible for payment.	It is unclear whether the member did not obtain an authorization, or if the member reached a visit limit on a current authorization.
PK	Prior authorization not obtained or exceeds the prior authorization visit limit – Member responsible for payment.	It is unclear whether the member did not obtain an authorization, or if the member reached a visit limit on a current authorization.

Code	Message	Deficiency
PZ	These services are not covered under this member's plan.	The message must set forth the contractual basis for the exclusion in an informative manner.
QA	Charge denied due to subscriber contract limitations-Member responsible for payment.	The message must set forth the contractual basis for the exclusion in an informative manner.
RF	The number of procedures or amount of time exceeds the maximum defined.	The message must state which of the conditions is applicable, what the maximum is and reference the contract provision.
UC	Procedure is not covered for members OR provider is not participating & service is non-emergent.	The message must state which of the conditions is applicable and reference the contract provision.
UP	Charges denied per subscriber contract, reimbursement rules or evidence of coverage. Member responsible for this charge.	The message must state which of the conditions is applicable, identifying whether the source of the denial is the contract, the reimbursement rules or the evidence of coverage and make specific reference to the contract provision or exclusion, if applicable.

5. N.J.S.A. 26:2J-8.1d(2)e and N.J.S.A. 17B:30-13.1(n), failure to fully explain a denial:

Claim Number	Denial Code Used	Sample
BW6920-005	LV	1999 Denied
84055L-001	KP	2000 Denied
DA7313-012	LV	2000 Denied
BY1211-044	KP	2000 Denied
DG4947-015	AX	2000 Denied
DA2698-016	KP	2000 Denied
DE3768-047	LV	2000 Denied
09973L-003	UP	2000 Denied
BX2330-044	LV	2000 Denied
BY6751-017	KP	2000 Denied
DG7454-015	PA	2000 Denied
BT0565-007	KP	1999 Retroactive Denial
BY7910-007	KP	1999 Retroactive Denial
BU4050-025	LV	1999 Retroactive Denial
BX1695-005	LV	1999 Retroactive Denial
BR5727-050	LV	1999 Retroactive Denial
BT1041-024	KP	1999 Retroactive Denial
BH3709-042	LV	1999 Retroactive Denial
80239J-001	LV	2000 Retroactive Denial
89387O-001	LB	2000 Retroactive Denial
DF3250-036	LA	2000 Retroactive Denial
BX5950-014	LA	2000 Retroactive Denial
BX8356-008	KP	2000 Retroactive Denial

6. N.J.S.A. 26:2J-8.1d(2) and N.J.S.A. 17B:30-13.1(e), failure to deny claims within 30 days of receipt:

Claim Number	Received Date	Denied Date	Days in Excess of 30
09973L-003	04/25/2000	06/02/2000	8
BY0518-029	01/14/2000	02/18/2000	5
DC4654-022	04/04/2000	05/10/2000	6
DF3119-042	05/19/2000	06/23/2000	5
DF5977-037	05/23/2000	06/27/2000	5
DF6583-002	05/24/2000	07/21/2000	28
DH0699-007	06/16/2000	07/21/2000	5

APPENDIX C - LATE INQUIRY RESPONSES

Inquiry number	Issue date	Response date	Working days over ten
29	08/25/00	10/13/00	24
53	09/27/00	10/16/00	3
59	08/31/00	10/16/00	21
60	08/31/00	09/25/00	3
61	09/05/00	10/13/00	18
66	09/01/00	10/13/00	19
69	09/05/00	10/13/00	18
74	09/06/00	11/09/00	36
89	09/20/00	10/12/00	6
100	09/25/00	10/19/00	8
105	09/29/00	10/20/00	5
109	09/27/00	10/16/00	3
110	09/28/00	10/16/00	2
114	10/04/00	10/24/00	4
121	10/03/00	10/25/00	6
133	10/05/00	01/18/01	62
174	10/23/00	11/13/00	5
175	10/23/00	11/09/00	3
179	10/25/00	01/10/01	41
180	10/25/00	11/13/00	3
184	10/26/00	01/18/01	46
186	10/27/00	11/21/00	7
187	10/30/00	12/13/00	20
189	10/31/00	11/29/00	9
190	10/31/00	12/12/00	18
193	11/06/00	12/06/00	10
196	11/09/00	01/18/01	36
199	11/15/00	12/06/00	3
200	11/15/00	12/06/00	3
201	11/17/00	12/22/00	13
202	11/16/00	12/22/00	14
205	11/21/00	01/02/01	16
206	11/21/00	12/14/00	5
209	11/29/00	01/16/01	20
210	11/30/00	02/13/01	41
212	12/15/00	01/09/01	5
213	12/13/00	01/17/01	11
214	12/18/00	01/09/01	9
215	12/20/00	01/08/01	2
218	01/04/01	01/12/01	17

VERIFICATION PAGE

1. I, Marleen J. Sheridan, am the Examiner-in-Charge of the Market Conduct Examination of Physicians Health Services of New Jersey conducted by examiners of the New Jersey Department of Banking and Insurance. This verification is based on my personal knowledge as acquired in my official capacity.

2. The findings, conclusions and recommendations contained in the foregoing report represent, to the best of my knowledge, a full and true statement of the Market Conduct examination of Physicians Health Services of New Jersey as of November 9, 2000.

3. I certify that the foregoing statements are true. I am aware that if any of the foregoing statements made by me is willfully false, I am subject to punishment.

_____ _____

Date: Marleen J. Sheridan
Examiner-In-Charge,
New Jersey Department
of Banking and Insurance