Market Conduct Examination

Triad Healthcare, Inc.
(A Licensed Organized Delivery System)

PLAINVILLE, CONNECTICUT

STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

Office of Consumer Protection Services

Market Conduct Examination and Anti-Fraud Compliance Section

Report Adopted: November 16, 2009

MARKET CONDUCT EXAMINATION

of

Triad Healthcare, Inc

(A Licensed Organized Delivery System)

located in

Plainville, Connecticut

as of

March 17, 2009

BY EXAMINERS

of the

STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

OFFICE OF CONSUMER PROTECTION SERVICES
MARKET CONDUCT EXAMINATION AND ANTI-FRAUD COMPLIANCE SECTION

REPORT ADOPTED:
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I. INTRODUCTION

This is a report of the Market Conduct activities of Triad Healthcare, Inc., a licensed Organized Delivery System (ODS), hereinafter referred to as "Triad" or "the Company". This review was limited to chiropractic services that Triad performed as an ODS on behalf of Aetna Health, Inc. Authority for this examination is found under **N.J.S.A. 26:2J-18.1** and **N.J.S.A. 17B:30-16**, made applicable to the operations of a health maintenance organization by **N.J.S.A. 26:2J-15b**. Further authority for this examination is found under the provisions of **N.J.A.C. 11:22-4.7**, made applicable to the operations of an ODS by **N.J.S.A. 17:48H-33**. Lastly**, N.J.A.C. 11:22-4.7** requires an ODS to open its books and records for an examination. Market Conduct Examiners of the New Jersey Department of Banking and Insurance (hereinafter the Department or DOBI) conducted the examination. The examiners present their findings, conclusions and recommendations in this report as a result of their market conduct examination of the Company. The Market Conduct Examiners were Examiner-in-Charge Clifton J. Day, Monica Koch and Robert Greenfield.

A. SCOPE OF EXAMINATION

The scope of the examination included chiropractic coverage provided in health benefit plans issued in New Jersey. The main purpose of this examination was to determine compliance with fair settlement practices, including Triad's claim determination methodology with respect to precertification or preauthorization of treatment. Specific emphasis was placed on Triad's remediation efforts incident to DOBI **Bulletin 07-23**, which required all New Jersey ODS's to re-adjudicate all claims improperly denied due to a network provider's failure to obtain preauthorization or precertification of medical treatment. Additional focus included appeal rights notification requirements outlined in **N.J.A.C. 11:24B-3** and **N.J.A.C. 11:24-8.4**, and record viability, accuracy and auditability requirements specified in **N.J.A.C. 11:22-1.5(d)** and **N.J.A.C. 11:2-17.12(b)**.

The review period for this examination was October 2006 to December 31, 2008 for all random sample and population review datasets. The examiners completed their fieldwork at the Company's Plainville, Connecticut offices from January 5, 2009 to January 9, 2009. Additional review work was completed thereafter, in Trenton, New Jersey.

The random selection process that the examiners used in this examination is in accordance with the National Association of Insurance Commissioners' (hereinafter "NAIC") Market Regulation Handbook, Chapters 16 and 20.

B. ERROR RATIOS

Error ratios are the percentage of files reviewed that the Company handled in error. Each file mishandled or not handled in accordance with applicable statutes is

an error, and the examiners cited all such errors in the report. Some files contained one error and others contained several. 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. The examiners count a file in error when a company mishandles it or treats an insured or member unfairly, even if no statute or regulation is applicable. In the event that a company corrects an error because of a consumer complaint or due to the examiners' findings, the examiners included it in the error ratio. If a company corrected an error independent of a complaint or DOBI intervention, the examiners did not include the error in the error ratios.

There are errors cited in this report that define practices 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 a business practice of a company that may be technical in nature. Although such practice would not comply with law, the examiners would not count each of these files as an error in determining the error ratios. The examiners indicate in the report that follows whenever they did not count a particular file in the error ratio.

The examiners submitted written inquiries to Company representatives on the errors and exceptions cited in this report. This provided Triad with the opportunity to respond to the examiners' findings and to provide comments on the statutory errors or mishandlings reported herein. On those errors and exceptions with which the Company disagreed, the examiners evaluated the individual merits of each response and considered all comments. In some instances, the examiners did not cite the files due to the Company's explanatory responses. In others, the errors or exceptions remained as cited in the examiners' inquiries. Finally, where the examiners did not submit an inquiry on stated findings, Triad retained the option to provide a complete rebuttal in response to the draft report.

For the most part, this is a report by exception, in that findings reported are mostly files in error.

C. COMPANY PROFILE

Triad Healthcare Inc. was established in December, 1996 as a subsidiary of the NCMIC Group (National Chiropractic Mutual Insurance Company), through the acquisition of Managed Chiropractics Inc., a chiropractic Independent Practice Association based in Denver, Co., SPINE of Burlington, MA, Chiropractic Network Services (CNS) of Lynnwood, WA and Associated Chiropractic Clinics (ACC) of Dallas, TX. During its early years, Triad Healthcare served an emerging PPO industry by offering a national network of credentialed chiropractic providers. Triad's early business models focused on building and managing networks of physical

medicine specialists for health plans, workers compensation companies, and employers.

In 2000, Triad re-defined its suite of products and services to focus on offering health plans, employers and other payers uniquely positioned in managed care solutions for the management of care for patients with pain, and by 2003, became an independently owned and operated corporation, with no financial or administrative ties to any entity (e.g., parent company, financial partner, etc.)

Triad developed a proprietary claims adjudication system that was designed around a set of rules that help to categorize claims for processing. Since it is configurable, the claims system permits processing rules, which can be tailored to meet the specific needs of health plan clients.

The Claims System is designed to produce various output formats. Remittance Advices and Explanations of Benefits are created in an electronic format that can be printed and distributed via postal service. Additionally, the output can be exported electronically in various and customizable file formats or made available upon a secured website.

Triad currently services Commercial and Medicare lines of business in Iowa, New Jersey, New York and South Dakota for Managed Care and HMO carriers. Triad's products and services include provider account management, provider data collection, outpatient care planning services and provider coaching, claims processing and payment including issuance of explanation of benefit statements and quality management assistance with complaints, appeals, grievances and reporting.

II. Claims Adjudication

A. INTRODUCTION

Based on electronic records that Triad provided to the examiners on January 5, 2009, the Company processed a total of 450,379 claim events during the period October 1, 2006 to December 31, 2008. The examiners define a claim event as one discreet date of service for a particular type or level of treatment associated with a unique Current Procedural Technology (CPT) code. Of these, Triad paid 238,924 claim events upon first submission and denied 211,455 claim events upon first submission. As indicated below, the examiners were unable to develop an accurate distribution of claim denials by type and frequency due to inconsistent use of claim denial codes and claim denial descriptions.

Incident to DOBI **Bulletin 07-23** referenced above in Section I.A, Scope of Examination, Triad reopened and reprocessed 36,466 previously denied claim events during the review period. The remediation process continued after the examination field work concluded.

B. ERROR RATIOS

The examiners calculated the error ratios by applying the procedure outlined in the introduction of this report. The examiners reviewed 40 claims from a population of 8,608 claims that Triad remediated pursuant to **Bulletin 07-23**. Of these, the examiners found all 40 claims in error for an error ratio of 100%.

C. EXAMINERS' FINDINGS

1. Failure to Fully Implement Remediation Plan in Accordance with New Jersey Department of Banking and Insurance Bulletin 07-23 (6,016 Claim Events in Error Representing $36,434 in Unremediated Benefits; 18 Random Claim Events) - Improper General Business Practice

On December 7, 2007, the New Jersey Department of Banking and Insurance issued **Bulletin 07-23** as a reminder to all insurers authorized to transact business in New Jersey, all Heath Service Corporations, Health Maintenance Organizations and Organized Delivery Systems that **N.J.A.C. 11:24B:5.2(c)6** prohibits an ODS from "…administratively denying and withholding all reimbursement on claims submitted by network providers for medically necessary services which would otherwise be covered but for the provider's failure to obtain required pre-certification, pre-authorization or acknowledgement or prior notice…" In order to avoid penalties for

noncompliance, the Bulletin further directed all applicable entities to submit a remediation plan to the Department for approval, as well as verification that erroneously denied claims were ultimately paid with interest.

In response to this Bulletin, Triad provided a Plan of Correction to the Department on January 31, 2008. That Plan included Triad's intent to isolate all CPT Codes that were the subject of improper denial due to lack of preauthorization. Once Triad identified all impacted CPT Codes, the Company began to issue written notice to all applicable providers advising that previously denied claims due to lack of preauthorization would be reviewed for medical necessity and payment where warranted. However, while reviewing claim records the examiners discovered two CPT Codes (98943 and 97010) that were subject to **Bulletin 07-23** but not remediated and not included in the Plan of Correction. In response to an inquiry, Triad advised that it mistakenly omitted these CPT Codes from its remediation plan.

a. Census Review

The examiners queried Triad's claim database and found that Triad denied an aggregate of 6,016 CPT Code 98943 and CPT Code 97010 events for lack of preauthorization. Combined, Triad erroneously denied a total of $36,434 in claimed benefits that were never remediated or reviewed for medical necessity as required by **Bulletin 07-23**.

b. Random Review

From the random selection of 40 claim files, the examiners found a total of 18 claims that contained a total of 26 CPT Codes (98943 and 97010) that Triad denied contrary to **N.J.A.C. 11:24B:5.2(c)6** and failed to remediate pursuant to **Bulletin 07-23**. In response to an inquiry, Triad advised that it would include these CPT Codes in its Plan of Correction (hereinafter referred to as "remediation plan").

Please See Appendix A1 for Random Claim Events in Error

2. Unfair Denials based on Erroneous Precertification Requirements (26,742 Claim Events in Error Representing $585,083 in Denied Benefits) - Improper General Business Practice

a. Provider Contract

Pursuant to **N.J.A.C. 11:24B-5.2(c)6**, and further in reference to **Bulletin 07-23** as addressed above, no provider agreement contract shall contain any restriction stating that "…payment to a provider with respect to a medically necessary health care service or supply will be denied if the service was not pre-certified or pre-authorized." The examiners note that, for the period October 2006 to June 2008, Triad's chiropractic provider contract did not include a precertification clause; nor did it specify that failure to precertify treatments would result in a denial of benefits.

Despite this contractual silence, Triad nevertheless denied all claim events in which a provider failed to obtain precertification. This resulted in a de facto inclusion of a precertification requirement in a manner that is inconsistent with **N.J.A.C. 11:24B-5.2(c)6**. Moreover, the examiners reference **N.J.A.C. 11:22-4.4**, which outlines an ODS's obligation to submit an application of licensure and to provide for the Department's review all information outlined in Exhibit A in the appendix to that subchapter. The examiners also reference that portion of Exhibit A, Checklist of Documents Required, Part A Section 8, which addresses the need for an ODS to submit for Departmental review all proposed provider agreements between the ODS and providers. To the extent that denials for lack of provider preauthorization were not specified in the provider contract submitted to the Department pursuant to **N.J.A.C. 11:22-4.4**, the examiners further reference **N.J.A.C. 11:22-4.6(a)**, which requires an ODS to file for approval any material modification to such contracts. Triad's imposition of a claim denial as a consequence of a provider's failure to submit an Individual Care Plan (ICP) for purposes of preauthorization serves as a material modification to the provider contract in a manner that is prohibited by **N.J.A.C. 11:22-4.6(a),** since it was not submitted to or approved by the Department.

Moreover, a flat denial for lack of preauthorization where benefits may be medically necessary is further inconsistent with **N.J.S.A. 26:2J-8.1d(1)** and **N.J.A.C. 11:22-1.5(a)1**, which permitted Triad 30 days to investigate and settle claims submitted electronically, and **N.J.S.A. 26:2J-8.1d(1)** and **N.J.A.C. 11:22-1.5(a)2**, which permitted Triad 40 days to investigate claims submitted manually. Triad had an obligation to attempt to resolve these claims simply by requesting an ICP rather than instantly denying these claims immediately upon receipt. Such denials are contrary to **N.J.A.C. 11:2-17.9(b)**, which obligated Triad to request additional proofs to establish entitlement to benefits, such as an ICP, where it is otherwise apparent that benefits may be payable. Denial at onset circumvents this requirement. Such automatic denial is also a violation of **N.J.S.A. 17B:30-13.1(d),** which prohibits refusal to pay a claim without conducting a reasonable investigation based upon all available information. The examiners do note, however, that Triad advised that it would reopen a claim if a provider submitted additional information in response to a denial.

b. Member Contract

Lastly, Triad's preauthorization denials are also inconsistent with **N.J.S.A. 17B:30-13.1(a)**, which prohibits misrepresentation of "…pertinent facts or insurance policy provisions relating to coverages at issue." The examiners reviewed the member benefit plan and found no language that imposes a preauthorization, prior approval or precertification requirement as a contingency for benefit eligibility. Therefore, denial of benefits based on lack of preauthorization misrepresents pertinent facts outlined in the member benefit plan.

In response to the examiners' inquiries, Triad disagreed with these errors but did state it willingness to cease its practice of denying claims for lack of

preauthorization. Based on discussion with DOBI relative to its January 2008 Plan of Correction, Triad amended its provider contract to include a preauthorization requirement and a 50% provider penalty where preauthorization is not obtained.

Based on datasets provided by the Company, Triad erroneously denied and is currently remediating a total of 26,742 claim events representing an aggregate denial of $585,083 in fee-scheduled benefits. See Recommendations.

3. Failure to Provide Reasonable Explanation for Denial of Benefits (35 Random Files in Error) and Utilization of Misleading Statements in Written Notice of Adverse Determinations (40 Random Sample Files in Error) – Improper General Business Practice

Pursuant to **N.J.S.A. 17B:30-13.1(n)**, Triad is required to provide a reasonable, factual explanation of the basis for denying a claim. **N.J.A.C. 11:2-17.8(a)** supplements **N.J.S.A. 17B:30-13.1(n)** by requiring Triad to provide a specific reference to the language of a policy provision and a statement of the facts which make that language operative when denying a claim due to a policy provision. Contrary to this statute and regulation, the examiners found 40 claims in error from the random sample in which Triad failed to provide a reasonable explanation for claim denial and further failed to state the policy provision applicable to the denial. Additionally, and contrary to **N.J.S.A. 17B:30-4,** Triad included misleading statements in its denial notice to the provider/member. The following examples are representative of these findings. However, this error occurred on all 40 claims that the examiners randomly selected for review.

a) Claim Number 169543. Triad issued a denial letter on December 18, 2008 for reprocessed CPT Codes 98940, 98943, 97010 and 97112 for date of service October 12, 2006. Triad's denial notice utilized denial code D-1, which stated that the Company did not review the denied services for medical necessity. However, the immediately following sentence stated that, "This coverage decision was based upon the Covered benefits/determination of Chiropractic Necessity (emphasis added)." The latter reason is clearly a contradiction to the former, and therefore not reasonable and factual within the context of **N.J.S.A. 17B:30-13.1(n)**. One of these statements is true and the other is false; contemporaneously, however, the reason for denial is counterintuitive and misleading within the context of **N.J.S.A. 17B:30-4**.

This denial notice also included two subsequent, successive "OR" arguments or conjunctions that do not satisfy the applicable reasonableness and factual notice requirements outlined above and specified in **N.J.S.A. 17B:30-13.1(n)**. A notice that requires the provider or member to determine which of the "OR" arguments is applicable is unreasonable. Moreover, in the first "OR" argument Triad stated that, "This coverage decision was based upon the General Provisions described in your Certificate of Coverage. Please reference your Certificate of Coverage under the section General Provisions for a full explanation of the coverage available." In the immediately succeeding "OR" argument Triad stated that, "This coverage decision was based upon the Exclusions and Limitations described in your Certificate of

Coverage with respect to experimental or investigational treatment. Please refer to your Certificate of Coverage under the section Exclusions and Limitation for a full explanation of the coverage available." Contrary to **N.J.A.C. 11:2-17.8(a)**, these reasons merely refer the claimant to that portion of the contract that contains language applicable to the denial rather than the actual language and facts that make that language operative. Regarding the latter "OR" argument, Triad never identified which of the four denied CPT Codes was experimental; nor did Triad state the facts or rationale behind this determination as required by **N.J.S.A. 17B:30-13.1(n)** and **N.J.A.C. 11:2-17.8(a)**.

b) Claim Number 169349. Triad issued a denial letter on December 18, 2008 for reprocessed CPT Codes 98941, 97010 and 97014 for date of service December 12, 2006. Triad's denial notice utilized denial code D-1 on CPT Codes 98941 and 97014, which stated that payment was denied because, lacking documentation of further improvement, ongoing treatment was not medically necessary. Similar to claim number 169543 referenced above, Triad included the same erroneous "OR" arguments on claim number 169349. Additionally, on denied CPT code 97010 on claim number 169349, Triad utilized denial code D-2, stating that, "These services were not reviewed for medical necessity." Contrary to **N.J.S.A. 17B:30-13.1(n)** and **N.J.A.C. 11:2-17.8(a)**, this language provides neither a reasonable explanation nor the factual basis for denial. Taken literally, it merely states what steps Triad did not take to develop its decision to deny payment. Further complicating the viability of this denial is Triad's continued utilization of the "OR" arguments in the same manner as claim number 169543.

The examiners note that the D-1 reason code for denial on claim number 169349 (denial due to lack of medical necessity) contradicts the D-1 denial reason code on claim number 169543 (services not reviewed for medical necessity). Moreover, Triad's denial on claim number 169349 also includes denial code D-2 for CPT code 97010 which states that, "These services were not reviewed for medical necessity." However, this reason was identified as denial code D-1 on claim number 169543. In response to the examiners' inquiries regarding these denial notice inconsistencies between claim numbers 169543 and 169349, Triad advised that denial codes are not static and can be overridden by the claim adjudicator to address any unique circumstances on any given claim. For purposes of the broader examination, the examiners were unable to rely on any systems-defined denial codes to isolate any specific type of denial. This issue is addressed further in item 4 below.

c) Claim Number 169195. Triad issued a denial letter on December 16, 2008 for reprocessed CPT Codes 98942, 97010, 97014, 97032, 97112 and 98941 for date of service November 8, 2006. Triad's denial notice utilized denial code D-1 on CPT code 97032, which stated that use of passive therapies were no longer medically necessary based on prior treatment history, date of injury, duration of treatment and overall positive response to treatment. On this file, medical necessity determination D-1 was based on maximum response to a passive modality (electrical stimulation). However, medical necessity determination denial code D-1 on claim number 169349

was based on minimum or non-existent response to an active modality (chiropractic manipulation). This serves as yet another example of denial code inconsistency.

On CPT Codes 98942, 97010, 97014, 97112 and 98941, Triad utilized denial code D-2, stating that, "These services were not reviewed for medical necessity." Contrary to **N.J.S.A. 17B:30-13.1(n)** and **N.J.A.C. 11:2-17.8(a)**, this language provides neither a reasonable explanation nor the factual basis for denial. Taken literally, it merely states what steps Triad did not take to develop its decision to deny payment. Further complicating the viability of this denial is Triad's continued utilization of the "OR" arguments in the same manner as claim numbers 169543 and 169349.

Please See Appendix A2 for all Random Files in Error

4. Failure to Maintain Auditable Claim Records and Unfair Denials

N.J.A.C. 11:22-1.5(d) and **N.J.A.C. 11:2-17.12** require a company to maintain an auditable record of claim transactions and records in a manner that permits the Department to reconstruct a company's claim settlement activities. Contrary to this requirement, the examiners found that Triad's electronic and manual claim record system and methodology does not reliably or accurately document claim settlement activity. Notably, Triad's response to inquiries regarding inaccurate or missing information resulted in the examiners' determination of unfair settlements prohibited by **N.J.S.A. 17B:30-13.1(f)**. The following examples are representative of these findings. However, these errors also occurred on all 40 claims that the examiners randomly selected for review due to, among other things, systemic form language.

a. Use of Inconsistent, Conflicting and Outdated Information on Written Claim Denials

In response to the examination call letter, Triad provided the examiners with a list of all denial codes and a narrative description of the denial reason that accompanied each code. Prior to arrival at the Company's Plainview, CT office, the examiners queried Triad's population-wide claim dataset to determine the frequency of each denial type and to establish reason subsets for sampling purposes. This process became meaningless because, as outlined in Section II.C.3 above, Triad utilizes claim denial codes that can be overwritten by the claim processor, resulting in inconsistent use of denial codes from one claim to another. This impeded the examiners' ability to sort denial codes by reason in any meaningful manner, thus impeding the claim reconstruction and analysis process.

As further outlined in Section II.C.3 above, Triad utilized "OR" arguments regarding exclusions due to coverage and contract provisions, as well similar arguments regarding the provider's purported use of experimental or investigational treatment, but without any specificity as to why and how Triad determined that such treatment was in fact experimental. Such ambiguity further impeded the examiners' ability to reconstruct claim settlements and ascertain the actual reason for denial.

Lastly, the examiners found that Triad's denial notices include CPT Codes that were previously paid. As an example, Triad denied reprocessed claim number 169543 on December 18, 2008 for CPT code 98940, 97112 and 98943 for date of service October 12, 2006. Triad utilized denial code D-1, stating that "Coverage … has been denied (because) … [t]hese services were not reviewed for medical necessity." In response to an inquiry and in a meeting with the medical director, Triad advised that these CPT Codes were in fact paid on February 5, 2007. Triad explained this disparity, indicating that its 2008 remediation program incident to **Bulletin 07-23** included a review of all Remittance Advices in which Triad denied at least one CPT code event. Consequently, all CPT codes, including those that were paid throughout 2006 through 2008, were also listed on the reprocessed denial notice as not being subject to review or payment due to lack of medical necessity by virtue of prior payment. However, this was not apparent when reviewing denial notices. This process impedes the provider's ability to reconcile denial notices with accounting records, and further undermines the ability to respond to Triad's request for records on remediated files.

As an example on claim number 169543 above, CPT Codes 98940, 97112 and 98943 were initially paid on February 5, 2007 and then reported to the provider during the subsequent remediation process as "denied" 22 months later, on December 18, 2008. This process not only complicates the audit process, but also causes additional confusion to providers since nothing prompts the provider that the reprocessed claim denials were in fact previously paid and therefore not subject to reprocessing under **Bulletin 07-23**. From the providers' perspective, these claims appeared to be unfairly denied due to the inability to reconcile information on the current Remittance Advice/denial notice with the prior Remittance Advice, which Triad could have issued up to two years prior to the current notice. This process is further complicated due to aggregation of multiple claims on one Remittance Advice as addressed in subsection b below.

b. Aggregation of Multiple Claims and CPT Codes on One Remittance Advice that Accompanies Claim Denial

While conducting the random file analysis, the examiners reviewed Triad's Remittance Advices (RA) which serve as the Company's Explanation of Benefits to the provider. The examiners noted that the RA contains payment determinations for multiple members with multiple dates of service. Included on the RA is the CPT code for a specific date and claim number corresponding to that date, billed amount, allowed amount, copayment amount, interest, net payment and adjustment or determination code.

The examiners reviewed one additional randomly selected, pre-remediated RA dated January 8, 2007 relative to claim number 169349 that the examiners previously addressed in Section II.C.3.b above. The examiners noted that pages one through three of this RA included 9 claims with a total of 35 CPT code claim events among

five members. Dates of service spanned the period December 19, 2006 to December 27, 2006. Page three of this RA listed the total amount billed for all 35 CPT Codes as $1,525.00, an aggregate copay of $79.00 and a net payment of $53.59, or only 3.5% of the entire amount billed by the provider. Triad denied 34 of these 35 CPT Codes under denial code D-2, which stated that, "These services were formally denied because they were not authorized in advance..." This language is significantly different from that described in Section II.C.3.a through c above. This disparity, combined with aggregated totals derived from several claims, members, dates of service and CPT Codes, complicates the regulatory reconstructive process on the one hand, while creating confusion at the provider level. The latter is evidenced by several DOBI provider complaints asserting the inability to reconcile service dates and net payout on individual CPT Codes by member, which is further complicated by inconsistent and contradictory use of denial codes.

c. Manual Input Errors when Creating/Updating Electronic Claim System.

Cognizant of the above inconsistencies, the examiners nevertheless attempted to match specific claim numbers with specific members, CPT Codes, dates of service, care plans and denials in order to reconstruct Triad's claim settlement activity. This process required that the examiners match a series of successive care plan filings that have specific beginning and ending dates with specific approved care plans, each having its own respective beginning and ending dates. The examiners then attempted to match dates of service with approved care plans to determine if denials were based on either pure medical necessity or the provider's failure to obtain preauthorization vis-a-vie an approved care plan. In many instances the examiners were unable to match dates of service recorded in the Company's electronic claim system with the treatment period stated in the care plan, thus defeating the examiners' attempts to reconstruct claim settlement. In response to the examiners' inquiries, Triad responded that keyboard input errors regarding dates of service caused some of these discrepancies. In other instances, Triad advised that provider documentation in response to its remediation plan under Bulletin 07-23 was not properly matched with the appropriate claim. The following examples illustrate these discrepancies and errors:

i. Claim Number 165378. Triad initially denied CPT Codes 99212, 98942 and 97012 for date of service February 26, 2007 due to the provider's failure to obtain preauthorization. Triad reopened the claim by issuing to the provider an impacted service letter on October 7, 2008, stating that the prior denials were subject to remediation pursuant to Bulletin 07-23. That letter also requested the provider to submit all applicable clinical records for purposes of determining payment eligibility. Triad received these records on November 19, 2008; however, the claim processing unit did not associate these records with the applicable CPT Codes for the February 26, 2007 date of service. Consequently, Triad's claim system erroneously coded this claim as non-payable due to the provider's failure to submit proper documentation in support of medical necessity. In response to an inquiry, Triad advised that this claim would be readjudicated.

ii. Claim Number 153141. The provider submitted medical documentation for CPT code 99204 for date of service April 20, 2007. Upon receipt on September 24, 2008, Triad erroneously coded the date of service as April 10, 2007. Consequently, Triad's claim system erroneously coded this April 20, 2007 claim as non-payable on the misconception that the provider failed to submit proper documentation in support of medical necessity for a non-existent April 10, 2007 date of service. In response to an inquiry, Triad advised that this claim would be readjudicated.

iii. Claim Number 155410. On March 6, 2007, Triad authorized as medically necessary CPT code 97035 for date of service March 2, 2007. Notwithstanding its approval, Triad erroneously denied this claim on April 2, 2007 for lack of medical necessity; Triad failed to associate the approved treatment time period with the applicable date of service. Consequently, the electronic claim system coded this transaction as an automatic denial due to lack of preauthorization. In January 2008, this CPT code was considered but not included in Triad's Bulletin 07-23 remediation plan; for unknown reasons, the claim system later interpreted the status of this claim as authorized. Since authorized status equates to the assumption of payment, Triad erroneously believed that this claim did not qualify for remediation when in fact the Company incorrectly denied the claim at onset in April 2007. In response to an inquiry, Triad advised the examiners that payment would be issued within seven days of February 9, 2009.

III. PROVIDER APPEAL MECHANISM

A. INTRODUCTION

The examiners reviewed Triad's internal appeal process and appeal mechanism for compliance with **N.J.A.C. 11:24B-3.9(a)**, **N.J.A.C. 11:24.8.4**, **N.J.A.C. 11:24.8.6** and the Health Claims Authorization, Processing and Payment Act (HCAPPA), **P.L. 2005, c.352**.

During the period January 2007 through December 2008, Triad advised that it received a total of 768 internal appeals. Of these, 298 internal appeals, or 39%, were resolved exclusively in favor of the provider, while 431 internal appeals, or 56%, were resolved exclusively in favor of Triad. An additional 30 internal appeals, or 4% of the total, were resolved with compromises between providers and Triad. Lastly, 9 internal appeals, or 1% of the internal appeals remained unresolved as of January 12, 2009. Triad reported that no provider or member filed for an external appeal during this same period.

B. ERRORS/EXCEPTION RATIOS

The examiners calculated the error ratios by applying the procedure outlined in the introduction of this report. For this review the examiners reviewed the same 40 files from Section II above, and found errors on all 40 files for an error ratio of 100%.

C. EXAMINERS' FINDINGS

1. Failure to Notify Provider and Member of Internal Appeal Rights on Remediated Preauthorization Denials that Triad Adjusted as Medical Necessity Denials (1,409 Claim Events in Error/40 Randomly Selected Filed in Error) – Improper General Business Practice

In accordance with **N.J.A.C. 11:24-8.4** and **N.J.A.C. 11:24-8.6**, made applicable to an Organized Delivery System pursuant to **N.J.A.C. 11:24B-3.9(a)**, Triad established an appeal mechanism to address adverse claim determinations such as denials, termination of or limitations in covered health care services. Specifically, Section 3.1 of Triad's Corporate Policy on Adverse Clinical Determination Appeals, and Section 2.1 of Triad's Corporate Policy on Administrative Denial of Services or Claims Payment states that, "Triad shall include an attached explanation of the relevant appeals process with all adverse determination notifications sent both to the member and to his/her health care provider." Inconsistent with the Company's appeal mechanism, Triad did not provide notice of appeal rights on 1,409 claim events that were denied due to lack of medical necessity (denial code D45). Failure to provide this disclosure is further contrary to **N.J.A.C. 11:24-8.3(e)** which requires a company

to include a written explanation of the appeals process along with a written notice of adverse determination. Where Triad's appeal mechanism established pursuant to **N.J.A.C. 11:24-8.4** and **N.J.A.C. 11:24-8.6** requires such notification, **N.J.A.C. 11:24-8.3(e)** is applicable. This error occurred as an improper general business practice during the months of September 2008 and November 2008. In response to an inquiry, Triad advised that it began issuing appeal rights notices with claim denials reprocessed pursuant to Bulletin 07-23 as of November 17, 2008.

2. Failure to Notify Provider and Member of External Appeal Rights Incident to Remediated and Non-Remediated Medical Necessity Denials (40 Random Sample Errors/2,399 Population Exceptions) – Improper General Business Practice

Pursuant to **N.J.A.C. 11:24-8.7(a)**, a member or provider "…who is dissatisfied with the results of an internal appeal process set forth at **N.J.A.C. 11:24-8.6** through **8.6** (stage one and stage two, respectively) … shall have the right to pursue (an) appeal (through) an independent utilization review organization (IURO)…" In order to assure that members and providers are aware of this right, **N.J.A.C. 11:24-8.3(e)** and Triad's own appeal mechanism requires a written claim denial to include an explanation of both the internal appeals process (**N.J.A.C. 11:24-8.5** for informal appeals and **N.J.A.C. 11:24-8.6** for formal appeals) and the external appeals process (**N.J.A.C. 11:24-8.7** through an IURO). Contrary to **N.J.A.C. 11:24-8.3(e)**, Triad's initial determination/denial letter does not identify the availability of an external appeal process; rather, it merely directs the member/provider to civil remedy incident to ERISA-based products.

The examiners found this deficient notice on 2,399 denied claim events that appeared in the overall population of denied claim events. This error occurred on all 40 files that the examiners randomly selected and reviewed in Section II of this report. Since this notice was a form utilized on all denials, the examiners cited this error as an improper general business practice.

3. Failure to Differentiate Time Period for Maximum Number of Days to File Internal Medical Necessity and Administrative Denial Appeals– Improper General Business Practice

Pursuant to U.S. Department of Labor regulation 29 CFR 2560.503-1(h)(3)1, a health care provider may initiate an internal medical necessity appeal within 180 calendar days from receipt of a payor's notice of claim denial or adverse determination. Pursuant to **N.J.A.C. 11:22-1.8(a)**, in conjunction with the New Jersey Health Claims Authorization, Processing and Payment Act (HCAPPA), P.L. 2005, c.352 effective July 11, 2006, a health care provider may initiate an internal prompt pay/administrative denial appeal within 90 calendar days from receipt of a payor's notice of an adverse administrative claim determination. Lastly, HCAPPA requires a company to describe its claim and appeals mechanism on a payor's website.

The examiners reviewed Traid's website and found, contrary to the above-stated requirements, that the Appeals and Grievances section, page 39 of the Company's web-based Provider Manual, states that "All appeals must be received within 180 days from the date of determination, unless other wise specified in the Plan Specific Addendum." The examiners reviewed and found that the New Jersey Plan Specific Addendum only included addresses where a provider should direct an appeal. Lacking any specificity or distinction with respect to 90-day administrative/HCAPPA appeals and 180-day medical necessity appeals, the examiners found that the web-based Provider Manual erroneously overstates by 90 days the time period for a provider to submit administrative appeals.

4. Failure to Utilize Proper Application Form for Appealing an Adverse Claim Determination - Improper General Business Practice

Pursuant to **Bulletin 06-16**, Triad should have provided in its appeal mechanism a specific form for medical providers to complete for purposes of filing an appeal due to adverse claim determinations. Accordingly, the Department created and disseminated through Bulletin 06-16 form number DOBICAPPCAR 07/06, designated as the Health Care Provider Application to Appeal a Claims Determinations. Page one of this form is a series of instructions. Page two of the form requests pertinent information on the provider, patient and claim handling process and outcome. Notably, this Bulletin permitted only non-substantive modification to this form, limited only to inclusion of a company logo. Inconsistent with **Bulletin 06-16**, Triad substantively modified form DOBICAPPCAR 07/06 to the extent that informational page one was omitted. Moreover, Triad modified page two of the form to the extent that it excludes information specified under the Bulletin, including but not limited to, information regarding assignment of benefits, release of medical records in the event of arbitration and whether or not the appeal was prompted due to company denial, inaction or delay. Triad's form also omits key instructions, such as, but not limited to, a directive to submit HCFA 1500(s) or UB92(s), Explanations of Benefits and itemized contract provisions relevant to the issue in dispute.

Triad disagreed with this error stating that, "The guidance provided with the form itself states the provider *may* use the State's form, but is not required to do so." The examiners disagree, as the guidance that the Department provided with the form was outlined in **Bulletin 06-16**, which states that, "Carriers may add their logo/brand if they desire. Other modifications are not permitted." The examiners found this inconsistency on all 40 claims reviewed from the random sample. The examiners cited this error as an improper general business practice since Triad utilized this language on all claim denials/adverse determinations.

IV. RECOMMENDATIONS

Triad should inform all responsible personnel who handle the files and records cited as errors in this report of the remedial measures that 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 a single error may indicate that more errors may have occurred.

Various non-compliant practices were identified in this report, some of which may extend to other jurisdictions. The Company is directed to take immediate corrective action to demonstrate its ability and intention to conduct business according to New Jersey law and regulations. When applicable, corrective action for other jurisdictions should be addressed.

The examiners acknowledge that during the examination, the Company agreed and had voluntarily complied with, either in whole or in part, some of the recommendations. On others, Triad remediated errors in response to Consent Order E09-46 issued in August, 2009. For the purpose of obtaining proof of compliance and for Triad 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 to be reopened for supplemental payments, the claim payment should be sent to the insured or provider with a cover letter containing the following first paragraph (variable language is included in parentheses):

"During a recent examination, the Market Conduct Examiners of the New Jersey Department of Banking and Insurance found errors in our claim denials and recommended a further review to determine if additional benefits and interest are payable. Our review indicated that we (improperly denied CPT Codes/underpaid CPT Codes) and are providing you with an updated (Explanation of Benefits/Remittance Advice). To correct this error, we are including a check for (insert amount) for the amount owed, as well as interest in the amount of (insert amount). If you have any questions regarding this process, please contact us at (toll free number) or write us at the address listed on the (Explanation of Benefits/Remittance Advice)."

On claims reopened due to failure to provide adequate notification of internal and external appeal rights, Triad should send to the insured a letter containing the following language:

"During a recent examination, the Market Conduct Examiners of the New Jersey Department of Banking and Insurance found that our claim settlement did not include adequate notice of your appeal rights incident to a denial of or reduction in benefits. To correct this error, we are providing you with an updated notice that permits you to submit an internal appeal for all claims denied from October 2006 through the present. If you have any questions regarding this process, please contact us at (toll free number) or write us at the address listed on the Explanation of Benefits."

B. CLAIM ADJUDICATION

1. Triad must conduct a systems analysis to identify and reprocess all instances in which the Company denied CPT code 98943 and 97010 for lack of preauthorization. This review must include all denials that occurred from October 2006 to the present. Where the review warrants payment, Triad must provide the cover letter referenced in the General Instructions section above. Where the review results in a denial, Triad must issue a valid notice of the provider's appeal rights pursuant to **P.L. 2005, c.352 (HCAPPA), N.J.A.C. 11:24-8.4**, **N.J.A.C. 11:24-8.6** and **N.J.A.C. 11:24B-3.9(a)**. Upon completion, Triad must provide the Commissioner with a resolution report that includes claim number, CPT code, date of service, amount billed, allowed amount, amount paid or denied, date paid, interest applied and dates utilized to calculate interest.

2. Based on the findings outlined in Sections II and III of this report regarding system input/date matching errors that caused erroneous denials, defective provider appeal notification, and in particular those findings outlined in sections II.C.2, 3 and 4, Triad must re-review its remediation results incident to **Bulletin 07-23** to assure that all denied impacted services have been properly readjudicated. To accomplish this, Triad should identify all impacted services that remained denied after completing its remediation program. Of those, Triad should review all available documentation to assure that: 1) provider treatment plans were properly matched to the correct date of service; 2) the denial was valid based on all other reasons. Where the remediated denial is deemed invalid, Triad must issue payment plus applicable interest to the provider or member. Where Triad deems the remediated denial valid, the Company must issue a valid appeal notice to the provider. Upon completion, Triad must provide the Commissioner with a resolution report that includes claim number, CPT code, date of service, amount billed, allowed amount, amount paid or denied, date paid, interest applied and dates utilized to calculate interest.

3. Pursuant to **N.J.A.C. 11:22-4.6(a)**, Triad must review its current provider contract to identify any language modifications that may have occurred between the date that it received initial contract language approval from the Department and the current period. Triad should also issue written instructions to all applicable personnel stating that language changes to provider contracts must be filed with and approved by the

Commissioner prior to use. Any changes identified from this review should be filed with the Commissioner for review.

4. Triad should issue written instructions to all personnel who process claims stating that **N.J.S.A. 26:2J-8.1d(1)** and **N.J.A.C. 11:22-5(a)1** require a company to pay clean electronic claims within 30 days following receipt by the payer of required documentation in support of an initial claim submission. These instructions should include a statement that, pursuant to **N.J.A.C. 11:2-17.9(b)**, Triad is obligated to utilize this time period in order to obtain a treatment plan. These written instructions should also state that failure to utilize this time for claim investigation is a violation of **N.J.S.A. 17B:30-13.1(d)** and **N.J.S.A. 17B:30-13.1(d)**, which prohibit denials devoid of proper investigation and unfair settlement.

5. The Company should issue written instructions to all claims personnel stating that **N.J.S.A. 26:2J-8.1d(1)** and **N.J.A.C. 11:22-1.5(a)2** require a company to pay clean mailed claims within 40 days following receipt by the payer of required documentation in support of an initial claim submission. These instructions should include a statement that, pursuant to **N.J.A.C. 11:2-17.9(b)**, Triad is obligated to utilize this time period in order to obtain a treatment plan. These written instructions should also state that failure to utilize this time for claim investigation is a violation of **N.J.S.A. 17B:30-13.1(d)** and **N.J.S.A. 17B:30-13.1(d)**, which prohibit denials devoid of proper investigation and unfair settlement.

6. Triad must issue written instructions to all applicable personnel stating that **N.J.S.A. 17B:30-13.1(a)** prohibits a company from misrepresenting pertinent facts or policy provisions.

7. In order to comply with **N.J.S.A. 17B:30-13.1(n), N.J.A.C. 11:2-17.8(a)** and **N.J.S.A. 17B:30-4**, Triad must cease its practice of utilizing misleading, contradictory and/or factually deficient statements in its claim denial notices. Specifically, Triad:

a) must avoid conjunctive statements that utilize "OR" conditions as the reason for denial;

b) may not include as reason for denial terms such as experimental or investigational unless the Company can support that assertion within the parameters outlined in **N.J.S.A. 17B:30-13.1(n)** and **N.J.A.C. 11:2-17.8(a)**;

c) may not state as the reason for denial any policy or contract provisions unless the Company provides specific reference to that language and the facts that make that language operative;

d) must modify its denial code set to avoid inconsistent and contradictory explanations of the reason for denial.

8. Triad must redesign its denial notice to comply with **N.J.S.A. 17B:30-13.1(n), N.J.A.C. 11:2-17.8(a)** and **N.J.S.A. 17B:30-4** for the reasons outlined in this report and recommendation number 7 above. Triad should submit for the Commissioner's review a modified denial notice format and template that addresses the informational concerns outlined in Section II.C.3 of this report.

9. The Company must remind all applicable staff that, pursuant to **N.J.A.C. 11:22-1.5(d)** and **N.J.A.C. 11:2-17.12**, Triad is required to maintain an auditable record of claim transactions and records in a manner that permits the Department to reconstruct a company's claim settlement activities. In order to comply with this requirement, Triad should:

a) cease its practice of including "OR" statements in its denial notices;

b) specify the exact reason(s) for denial on the notice with supporting information required by and in accordance with **N.J.S.A. 17B:30-13.1(n), N.J.A.C. 11:2-17.8(a)** and **N.J.S.A. 17B:30-4**;

c) update its denial notices to exclude claims previously adjudicated. Alternately, provide information on the notice that reflects current status in a manner that facilitates a provider's ability to discern the correct status of the claim or CPT code event;

d) redesign its practice of aggregating multiple claims and CPT Codes by multiple members on one remittance advice;

e) develop quality control measures to detect and prevent errors when claim staff associate treatment plans with specific treatment periods and service dates. Such measures should include methods to detect and prevent date keying and other errors that lead to invalid claim denials and the inability of regulatory agencies to reconstruct claim activity.

10. On claims numbers 169543, 169349 and 169195, Triad should provide evidence that these claims were reprocessed in the manner indicated in the Company's responses to the examiners' inquiries.

C. PROVIDER APPEALS MECHANISM

11. In order to comply with **N.J.A.C. 11:24-8.3(e)** and **N.J.A.C. 11:24-8.7(a),** and the Company's own appeal mechanism established pursuant to **N.J.A.C. 11:24-8.4** and **N.J.A.C. 11:24-8.6,** Triad must provide written instructions to all applicable personnel stating that all claims adjudicated as adverse determinations must be accompanied by an actual and accurate notice of the provider's internal and external appeal rights.

12. Triad must correct its web-based Provider Manual and all other non web-based manuals or protocols to distinguish between maximum 90-day appeal limitations on HCAPPA administrative denials and maximum 180-day appeal limitations on

medical necessity/utilization management denials. Triad should also notify all providers of this change in writing, upon receipt of the Adopted Market Conduct Report. In addition, all applicable revisions to the provider manual and other appeal-related documents should also be submitted in writing to providers in the next recurring annual appeal and Alternate Dispute Resolution (ADR) mechanism description required pursuant to **N.J.A.C. 11:22-1.8(c)**.

13. Pursuant to **P.L 2005, c. 352 (HCAPPA)** and **Bulletin 06-16,** Triad must cease its practice of utilizing a modified version of appeal form DOBICAPPCAR 07/06. For compliance purposes, Triad must submit to the Commissioner a revised appeal form that complies with **P.L 2005, c. 352 (HCAPPA)** and **Bulletin 06-16**. This form must contain instructional page one as well as all fields specified on page two of the approved form template.

APPENDIX A

1. Failure to Fully Implement Remediation Plan in Accordance with New Jersey Department of Banking and Insurance Bulletin 07-23 (18 Claims/26 CPT Claim Events in Error)

Claim No.	CPT Code	DOS	Claim No.	CPT Code	DOS
159005	97010	11/9/2006	169342	98943	12/22/2006
159005	98943	11/9/2006	169342	97010	12/22/2006
164607	98943	1/29/2007	169346	97010	12/19/2006
165509	97010	3/20/2007	169349	97010	12/20/2006
166625	98943	7/23/2007	169543	97010	10/12/2006
166754	98943	8/1/2007	169543	98943	10/12/2006
166754	97010	8/1/2007	169723	97010	12/27/2006
169195	97010	11/8/2006	169727	98943	3/2/2007
169279	97010	11/10/2006	169727	97010	3/2/2007
169286	98943	12/16/2006	169728	97010	3/5/2007
169286	97010	12/16/2006	169728	97010	3/5/2007
169329	98943	11/22/2006	169730	97010	3/14/2007
169329	97010	11/22/2006	170347	97010	7/11/2007

2. Failure to Provide Reasonable Explanation for Denial of Benefits and Utilization of Misleading Statements in Written Notice of Adverse Determinations (40 Random Sample Files in Error) – Improper General Business Practice

Claim No	Claim No	Claim No
169329	**156739**	**165378**
169723	**160732**	**153141**
169730	**161298**	**155410**
169728	**165379**	**165817**
169727	**165629**	**159005**
169346	**166417**	**168278**
169342	**166468**	**164934**
169286	**166489**	**169681**
169195	**166490**	**153061**
168527	**166890**	**156837**
162273	**166648**	
162326	**170755**	
166754	**168003**	
166625	**165974**	
160535	**153152**	

VERIFICATION PAGE

I, Clifton J. Day, am the Examiner-in-Charge of the Market Conduct Examination of Triad Healthcare, Incorporated, 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.

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 Triad Healthcare, Incorporated, as of March 17, 2009.

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	Clifton J. Day, MPA, CPM, CSM. Examiner-In-Charge and Manager, Market Conduct Examinations and Anti-Fraud Compliance Unit, New Jersey Department of Banking and Insurance