CONSENT ORDER NO. E11- 27

STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

In the Matter of:

Proceedings by the Commissioner of Banking and Insurance, State of New Jersey, to impose an administrative sanction on Oxford Health Plans (NJ), Inc. and United Healthcare of New Jersey, Inc.	)))))	**CONSENT ORDER**

TO: Oxford Health Plans (NJ), Inc.
United Healthcare of New Jersey, Inc.
48 Monroe Turnpike
Trumbull, CT 06611

This matter having been opened to the Commissioner of Banking and Insurance ("Commissioner") of the Department of Banking and Insurance ("Department") of the State of New Jersey, upon the filing of a Market Conduct Examination Report containing the results of the 2008-2009 market conduct examination ("examination") of Oxford Health Plans (NJ), Inc. and United Healthcare of New Jersey, Inc., (collectively the "Companies"), health maintenance organizations authorized to transact business in New Jersey pursuant to N.J.S.A. 26:2J-1 et seq., performed by the Department with the assistance of consultants; and

IT APPEARING that Department's examination was conducted to evaluate the Companies' compliance with various statutes and regulations applicable to health maintenance organizations. The examination revealed certain instances in which the Companies' practices did not comply with various provisions of applicable statutes and regulations. These instances, as fully set forth in the January 20, 2011 pre-adopted report, are incorporated herein by reference; and

IT FURTHER APPEARING that the Companies represent that they have complied or will comply with the recommendations in the January 20, 2011 pre-adopted

report and have taken or will take corrective measures to address the acts and omissions set forth in the report, including the reconsideration of claims with dates of service within eighteen (18) months from the date this Consent Order is executed that were previously denied by the Companies for failure to timely file, where the provider submitted the claim within one hundred and eighty (180) days from the date of service and where the provider has or can now produce proof that he, she, or it had a valid assignment of benefit from the member at the time the claim was submitted, such reconsideration shall be subject to all terms and conditions of coverage, except that a claim submitted as described above within one hundred and eighty days (180) days from the date of service with a valid assignment shall not be denied as untimely; and

IT FURTHER APPEARING that the Companies, without admitting any violation of the insurance statutes and regulations or any wrongdoing, having waived their right to a hearing, and having consented to pay an administrative fine in the amount of three hundred seventy five thousand dollars ($375,000) and to reimburse the Department for the costs of the 2008-2009 market conduct examination in the amount of six hundred thousand dollars ($600,000), in order to fully and completely resolve all issues arising from the examination; and

IT FURTHER APPEARING that this matter may be resolved upon the consent of the parties to these proceedings without resort to a formal hearing; and

NOW, THEREFORE, IT IS on this 8th day of April, 2011,

ORDERED AND AGREED that within thirty (30) days of execution of this Consent Order, the Companies shall present to an authorized representative of the Department payment in the amount of nine hundred seventy five thousand dollars ($975,000) by company check, certified check, cashier's check or money order, payable to the State of New Jersey, General Treasury, or by wire transfer; and

IT IS FURTHER ORDERED AND AGREED that the Companies shall provide the details of the reprocessing conducted as a result of the reconsideration of claims

described above, and shall provide the Department with a report, in a format to be determined by the Department, of all restitution made as a result of said claims reprocessing on a quarterly basis until the Department determines no further reports are needed; and

IT IS FURTHER ORDERED AND AGREED that the Companies shall institute measures and monitor operations in order to identify and remedy practices which may result in the instances of noncompliance addressed in this Order; and

IT IS FURTHER ORDERED AND AGREED that, upon execution of this Consent Order, the attached Report will be adopted and filed as an official record of the Department.

Thomas B. Considine
Commissioner of Banking and Insurance

Consented to as to form and content:
Oxford Health Plans (NJ), Inc.
United Healthcare of New Jersey, Inc.

By: _____ CFO

Dated: 4/6/11

Market Conduct Examination

Oxford Health Plans (NJ), Inc.
United Healthcare of New Jersey
Trumbull, CT

STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

Office of Consumer Protection Services

Market Conduct Examinations and Anti-Fraud Compliance Section

Date Adopted: April 12, 2011

MARKET CONDUCT EXAMINATION

Of

Oxford Health Plans (NJ), Inc.
United Healthcare of New Jersey

Located in

Trumbull, CT

As of

May 8, 2009 for the Review Period Calendar Year 2006

By

RSM MCGLADREY, Inc.

on behalf of the

DEPARTMENT OF BANKING AND INSURANCE

and

EXAMINERS FROM THE DEPARTMENT OF BANKING AND INSURANCE

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

REPORT ADOPTED :
APRIL 12, 2011

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I. INTRODUCTION

This is a draft report of the Market Conduct activities of Oxford Health Plan (NJ), Inc. (hereinafter referred to as "OHP-NJ") and United Healthcare of New Jersey, Inc. (hereinafter referred to "UHC-NJ") and where applicable, referred to as "the Companies". Testing was also conducted of OHP-NJ's and UHC-NJ's "Organized Delivery Systems" (ODS) of Orthonet and United Behavioral Health (UBH). Authority for this exam 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 (hereinafter "HMO") by **N.J.S.A. 26:2J-15b.** Under the provisions of **N.J.S.A. 26:2J-18.1** and **N.J.A.C. 11:24-2.12** an HMO is required to open its books and records for an examination. Staff Market Conduct Examiners from the New Jersey Market Conduct Unit of the New Jersey Department of Banking and Insurance (NJDOBI) and examiners from RSM McGladrey, Inc. (collectively, the examiners) conducted this examination. The examiners present their findings and recommendations in this report as a result of their market conduct examination of OHP-NJ and UHC-NJ. A sampling of the specific sections of New Jersey statutes, regulations and directives referenced in the findings of this report can be found in Appendix A. The Market Conduct Examiner-in-Charge was Clifton J. Day.

A. SCOPE OF EXAMINATION

The scope of the examination included health coverage sold in New Jersey by OHP-NJ and UHC-NJ. The main purpose of this examination was to determine whether OHP-NJ and UHC-NJ complied with laws that impose mandated benefit coverages and time constraints on HMO claims processing operations. **N.J.S.A. 26:2J-8.1**, **N.J.A.C. 11:2-17.6(b)** and **N.J.A.C. 11:22** et seq., made applicable to the operations of HMOs by **N.J.S.A. 26:2J-15b**, define time constraint limits. **N.J.S.A. 26:2J-4.1** et seq., and **N.J.S.A. 17B:27-46.1** et seq. and **N.J.A.C. 11:24-5 et seq.** define mandated benefits.

The initial review period for this examination was January 1, 2006 to December 31, 2006; however, in certain instances transactions were reviewed from periods subsequent to 2006 in order to facilitate our understanding of a particular issue or error. The examiners completed their fieldwork at OHP-NJ Trumbull, Connecticut office from July 7, 2008 to February 13, 2009. They completed additional review off-site and composed this report on various dates thereafter.

There were four primary areas of focus in this examination, including carrier networks, contract issues, preauthorization, claims (including prompt pay). This review also included electronic, population-wide reviews of paid and denied claims to determine timeliness in claim settlement and responses to utilization management appeals and provider appeals. The examiners also reviewed OHP-NJ's and UHC-NJ's compliance with mandated and non-mandated benefits laws, and reviewed randomly selected mandated and non-mandated benefit claims.

For the purpose of this examination, the examiners used a generic definition of "claim" – any demand or request for payment made by an enrollee or medical provider. Whenever possible, the examiners utilized data from OHP-NJ's and UHC-NJs' on-line systems.

In accordance with **N.J.S.A. 26:2J-8.1** and **N.J.A.C. 11:22-1.2(a)**, the examiners define a "clean" claim as follows:

1. The claim is for a service or supply covered by the health benefits plan or dental plan;

2. The claim is submitted with all the information requested by the carrier on the claim form or in other instructions distributed to the provider or covered person;

3. The person to whom the service or supply was provided was covered by the carrier's health benefits or dental plan on the date of service;

4. The carrier does not reasonably believe that the claim has been submitted fraudulently.

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.

The examiners reviewed documentation provided by OHP-NJ and UHC-NJ and performed random sampling of their claim files. Examiners noted instances in which OHP-NJ and UHC-NJ denied claims incorrectly, did not pay claims accurately or timely, claims staff did not follow OHP-NJ's and UHC-NJ's procedures for claim payments, did not maintain auditable records of claim payments, denied claims without conducting reasonable investigations, attempted to recoup provider claim payments outside of New Jersey's insurance statute and regulation timelines, maintained incomplete claim files, relied upon persons other than licensed physicians to make medical necessity decisions when the Companies questioned treatment modality and ultimately the medical necessity of physician medical determinations and understated the maximum period of time that a provider has to submit a Stage 2 complaint.

The examiner's initial request for data provided to OHP-NJ and UHC-NJ was incomplete and required numerous follow-ups and meetings with OHP-NJ and UHC-NJ to assure receipt of complete datasets.

In addition, the examiners were provided limited access to OHP-NJ's and UHC-NJ's claim systems for file review when in fact the examiners clearly requested unfettered access to all information. The examiners found that the initial access provided by UHC-NJ did not actually provide unfettered access to all the sampled claim files selected. As an example, when the examiners began the on-site UHC-NJ file review, the examiners were not able to retrieve any of the claims on the UNET system (UHC-NJ claim system). The examiners also found that it was necessary to navigate through 21 search engines first in order to locate where the actual sampled claim file was stored; however, the examiners did not have access to all of the engines. Additionally, the examiners were not able to retrieve claim files that had been purged from the claim systems. Not until more than 30 days into the field review did the Companies provide the necessary system upgrades to allow the examiners access to a critical system called "Seamless."

The examination team found searching and retrieving information from within the claim systems to be challenging, time consuming and caused major delays in retrieving data which caused a delay in completing the examination. One major factor was that these internal claim systems do not communicate with each other, which at times caused OHP-NJ's and UHC-NJ's claim staff to provide delayed responses to the examiners.

Although the examiner's questions, requests for information and inquires were eventually responded to, OHP-NJ and UHC-NJ continuously required extensions and additional time to respond which was a major inhibiting factor in completing this examination timely. The examiners surmised that some of OHP-NJ's and UHC-NJ's inability to provide the information on a timely basis was impacted by systems limitations that impeded the Companies' ability to produce sufficient examination information.

B. ERROR RATIOS

Error ratios are the percentage of files reviewed by the examiners that OHP-NJ and UHC-NJ handled in error. Each file mishandled or not handled in accordance with applicable statutes, regulations or NJDOBI Directive is considered to be a separate and distinct error, all of which are cited in this report. Some files contained one error and others contained several. Multiple errors in any specific file were counted as such and noted in the report. The examiners counted a file in error when OHP-NJ and UHC-NJ or its ODS' mishandled it or treated an insured unfairly, even if no statute or regulation is applicable. Even though OHP-NJ and UHC-NJ subsequently corrected some errors due to the examiners' findings, the examiners still included such files in the error ratio.

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 this report.

For purposes of the census database computer analyses conducted during this review period, the examiners define an exception as a file or record in a database that does not meet specified criteria as set forth in electronic queries. The file or record has not been reviewed in depth by an examiner. However, the frequency, type or severity of these exceptions may result in the examiners extracting sub-populations and review samples for further, detailed analysis.

The examiners submitted written inquiries to OHP-NJ's and UHC-NJ's representatives on the errors and exceptions cited in this report. This provided OHP-NJ and UHC-NJ with the opportunity to respond to the examiners' findings and to provide comments and supporting documentation on the statutory errors or mishandlings reported herein. On those errors and exceptions with which OHP-NJ and UHC-NJ disagreed, the examiners evaluated the individual merits of each response and considered all comments and supporting documentation where provided. For the most part, this is a report by exception, in that findings reported are mostly files in error. The following chart is a summary of the Companies' overall performance. The errors reflected in this chart are described in the sections that follow.

Examined Entity	Files Reviewed	Files in Error	Error Ratio
OHP-NJ			
Carrier Networks	5	0	0%
Contract Issues	15	0	0%
Preauthorization	33	1	3%
Claims	448	140	31%
Underwriting	10	0	0%
Subtotals	**511**	**141**	**28%**
ORTHONET			
Carrier Networks	0	0	0%
Contract Issues	15	0	0%
Preauthorization	5	2	40%
Claims	38	10	26%
Underwriting	10	0	0%
Subtotals	**68**	**12**	**18%**
UHC-NJ			
Carrier Networks	10	0	0%
Contract Issues	24	0	0%
Preauthorization	30	0	0%
Claims	125	24	19%
Underwriting	10	0	0
Subtotals	**199**	**24**	**12%**
UBH			
Carrier Networks	5	0	0%
Contract Issues	0	0	0%
Preauthorization	12	0	0%
Claims	3	1	33%
Underwriting	0	0	0%
Subtotals	**20**	**1**	**5%**
Overall Totals	**798**	**178**	**22%**

C. COMPANY PROFILE

Oxford Health Plans (NJ), Inc.

Oxford Health Plans (NJ), Inc. ("OHP-NJ") is an HMO domiciled in the State of New Jersey. It was organized under the laws of New Jersey as OHP-NJ on April 17, 1985. OHP-NJ applied for and was granted authority to operate as a New Jersey HMO by the State Department of Health and Senior Services and the New Jersey Department of Banking and Insurance. It commenced operations on September 12, 1985. The primary business of OHP-NJ is to provide medical expense coverage for comprehensive health care services to its members on a prepaid basis.

OHP-NJ 's main office is in Trumbull, Connecticut. OHP-NJ is a wholly owned subsidiary of Oxford Health Plans LLC and Oxford Health Plans, Inc., ("Oxford"), a Delaware Corporation. Oxford was acquired by UnitedHealth Group Inc. ("United") on July 29, 2004. Oxford is a subsidiary of United.

OHP-NJ offers an array of managed care benefit plans to groups and individuals through its HMO and insurance company subsidiaries. As of December 2007, OHP-NJ had approximately 74,500 providers in its nationwide network, providing services to 125,437 members.

United Healthcare of New Jersey, Inc.

UnitedHealthcare of New Jersey, Inc. ("UHC-NJ") was an HMO domiciled in the State of New Jersey. It was organized under the laws of New Jersey as UnitedHealthcare of New Jersey, Inc., on February 20, 1986. UHC-NJ applied for and was granted authority to operate as a New Jersey HMO by the New Jersey Department of Health and Senior Services, and the New Jersey Department of Banking and Insurance. It commenced operations on May 7, 1987.

UHC-NJ's main office is in Minnetonka, Minnesota. UnitedHealthcare Services has approximately 76,000 employees and conducts business in all 50 states, as well as internationally. The parent company, UnitedHealth Group, Inc., offers an array of managed care benefit plans to groups and individuals through contractual arrangements with hospitals and health care providers. The medical care provided to the enrollees is on a fee-for-service or capitated basis.

Effective December 31, 2006, the New Jersey Department of Banking and Insurance approved the merger of UHC-NJ and OHP-NJ. OHP-NJ is the surviving entity and UHC-NJ ceased to exist.

D. IDENTIFYING MANDATED BENEFIT CLAIMS

A portion of this examination focused on how OHP-NJ and UHC-NJ complied with New Jersey HMO mandated benefit laws. The intent of these laws is to create legal rights to medical and other services for members and their dependents. Generally, they vary in the rights they establish, and vary in the degree of reliable data that they make possible. For example, **N.J.S.A. 26:2J-4.20** mandates coverage for biologically based mental illness. In that example, a reliable claim population can be compiled for examination purposes by identifying specific diagnostic codes. On the other hand, **N.J.S.A. 26:2J-10.1** requires HMOs to offer coverage to dependent children who are born out of wedlock, data that is generally not identified in company records. In that example, data is less reliable for purposes of conducting an examination.

The examiners were able to identify mandated benefits in OHP-NJ's and UHC-NJ's datasets because they equate to specific Current Procedural Terminology (hereinafter "CPT") codes, International Classification of Diseases (hereinafter "ICD") codes, or Healthcare Common Procedure Coding System (hereinafter "HCPCS") codes. The examiners then selected random samples from the resulting populations of those claims with selected mandated benefits.

II. CARRIER NETWORKS

The examiners reviewed OHP-NJ's, UBH's and UHC-NJ's Carrier Networks to determine if new providers were appropriately listed in applicable network directories. The examiners also reviewed terminated provider contracts to determine if the providers were appropriately removed from the network directories. The examiners found no errors in this review.

III. FAILURE TO FACILITATE EXAMINATION

A. INTRODUCTION

This section addresses two broad categories in which: 1) Oxford failed to properly respond to record requests relative to extrapolated recoupment demands; and 2) Orthonet failed to retain auditable records. These violations are presented below.

B. OXFORD RECOUPMENTS

On October 10, 2008, the examiners requested detailed file documentation relative to the Company's efforts to recoup overpayments. Although the technical aspects of recoupment are addressed in section V.D.1 below, this section focuses on the Company's failure to voluntarily provide access to relevant recoupment-based documents that were necessary for this examination. The following sections outline two instances in which Oxford failed to facilitate this examination. These include erroneous application of privacy laws relative to protected health information and false characterization of record retrievability.

1. Erroneous Application of Federal Privacy Laws to Limit Examiner Access to Company Records

In response to the examiners' request for 32 complete Special Investigation Unit (SIU) files and detailed claim information relative to recoupment demands in which Oxford questioned the medical necessity of the provider's treatment plan, Oxford erroneously attempted to invoke federal protection under the Health Insurance Portability and Accountability Act (HIPAA, P.L. 104-191, 1996) as a reason to deny the examiners' access to the members' medical records. Oxford based this denial on a claim that its files contained protected health information (PHI) that could not be disclosed to the examiners due to HIPAA protections afforded to the member. The examiners note that Oxford attempted to deny access to medical information in the general review sample more than two months prior to Oxford's refusal to provide information on SIU/recoupment files.

Despite numerous discussions and the examiners' written request for relevant recoupment information, Oxford maintained its position that any PHI-related material would not be provided to the examiners. In response, the examiners notified Oxford that **45 C.F.R. 164.512(d)1** states specifically that "A covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of...entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards." The New Jersey Department of Banking and Insurance is a health oversight agency as that term is defined in **45 CFR 164.501**.

Moreover, **45 CFR 164.512(a)1** states "a covered entity may use or disclose protected health information to the extent that such use or disclosure is required by law

and the use or disclosure complies with and is limited to the relevant requirements of such law. The Department's market conduct examination of Oxford's books and records is authorized under **N.J.S.A. 26:2J-15b**, **N.J.S.A. 26:2J-18b**, **N.J.S.A. 26:2J-18.1b**, **N.J.S.A. 17B:30-16** and by **N.J.A.C. 8:38-2.12(a)** recodified under **N.J.A.C. 11:24-1 et seq**. Accordingly, Oxford's continued refusal to provide PHI at the Department's request and in conjunction with this examination is a violation of the above-referenced statutes and regulations.

2. False Characterization of Record Retrievability

It should be noted that the examiners affirmatively cited Oxford for failure to facilitate this examination via written inquiry during the field stage of this examination. That inquiry also reiterated the examiners' request for relevant SIU files and all claim materials associated with the 32 recoupment files referenced above. In response, Oxford then stated that the SIU files could not be provided any sooner than three weeks because all SIU files were stored off-site and required retrieval from storage.

The examiners note, however, that all 32 recoupment files were active since the Company was still in the process of negotiating recoupment settlements with the providers, making claims of offsite storage improbable. Moreover, the Company's filed and approved fraud prevention and detection manual states that Oxford retains "...four years of case files stored in the file room (next to our internal investigators) and cases from previous years are stored at our record retention center and are retrievable within 24 hours" (emphasis added).

Accordingly, the examiners cited Oxford for failure to facilitate this examination in violation of **N.J.S.A. 26:2J-15b**, **N.J.S.A. 26:2J-18b**, **N.J.S.A. 26:2J-18.1b**, **N.J.S.A. 17B:30-16** and **N.J.A.C. 11:24-1 et seq**.

C. ORTHONET CLAIM RECORD INAUDITABILITY

Similar to Sections V.B and V.F and G as addressed below, the examiners attempted to analyze the entire electronic population of paid and denied claims in order to determine Orthonet's compliance with New Jersey prompt pay requirements outlined in **N.J.A.C. 11:22-1.5** and **N.J.A.C. 11:22-1.6**. In response to the examiners' record requests, Orthonet stated that it does not maintain auditable electronic records that permit measurement of payment and denial time frames. Accordingly, the examiners cited Orthonet for failure to comply with **N.J.A.C. 11:22-1.5(d)**, which requires payers to maintain an auditable record as to when a claim payment is issued to providers or covered members. Notably, the examiners cited United Healthcare for failure to maintain auditable claim records in an examination that was finalized in March 2007. The Company agreed to correct that error in response to the post-March 2007 examination compliance period. It is apparent in the current examination that the Company did not apply auditability requirements to Orthonet. This eliminated the examiners' opportunity to conduct census compliance reviews. Since United Healthcare and Oxford were aware of this requirement, the examiners cited Orthonet's failure to facilitate this examination pursuant to **N.J.S.A. 26:2J-15b**, **N.J.S.A. 26:2J-18b**, **N.J.S.A. 26:2J-18.1b**, **N.J.S.A. 17B:30-16** and **N.J.A.C. 11:24-1 et seq**.

IV. PROVIDER PREAUTHORIZATION ON OHP-NJ, UHC-NJ AND ORTHONET CLAIMS

A. INTRODUCTION

This section addresses OHP-NJ, Orthonet and UHC-NJ's compliance with New Jersey laws and regulations governing a carriers' handling of medical protocols that require preauthorization. As indicated below, the Companies applied a flat denial where a provider may not have obtained prior authorization for treatment. Since the Companies did not provide any documentation demonstrating that the treatment was not medically necessary, these denials are unfair within the context of **N.J.S.A. 17B:30-13.1(f)**. The examiners' additional findings are presented below.

1. Unfair Flat Denial of Medically Necessary Claims - 3 Files in Error on Orthonet Files

Pursuant to **N.J.A.C.** 11:4-42.8(a)3, the penalty for a provider's failure to obtain preauthorization for medically necessary treatment may not exceed 50% of the charges that would have otherwise been approved had the provider complied with administrative preauthorization requirements. The examiners found 3 claims in which Orthonet issued a flat denial in response to a provider's claim which the company ultimately deemed as medically necessary.

Orthonet

1a. Claim #2006021799901912 / Member ID 810290601 (CPT 97014 – Electric Stimulation Therapy)

The referenced claim with a date of service of 12-07-05 was received on 2-17-06; on 2-28-06, OrthoNet denied the claim with a D2 denial code (Not authorized).

The patient was treated for contusion of hands requiring the use of electrical stimulation as determined by the attending physician; documentation to determine medical necessity of the procedure was requested and not provided to the examiners. Accordingly, the Company could not demonstrate that this procedure was not medically necessary. OrthoNet's failure to pay (or partially pay) a medically necessary claim for which a provider failed to obtain a prior authorization is inconsistent with **N.J.A.C. 11:24B-5.2(c)6.** Relying on the physician's decision to treat, as well as the Company's failure to rebut that decision, medical necessity was apparent. Accordingly, the examiners further cited OHP-NJ pursuant to **N.J.A.C. 11:2-17.8(i)**, which prohibits a carrier from denying benefits when it is reasonably clear that benefits are payable.

1b. Claim #2006030699900669 / Member ID 788569501 (CPT 97112 – Neuromuscular Reeducation)

The referenced claim with a date of service of 8-01-05 was received on 3-06-06; on 3-14-06, OrthoNet denied the claim with a D2 denial code (Not authorized).

The patient was treated for sprain of cruciate ligament of knee requiring the use of neuromuscular reeducation as determined by the attending physician; documentation to determine medical necessity of the procedure was requested and not provided to the examiners. OrthoNet's failure to pay (or partially pay) a medically necessary claim for which a provider failed to obtain a prior authorization does not appear to be in compliance with **N.J.A.C. 11:4-42.8(3).** Relying on the physician's decision to treat, as well as the Company' failure to rebut that decision, medical necessity was apparent. Accordingly, the examiners further cited OHP-NJ pursuant to **N.J.A.C. 11:2-17.8(i)**, which prohibits a carrier from denying benefits when it is reasonably clear that benefits are payable.

1c. Claim #2006051199900150 (CPT 97039 – Unlisted Modality)

The referenced claim with a date of service of 12-28-05 was initially received on 1-16-06 under claim # 2006011699900120 and denied on 1-24-06 with a D-2 denial code (Not Authorized). The primary diagnosis recorded in Orthonet's claim system is V58.73 (Aftercare following surgery of the circulatory system not elsewhere classified). This service (CPT 97039) appears to be medically necessary to restore the patient physical functioning following surgery of the circulatory system.

Orthonet's failure to pay (or partially pay) a medically necessary claim for which a provider failed to obtain a prior authorization does not appear to be in compliance with **N.J.A.C. 11:24B:5.2(c)6** and **N.J.A.C. 11:2-17.8(i)**.

2. Unfair Denial of Medically Necessary Claims due to Company Failure to Recognize Affirmative Preauthorization of Medical Procedures (1 File in Error)

2a. Claim #6213N26615 (line 1; CPT 93510-26 –Left heart catheterization - professional component)

The referenced claim with a date of service 7-13-06 was an electronic claim received on 8-01-06 from a participating provider. The preauthorization had been approved for foe the provider, and the service was performed by another physician affiliated with that provider. On 8-24-06, OHP-NJ denied the claim with a D-2 denial code (not authorized by OHP-NJ). On 8-29-06, the provider called to dispute OHP-NJ's denial; on the same day, OHP-NJ reversed the transaction and paid the claim on 9-01-06.

OHP-NJ's failure to pay (or partially pay) a medically necessary claim for which a provider did in fact obtain a prior authorization is inconsistent with **N.J.A.C. 11:4-42.8(3)** and **N.J.S.A. 17B:30-13.1(f)**, which prohibits unfair settlements. Since medical necessity was apparent, the examiners further cited OHP-NJ pursuant to **N.J.A.C. 11:2-17.8(i)**, which prohibits a carrier from denying benefits when it is reasonably clear that benefits are payable.

V. CLAIMS REVIEW

A. INTRODUCTION

The examiners randomly selected and manually reviewed a total of 798 claim events from a total of 2,298,061 claim events that were processed by OHPNJ, UHCNJ, Orthonet and UBH during the review period (January 1, 2006 through December 31, 2006). Section I.B above itemizes all 798 randomly selected claim events by all four companies that comprised this analysis. The examiners report an overall error ratio of 22%. In reviewing these claims, the examiners tested for compliance with statutes and regulations that govern the handling of claims, including **N.J.A.C. 11:22** et seq. (Prompt Payment of Claims), **N.J.S.A. 17B:30-13.1** and **N.J.A.C. 11:2-17.1** et seq. (Unfair Claim Settlement Practices Act), and other statutes and regulations that appear throughout this report, as well as standards outlined in the NAIC Market Regulation Handbook.

Regarding mandated benefits, HMOs must provide certain coverages that were once the subject of common policy exclusions. Each contract, member booklet, certificate or agreement for health care services delivered or issued in this State to any enrollee must set out the services and benefit to which the enrollee is entitled. These include all New Jersey mandated benefits, coverage and offers that conform to provisions in **N.J.S.A. 26:2J** et seq. and **N.J.S.A. 17B:27-54, 55,57,59, 60, 62, 63** and **66**. HMO's must provide these coverages to the same extent as for any other covered illness or injury.

The examiners requested the companies to exclude all Medicare, Medicaid, Federal Employee Health Benefit Plan (FEHBP) and ERISA claims when establishing the overall population of 2,298,061 claim events. The results from the random sample begin at section V.C.1 below.

The examiners also conducted a population-wide time study to determine Oxford's and UHC's compliance with prompt pay rules stated in **N.J.A.C. 11:22-1.5** and **N.J.A.C. 11:22-1.6**. The results of this review appear in section V.B below.

B. CENSUS POPULATION PROMPT PAY ANALYSIS-OXFORD

The examiners queried databases of mailed and electronic claims that Oxford received during the examining period (January 1, 2006 to December 31, 2006). In that time, the Company processed 1,012,375 claims. This total included 186,016 mailed and 826,359 electronic claims. Itemized differently, the total contained 844,284 paid and 168,091 denied claims. These populations exclude all Medicare, Medicaid, FEHBP and ERISA claims.

The examiners reviewed the population to verify compliance with statutory and regulatory guidelines regarding prompt claim payments and denials. Oxford supplied the examiners with databases for each of the following: Paid Mandated benefits (111,251 claims), Paid Non-Mandated benefits (733,033 claims), Denied Mandated benefits (16,636 claims), and Denied Non-Mandated benefits (151,455 claims).

In reviewing these claims, the examiners checked for compliance with statutes and regulations that govern the handling of claims, particularly **N.J.S.A. 26:2J-8.1** et seq. ("HINT" – the Health Insurance Network Technology Act). They also checked for compliance with **N.J.A.C. 11:22-1** et seq. (Prompt Payment of Claims), **N.J.S.A. 17B:30-13.1** and **N.J.A.C. 11:2-17.1** et seq. (Unfair Claim Settlement Practices Act), **N.J.S.A. 26:2J-8.1d(1)** and **N.J.S.A. 26:2J-8.1(12)**. The examiners also utilized the NAIC Market Regulation Handbook, Chapters 16 and 20.

1. Population Review, Prompt Pay Exceptions, Mandated and Non-Mandated Errors

a. Population Review, Mailed Paid Claims

	Population	Exceptions	Exception Ratio
Mandated Mailed Paid	14,691	235	1.60%
Non-Mandated Mailed Paid	117,237	1,248	1.06%
Total	131,928	1,483	1.12%

The examiners queried populations of Mandated and Non-Mandated Benefit claims for the examining period (January 1, 2006 to December 31, 2006). As noted, Oxford's overall prompt pay exception rate was 1.12%.

b. Population Review, Electronic Paid Claims

	Population	Exceptions	Exception Ratio
Mandated Electronic Paid	52,566	18,542	35.27%
Non-Mandated Electronic Paid	588,802	28,273	4.80%
Total	641,368	46,815	7.30%

Oxford's population of 641,368 electronically paid claims contained 46,815 prompt pay exceptions. This resulted in an exception ratio of 7.30%, with a significantly greater difference in ratios between mandated and non-mandated claims (35.27% and 4.80%, respectively). Statistically, the probability of delay for a mandated benefit claim was slightly less than 7.5 times higher than that of a non-mandated benefit claim.

c. Population Review, Mailed Denied Claims

	Population	Exceptions	Exception Ratio
Mandated Mailed Denied	5,908	1,786	30.23%
Non-Mandated Mailed Denied	48,180	17,085	35.46%
Total	54,088	18,871	34.89%

The examiners queried the entire population of denied mailed claims for the examining period (January 1, 2006 to December 31, 2006). As the examiners note above, Oxford's mailed denied claim exception ratio was 34.89%.

d. Population Review, Electronic Denied Claims

	Population	Exceptions	Exception Ratio
Mandated Electronic Denied	10,728	3,380	31.51%
Non-Mandated Electronic Denied	103,275	32,892	31.85%
Total	114,003	36,272	31.82%

The Company's population of 114,003 electronically denied claims contained 36,272 exceptions. This was a 31.82% exception ratio, with no significant difference in ratios between mandated and non-mandated claims (31.51% and 31.82%, respectively).

2. Population Review of Overall Settlement Delays and Applicable Interest Exceptions on Paid Mandated and Non-Mandated Claims

a. Overall Settlement Delays on Paid Mandated and Non-Mandated Claims

	Population	Exceptions	Exception Ratio
Non-Mandated Electronic	615,796	26,819	4.36%
Non-Mandated Mailed	117,237	1,248	1.06%
Mandated Electronic	96,560	4,711	4.88%
Mandated Mailed	14,691	235	1.60%
Total	844,284	33,013	3.91%

The examiners queried populations of Mandated and Non-Mandated Benefit claims for the examining period (January 1, 2006 to December 31, 2006). As noted, Oxford's overall exception rate for settlement delays on mandated and non-mandated paid claims was 3.91%. The examiners found a significant difference between mandated and non-mandated claims that were submitted electronically or by mail (4.43% and 1.12%respectively). Statistically, the probability of delay for a mandated benefit claim was almost 4 times higher than that of a non-mandated benefit claim.

b. Interest Errors on Paid Mandated and Non-Mandated Claims

The examiners also ran queries of paid claim databases for interest payments on late claims. The results of those queries are as follows:

	Late Payments	No Interest	Exception Ratio
Non-Mandated Electronic	26,819	14,825	55.28%
Non-Mandated Mailed	1,248	728	58.33%
Mandated Electronic	4,711	2,614	55.49%
Mandated Mailed	235	135	57.45%
Total	33,013	18,302	55.44%
Average			56.39%

The Company's population of 33,013 late payments on claims where interest was due contained 18,302 exceptions. This represents an overall 55.44% exception ratio, with no significant difference in ratios between mandated and non-mandated claims that were submitted electronically or by mail. Therefore, Oxford was equally likely to omit interest on all claim types reviewed (mandated and non-mandated mailed and electronic claims).

C. RANDOM SAMPLE PROMPT PAY ANALYSIS-OXFORD

The examiners randomly selected records from Oxford's overall population of claims in order to review specific files and Oxford's overall compliance with prompt pay requirements outlined in **N.J.A.C. 11:22-1.5(a)-(c)**, **N.J.AC. 11:22-1.6(c)**, **N.J.S.A. 26:2J-8.1(9)**, **N.J.A.C. 11:2-17.9(b)** and **N.J.S.A. 17B:30-13.1(d)**.

Specifically, **N.J.A.C. 11:22-1.5(a)1** permits 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** permit 40 days to investigate claims submitted manually. Additionally, **N.J.S.A. 26:2J-8.1(12)** requires interest at 12% effective July 11, 2006 or 10% prior to that date pursuant to **N.J.A.C. 11:22-1.6(c)**. Lastly, **N.J.A.C. 11:2-17.9(b)** obligates a payer to request additional proofs to establish entitlement to benefits, and **N.J.S.A. 17B:30-13.1(d)** prohibits refusal to pay a claim without conducting a reasonable investigation based upon all available information.

The examiners' findings and applicability of the above-referenced requirements are outlined in the subsections that follow, identified as Paid Claims and Denied Claims.

Paid Claims

1. Delayed Settlements and Failure to Pay Interest as Required (11 Files in Error) Improper General Business Practice

The following sections address Oxford's failure to settle claims timely and Oxford's failure to pay the correct amount of interest, as well as failure to pay interest in entirety.

Paid Mandated Benefits

1a. Claim #5341H02697 (Line 1; CPT 97802; DOS 12/07/05)

The above-referenced was an electronic claim received by OHP-NJ on 12/07/05 and paid on 01/06/06 with a mail date of 01/08/06. Therefore, it took OHP-NJ 32 days to pay this claim, contrary to **N.J.A.C. 11:22-1.5(a)1.** No interest payment was issued by OHP-NJ on this claim, contrary to **N.J.A.C. 11:22-1.6(c)**.

1b. Claim #6044625216 (Line 2; CPT FRINT; DOS 10/14/05)

The above-referenced was the interest payment claim line issued by OHP-NJ for a service billed on this date of service and identified on claim line 1. This was a paper claim received by OHP-NJ on 02/13/06 and paid on 04/01/06 as the secondary carrier with a mail date of 04/03/06. Therefore, it took OHP-NJ 49 days to pay this claim.

In calculating the number of days it took OHP-NJ to pay this claim, it is apparent that OHP-NJ did not take into account the mailing date of the actual payment (i.e. check), as specified under **N.J.A.C. 11:22-1.5(c)**. The paid date is identified by OHP-NJ as the date the check is printed and not the actual mailed date which was later. Consequently, OHP-NJ only paid $0.08 to the provider for the interest owed on this claim instead of the correct amount of $0.09.

The processing of this claim does not support **N.J.S.A. 17B:30-13.1**, **N.J.A.C. 11:22-1.5(a)-(c)** and **N.J.AC. 11:22-1.6(c)** and **N.J.S.A. 26:2J-8.1(9)**.

1c. Claim #6068N24373 (Line 3; CPT 90700; DOS 03/03/06)

The above-referenced was an electronic claim received by OHP-NJ on 03/09/06 and paid on 04/08/06 with a mail date of 04/10/06. Therefore, it took OHP-NJ 32 days to pay this claim. No interest payment was issued by OHP-NJ on this claim.

The processing of this claim does not support, **N.J.A.C. 11:22-1.5(a)-(c)**, **N.J.AC. 11:22-1.6(c)** and **N.J.S.A. 26:2J-8.1(9)**.

Paid Non-Mandated Benefits

1d. Claim #6005D02446 (Line 6; CPT J9045; DOS 12/27/05)

The above-referenced was an electronic claim received by OHP-NJ on 01/05/06 and paid on 02/15/06 with a mail date of 02/16/06. Therefore, it took OHP-NJ 42 days to pay this claim. No interest payment was issued by OHP-NJ on this claim.

The processing of this claim does not support **N.J.A.C. 11:22-1.5(a)-(c)**, **N.J.AC. 11:22-1.6(c)** and **N.J.S.A. 26:2J-8.1(9)**.

1e. Claim #6010H02238 (Line 1, CPT 90847; DOS 12/07/06

The above-referenced was an electronic claim received by OHP-NJ on 01/10/06 and paid on 02/09/06 with a mail date of 02/13/06. Therefore, it took OHP-NJ 34 days to pay this claim. No interest payment was issued by OHP-NJ on this claim.

The processing of this claim does not support **N.J.A.C. 11:22-1.5(a)-(c)**, **N.J.AC. 11:22-1.6(c)** and **N.J.S.A. 26:2J-8.1(9)**.

1f. Claim #6012H01788 (Line 18, CPT Q0137; DOS 12/01/05

The above-referenced was an electronic claim received by OHP-NJ on 01/12/06 and paid on 02/11/06 with a mail date of 02/13/06. Therefore, it took OHP-NJ 32 days to pay this claim. No interest payment was issued by OHP-NJ on this claim.

The processing of this claim does not support **N.J.A.C. 11:22-1.5(a)-(c)**, **N.J.AC. 11:22-1.6(c)** and **N.J.S.A. 26:2J-8.1(9)**.

1g. Claim #6021N30501 (Line 8; CPT 80050; DOS 01/13/06)

The above-referenced was an electronic claim received by OHP-NJ on 01/21/06 and paid on 02/22/06 with a mail date of 02/23/06. Therefore, it took OHP-NJ 33 days to pay this claim.

In calculating the number of days it took OHP-NJ to pay this claim, it is apparent that OHP-NJ did not take into account the mailing date of the actual payment (i.e. check), as specified under **N.J.A.C. 11:22-1.5(c)**. Therefore, OHP-NJ only paid $0.12 to the provider for the interest owed on this claim instead of the correct amount of $0.19.

The processing of this claim does not support **N.J.A.C. 11:22-1.5(a)-(c)**, **N.J.AC. 11:22-1.6(c)** and **N.J.S.A. 26:2J-8.1(9)**.

1h. Claim #5364U01823, DOS 11/21/05, Billed Amount $488

The above-referenced was an electronic claim received by OHP-NJ on 12/30/05 and paid on 02/01/06 with a mail date of 02/02/06. Therefore, it took OHP-NJ 34 days to pay this claim with an interest amount of $0.35 included in the payment.

In calculating the number of days it took OHP-NJ to pay this claim, it is apparent that OHP-NJ did not take into account the mailing date of the actual payment (i.e. check), as specified under **N.J.A.C. 11:22-1.5(c)(1)**. OHP-NJ identified the paid date as the date the check is printed and not mailed. As a result, OHP-NJ only calculated $0.35 as the interest amount owed on this claim instead of the correct amount of $0.47. The interest amount calculated and paid on this claim does not support **N.J.A.C. 11:22-1.5(c)(1)** and **N.J.A.C 11:22-1.6(c)**.

1i. Claim #6314N28578.01, DOS 11/06/06, Billed Amount $198

The above-referenced was an electronic claim received by OHP-NJ on 11/10/06 and paid on 12/15/06 with a mail date of 12/18/06. Therefore, it took OHP-NJ 34 days to pay this claim with an interest amount of $0.11 included in the payment.

In calculating the number of days it took OHP-NJ to pay this claim, it appears OHP-NJ did not take into account the mailing date of the actual payment (i.e. check), as specified under **N.J.A.C. 11:22-1.5(c)(1)**. OHP-NJ identified the paid date as the date the check is printed and not mailed. As a result, OHP-NJ only calculated $0.11 as the interest amount owed on this claim instead of the correct amount of $0.18.

1j. Claim #6283N23631.01, DOS 10/01/06, Billed Amount $540

The above-referenced was an electronic claim received by OHP-NJ on 10/10/06 and paid on 11/14/06 with a mail date of 11/15/06. Therefore, it took OHP-NJ 36 days to pay this claim with an interest amount of $0.50 included in the payment.

In calculating the number of days it took OHP-NJ to pay this claim, it appears OHP-NJ did not take into account the mailing date of the actual payment (i.e. check), as specified under **N.J.A.C. 11:22-1.5(c)(1)**. OHP-NJ identified the paid date as the date the check is printed and not mailed. As a result, OHP-NJ only calculated $0.50 as the interest amount owed on this claim instead of the correct amount of $0.66.

1k. Claim #6303D00492, DOS 10/13/06, Billed Amount $192

The above-referenced was an electronic claim received by OHP-NJ on 10/30/06 and paid on 12/01/06 with a mail date of 12/04/06. Therefore, it took OHP-NJ 35 days to pay this claim with an interest amount of $0.11 included in the payment.

In calculating the number of days it took OHP-NJ to pay this claim, it appears OHP-NJ did not take into account the mailing date of the actual payment (i.e. check), as specified under **N.J.A.C. 11:22-1.5(c)(1)**. OHP-NJ identified the paid date as the date the check is printed and not mailed. As a result, OHP-NJ only calculated $0.11 as the interest amount owed on this claim instead of the correct amount of $0.28.

Additional Details Regarding Delay Calculations and Conclusions on Interest Calculations-Improper General Business Practice

In response to the examiners inquiries, the Company stated that payments are mailed the first business day after the check is printed; however, checks are not mailed on Fridays, Saturdays, or Sundays. Therefore, payments printed on these days are combined and mailed the following business day (i.e. Monday). On average, therefore, every interest calculation that occurs on a Thursday fails to include at least two days of interest. Therefore, OHP-NJ is calculating interest inconsistent with **N.J.S.A. 26:2J-8.1(12)** and **N.J.A.C. 11:22-1.6(c)**. An exception to these payment dates are those issued via electronic wire. Checks and EOBs related to payments issued by electronic wire are sent out the same day.

OHP-NJ agreed with the examiners' findings that the mail date was not accurately taken into consideration when interest was being calculated for the claims noted. Accordingly, the examiners cited interest errors as an improper general business practice.

Denied Claims

2. Delayed Settlements on Denied Claims (10 Files in Error) Improper General Business Practice)

The following sections address Oxford's failure to deny claims timely.

Denied Mandated Benefits

2a. Claim #6322N27729 (Line 1; CPT E1390; DOS 04/13/06)

The above-referenced was an electronic claim received by OHP-NJ on 11/18/06 and denied on 12/17/06 with a TFD1 denial code (filing deadline has passed) and a mail date of 12/19/06. Therefore, it took OHP-NJ 31 days to deny this claim.

The processing of this claim is inconsistent with **N.J.A.C. 11:22-1.5(a)-(c)** and **N.J.A.C. 11:22-1.6(c)**.

2b. Claim #6178N29661 (Line 6; CPT S5180; DOS 06/21/06)

The above-referenced was an electronic claim received by OHP-NJ on 06/27/06 and denied on 07/12/06. Although it took OHP-NJ only 15 days to deny this claim, the denial was for missing or additional information. It does not appear a separate or prior notification was sent to the member and/or provider regarding a delay due to an investigation or request for the missing or additional information.

This type of denial is inconsistent with **N.J.A.C. 11:22-1.6(a)(2)** and **N.J.A.C. 11:2-17.9(b)**. Please see Additional Details below for supplemental information regarding **N.J.A.C. 11:22-1.6(a)(2).**

2c. Claim #6269N29751 (Line 1; CPT 99395; DOS 07/05/06)

The above-referenced was an electronic claim received by OHP-NJ on 09/26/06 and denied on 09/27/06 with a T519 denial code (OHP-NJ is unable to process this claim due to missing information). Although it took OHP-NJ only one day to deny this claim, the denial was for missing and/or additional information. File material reveals that a separate or prior notification was not sent to the member and/or provider regarding a delay due to an investigation or request for the missing or additional information. This type of denial is inconsistent with **N.J.A.C. 11:22-1.6(a)(2)** and **N.J.A.C. 11:2-17.9(b)**. Please see Additional Details below for details regarding **N.J.A.C. 11:22-1.6(a)(2).**

2d. Claim #6303623946 (Line 4; CPT S9500; DOS 01/21/06)

The above-referenced was a paper claim received by OHP-NJ on 10/30/06 and denied on 11/05/06. Although it took OHP-NJ only 6 days to deny this claim, the denial was for missing and/or additional information. It does not appear a separate or prior notification was sent to the member and/or provider regarding a delay due to an investigation; nor was there a request for the missing or additional information.

This type of denial does not support **N.J.A.C. 11:22-1.6(a)(2)** and **N.J.A.C. 11:2-17.9(b)**. Please see Additional Details below for details regarding **N.J.A.C. 11:22-1.6(a)(2).**

2e. Claim #6319I01639 (Line 1; CPT ERHOS; DOS 11/08/06)

The above-referenced was a paper claim received by OHP-NJ on 11/15/06 and denied on 11/21/06 with a D13 denial code (OHP-NJ is unable to process this claim due to missing information). Although it took OHP-NJ only 6 days to deny this claim, the denial was for missing and/or additional information. File materials reveal that a separate or prior notification was not sent to the member and/or provider regarding a delay due to an investigation; nor was there a request for the missing or additional information.

This type of denial does not support **N.J.A.C. 11:22-1.6(a)(2)** and **N.J.A.C. 11:2-17.9(b)**. Please see Additional Details below for details regarding **N.J.A.C. 11:22-1.6(a)(2).**

Denied Non-Mandated Benefits

2f. Claim #6010H00094 (Line 1; CPT Q4055; DOS 11/07/05)

The above-referenced was an electronic claim received by OHP-NJ on 01/10/06 and denied on 02/11/06 with a D4 denial code (duplicate of claim already processed) and a mail date of 02/14/06. Therefore, it took OHP-NJ 35 days to deny this claim.

The processing of this claim does not support **N.J.A.C 11:22-1.6(c)**.

2g. Claim #5355N29439 (Line 2; CPT 97110; DOS 09/23/05)

The above-referenced was an electronic claim received by OHP-NJ on 12/21/05 and denied on 01/25/06 with a D4 denial code (duplicate of claim already processed) and a mail date of 01/26/06. Therefore, it took OHP-NJ 36 days to deny this claim.

The processing of this claim does not support **N.J.A.C 11:22-1.6(c)**.

2h. Claim #6069U00437 (Line 10; CPT 87088; DOS 12/26/05)

The above-referenced was an electronic claim received by OHP-NJ on 03/10/06 and denied on 04/07/06 with a D1 denial code (not a covered benefit) and a mail date of 04/11/06. Therefore, it took OHP-NJ 32 days to deny this claim.

The processing of this claim does not support **N.J.A.C 11:22-1.6(c)**.

2i. Claim #6125U00969 (Line 1; CPT 72020; DOS 05/05/06)

The above-referenced was an electronic claim received by the Company on 05/05/06 and denied on 06/04/06 with a D1 denial code (not a covered benefit) with a mail date of 06/06/06. Therefore, it took the Company 32 days to deny this claim

The processing of this claim does not support **N.J.A.C 11:22-1.6(c)**.

2j. Claim #6177719721 (Line 3; CPT 97110; DOS 06/10/06)

The above-referenced was a paper claim received by the Company on 06/26/06 and denied on 07/16/06 with a D35E denial Code (These services require clinical review). Although it took the Company only 20 days to deny this claim, the denial was for missing and/or additional information. It does not appear a separate or prior notification was sent to the member and/or provider regarding a delay due to an investigation or request for the missing or additional information. This type of denial does not appear to support **N.J.A.C. 11:22-1.6(a)(2)** and **N.J.A.C. 11:2-17.9(b)**. Please see Additional Details below for details regarding **N.J.A.C. 11:22-1.6(a)(2).**

Additional Prompt Pay Details-Paid and Denied Claims-Failure to Request Additional Information Necessary for Claim Payment

- **N.J.A.C. 11:22-1.6(a)(2)**

A review of the Communication History screen of OHP-NJ's claims system for the above-referenced claims does not provide any details supporting an attempt by OHP-NJ to engage in a good faith effort to expeditiously obtain additional and/or missing information..., as referenced under **N.J.A.C. 11:22-1.6(a)(2)** and **N.J.A.C. 11:2-17.9(b)**. It is OHP-NJ's practice to utilize its EOB and RA as a form of notification to the covered member and provider for missing or additional information. OHP-NJ has also verbally acknowledged that it does not consider its EOB or RA as a formal notification for missing or additional information; instead, it is a denial for missing or additional information. No follow-up or further attempts are made by OHP-NJ to obtain the requested information once it has closed and denied a claim for this reason.

Additionally, although a review of the Communication Events section of the Communication History screen reveals notes regarding telephone calls received and made by OHP-NJ, there are no details specifying the nature of the call to support attempts to expeditiously obtain the missing or additional information prior to denying the claim.

This practice shifts the burden to the provider and covered member to initiate and follow-up on claim denials related to missing or additional information. Although such denials by OHP-NJ may include details of the missing or additional information on its EOB and RA, it does not always identify with specificity the additional information or documentation that is required as referenced under **N.J.A.C. 11:22-1.6(a)(2)**. Instead, the additional remarks relating to the denial code on the EOB and RA may or may not provide a list of the type of missing or additional information requested by OHP-NJ.

- **N.J.A.C. 11:22-1.5(d)**

In accordance with **N.J.A.C. 11:22-1.5(d)**, a carrier or its agent shall maintain an auditable record of when payments were transmitted to health care providers or covered persons whether by United States mail or otherwise.

The examiners provided OHP-NJ via e-mail two spreadsheets requesting the details of the following sampled paid claims populations: Paid Mandated and Paid Non-Mandated Benefit Claims. OHP-NJ was requested to complete the unpopulated fields within these spreadsheets, including those under the Check Mail Date column. The examiners noted that the data provided in response to the latter column reflected the same dates as those provided under the Check Cut Date columns, which are the dates a check, EOB, and RA are printed. This response did not appear to reflect information relayed to examiners during their walk-through of the OHP-NJ's mailroom process.

Subsequently another request was forwarded to OHP-NJ requesting mailing dates for 23 specific claim lines and supporting documentation for these mailing dates. The examiner included in the request a note highlighting the assumption of mailing dates not falling on the same dates as those printed on an EOB, RA, or check as it was described to examiners during the walk-through that mailing dates occur on specific days of the week. This was the examiners' second request for mailing dates on these

claim lines as these were included in the aforementioned sampled paid claims populations initially provided to OHP-NJ on September 29, 2008. OHP-NJ's complete response to this request was received on December 10, 2008; however, the examiners noted that some of the mailing dates provided occurred on a weekend (i.e. Saturday or Sunday). This resulted in a follow-up email to OHP-NJ confirming whether it operates on the weekends and therefore, verifying again that the mailing dates provided were accurate. OHP-NJ then resubmitted its response to this request with updates to the dates provided and a note confirming that EOBs, RAs, and checks are not mailed on Fridays, Saturdays, Sundays, or holidays. Payments printed on these days are instead grouped together and mailed the following business day (i.e. Monday). As a result, it took examiners three attempts to obtain correct mailing dates from OHP-NJ for selected claim lines.

Furthermore, attached with OHP-NJ's response to this request were copies of checks, EOB, and RAs with dates printed on these documents. These documents along with the preceding mailing process included in response to this request appear to be OHP-NJ's supporting documentation for its payment mailing dates. For payments issued via electronic wire, the check and EOB/RA are sent out the same day. OHP-NJ's Oracle Financial system records this date.

Therefore, in review of OHP-NJ's responses regarding its payment mailing dates, it appears OHP-NJ does not maintain auditable records concerning when payments are transmitted to providers—only records of when checks and EOB/RAs are printed.

The examiners further discovered and OHP-NJ agreed that due to an oversight, the mail date was not accurately taken into consideration when interest was being calculated for the claims noted. Accordingly, the examiners cited this error as an improper general business practice.

D. OVERALL RANDOM SAMPLE FINDINGS - OXFORD HEALTH PLANS (NJ), INC.

1. Unfair Provider and Hospital Recoupment Practices

Pursuant to P.L 2005, C. 352 (Health Claims Authorization, Processing and Payment Act, or HCAPPA) and **N.J.S.A 26:2J-8.1(10)**, carriers are permitted to recoup overpayments issued to providers and hospitals. Except in the event of fraud, inappropriate patterns of billing or claims subject to coordination of benefits, a payer may seek reimbursement for overpayment of a claim for a period not exceeding 18 months after the initial claim payment. HCAPPA and **N.J.S.A 26:2J-8.1(10)** further specify that a payer can extrapolate recoupments beyond 18 months after initial claim payment only where: 1) the payer establishes clear evidence of fraud in accordance with investigation standards outlined in the payer's fraud prevention plan and affirmatively refers its investigation to the New Jersey Office of the Insurance Fraud Prosecutor; 2) the health care provider alters or fails to maintain relevant claim or clinical records; 3) claim adjudication is referred to judicial, quasi-judicial or administrative proceedings. Moreover, **N.J.S.A 26:2J-8.1(11)(a)(i)** and P.L 2005, c. 352 prohibit a carrier from requiring a reimbursement within 45 calendar days after notice to the health care provider.

While conducting the random review and monitoring ongoing complaints, the examiners found multiple instances in which Oxford failed to comply with P.L 2005, c. 352, **N.J.S.A 26:2J-8.1(10)** and **N.J.S.A 26:2J-8.1(11)**. The examiners' findings are outlined below.

1.a Failure to Refer Investigation to the New Jersey Office of Insurance Prosecutor (OIFP) prior to Demand for Recoupment (24 Files in Error) Improper General Business Practice

Based on several provider complaints and randomly selected files, the examiners requested a list and detailed information on all recoupment demands that Oxford and its Special Investigative Unit (SIU) issued to health care providers between January 1, 2006 and August 8, 2008. In response, Oxford provided a total of 29 files for the examiners' review. On three of these, Oxford demanded recoupment prior to the July 11, 2006 HCAPPA effective date; the examiners excluded these files from this review. The examiners reviewed the remaining 26 recoupment files and found that, in violation of **N.J.S.A 26:2J-8.1(10)(d)**, Oxford failed in 24 out of 26 instances (92%) to refer its fraud investigation results to the OIFP prior to issuing a demand for recoupment. The 24 files in error are itemized in the following chart, which reveals a total of $1,303,320 in invalid recoupment demands.

Provider Number	Amount Demanded	Date of Demand	Date of OIFP Referral
MP090	$20,380	8/7/08	08/11/2008
P413746	$35,196	11/10/2006	08/11/2008
HUP019	$30,519	7/2/2008	08/11/2008
P483608	$42,191	7/1/2008	08/11/2008
BP281	$18,526	7/1/2008	08/11/2008
UP095, P826143	$66,410	6/14/2007	12/18/2007
EP193	$21,578	8/7/2008	08/11/2008
UP019	$17,471	4/11/2008	08/11/2008
P2106431	$44,324	7/1/2008	08/11/2008
EP039	$35,890	8/7/2008	08/11/2008
P2375884	$21,601	5/8/2008	08/11/2008
ES254	$49,477	7/10/2008	08/11/2008
P2040714	$46,034	8/7/2008	08/11/2008
HS141	$127,667	2/18/2008	04/09/2008
MP125	$17,341	8/7/2008	08/11/2008
MES286	$53,954	3/2/2007	08/11/2008
US292	$32,963	11/10/2006	08/11/2008
P3415691	$41,576	6/16/2008	08/11/2008
LP140	$32,572	11/10/2006	08/11/2008
EP079,P2711887, P780745	$266,515	11/10/2006	08/11/2008
MP133	$20,456	7/11/2008	08/11/2008
P946294	$35,300	7/10/2008	08/11/2008
IS417	$66,213	5/27/2008	08/11/2008
P1285021	$159,166	11/10/2006	08/11/2008
Totals	**$1,303,320**		

It should be noted that, of the 24 recoupments in error, Oxford issued 22 OIFP referrals (92%) on August 11, 2008; these referrals were in response to an August 8, 2008 teleconference between Oxford and the Department in which the latter advised the former of OIFP reporting requirements as a prerequisite to a recoupment demand. Prior to that, Oxford was, contrary to **N.J.S.A 26:2J-8.1(10)**, mistaken in its belief that an OIFP referral need not precede a recoupment demand. Oxford's compliance level, devoid of Departmental intervention, was only 8%. The Company independently referred only 2 files to the OIFP prior to issuing a recoupment demand.

Furthermore, and contrary to **N.J.S.A. 17:33A-15** and **N.J.A.C. 11:16-1** et seq., Oxford also failed to comply with Appendix A, P.47 of it own fraud prevention and detection plan dated March 2000 that requires referral of fraudulent activity to the OIFP. Given the significant period of time that lapsed between demand and OIFP referral, it is unknown when or if Oxford planned to issue referrals to the OIFP since a recoupment demand is an indicator of a completed fraud investigation.

1.b Failure to Establish Clear Evidence of Fraud on Extrapolated Recoupment Demands (26 Files in Error) Improper General Business Practice

As indicated above, **N.J.S.A 26:2J-8.1d(10)(d)** permits extrapolated recoupments only where a carrier establishes "clear evidence of fraud." Based on a review of the SIU files that Oxford provided to the examiners, as well as through inquiries relative to Oxford's overall methodology for combating provider upcoding fraud and abuse, the examiners found that Oxford did not demonstrate clear evidence of fraud on any of the 24 extrapolated recoupment files listed above.

Oxford reviews electronic claim data to identify statistical outliers that purport to identify potential upcoding of medical procedures. Oxford was unable to provide any documentation that illustrates the statistical validity or success rate at which its outlier detection methodology actually results in intentional and unintentional upcoding, or the extent to which an outlier yields a false indication of upcoding. The examiners were therefore unable to determine the extent to which Oxford's statistical outlier methodology validly and reliably identifies potential upcoding fraud for further review.

Once outliers are identified, Oxford selects those providers associated with an outlier for referral to a third party entity that compares the provider's billed code with the provider's medical records and notes. Ultimately, this entity utilizes trained medical procedure billing coders to determine if the provider's medical records support the provider's billing code that was submitted to the company for payment.

Although this process may result in discovery of a series of inappropriate or upcoded billings, it does not distinguish between intentional upcoding fraud and unintentional upcoding errors. Moreover, this entity does not conduct any statistical reliability tests to determine the extent to which its conclusions of fraud are valid or invalid. This entity was therefore unable to provide the examiners with any statistical confidence levels, success rates, failure rates or overall accuracy with respect to intentional or unintentional upcoding fraud versus simple error or conceptual

misunderstanding. Nevertheless, Oxford deemed fraudulent intent on the 24 files referenced above as evidenced by extrapolated recoupment demands

Based on the above, Oxford's determination of fraud is presumptive and devoid of substantive basis within the context of **N.J.S.A. 17:33A-9.a** and **N.J.S.A 26:2J-8.1d(10)(d)**. Combined, these statutes require both belief and clear evidence that fraud has been knowingly perpetrated in order to extrapolate a recoupment demand.

The examiners note that the third party code audit entity does not routinely utilize a physician to review a coder's determination of billing code propriety and level of care provided by the member's physician. The examiners further note that Oxford rarely requires staff physicians to review the entity's determination of billing code and medical procedure propriety. Oxford relies on billing coders, and not physicians, to determine coding propriety and ultimately medical necessity since the code auditors have made a determination that provider payment rates should be down coded to lesser levels of medical treatment. This practice is prohibited by **N.J.S.A. 26:2S-6b(1)**, which states that all decisions to deny or reduce benefits or benefit payments shall be made by a physician.

1.c Failure to Allow Medical Provider 45 Days to Resolve Recoupment Demands (5 Files in Error) Improper General Business Practice

Pursuant to **N.J.S.A 26:2J-8.1d(11)(a)(i)**, a carrier is prohibited from requiring a recoupment reimbursement within 45 calendar days after notice to the health care provider. Contrary to this statute, the examiners found five recoupments in which Oxford required payment within 30 calendar days. These errors are itemized in the chart that follows.

Claim Number	Provider or Facility	Date of Service	Date of Demand
3079120547	Facility	2/27/03	8/22/06
3296H02263	Facility	10/5/03	8/22/06
5020H02399	Facility	12/27/04	8/22/06
5033H02005	Facility	1/26/05	8/22/06
4280H03483	Facility	9/28/04	8/22/06

2 Unfair Random Sample Denials on Otherwise Payable Claims and Failure to Specify on Denial Notice Applicable Policy Provisions in Support of Claim Denial – Health Care Professionals (18 Files in Error) Improper General Business Practice

N.J.A.C. 11:2-17.8(i) prohibits an insurer from denying a claim when it is reasonably clear that benefits are payable. Contrary to this requirement, the examiners found 18 claims that met clean claim attributes outlined in **N.J.A.C. 11:22-1.2(a)** that the Company denied. The examiners also found that, contrary to **N.J.A.C. 11:2-17.8(a)**, the company failed to specify the policy provisions, conditions and exclusions that support these denials. These errors appear in the chart below.

Claim Number	Claim Identifier	Claim Number	Claim Identifier
1. 6067604066	line 3; CPT 90713	2. 6129N35179	line 5; CPT 84144
3. 6129N35259	line 1; CPT 99215	4. 6193405512	line 2; CPT 90471
5. 6230N23772	line 1; CPT 99392	6. 6272N22445	line 1; CPT 36415
7. 6272N22483	line 2; CPT 58340	8. 6272N22600	line 4; CPT 83001
9. 6277U03775	line 1; CPT 99394	10. 6321203982	line 2; CPT 99392
11.6347N23449	line 1; CPT 99213	12. 6361617326	line 2; CPT 99173
13.6101704888	line 1; CPT 99213	14. 6261200569	line 2; CPT 97014
15.83145657	ID 824355503	16. 6066H02591	line 46; CPT 85362
17.6131710068	line 1; CPT J1580	18. 6118611813	line 2; CPT 80100

Note: Items 1 – 15 apply to healthcare professionals. Items 16 – 18 apply to healthcare facilities.

3 Unfair Denials on Otherwise Payable Claims - Health Care Professionals (17 Certificates in Error) Improper General Business Practice

The examiners requested and reviewed 17 commercial health care Certificates of Coverage. Upon review, the examiners determined that any clean claim submitted under these certificates would be subject to **N.J.A.C. 11:2-17.8(i)** because such claims would be otherwise payable.

The Certificates in error are as follows:

1. GJSH – NJ Large HMO Select
2. HNJF – NJ Freedom High UCR
3. JCHF – NJ Archdiocese of Newark Freedom Plan High UCR
4. LA1F – NJ Archdiocese of Newark FP Gated STD. UCR
5. LBJF – New Jersey STD UCR Freedom
6. LBJH – New Jersey HMO
7. LHJF – NJ Freedom High UCR
8. LSJH – NJ Large HMO Select
9. LVJF – New Jersey Very High UCR Freedom
10. NJSH – NJ State Health Plan
11. NOJF – New Jersey STD UCR Freedom 51-99 Lives
12. ONJF – New Jersey STD UCR Freedom
13. ONJH – New Jersey HMO
14. ONVF – Oxford NJ Freedom UHC Public Sector
15. T1LF – NJLG Freedom Plan Classic STD UCR 51-99 Lives
16. VHJF – New Jersey Very High UCR Freedom
17. WJOH – Paine Webber New Jersey HMO

4. Erroneous Reasons For Denial (Two Claims in Error)

4a. Claim #6052N20006 (line # 1; CPT G0202 – Screening Mammography)

The referenced claim with a date of service of 2-13-06 was an electronic claim received by OHP-NJ on 2-21-06 and was manually adjudicated. On 3-03-06, OHP-NJ

denied the claim with a D-22 denial code (Services not authorized by PCP). In fact, the remittance advice (RA) sent to the non-participating provider states, in part, "OHP-NJ has denied this claim because we have no record of receiving an Electronic Referral from the Member's Primary Care Physician, OB/GYN or Select Specialist. The referring Provider must submit an electronic referral for specialty services in advance..."

On 3-09-06, the member called OHP-NJ and complained that she was balance-billed by the non-participating provider. On 3-13-06, OHP-NJ reversed the initial denial reason and issued another RA on 3-14-06 under claim number 6052N20006.01 with a D-1 denial code (not a covered benefit) since the service was performed by a non-participating provider. The denial reason initially given to the provider was not accurate.

Based on the information stated above, OHP-NJ did not correctly identify the reason (s) why the above claims were denied as prescribed by **N.J.A.C. 11:22-1.6(1)**. The Company agreed with the examiners' findings.

4b. Claim #6361Q00520 (line 2; CPT 96110 – Developmental Testing)

The referenced claim with a date of service of 12-22-06 was received electronically on 12-27-06 under claim number 6361Q00520 and claim number 6361Q01324. Claim number 6361Q00520 was auto-adjudicated and denied on 12-28-06 with a T-101 transaction code (Duplicate of claim # 6361Q01324 already processed). Claim number 6361Q01324, on the other hand, was manually adjudicated and denied on 1-24-07 with a D-19A denial code (Primary Care Doc/Specialist Service). In fact, the remittance advice (RA) sent to the participating provider states in part,

> "Primary care physicians are not eligible to receive reimbursement for services usually performed by Consulting Specialists in the OHP-NJ network of providers."

The denial reason given to the provider is not accurate. In response to the examiners' inquiries regarding how the referenced claim was processed, OHP-NJ stated:

> "Incorrect denial code was used. Per review there is no authorization on file. The claim line should have been denied with adjustment D2 – not authorized by OHP-NJ. "

Based on the information stated above, it appears that OHP-NJ did not correctly identify the reason(s) why the above claims were denied as prescribed by **N.J.A.C 11:22-1.6(a)1**. The Company agreed with the examiners' findings.

5. Failure to Provide Member/Provider with Explanation of Benefit on Denied Mandated and Non-Mandated Benefits - 64 Claims in Error (28 Mandated Benefit Claims and 36 Non-Mandated Benefit Claims) – Improper General Business Practice

Pursuant to **N.J.A.C. 11:22-1.6(a)**, a carrier is obligated to issue an explanation of benefit upon the denial of a claim. Contrary to this requirement, the examiners found a total of 64 claims in which OHP-NJ failed to provide a written explanation of benefit to the provider and/or member. These claims are itemized in the chart that follows.

Claim Number	Claim Line	CPT Code	Date of Service	Date of Denial	Denial Code	Claim Type
6016510113	17	90732	11/7/05	2/15/06	D1X	M
6052N20006.01	1	G0202	2/13/06	3/14/06	D1	M
6066H02591	46	85362	11/1/05	3/30/06	D99	M
6067603195	5	A7038-NU	2/1/06	4/4/06	D2	M
6067604066	3	90713	11/28/05	3/12/06	TFD2	M
6086615939	1	ERHOS	9/20/05	3/30/06	D99	M
6087202589	3	G0074	11/23/05	4/12/06	D1	M
6121500183	81	90747	3/27/06	5/21/06	D1X	M
6131710068	1	J1580	2/4/06	5/14/06	TFD2	M
6140N26986	2	99214	5/16/06	5/24/06	D22	M
6160N28873.01	1	90471	6/7/06	7/7/06	D1	M
6178N29661	6	S5180-NU	6/21/06	7/12/06	D9	M
6188N26729	2	G0862	6/29/06	7/26/06	D1	M
6082403947	2	90471	11/2/05	3/26/06	TFD2	M
6202Q01229	2	86580	7/13/06	8/8/06	D22	M
6230N23772	1	99392	3/31/06	8/20/06	TFD2	M
6137N29800	4	83001	5/9/06	5/24/06	D22	M
6257N19081	1	36415	5/1/06	9/17/06	TFD2	M
6215N18667	2	58340	4/7/06	8/26/06	TFD2	M
6272N22600	4	83001	5/31/06	9/30/06	TFD2	M
6277U03775	1	99394	4/21/06	10/8/06	TFD2	M
6282608369	5	90669	4/22/06	10/11/06	T416	M
6303623946	4	S9500	1/21/06	11/5/06	D9C	M
6319I01639	1	ERHOS	11/8/06	11/21/06	D13	M
6321203982	2	99392-25	7/17/06	11/22/06	TFD2	M
6322N27729	1	E1390-RR	4/13/06	12/17/06	TFD1	M
6331605917	2	99213	6/10/06	11/28/06	TFD2	M
6306N27089	2	76645-26	8/9/06	11/8/06	D22	M
6006U00521	1	92391	12/23/05	1/14/06	D13C	NM
5287505293	1	AMBSG	3/8/05	10/20/05	D99	NM
5343N31396	1	97112	10/19/05	12/22/05	D4	NM
5343N31400	5	97110	10/26/05	1/4/06	D35E	NM
6034X01325	16	86140-26	1/20/06	2/4/06	T531	NM
6054202078	1	97110	6/1/05	3/9/06	D22	NM
605440846B	2	95117	7/27/04	02/28/06	T416	NM
6069U00437	10	87088	12/26/05	4/7/06	D1	NM
6093500209	5	93798	12/8/04	4/8/06	D99	NM
6101401795	1	99213	12/7/05	4/14/06	TFD2	NM
6107609018	1	92014	1/5/06	4/23/06	D22	NM
6112N03119	1	93970-26	4/6/06	4/23/06	D2	NM
6116P00271	3	80048-26	8/17/05	4/27/06	T416	NM

6063N23216	1	99397	2/13/06	4/13/06	T519	NM
6047D02984	5	86592-26	2/5/06	2/23/06	T531	NM
6125U00969	1	72020	4/24/06	6/4/06	D1	NM
6144Q00265	1	98940	5/15/06	6/11/06	D2F	NM
6151H01257	1	93350-TC	5/23/06	6/25/06	D2	NM
6174N16635	1	99213	6/19/06	6/28/06	D22	NM
6178N25472	1	99214	6/22/06	6/28/06	D22	NM
6146N30052	1	99222	5/18/06	5/27/06	*	NM
6193N27558	1	99213	6/30/06	7/16/06	D22	NM
6198408885	1	99214	6/19/06	8/13/06	D9M	NM
6199N23846	2	J3130	6/9/06	7/19/06	D22	NM
6208N26515	14	85730-26	7/2/06	8/2/06	T531	NM
6219206110	1	99213	5/25/05	8/13/06	T416	NM
4289N26316	1	97140	10/24/04	10/28/04	D2F	NM
6220N22839	3	36415	8/4/06	9/1/06	D22	NM
6180613239	2	00810-AA	3/9/06	7/24/06	D99	NM
6230I01454	1	93731-TC	8/10/06	8/26/06	D2	NM
6104D03487	6	82247-26	3/16/06	4/24/06	T531	NM
6279502016	2	97110	1/6/06	10/31/06	D1X	NM
6284N35247	1	95117	7/28/05	10/15/06	T416	NM
6306406336	1	99214-25	10/6/06	11/8/06	D22	NM
6314N30995	1	93010	6/12/06	11/12/06	D2	NM
6347415230	6	95934	11/30/06	12/17/06	D22	NM

* Not Available

6. Incorrect Denial of Mandated and Non-Mandated Claims

Pursuant to **N.J.S.A. 17B:30-13.1c**, a company is required to reasonably and promptly investigate claims based on all available information. In addition, where a claim settlement extends beyond the regulatory maximum settlement periods (30 days from notice of claim on claims submitted electronically and 40 days from notice of claim on claims submitted by mail) specified in **N.J.A.C. 11:22-1.5(a)-(c)**, a company is required to pay interest to the provider. For late claims settled prior to July 11, 2006, **N.J.A.C. 11:22-1.6(c)** specified a rate of 10% on the unpaid balance. For claims settled late as of July 11, 2006, P.L. 2005 c.352 requires interest at a rate of 12% on the unpaid benefit. The company failed to comply, either individually or in combination, with these requirements as indicated below.

Denials on Mandated Benefits

6a. Claim #6226426692 (line # 3; CPT A6550 – Wound Care Set) Total of 147 System-wide Denials – Improper General Business Practice

The referenced claim with a date of service of 7-12-06 was a paper claim initially received on 8-14-06 and was manually adjudicated. On 8-29-06, OHP-NJ denied the claim with a D-1H denial code (Medical supplies not covered). On 10-09-06, the member called OHP-NJ and complained that she was balance billed by the participating provider. On 10-25-06, in response to the member's complaint, OHP-NJ wrote:

"OHP-NJ has denied payment D1H (Medical Supplies Not Covered) correctly on the referenced claim because you do not have a supply benefit."

On 12-11-06, the member appealed OHP-NJ 's determination in writing. On 12-21-06, in response to the member's second complaint, OHP-NJ wrote:

"<Persons Name> letter dated October 25, 2006 correctly upheld the denial of payment for these claims based on the absence of your policy to include a Supply benefit. Although <Person's Name> determination is correct based on the benefits listed in your 2006 package in OHP-NJ's current records, I had questioned if the Supply benefit, in-fact, was to be included in your 2006 benefits purchased under employer's benefit package. As a result of this current review, OHP-NJ's Benefits Department has confirmed that this benefit had been omitted in OHP-NJ's records and has corrected your 2006 package to include the Supply benefit. Accordingly, the referenced claims have been reprocessed on an in-network basis according to the provider's contractual fees."

On 12-21-06, OHP-NJ reversed the initial denial and paid the claim on 1-01-07 with an A5J adjustment code (Adjusting Line of Payment) under claim number 6226426692.01.

Based on the above, OHP-NJ is not in compliance with **N.J.S.A. 17B:30-13.1** as the Company denied the referenced claim without conducting a reasonable investigation. Moreover, since the policy did in fact include the referenced benefit, OHP-NJ also failed to comply with **N.J.A.C. 11:2-17.8(i)**, which prohibits claim denial when it is reasonably clear that benefits were payable. Lastly, the Company failed to pay interest as required by **N.J.S.A. 26:2J-8.1(12)**.

OHP-NJ agreed with the examiner's finding on claim #6226426692.

6b. Claim #6224Q00065 (line # 2; CPT 86580 – Skin test; tuberculosis) – Improper General Business Practice

The referenced claim with a date of service of 7-13-06 was an electronic claim initially received on 7-21-06 under claim number 6202Q01229 and was auto-adjudicated. The auto-adjudicator denied the claim on 8-08-06 with a D-22 denial code (Services not authorized by PCP). The denial of a mandated preventive care service by the auto-adjudicator is a systemic error. On 8-12-06, OHP-NJ received the same claim under claim number 6224Q00065, and the auto-adjudicator denied the claim on 8-13-06 with a T-100 transaction code (Duplicate of Claim Already Processed).

Based on the above, OHP-NJ is not in compliance with **N.J.S.A. 17B:30-13.1** as they denied the referenced claim without conducting a reasonable investigation. Moreover, the auto-adjudicator denial of this CPT code occurred on a systemic basis. Accordingly, the examiners cited this error type as an improper general business practice.

c. Claim #6009Q02414 (line #1; CPT 76091 – Bilateral Mammography)

The referenced claim with a date of service of 12-09-05 was an electronic claim initially received on 12-16-05 under claim number 5350Q00641 and was manually adjudicated. On 12-30-05, OHP-NJ denied the claim with a D-22 denial code (services not authorized by PCP). On 1-05-06, the provider called OHP-NJ and complained that the claim was not paid correctly. On 1-05-06, OHP-NJ reversed the initial denial because a referral was not needed for a preventive mammography per the provisions of the member's certificate of coverage. OHP-NJ paid the claim on 1-07-06 with an A37 adjustment code (paid at agreed or contracted rate) under claim number 5350Q00641.01. On 1-09-06, the same claim was filed under claim number 6009Q02414 and was denied by the auto-adjudicator on 1-11-06 with a T-100 transaction code (duplicate of a claim already processed).

Based on the above, OHP-NJ is not in compliance with **N.J.S.A. 17B:30-13.1** as they denied the referenced claim without conducting a reasonable investigation.

6d. Claim #6144H02216 (line # 1; CPT ERHOS – ER Hospital Facility

The referenced claim with a date of service of 5-15-06 was an electronic claim initially received on 5-24-06 and was auto-adjudicated. On 5-25-06, the auto-adjudicator denied the claim with a T-999 transaction code (this claim has been denied as it represents a duplicate submission of a claim previously processed by OHP-NJ).

On 1-18-07, the provider appealed OHP-NJ's denial. It appears that the auto-adjudicator incorrectly denied claim number 6144H02216 as a duplicate of claim number 6144H02217. Both claims have the same date of service; however, claim number 6144H02216 shows an admission hour of "00" (midnight), and claim number 6144H02217 shows an admission hour of "17" (five o'clock PM). According to OHP-NJ's Emergency Room facility guidelines:

> "A member may visit the emergency room more than once on the same DOS. A processor must review the admission hour on each claim before denying a claim as a duplicate. If the admission hours are different, both claims may be reimbursed."

On 1-25-07, OHP-NJ reversed the initial denial and paid the claim with an A37 adjustment code (paid at agreed or contracted rate) under claim number 6144H02216.01.

Based on the above, OHP-NJ is not in compliance with **N.J.S.A. 17B:30-13.1** as they denied the referenced claim without conducting a reasonable investigation. Furthermore, it does not appear that any applicable prompt pay interest has been paid. Finally, the erroneous denial of the referenced claim by the auto-adjudicator occurred as a systemic error.

6e. Claim #6233203668 (line 1; CPT H2014 – Skills training and development, per 15 minutes)

The referenced claim with a date of service of 4-15-05 was a paper claim received on 8-21-06 and was manually adjudicated. On 9-17-06, OHP-NJ denied the

claim with a D13M denial code (please resubmit with correct code). In response to an inquiry (GE-11) from the examiners, OHP-NJ wrote (Emphasis Added):

> "HCPCS code H2014 is not specifically listed in any online OHP-NJ Policy. Summary: Per Review claim 6233203668 should have been paid out on a retro-cert basis not denied D13M. Per the Ingenix HCPCS Level II 2005 book, the H codes are used by state Medicaid agencies and are mandated by state law to establish separate codes for identifying mental heath services that include alcohol and drug treatment services. HCPCS code H2014 does not link from the pre-certification tool to an OHP-NJ policy. This code does pull a benefit (in-network only) which would render it payable at this time. Additionally, with place of service 12 being billed the home healthcare processing map supports paying Retro-cert (RC) when no auth is on file. This code also pulled a non-bio mental health benefit... Claim 6233203668 should have been paid out on a RC basis not denied D13M."

Based on the above, OHP-NJ is not in compliance with **N.J.S.A. 17B:30-13.1** as the company denied the referenced claim without conducting a reasonable investigation.

OHP-NJ agreed with the examiner's findings for claim #6233203668.

6f. Claim #6269N29751 (line # 1; CPT 99395 – Periodic comprehensive preventive medicine reevaluation)

The referenced claim with a date of service of 7-05-06 was an electronic claim received on 9-26-06 and was auto-adjudicated. On 9-27-06, the auto-adjudicator denied the claim with a T-519 transaction code (insufficient information). The 99395 CPT code billed by the provider is for patients aged 18 through 39; the member was 17 years old on the date of service, and the provider should have billed with a 99394 CPT code, which is a periodic comprehensive preventive medicine reevaluation for patients aged 12 through 17. In response to a memorandum from the examiners, OHP-NJ wrote:

> "This claim was paid correctly; the auto-adjudicator denies claims that are not accurately billed. Per review it can be reprocessed to pay; per online documentation a processor may change coding when the age-specific CPT code submitted does not correspond with the member's age."

The referenced claim was not processed according to OHP-NJ's internal policy; therefore, OHP-NJ is not in compliance with **N.J.S.A. 17B:30-13.1** as they denied the referenced claim without conducting a reasonable investigation.

6g. Claim #6319I01639 (line # 1; CPT ERHOS – ER Hospital Facility)

The referenced claim with a date of service of 11-08-06 was an electronic claim received on 11-15-06 and was manually adjudicated. On 11-21-06, OHP-NJ denied the claim with a D-13 denial code (insufficient info to process item). In fact, the remittance advice (RA) sent to the provider on 11-21-06 explained the denial reason as follows:

"Adjustment Code Descriptions: D13 OHP-NJ is unable to process this claim due to missing information. OHP-NJ requires that all claims include an itemized bill of services rendered, medical diagnosis code(s), CPT code(s), place of service and any other pertinent clinical information which supports the service performed.
Claim Remarks: 6319I01639 – Please resubmit to verify if separate ER visit from 6318I01998 with services billed on 11/08/06."

The examiners discussed the referenced claim with OHP-NJ who explained that, although the hour a patient is discharged from a hospital is not a prerequisite for processing claims, the claim processor requested the discharge time for the patient's ER visit on 11-07-06. According to OHP-NJ's Emergency Room facility guidelines:

"A member may visit the emergency room more than once on the same DOS. A processor must review the admission hour on each claim before denying a claim as a duplicate. If the admission hours are different, both claims may be reimbursed."

Claim number 6318I01998 shows an admission hour of "22" (10 o'clock PM) on 11-07-06, and claim number 6319I01639 shows an admission hour of "09" (nine o'clock AM) on 11-08-06. On 2-14-07, in response to the claim processor's request for additional information, the provider, an acute care hospital, supplied the patient's medical records including the original bill and the patient's Discharge Instructions on 11-08-06. Despite all the necessary information available to the processor, on 3-01-07, OHP-NJ denied the claim with a D107 denial code (Requested Info Not received) under claim number#6319I01639.01.

In fact, the RA sent on 3-01-07 explained the denial reason as follows:
"Adjustment Code Descriptions: D107 We had previously requested additional information that is necessary to process your claim. The information submitted does not comply with that request; therefore, your claim has been denied. Participating provider may not balance bill the member for this service.
Claim Remarks: 6319I01639 – Submit discharge time thank you."

Finally, per a discussion with the examiners regarding the facts of the referenced claim, OHP-NJ explained that the claim processor should have paid the claim without requesting additional information from the provider.

Based on the above, OHP-NJ is not in compliance with **N.J.S.A. 17B:30-13.1** as they denied the referenced claim without conducting a reasonable investigation.

OHP-NJ agreed with examiner's findings for claim #6319I01639

6h. Claim #2006051199900150 (CPT 97039 – Unlisted Modality)

The referenced claim with a date of service of 12-28-05 was initially received on 1-16-06 under claim number 2006011699900120 and denied on 1-24-06 with a D-2 denial code (Not Authorized). The primary diagnosis recorded in Orthonet's claim system is V58.73 (Aftercare following surgery of the circulatory system not elsewhere classified). This service (CPT 97039) appears to be medically necessary to restore the patient physical functioning following surgery of the circulatory system.

Orthonet's failure to pay (or partially pay) a medically necessary claim for which a provider failed to obtain a prior authorization is inconsistent with **N.J.A.C. 11:24B-5.2(c)6** and **N.J.A.C. 11:2-17.8(i)**.

Denials on Non-Mandated Benefits

6i. Claim #6144Q00265 (line 1; CPT 98940 – Chiropractic manipulative treatment)

The referenced claim with a date of service of 5-15-06 was an electronic claim received on 5-24-06 and was manually adjudicated. On 6-11-06, OHP-NJ denied the claim with a D2F denial code (Chiropractic Service not Authorized). In fact, the Remittance Advice (RA) sent to the participating provider explained the denial reason as follows:

"D2F: Your provider was required to authorize this service in advance but failed to do so."

In response to an inquiry from the examiners, OHP-NJ wrote:

"Claim 6144Q00265 should have been paid according to payment policy and the member's chiropractic benefit in effect on date of service and the date the claim was processed...Member's benefit reads: The member may see a chiropractor for 1 visit per calendar year without a care plan. A care plan may be required after 1 visit. Based on the medical documentation in the care plan, a treatment plan (number of visits over a length of time) will be determined."

OHP-NJ's failure to pay the referenced claim as stipulated in the member's benefit contract fails to demonstrate good faith to effectuate prompt, fair and equitable settlement of a claim.

OHP-NJ agreed with the examiner's findings for claim #6144Q00265.

6j. Claim #6240209547 (line 1; CPT 99214 – Office visit for the evaluation and management of an established patient)

The referenced claim with a date of service of 3-31-06 was a paper claim initially received on 4-28-06 under claim number 6118408041 and was manually adjudicated. On 5-14-06, OHP-NJ denied the claim with a D1X denial code (COB not covered). In fact, the explanation of benefit sent to the member/patient explained the denial reason as follows:

"D1X: OHP-NJ's payment of this service represents payment as the secondary carrier. These charges have been denied since they represent services which are not covered under your health benefits plan."

In a discussion with the examiners regarding the facts of the referenced claim, OHP-NJ explained that the claim processor incorrectly denied the claim; since this was a coordination of benefit claim, an in-network urologist did not need a referral from the

member's primary care physician. In fact, OHP-NJ's policies regarding COB claims states:

> "...When OHP-NJ is secondary (or tertiary), pre-certification and referral requirements are modified: If a referral or authorization has not been requested/entered, OHP-NJ will waive the requirement deferring to the primary carrier's requirements."

On 8-28-06, the same claim was received under claim number 6240209547, and OHP-NJ denied the claim on 9-17-06 with a D4 denial code (Duplicate of Claim Already Processed). The examiner cited the Company pursuant to **N.J.A.C. 11:2-17.8(i)** because this claim was payable, and under **N.J.A.C. 11:2-17.9(b)** due to the Company's failure to investigate the eligibility of this claim.

OHP-NJ agreed with the examiner's findings for claim #6240209547.

6k. Claim #6107609018 (line 1; CPT 92014 – Ophthalmologic Services)

The referenced claim with a date of service of 1-05-06 was a paper claim received on 4-17-06 and was auto-adjudicated. On 4-23-06, OHP-NJ denied the claim with a D-22 denial code (Service not authorized by PCP). In fact, the RA sent to the participating provider explained the denial reason as follows:

> "D22: OHP-NJ has denied this claim because we have no record of receiving an Electronic Referral from the Member's Primary Care Physician, OB/GYN or Select Specialist..."

On 5-12-06, the provider appealed OHP-NJ's determination; the appeal packet supplied to OHP-NJ contained a referral form signed by the member's primary care physician on 12-29-05 for CPT code 92014. Despite the additional information provided, and inconsistent with **N.J.A.C. 11:2-17.8(i)**, OHP-NJ refused to pay the claim when it was reasonably clear that full benefits were payable. On 5-17-06, OHP-NJ reversed its initial determination but denied the claim again on 5-21-06 with a D-99 denial code (Filing Deadline has passed) even though the claim was clean within the context of N.J.A.C 11:22-1.2(a).

6l. Claim #6177719721 (line 3; CPT 97110 – Therapeutic procedure)

The referenced claim with a date of service of 6-10-06 was a paper claim received on 6-26-06 and was manually adjudicated. On 7-16-06, OHP-NJ denied the claim with a D-35E denial code (Notes needed for OrthoNet Review). In fact, the RA sent to the provider explained the denial reason as follows:

> "D35E: These services require clinical review...For OHP-NJ to consider payment, we need to review medical documentation from this visit. Medical documentation includes: (1) office notes that detail your condition and progress, and (2) results of available x-rays or other imaging studies. We will use this information to evaluate medical necessity and to confirm that the service billed matches the service provided..."

On 7-31-06, OHP-NJ received the information requested from the provider. OHP-NJ nevertheless denied the claim. In response to an inquiry (JF-20) from the examiners, OHP-NJ wrote:

> "Per review of notes, Authorization 82156071 was created and approved for five (5) dates of service-(6/10/06, 6/12/06, 6/14/06 and 6/17/06). Therefore, this claim should have been reprocessed and paid, per review of notes. This was human oversight (sic)"

OHP-NJ's denial of the referenced claim in contrary to **N.J.A.C. 11:2-17.8(i)** since the Company obtained all information necessary to pay this claim.

OHP-NJ agreed with the examiner's findings for claim #6177719721.

6m. Claim #611070692D (line 3; CPT 97035 – Ultrasound)

The referenced claim with a date of service of 2-02-06 was a paper claim received on 4-20-06 and was manually adjudicated. OHP-NJ's claim processing system shows that the provider, a participating physical therapist, charged $35 for the ultrasound therapy performed on the patient/member. On 5-08-06, OHP-NJ adjudicated the claim with a T477 transaction code (paid at Agreed or Contracted). However, the RA sent to the provider does not have a payment amount; in fact, the RA shows a Maximum Allowable amount of "0" and a payment amount of "0". The standard fee region rate for the service provided is $50 per the agreement between OHP-NJ and the physician.

OHP-NJ's failed to pay the referenced claim in accordance with the physician agreement.

OHP-NJ agreed with the examiner's findings for claim #611070692D.

6n. Claim #6012Q02735 (line 3; CPT 91105 – Gastric Intubation)

The referenced claim with a date of service of 10-14-05 was initially received on 11-08-05 under claim number 5312Q01660. Claim number 5312Q01660 was an electronic claim and was auto-adjudicated. On 11-09-05, OHP-NJ denied the claim with D-3 denial code (Review member information). In fact, the RA sent to the provider explained the denial reason as follows:

> "D3: These services have been denied since the Member was not covered by OHP-NJ on the date services were performed."

In a response to an inquiry from the examiners, OHP-NJ wrote:

> "On 10/27/2005 an ATC (Addition/Change/Termination) form was received from the parent. A Member Enrollment Representative processed the transaction and enrolled the baby. This was an inadvertent error as the group had a special arrangement which stated that the newborn additions must come from a group report. On 11/01/2005 a processor dedicated to New Jersey transactions received a duplicate ATC from the member. In researching the issue realized the

enrollment error and termed the newborn account (sic). On 01/01/2006 the group's report was received by OHP-NJ requesting the newborn enrollment and the account was reinstated on 1/6/06 for an effective date of 10/15/05. Claim 5312Q01660 was received on 11/8/05 and was submitted under the mother's ID number 3706381*01. In these situations processors are instructed to look to see if the newborn has their own ID number. There was a newborn ID number, 3706381*03 and per policy claim should be updated to reflect the newborn ID number. Being that the newborn's ID had been terminated and rendered non-effective, the claim was correctly denied D3-Review Member Information due to the fact the member was not enrolled on the date of service. Once the account was correctly activated, the claim was reprocessed per retro enrollment reprocessing guidelines. (Refer to claim 5312Q01660.01 paid per provider contracted fees in the amount of $257.21 on 1/18/06 check #541663.) Claim 5312Q01660 was processed correctly."

The review of the referenced claim shows that OHP-NJ did not process the claim correctly. The "special arrangement", which requires that newborn coverage can only be added upon receipt of a "group report" as described above, and OHP-NJ's denial of coverage to a newborn do not appear to be in compliance with **N.J.A.C. 11:24-3.2** – Nondiscriminatory enrollment practices, which states in part:

"(b) ...contracts of an HMO which provide coverage of a family member or dependents of a member shall also provide coverage to a newborn child of a member from the moment of birth until 31 days after the date of birth as if that child were enrolled, without additional premium for these 31 days. The coverage for newly-born children shall consist of coverage of at least injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities."

On 1-16-06, OHP-NJ reversed its initial denial and paid the claim on 1-18-06 under claim number 5312Q01660.01. On 1-12-06, the same claim was received under claim number 6012Q02735 and was denied with a T-100 transaction code (Duplicate of claim already processed).

Based on the information stated above, OHP-NJ was not in compliance with the requirements of **N.J.S.A. 17B:30-13.1**, **N.J.A.C. 11:24B:5.2(c)6** and **N.J.A.C. 11:2-17.8(i)**.

Denials on Infertility Claims

6o. Claim #6100414741 (line 1; CPT 99214 – Office or other outpatient visit)

The referenced claim with a date of service of 12-30-05 was a paper claim received on 4-10-06 and was auto-adjudicated. On 4-13-06, OHP-NJ denied the claim with a TFD2 denial code (OHP-NJ's certificate of coverage required that claims be submitted within 90 days of the date of service). The provider filed the claim 101 calendar days after the date of service.

OHP-NJ's refusal to pay a claim filed by a participating health care professional when the claim was clean within the context of N.J.A.C. 11:22-1.2(a), is inconsistent with **N.J.A.C. 11:2-17.8(i).**

6p. Claim #6121708340 (line 2; CPT 76857 – Ultrasound, pelvic)

The referenced claim with a date of service of 4-26-06 was a paper claim received on 5-01-06 and was auto-adjudicated. On 5-08-06, OHP-NJ denied the claim with a D-22 denial code (OHP-NJ has denied this claim because we have no record of receiving an Electronic Referral from the Member's Primary Care Physician, OB/GYN or Select Specialist) although there was a referral on file prior to the date the service was rendered.

On 8-23-05, the provider appealed OHP-NJ's determination. On 9-11-06, OHP-NJ reversed its initial denial, and paid the claim on 9-13-06 with an A37 adjustment code (paid as agreed).

OHP-NJ's initial denial of the referenced claim is inconsistent with **N.J.A.C. 11:2-17.8(i)**.

6q. Claim #6123N31930 (line 3; CPT 89261 – Sperm Isolation)

The referenced claim with a date of service of 12-26-05 was an electronic claim received on 5-03-06 and was manually adjudicated. On 5-10-06, OHP-NJ denied the claim with a D-22 denial code (OHP-NJ has denied this claim because we have no record of receiving an Electronic Referral from the Member's Primary Care Physician, OB/GYN or Select Specialist) although there was a referral on file for a provider affiliated with the treating physician.

OHP-NJ's failure to pay the referenced claim does not appear to be in compliance with **N.J.A.C. 11:2-17.8(i).**

Denials on Provider Appeals

6r. Claim #6103U02458 / Provider ID P1954183

The referenced claim with a date of service of 1-06-06 was an electronic claim received on 4-13-06 (97 calendar days after the date of service) and was auto-adjudicated. On 4-14-06, OHP-NJ denied the claim with a TFD2 denial code (Filing deadline has passed). On 6-30-06, OHP-NJ received an appeal from the provider disputing the denial of the referenced claim. On 7-06-06, OHP-NJ responded to the appeal and upheld its initial determination.

OHP-NJ 's refusal to pay a clean claim filed by a participating health care professional is contrary to N.J.A.C. 11:2-17.8(i).

6s. Claim #6129D00019; #6129D00018; #6129D00017 / Provider ID ANC 1055

- Claim number 6129D00019: The referenced claim with dates of service from 12-20-05 through 3-02-06 was received on 5-09-06 (140 days after the first date of service of 12-20-05). On 5-24-06, OHP-NJ denied services offered from 12-20-05 through 2-01-06 with a TFD2 denial code (filing deadline has passed).

- Claim number 6129D00018: The referenced claim with dates of service from 1-06-06 through 2-09-06 was received on 5-09-06 (123 days after the first date of service of 1-06-06). On 5-24-06, OHP-NJ denied the services offered from 1-06-06 through 1-25-06 with a TFD2 denial code (filing deadline has passed).

- Claim number 6129D00017: The referenced claim with dates of service from 1-06-06 through 1-17-06 was an electronic claim received on 5-09-06 (123 days after the first date of service of 1-06-06). On 5-24-06, OHP-NJ denied services offered from 1-06-06 through 1-17-06 with a TFD2 denial code (filing deadline has passed).

OHP-NJ 's refusal to pay a clean claim filed by a participating health care professional is inconsistent with N.J.A.C. 11:2-17.8(i).

6t. Claim #6075H02082 / Provider ID HO3062

The referenced claim with a date of service of 3-07-06 was an electronic claim received on 3-16-06 and was manually adjudicated. On 4-08-06, OHP-NJ denied the claim with a D-2 denial code (Not Authorized by OHP-NJ). On 7-18-06, OHP-NJ received an appeal from the participating hospital. In the appeal letter, the hospital wrote:

> "Per our 1/1/02 contract under Provision of Approved Services section 4.3: "Hospital and OHP-NJ acknowledge it is the responsibility of the admitting physician to obtain a pre-certification for OP services...Any failure of the admitting physician to obtain necessary pre-certifications for covered services shall not result in a denial of payment to the hospital."

On 7-24-06, OHP-NJ reversed its initial determination and paid the claim on 8-11-06."

OHP-NJ's initial denial of the referenced claim does not appear to be in compliance with **N.J.A.C. 11:2-17.8(i).**

8u. Claim #6091N26989 / Provider ID P1726416

The referenced claim with a date of service of 3-08-06 was an electronic claim received on 4-01-06 and was auto-adjudicated. On 4-02-06, OHP-NJ denied the claim with a D-2 denial code (Not Authorized by OHP-NJ) although there was a preauthorization on file. On 7-03-06, OHP-NJ received an appeal from the provider. On 7-07-06, OHP-NJ responded to the appeal and upheld the initial denial.

OHP-NJ's refusal to pay the referenced claim is inconsistent with **N.J.A.C. 11:2-17.8(i)**.

6v. Claim #6125H01069 / Provider ID HO1016 – Denial due to Intelliclaim Bundling Software

The referenced claim with a date of service of 4-17-06 was an electronic claim received 5-05-06 and was manually adjudicated. The provider bill included the following CPT codes: Drugs/other; 73110-RT; 90772; 99283-25; and 29125-RT. On 6-01-06, OHP-NJ processed the claim as follows:

- Line 1 – it appears that Intelliclaim bundled the drugs, CPT 73110-RT, CPT 90772, and CPT 29125-RT CPT under CPT ERHOS (Emergency Room), and a payment was issued with the adjustment code A37 (paid at agreed or contracted rate).
- Line 2 – CPT 99283-25 (Emergency department visit; unrelated evaluation and management service by the same physician on the same day of the procedure) was processed separately and denied with a TCOD transaction code (this service is ineligible for reimbursement as a separate procedure under OHP-NJ policy).

On 7-24-06, OHP-NJ received an appeal from the provider. In the appeal letter, the provider writes:

> "Claim was denied and should not have been for CPT code 99283, charge amount of 674.00, denial code of TCOD. Claim is for Emergency room visit and our contract states to be reimbursed at 90% of total charges."

On 7-26-06, OHP-NJ responded to the provider and upheld the initial denial of CPT code 99283-25. On 7-26-06, OHP-NJ reversed the referenced claim and reprocessed the claim under claim #6125H01069.01 as follows:

- Line 1: OHP-NJ unbundled CPT 90772 from CPT ERHOS; CPT ERHOS, which now includes the drugs, CPT 73110-RT, and CPT 29125-RT was paid with a reduced payment amount
- Line 2: CPT 90772, which was unbundled from CPT ERHOS, was denied with a D11 denial code (included in primary procedure fee).
- Line 3: CPT 99283-25 was unchanged.

OHP-NJ erroneously bundled and denied Line 3 CPT 99283-25 upon initial submission. In response to the appeal, OHP-NJ should have, but did not, unbundle and pay CPT 99283-25 because it was payable under the contract. The Company's use of Intelliclaim (a bundling software) was inconsistent with **N.J.A.C. 11:2-17.8(i)**.

6w. Claim #6110N24301 / Provider ID P413315

The referenced claim with a date of service of 4-14-06 was an electronic claim received on 4-20-06 and was manually adjudicated. On 5-08-06, OHP-NJ processed the referenced claim as follows:

- Line 1 – CPT 98941 (chiropractic manipulative treatment; spinal) was paid.
- Line 2 – CPT 98943 (chiropractic manipulative treatment; extra spinal) was denied with a D38F denial code (service denied after CCR review).

- Line 3 – CPT 97140-59 (manual therapy techniques; distinct procedural service) was denied with a D2F denial code (chiropractic service not authorized).
- Line 4 – CPT 97112 (therapeutic procedure) was denied with a TCPS procedure code (this service is ineligible for reimbursement as a separate procedure under OHP-NJ Policy) although it was preauthorized on 4-14-06 by the Company.

On 7-05-06, OHP-NJ received an appeal from the provider. On 7-13-06, OHP-NJ reversed the referenced claim. On 7-18-06, the Company reprocessed the claim as follows:

- Line 1 was unchanged.
- Line 2 was unchanged.
- Line 3 was unchanged.
- Line 4 was paid with the code A5J (adjusting line of payment).

OHP-NJ erroneously bundled and denied Line 4 CPT 97112 upon initial submission. In response to the appeal, OHP-NJ actually reversed its denial and paid the claim as required. The Company's use of Intelliclaim (bundling software) was inconsistent with **N.J.A.C. 11:2-17.8(i)**.

OHP-NJ agreed with the examiner's findings for claim #6110N24301.

7. **Erroneous Claim Settlement Methodology Resulting in Claim Underpayments – Mandated Benefits**

7a. Claim #6044625216 (line 2; CPT ERHOS – Emergency Room) Coordination of Benefit Error

The referenced claim with a date of service of 10-14-05 was a paper claim received on 2-13-06 and was manually adjudicated. The participating provider billed $1,215 for the service, and the primary carrier approved $243. After a $56.41 deductible and a $37.32 (or 20%) co-insurance deduction, the primary carrier paid $149.27 to the provider. OHP-NJ, the secondary carrier, only paid the $37.32 co-insurance amount and 8 cents in interest on 4-01-06 (or 7 calendar days after the 40 day threshold stipulated in **N.J.A.C. 11:22-1.5**). However, OHP-NJ's liability, according to the coordination of benefits requirements stipulated in **N.J.A.C. 11:4-28.7**, should have been $93.73 ($56.41 + $37.32) and 18 cents in interest. Therefore, the Company failed to comply with **N.J.A.C. 11:4-28.7** and **N.J.A.C. 11:22-1.5**.

OHP-NJ agreed with the examiner's findings for claim #6044625216

7b.Claim #6068H02083 (line 2; CPT 76092 – Screening Mammography) Systemic Deductible Error

The referenced claim with a date of service of 2-21-06 was an electronic claim received on 3-09-06 and was manually adjudicated. The provider billed $118 for the service; according to the fee schedule used by OHP-NJ, the maximum allowable amount is $86.14. OHP-NJ's computer system applied a deductible of $86.14 to the allowable

amount; as a result, OHP-NJ closed the claim on 3-17-06 with a zero payment amount. On 4-10-06 the member disputed the zero payment.

In a discussion with the examiners regarding the facts of the referenced claim, OHP-NJ indicated that for health benefit plans with an in-network deductible, the claim system automatically applies a deductible to the allowable amount; a human processor has to overwrite the system to reverse the transaction. On 5-02-06 (or 46 calendar days after the initial denial of the claim), a human processor reversed the initial denial and paid the claim ($86.14) with interest ($0.61) on 5-04-06 under claim #6068H02083.01.

The erroneous application of a deductible to a preventative mammogram by OHP-NJ's claim system appears to be a systemic error and an unfair claim settlement practice prohibited by **N.J.S.A. 17B:30-13.1f** which requires fair settlements.

OHP-NJ agreed with the examiner's findings for claim #6068H02083

7c. Claim #6070H01948/6070H01948.01 (line 1; CPT RMNEW – Inpatient Room & Board Newborn) Newborn Enrollment Error

The referenced claim with a date of service of 2-15-06 was an electronic claim received on 3-11-06 and was manually adjudicated. On 3-23-06, OHP-NJ denied the claim with a D-18 denial code (not a covered dependent). In fact, the RA sent to the provider explained the denial reason as follows:

"D-18: OHP-NJ cannot process this claim since the patient is not a covered dependent under the subscriber's policy."

OHP-NJ's denial of coverage to a newborn is inconsistent with **N.J.A.C. 11:24-3.2** – Nondiscriminatory enrollment practices, which states in part:

"(b) ...contracts of an HMO which provide coverage of a family member or dependents of a member shall also provide coverage to a newborn child of a member from the moment of birth until 31 days after the date of birth as if that child were enrolled, without additional premium for these 31 days. The coverage for newly-born children shall consist of coverage of at least injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities."

On 4-19-06, OHP-NJ reversed its initial determination and paid the claim on 4-21-06 with interest under claim number 6070H01948.01.

Based on the information stated above, it OHP-NJ did not correctly identify the reason(s) why the above claims were denied as prescribed by **N.J.S.A 17B:30-13.1(d)** and **N.J.A.C. 11:2-17.8(i)**.

OHP-NJ agreed with the examiner's findings for claim number 6070H01948/6070H01948.01.

8. Erroneous Claim Settlement Methodology Resulting in Claim Underpayments – Non-Mandated Benefits

8a. Claim # 6216N27624 (line 1; CPT 99244) In-Network Denial Devoid of Referral Contrary to Provider Agreement (Improper General Business Practice/22,922 Participating Provider Denials)

The referenced claim with a date of service of 8-01-06 was an electronic claim received on 8-04-06 and was manually adjudicated. On 8-09-06, OHP-NJ denied the claim with a D-22 denial code. In fact, the Remittance Advice sent to the provider explained the denial reason as follows:

> "D-22: OHP-NJ has denied this claim because we have no record of receiving an Electronic Referral from the Member's Primary Care Physician, OB/GYN or Select Specialist. The Referring Provider must submit an electronic referral for specialty services in advance and include the number of visits and the OHP-NJ Participating Specialist ID."

However, OHP-NJ's policies and procedures regarding referral requirements for claims that are manually processed state:

> "The following steps should be taken if a valid referral cannot be located for a participating provider...Review Field 17 on a CMS-1500 form or the referring field on an EDI claim. If a participating provider is located, it is considered a valid referral."

On 10-03-06, OHP-NJ reversed the claim and paid the claim on 10-05-06 with an A-34A adjustment code. The Adjustment is described as follows:

> "A34A: There is no referral on file for this service, however because the claim documentation indicates that an in-network provider made this in-network referral, we have made an exception to pay this service. In the future your referring provider must submit an electronic referral to OHP-NJ prior to services..."

Based on the information stated above, the initial denial of the referenced claim was contrary to OHP-NJ's policies and procedures, contrary to **N.J.S.A. 17B:30-13.1(d)** and **N.J.A.C. 11:2-17.8(i)**.

The examiners determined this error to be an improper general business practice by matching all D22 denial codes to the overall population of paid in-network physicians. Based on this data, Oxford inappropriately denied a total of 22,922 in-network physicians under denial code D22.

9. Improper Use of Multiple Denial Codes – Non-Mandated Benefits

9a. Claim #5343N31400 (line 5; CPT 97110), Claim #6033N34126 (line 5; CPT 97110), Claim #6145N29198 (line 5; CPT 97110), Claim #6224N27752 (line

5; CPT 97110), Claim #6257N27115 (line 5; CPT 97110) and Claim #6342N28866 (line 5; CPT 97110)

Claim 5343N31400 line 5 has a date of service of 10/26/05 and was received on 12/9/05. On 1/4/06, OHP-NJ denied the claim with a D35E denial code (notes needed for OrthoNet review). Claim 6033N34126 line 5 was received on 2/2/06 and denied on 2/16/06 with a D22 denial code (service not authorized by PCP). Claim 6145N29198 line 5 was received on 5/25/06 and denied on 6/7/06 with a T416 denial code (filing deadline has passed). Claim 6224N27752 line 5 was received on 8/12/06 and denied on 8/23/06 with a T416 denial code. Claim 6257N27115 line 5 was received on 9/14/06 and denied on 9/24/06 with a T416 denial code. Finally, claim 6342N28866 was received on 12/8/06 and denied on 12/17/06 with a D2 denial code (not authorized by OHP-NJ). It would appear that claim 6033N34126 line 5 was denied based on the notes requested in the review of claim 5343N31400 line 5. It would further appear that claims 6145N29198, 6224N27752 and 6257N27115 were denied for a reason other than that cited on claim 6033N34126 line five. Finally, it would appear that claim 6342N28866 line 5 was denied for a reason other than those cited on claim 6033N34126 line 5 and claim 6145N29198 line 5.

Based on the information stated above, OHP-NJ did not comply with **N.J.S.A. 11:22-1.6(a)(1)(iv)**.

10. Claim Denials due to Incomplete or Missing Information (D20)

10a. Claim #6089H01965 (Line 1; DOS 11/07/05; CPT Q4055; Billed $1,137.45

The above-referenced was an electronic claim denied on 5/03/06 for missing information, for the following reason under code D20:

"Upon receipt of this claim we determined that we did not have all of the information necessary to complete processing and a letter was sent to you and/or your provider requesting this information. Thirty days have passed since this request was made and this notice is being generated as a reminder. Please refer to our original letter for a detailed description of what was requested. Please submit the requested information, along with a copy of this Remittance Advice to: Correct/Resubmitted Claims, PO Box 7017, Bridgeport, CT 06601-7017.)"

A review of the Company's "Communication History" screen reveals that the requested information (Worker's Compensation Questionnaire) was received by OHP-NJ on 04/13/06 (not 04/30/06 as reported by OHP-NJ on sampled population). Therefore, the denial reason for this claim is incorrect and should have been processed for payment or denied for the appropriate reason assuming the claim could not still be processed for payment due to the information received. Identification of these variables is particularly important on claim events that are reprocessed with different claim numbers such as resubmissions or, where applicable, upon appeal. Moreover, lack of such information impeded the examiners' ability to reconstruct the claim settlement, contrary to N.J.A.C. 11:2-17.12(b).

The examiner has further noted that the letter sent to the member requesting the missing information does not provide specific information regarding the claim(s) the request is related to (i.e. claim number, date of service, billed amount, etc.). Therefore, the member does not have information as to the claim(s) that may potentially be denied if the requested information is not received by OHP-NJ.

Additionally, a review of the claims and communication history screens do not indicate further attempts are made by OHP-NJ to obtain the requested missing information once the claim has been denied for this reason code (D20).

Based on the information stated above, OHP-NJ did not comply with **N.J.A.C. 11:22-1.6**and **N.J.A.C. 11:2-17.12 (b)**.

10b. Claim #6153707357 (Line 3; DOS 05/27/06; CPT 97802; Billed $50)

The above-referenced was a paper claim denied on 7/09/06 for missing information under code D20 as follows:

> "Upon receipt of this claim we determined that we did not have all of the information necessary to complete processing and a letter was sent to you and/or your provider requesting this information. Thirty days have passed since this request was made and this notice is being generated as a reminder. Please refer to our original letter for a detailed description of what was requested. Please submit the requested information, along with a copy of this Remittance Advice to: Correct/Resubmitted Claims, PO Box 7017, Bridgeport, CT 06601-7017.)"

A review of the sampled population provided by OHP-NJ for this review reveals that the necessary claim information required for processing this claim was received on 07/06/06; however, the examiner was unable to locate the necessary information that was received. If the necessary or requested information was received by OHP-NJ on this date, then it appears the reason code (D20) utilized for this claim denial was incorrect.

The examiner has further noted that the letter sent to the member requesting the missing information does not provide specific information regarding the claim(s) the request is related to (i.e. claim number, date of service, billed amount, etc.). Therefore, the member does not have information as to the claim(s) that may potentially be denied if the requested information is not received by the Company.

Based on the information stated above, OHP-NJ did not comply with **N.J.A.C. 11:22-1.6** and **N.J.A.C. 11:2-17.12 (b)**.

10c. Claim #6172412012 (Line 2; DOS 05/09/02; CPT 81000; Billed $10

The above-referenced was a paper claim denied on 7/24/06 for missing information under code D20 as follows:

"Upon receipt of this claim we determined that we did not have all of the information necessary to complete processing and a letter was sent to you and/or your provider requesting this information. Thirty days have passed since this request was made and this notice is being generated as a reminder. Please refer to our original letter for a detailed description of what was requested. Please submit the requested information, along with a copy of this Remittance Advice to: Correct/Resubmitted Claims, PO Box 7017, Bridgeport, CT 06601-7017.)"

A review of the sampled population provided by OHP-NJ for this review indicates that the necessary claim information required for processing this claim was received on 07/23/06; however, the examiners were unable to locate the necessary information that was received. If the necessary or requested information was received by OHP-NJ on this date, then it appears the reason code (D20) utilized for this claim denial was incorrect.

The examiner has further noted that the letter sent to the member requesting the missing information does not provide specific information regarding the claim(s) the request is related to (i.e. claim number, date of service, billed amount, etc.). Therefore, the member does not have information as to the claim(s) that may potentially be denied if the requested information is not received by OHP-NJ.

Additionally, a review of the claims and communication history screens do not indicate that further attempts were made by OHP-NJ to obtain the requested missing information once the claim has been denied for this reason code (D20).

Based on the information stated above, OHP-NJ did not comply with **N.J.A.C. 11:22-1.6** and **N.J.A.C. 11:2-17.12 (b)**.

10d. Claim #628240403B (Line 3; DOS 05/27/06; CPT 97802; Billed $50)

The above-referenced was a paper claim denied on 12/1/06 for missing information under code D20 as follows:

"Upon receipt of this claim we determined that we did not have all of the information necessary to complete processing and a letter was sent to you and/or your provider requesting this information. Thirty days have passed since this request was made and this notice is being generated as a reminder. Please refer to our original letter for a detailed description of what was requested. Please submit the requested information, along with a copy of this Remittance Advice to: Correct/Resubmitted Claims, PO Box 7017, Bridgeport, CT 06601-7017)."

A review of the sampled population provided by OHP-NJ for this review appears to indicate that the necessary claim information required for processing this claim was received on 11/22/06; however, the examiner was unable to locate the necessary information that was received. If the necessary or requested information was received by OHP-NJ on this date, then it appears the reason code (D20) utilized for this claim denial was incorrect and processed past the 40 day limit at 57 days.

The examiner has further noted that the letter sent to the member requesting the missing information does not provide specific information regarding the claim(s) the request is related to (i.e. claim number, date of service, billed amount, etc.). Therefore, the member does not have information as to the claim(s) that may potentially be denied if the requested information is not received by OHP-NJ.

Based on the information stated above, it appears that OHP-NJ did not comply with **N.J.A.C. 11:22-1.6**, **N.J.A.C. 11:22-1.5** and **N.J.A.C. 11:2-17.12 (b)**.

10e. Claim #61313H00812 (Line 1; DOS 11/02/06; CPT ERHOS; Billed $696)

The above-referenced was a paper claim denied on 12/13/06 for missing information under code D20 as follows:

> "Upon receipt of this claim we determined that we did not have all of the information necessary to complete processing and a letter was sent to you and/or your provider requesting this information. Thirty days have passed since this request was made and this notice is being generated as a reminder. Please refer to our original letter for a detailed description of what was requested. Please submit the requested information, along with a copy of this Remittance Advice to: Correct/Resubmitted Claims, PO Box 7017, Bridgeport, CT 06601-7017)."

A review of OHP-NJ's "Letter Event Summary" screen from the PULSE system reveals the letter regarding the missing information (Accidental Injury Form) requested by OHP-NJ was sent only to the member. No notice or letter was sent to the provider regarding the requested information and therefore, it appears this claim was denied for the incorrect denial reason.

Furthermore, the sampled population provided by OHP-NJ for this review appears to indicate that the necessary claim information required for processing this claim was received on 12/10/06; however, the examiner was unable to locate the necessary information that was received. If the necessary or requested information was received by OHP-NJ on this date, then it appears the reason code (D20) utilized for this claim denial was incorrect and processed past the 30 day limit at 35 days.

The examiner has further noted that the letter sent to the member requesting the missing information does not provide specific information regarding the claim(s) the request is related to (i.e. claim number, date of service, billed amount, etc). Therefore, the member does not have information as to the claim(s) that may potentially be denied if the requested information is not received by OHP-NJ.

Based on the information stated above, it appears that OHP-NJ did not comply with **N.J.A.C. 11:22-1.6**, **N.J.A.C. 11:22-1.5** and **N.J.A.C. 11:2-17.12 (b)**.

10f. Claim #5361200550 (Line 2; DOS 12/22/05; CPT 90806; Billed $100)

The above-referenced was a paper claim denied on 1/29/06 for missing information under Code D20 as follows:

> "Upon receipt of this claim we determined that we did not have all of the information necessary to complete processing and a letter was sent to you and/or your provider requesting this information. Thirty days have passed since this request was made and this notice is being generated as a reminder. Please refer to our original letter for a detailed description of what was requested. Please submit the requested information, along with a copy of this Remittance Advice to: Correct/Resubmitted Claims, PO Box 7017, Bridgeport, CT 06601-7017)."

It appears this claim was denied with an incorrect denial reason. A review of OHP-NJ's "Letter Event Summary" screen from the PULSE system reveals a letter was sent to the provider indicating the diagnosis code (ICD-9) was not furnished on the original claim; however, a diagnosis code was submitted—it was just an invalid code.

It appears the provider resubmitted the claim with the valid diagnosis code on 01/10/06 but OHP-NJ continued to deny this pended claim with D20 and created a new claim with the payment under a new number (#6010704900).

The examiners have further noted that the letter sent to the member requesting the missing information does not provide specific information regarding the claim(s) the request is related to (i.e. claim number, date of service, billed amount, etc.). Therefore, the member does not have information as to the claim(s) that may potentially be denied if the requested information is not received by OHP-NJ.

Based on the information stated above, it appears that OHP-NJ did not comply with **N.J.A.C. 11:22-1.6** and **N.J.A.C. 11:2-17.12 (b)**.

10g. Claim #6110705857 (Line 2; DOS 04/03/06; CPT 97032-59; Billed $44.45)

The above-referenced was a paper claim denied on 5/26/06 for missing information under Code D20 as follows:

> "Upon receipt of this claim we determined that we did not have all of the information necessary to complete processing and a letter was sent to you and/or your provider requesting this information. Thirty days have passed since this request was made and this notice is being generated as a reminder. Please refer to our original letter for a detailed description of what was requested. Please submit the requested information, along with a copy of this Remittance Advice to: Correct/Resubmitted Claims, PO Box 7017, Bridgeport, CT 06601-7017)."

A review of the sampled population provided by OHP-NJ for this review appears to indicate that the necessary claim information required for processing this claim was received on 05/24/06; however, the examiner was unable to locate the necessary information that was received. If the necessary or requested information was received by OHP-NJ on this date, then it appears the reason code (D20) utilized for this claim denial was incorrect.

On 06/24/07, it is noted that OHP-NJ reprocessed this claim for a subsequent denial (see 6110705857.01) for D35F which is requesting medical documentation for clinical review. It appears this should have been requested with the initial denial for D20 to support that OHP-NJ conducted a reasonable investigation when it was in receipt of the claim.

The examiner has further noted that the letter sent to the member requesting the missing information (Accidental Injury Form) does not provide specific information regarding the claim(s) the request is related to (i.e. claim number, date of service, billed amount, etc.). Therefore, the member does not have information as to the claim(s) that may potentially be denied if the requested information is not received by OHP-NJ.

Based on the information stated above, it appears that OHP-NJ did not comply with **N.J.A.C. 11:22-1.6** and **N.J.A.C. 11:2-17.12 (b)**.

10h. Claim #6179707644 (Line 47; DOS 05/01/06; CPT 98941; Billed $45)

The above-referenced was a paper claim denied on 8/16/06 for missing information under Code D20 as follows:

"Upon receipt of this claim we determined that we did not have all of the information necessary to complete processing and a letter was sent to you and/or your provider requesting this information. Thirty days have passed since this request was made and this notice is being generated as a reminder. Please refer to our original letter for a detailed description of what was requested. Please submit the requested information, along with a copy of this Remittance Advice to: Correct/Resubmitted Claims, PO Box 7017, Bridgeport, CT 06601-7017)."

A review of the sampled population provided by OHP-NJ for this review appears to indicate that the necessary claim information requested (Accidental Injury Form) for processing this claim was received on 08/12/06; however, the examiner was unable to locate the necessary information that was received. If the necessary or requested information was received by OHP-NJ on this date, then it appears the reason code (D20) utilized for this claim denial was incorrect and processed past the 40 day limit at 51 days.

The examiner has further noted that the letter sent to the member requesting the missing information does not provide specific information regarding the claim(s) the request is related to (i.e. claim number, date of service, billed amount, etc.). Therefore, the member does not have information as to the claim(s) that may potentially be denied if the requested information is not received by OHP-NJ.

Based on the information stated above, it appears that OHP-NJ did not comply with **N.J.A.C. 11:22-1.6 N.J.A.C. 11:22-1.5** and **N.J.A.C. 11:2-17.12 (b)**.

10i. Claim #6299H00747 (Line 3; DOS 10/17/06; CPT 78480; Billed $1,755)

The above-referenced was an electronic claim denied on 11/28/06 for missing information under Code D20 as follows:

> "Upon receipt of this claim we determined that we did not have all of the information necessary to complete processing and a letter was sent to you and/or your provider requesting this information. Thirty days have passed since this request was made and this notice is being generated as a reminder. Please refer to our original letter for a detailed description of what was requested. Please submit the requested information, along with a copy of this Remittance Advice to: Correct/Resubmitted Claims, PO Box 7017, Bridgeport, CT 06601-7017)"

A review of the sampled population provided by OHP-NJ for this review appears to indicate that the necessary claim information required for processing this claim was received on 11/26/06; however, the examiner was unable to locate the necessary information that was received. If the necessary or requested information was received by OHP-NJ on this date, then it appears the reason code (D20) utilized for this claim denial was incorrect and processed past the 30 day limit at 35 days.

The examiner has further noted that the letter sent to the member requesting the missing information does not provide specific information regarding the claim(s) the request is related to (i.e. claim number, date of service, billed amount, etc.). Therefore, the member does not have information as to the claim(s) that may potentially be denied if the requested information is not received by OHP-NJ.

Based on the information stated above, it appears that OHP-NJ did not comply with **N.J.A.C. 11:22-1.6 N.J.A.C. 11:22-1.5** and **N.J.A.C. 11:2-17.12 (b)**.

10j. Claim #6313H01352 (Line 1; DOS 10/11/06; CPT 99381; Billed $120)

The above-referenced was an electronic claim denied on 12/17/06 for missing information under Code D20 as follows:

> "Upon receipt of this claim we determined that we did not have all of the information necessary to complete processing and a letter was sent to you and/or your provider requesting this information. Thirty days have passed since this request was made and this notice is being generated as a reminder. Please refer to our original letter for a detailed description of what was requested. Please submit the requested information, along with a copy of this Remittance Advice to: Correct/Resubmitted Claims, PO Box 7017, Bridgeport, CT 06601-7017)."

A review of OHP-NJ's "Letter Event Summary" screen from the PULSE system reveals the letter regarding the missing information (Accidental Injury Form) requested by OHP-NJ was sent only to the member. No notice or letter was sent to the provider regarding the missing information and therefore, it appears this claim was denied for the incorrect denial reason.

The "Claims History" screen also appears to reveal activity supporting an adjustment on this claim as it was reversed to zero out the charges billed on the submitted claim; however, the examiner could not locate a subsequent adjusted claim to support the reversals.

Furthermore, the sampled population provided by OHP-NJ for this review appears to indicate that the necessary claim information required for processing this claim was received on 12/15/06; however, the examiner was unable to locate the necessary information that was received. If the necessary or requested information was received by OHP-NJ on this date, then it appears the reason code (D20) utilized for this claim denial was incorrect and processed past the 30 day limit at 40 days.

The examiner has further noted that the letter sent to the member requesting the missing information does not provide specific information regarding the claim(s) the request is related to (i.e. claim number, date of service, billed amount, etc.). Therefore, the member does not have information as to the claim(s) that may potentially be denied if the requested information is not received by OHP-NJ.

Based on the information stated above, it appears that OHP-NJ did not comply with **N.J.A.C. 11:22-1.6** **N.J.A.C. 11:22-1.5** and **N.J.A.C. 11:2-17.12 (b)**.

11. Coordination of Benefits (COB) Claims

11a. Claim #5353412606, DOS 10/26/05, CPT 99213

The above-referenced is a COB claim that was processed incorrectly by OHP-NJ. The adjustment code processed with this claim was A27 as follows:

> "OHP-NJ's payment on this service represents payment as the secondary carrier. The allowed amount represents Medicare's allowed amount. Participating Providers may not balance bill Members for Covered Services in excess of the applicable co-pay, co-insurance, or deductibles."

Per Medicare's EOB, the allowed amount is shown as $56.57, but OHP-NJ processed this claim with the allowed amount as $54.57. Therefore, it appears an additional $2.00 is owed to the provider on this claim. It should also be noted that subsequent payment to the provider for the additional $2.00 should include interest at 12% per annum (P.L. 2005, c.352 and **N.J.S.A. 26:2J-8.1(12)**)

Additionally, on the date of service, the member was only 52 years-old and therefore, appears to have been entitled to Medicare coverage due to disability. However, OHP-NJ's eligibility system (PULSE) does not appear to have been updated regarding the member's Medicare coverage reason as it is listed as "Unknown."

An insured's entitlement to Medicare coverage due to disability or End Stage Renal Disease (ESRD) will affect an insured's payment as the primary or secondary carrier. Therefore, it does not appear that OHP-NJ's determination as the secondary carrier on this claim is validated as its records reveal the Medicare coverage reason as unknown.

Based on the information stated above, OHP-NJ did not comply with P.L. 2005, c.352, **N.J.S.A. 26:2J-8.1(12)** and **N.J.A.C. 11:4-28.6(a)(2)**.

The Company agreed with the examiner's findings on claim #5353412606.

11b. Claim #6170620908, DOS 06/02/06, CPT 78465-TC

The above-referenced is a COB claim that was processed incorrectly by OHP-NJ. File materials indicate that the insured's entitlement to Medicare coverage was due to age. According to Federal laws specific to Medicare beneficiaries (Title **42 C.F.R. § 411.172**), entitled Medicare coverage due to age is secondary to the insured's group health insurance policy, if the employer group providing that coverage has at least 20 employees and the insured is an active employee.

In an attempt to confirm the employer group size and the accuracy of OHP-NJ's determination as the secondary carrier, the examiner sent a request for copies of the employer group census for the sampled population and its guidelines for determining a small or large employer group. In response to this request, OHP-NJ provided group subscriber listings for each of the members listed on the sampled population. An employer group size is based on the number of active employees the group employed and not based on the number of subscribers participating in the health benefits plan. Furthermore, OHP-NJ indicated in its response that it does not require groups to submit a census every year—it must be submitted only if a large group's enrollment drops below 37 or a small group grows to 51 or over.

Additionally, according to the subscriber listing provided with the Company's response to the examiner's request, the insured's group coverage with OHP-NJ has a total of 46 subscribers participating in the plan as of 08/21/06. Therefore, it appears the employer group had a minimum of at least 20 employees and as a result OHP-NJ should have paid benefits on this claim as the primary carrier—not secondary.

Based on the information stated above, this response does not appear to support that OHP-NJ's practice is to comply with **N.J.A.C. 11:21-6.2**, which requires small employer carriers to verify on an annual basis that a small employer still meets the definition of a small employer group by completing the New Jersey Small Employer Certification form. In addition, it appears to be inconsistent with the coordination of benefit rules pursuant to **N.J.A.C. 11:4-28.6(a)(2).** The examiners cited this error as an improper general business practice.

11c. Claim #6265203390, DOS 08/02/06, CPT 92014

The above-referenced is a COB claim that appears to have been processed incorrectly by OHP-NJ. It appears the insured's entitlement to Medicare coverage was due to age.

Please see claim #6170620908 above for details and examiner's findings as it is for the same member but different date of service.

11d. Claim #626842640B, DOS 08/21/06, CPT 76075-TC

The above-referenced is a COB claim that appears to have been processed incorrectly by OHP-NJ. It appears the insured's entitlement to Medicare coverage was due to age.

Please see claim #6170620908 above for details and examiner's findings as it is for the same member but different date of service.

11e. Claim #6286201001, DOS 08/21/06, CPT 76092-26

The above-referenced is a COB claim that appears to have been processed incorrectly by OHP-NJ. It appears the insured's entitlement to Medicare coverage was due to age.

Please see claim #6170620908 above for details and examiner's findings as it is for the same member but different date of service.

11f. Claim 6167N32864, DOS 06/13/06, CPT 99212

The above-referenced is a COB claim that OHP-NJ apparently incorrectly processed as a primary carrier. The examiners found that OHP-NJ should have processed this claim as the secondary carrier. However, this information cannot be confirmed as number of employees participating in a health benefits plan does not determine an employer group size.

Nonetheless, during a weekly claims call with OHP-NJ, it was revealed that the member's Medicare information was not updated in OHP-NJ's COB system until December 19, 2007, and after the claim was already processed as if no other coverage existed. OHP-NJ never reprocessed this claim to correctly coordinate benefits with Medicare. A review of this claim revealed that out of the $43.36 payment, the Company paid a total amount of only $13.36 to the provider and applied $30 toward the member's copayment.

Based on the information stated above, this response does not appear to support that OHP-NJ complies with **N.J.A.C. 11:21-6.2**, which requires small employer carriers to verify on an annual basis that a small employer still meets the definition of a small employer group by completing the New Jersey Small Employer Certification form. In addition, it appears to be inconsistent with the coordination of benefit rules pursuant to **N.J.A.C. 11:4-28.6(a)(2)**.

It should also be noted that **N.J.A.C. 11:4-28.7(e)(2)**, states in part that "the covered person shall only be liable for the copayment, deductible and coinsurance under the secondary plan if the covered person has no liability for a copayment, coinsurance or deductible under the primary plan and the total payments by both the primary and secondary plans are less than the provider's billed charges."

Therefore, according to **N.J.A.C. 11:4-28.7(e)(2)**, it appears the member should not have been subject to the deductible and OHP-NJ should have paid the provider the entire $43.36 allowable amount.

ADDITIONAL FINDINGS:

The following are violations related to COB provisions observed by the examiners outside the random COB claims sample reviewed.

- Claim 6132702832 (DOS 03/08/06, CPT E1390, Billed $275)

This is a COB claim from the denied mandated claims population with Medicare as the primary carrier, which appears to have been processed incorrectly by OHP-NJ.

Per Medicare's EOB, Medicare allowed $200.41 out of the total $275 billed by the provider on this claim. The member's co-insurance was $40.08 and $74.59 exceeded the provider's fee schedule or maximum allowable amount. Therefore, the resulting total payment by Medicare as the primary carrier on this claim was $160.33.

In coordinating benefits with Medicare as the primary carrier, OHP-NJ applied the entire allowable amount ($200.41) towards the member's deductible and paid $0 to the provider.

According to **N.J.A.C. 11:4-28.7(e)(2)**, "the covered person shall only be liable for the copayment, deductible and coinsurance under the secondary plan if the covered person has no liability for a copayment, coinsurance or deductible under the primary plan and the total payments by both the primary and secondary plans are less than the provider's billed charges."

Therefore, according to **N.J.A.C. 11:4-28.7(e)(2)**, it appears the member should not have been subject to the deductible and the Company should have paid the provider the remaining $40.08 allowable that had been applied towards the member's co-insurance amount by the primary carrier.

- Claim 619840885 (DOS 06/19/06, CPT 99214, Billed $150)

This is a COB claim from the denied non-mandated claims population with Medicare as the primary carrier, which appears to have been processed incorrectly by the Company.

This COB-related claim was denied on 08/13/06 for denial code D9M, which states that, "Our records reflect that Medicare is the primary insurer for this service. Please submit these charges to the primary carrier for processing..." A review of the Company's claims history screen does not support that: 1) the claim was subsequently paid and; 2) any follow-up efforts were made by the Company to obtain the necessary information required for it to determine its benefits as the secondary plan once it denied the claim for the missing EOB from the primary carrier.

According to **N.J.A.C. 11:4-28.9(a)(2)(ii)**, "...(2) If the complying plan is the secondary plan, it shall: (ii) Assume the primary position and pay its benefits as the primary plan, if the noncomplying plan is unwilling to act as the primary plan or does not supply the information necessary for the complying plan to determine its benefits as the secondary plan."

Therefore, according to **N.J.A.C. 11:4-28.9(a)(2)(ii)**, it appears OHP-NJ had information indicating other coverage existed. When the necessary information was not received from the primary carrier (i.e. EOB), OHP-NJ should have assumed the primary position and processed the claim allowing benefits as the primary plan.

Furthermore, in accordance with **N.J.A.C. 11:4-28.7(f)**, the secondary plan shall not reduce allowable expenses on the basis that precertification, notification or second surgical opinions were not given where the services or supplies in question were determined to have been medically necessary.

A review of OHP-NJ's COB guidelines under the Overview section of the "Confirmed Coordination of Benefits" procedures indicate that when OHP-NJ is confirmed as the secondary carrier, the service should not be reviewed for medical necessity.

According to discussions with the OHP-NJ, this process appears to be applicable and beneficial only under plans in which there is an out-of-network benefit or pre-certification or prior authorization on file for the billed service.

If the billed service is submitted by a non-participating provider for a member covered under a plan with no out-of-network benefits or pre-certification or prior authorization on file, the claim will be denied as an uncovered benefit without consideration of medical necessity.

Therefore, it appears that OHP-NJ is not in compliance with **N.J.A.C. 11:4-28.7(f)** and needs to include in its procedures for claims involving COB a statement that all services submitted by a non-participating provider should be reviewed for medical necessity if no pre-certification, prior authorization or out-of-network benefits are available.

12. Non-Par Small Group-Claim Underpayments due to Failure to Pay at 80th PHCS Percentile (Improper General Business Practice)

12a. Claim 6364N25482, Line 1, DOS 12/18/06, CPT 73130-26, Billed Amt $42, Paid Amt $27.16

According to **N.J.A.C. 11:21-7.13**, out-of-network claims for small employer groups shall be paid at the 80th percentile of PHCS Fee Schedules or on actual charges. The above-referenced is a non-par small employer group claim that appears to have been paid incorrectly. It appears OHP-NJ owes the provider an additional $14.84 payment.

A review of the PHCS Fee Schedule released by Ingenix during this date of service reveals the 80th percentile for this procedure code within the provider's geographic area (07960) as $42. Therefore, the correct allowable amount for this procedure by OHP-NJ should have been for $42 and not $27.16.

Based on the information stated above, OHP-NJ is not in compliance with **N.J.A.C. 11:21-7.13**.

OHP-NJ agreed with examiners' findings for claim #6364N25482.

12b. Claim 6365V03169, Line 3, DOS 12/29/06, CPT 90471, Billed Amt $20, Paid Amt $7.66

According to **N.J.A.C. 11:21-7.13**, out-of-network claims for small employer groups shall be paid at the 80th percentile of PHCS Fee Schedules or on actual charges. The above-referenced is a non-par small employer group claim that appears to have been paid incorrectly. It appears OHP-NJ owes the provider an additional $12.34 payment.

A review of the PHCS Fee Schedule released by Ingenix during this date of service reveals the 80th percentile for this procedure code within the provider's geographic area (07020) as $30. It should be noted that providers cannot be reimbursed for more than what was billed; therefore, the correct allowable amount by OHP-NJ should have been for the billed amount ($20) and not $7.66.

Based on the information stated above, OHP-NJ is not in compliance with **N.J.A.C. 11:21-7.13**.

OHP-NJ agreed with examiner's findings for claim #6365V03169.

12c. Claim 7001D05485, Line 1, DOS 12/16/06, CPT 99232, Billed Amt $150, Paid Amt $120

According to **N.J.A.C. 11:21-7.13**, out-of-network claims for small employer groups shall be paid at the 80th percentile of PHCS Fee Schedules or on actual charges. The above-referenced is a non-par small employer group claim that appears to have been paid incorrectly. It appears OHP-NJ owes the provider an additional $5.00 payment.

A review of the PHCS Fee Schedule released by Ingenix during this date of service reveals the 80th percentile for this procedure code within the provider's geographic area (07834) as $125. Therefore, the correct allowable amount for this procedure by OHP-NJ should have been for $125 and not $120.

Based on the information stated above, OHP-NJ is not in compliance with **N.J.A.C. 11:21-7.13**.

OHP-NJ agreed with examiners' findings for claim #7001D05485.

12d. Claim 7139N20386, Line 1, DOS 05/14/07, CPT 87491, Billed Amt $110, Paid Amt $60.50

According to **N.J.A.C. 11:21-7.13**, out-of-network claims for small employer groups shall be paid at the 80th percentile of PHCS Fee Schedules or on actual charges. The above-referenced is a non-par small employer group claim that appears to have been paid incorrectly. It appears OHP-NJ owes the provider an additional $49.50 payment.

A review of the PHCS Fee Schedule released by Ingenix during this date of service reveals the 80th percentile for this procedure code within the provider's geographic area (07608) as $140. It should be noted that providers cannot be reimbursed for more than what was billed; and therefore, the correct allowable amount by OHP-NJ should have been for the billed amount ($110) and not $60.50

Based on the information stated above, OHP-NJ is not in compliance with **N.J.A.C. 11:21-7.13**.

OHP-NJ agreed with examiners' findings for claim #7139N20386.

12e. Claim 7202N30196, Line 1, DOS 02/16/07, CPT 73110-26, Billed Amt $39, Paid Amt $12

According to **N.J.A.C. 11:21-7.13**, out-of-network claims for small employer groups shall be paid at the 80th percentile of PHCS Fee Schedules or on actual charges. The above-referenced is a non-par small employer group claim that appears to have been paid incorrectly. It appears OHP-NJ owes the provider an additional $27.00 payment.

A review of the PHCS Fee Schedule released by Ingenix during this date of service reveals the 80th percentile for this procedure code within the provider's geographic area (08701) as $54. It should be noted that providers cannot be reimbursed for more than what was billed; and therefore, the correct allowable amount by OHP-NJ should have been for the billed amount ($39) and not $12.

Based on the information stated above, OHP-NJ is not in compliance with **N.J.A.C. 11:21-7.13**.

OHP-NJ agreed with examiners' findings for claim #7202N30196.

E. APPEALS ON OHP-NJ BUSINESS

1. Utilization Management Appeals -1st Level

1a. Member #604606102, Claim #6067U03408, CPT Code 72141

The referenced member was denied coverage for CPT code 72141 (MRI Cervical Spine w/o Contrast) as "Not Medically Necessary." Upon review of the appeal, OHP-NJ allowed the procedure and paid the maximum allowable. A review of the patient's medical records shows that the member had a history of lumbago (low back pain), cervicalgia, and pain in shoulder region; therefore, OHP-NJ 's denial of coverage for CPT code 72141 does not appear to be justified.

OHP-NJ's denial of coverage for services that are medically necessary for the treatment or evaluation of the member's injury does not appear to be in compliance with **N.J.S.A. 17B:30-13.1(d)** and **N.J.A.C. 11:2-17.8(i)**.

1b. Member #617053801, Claim #5251704364, CPT Codes 21040, 21215 and D7210

The referenced member was denied benefits posterior to having the procedures approved by OHP-NJ. On 08/03/05 and 07/29/05, CPT codes 21040 (excise mandible lesion), 21215 (lower jaw bone graft) and D7210 (surgical removal erupted tooth) were entered into the system as approved. A letter confirming the approval of the referenced service codes was sent to the physician on 8/12/05; on 08/29/05, service was provided based upon the approval. On 10/8/2005, payment was denied for three of the four service codes previously approved.

OHP-NJ's refusal to pay the benefits for services that were provided based on a prior approval is inconsistent with **N.J.A.C. 11:24-8.3(d)**.

2. Utilization Management Appeals (Stage 2 and 3)

STAGE 2 APPEALS (INTERNAL FORMAL)

2a. Claim #6074H02681 (Line 1; DOS 03/02/06; CPT RMREH; Billed $3,183.05)

The above-referenced is an electronic claim related to a Utilization Management (UM) Appeal (Stage 2) denial for inpatient substance (alcohol) abuse rehabilitation on the basis of lacking medical necessity.

OHP-NJ continued to uphold its denial because the member was not exhibiting severe medical complications from withdrawal that required 24 hour nursing. Per records reviewed, the member did not at the time of admission appear to exhibit imminent risk of harm to her or others nor failed treatment at a lower level of care such as intensive outpatient treatment.

The examiner is not rendering a determination regarding OHP-NJ's decision to uphold the appeal denial; however, OHP-NJ took 19 working days to acknowledge the appeal. This is inconsistent with a maximum 10 working day time period specified in **N.J.A.C. 11:24-8.6(c)**. Further inconsistent with a 20 working day maximum period to resolve such appeals as stated in **N.J.A.C. 11:24-8.6(d)**, the examiners found that OHP-NJ took 38 working days to conclude this appeal. Although OHP-NJ reported that it was in receipt of the appeal request on 04/26/06, a review of the appeal revealed a printed fax date of 04/03/06.

Furthermore, it appears OHP-NJ reported that the Stage 2 appeal was concluded on 05/25/06; however, the appeal denial letter drafted to the member shows a 05/24/06 date.

2b. Claim #6297H00756 (Line 1; DOS 10/12/06; CPT RMBRD; Billed $11,346.60)

The above-referenced is an electronic inpatient claim related to a Utilization Management Appeal (Stage 2) denial for a hospital admission for chest pain on the basis of lacking medical necessity.

It is noted that an email from OHP-NJ's RN dated 12/22/06, had recommended a reversal of the first appeal denial. The recommendation was based on her observation that the ER hospital admission occurred after normal office hours (6 p.m.) and the member had high cholesterol and a family history of cardiac disease. Furthermore, she notes that "in accordance with Milliman* guidelines, family history and high cholesterol recommend reversal of decision with coverage provided at contracted rate for 1 inpt day."

Since Milliman guidelines acknowledge the medical necessity of an inpatient hospital admission for a person with high cholesterol and a family history of cardiac disease, the examiners disagree with OHP-NJ's decision to uphold the appeal denial.

The UM appeal file also appears to be incomplete as the examiner could not locate documentation indicating the medical professional that conducted and reviewed the Stage 2 appeal. Documentation related to all appeal level review is necessary in order for the examiner to establish a complete account of the appeal processes and measures assumed by all parties involved.

Based on the information stated above, it appears that OHP-NJ was not in compliance with **N.J.A.C. 11:2-17.12(a)** and **(b)**, which require a company to retain file documentation necessary for regulatory reconstruction of the claims settlement. Lastly, OHP-NJ failed to comply with **N.J.S.A. 17B:30-13.1(f)**, which prohibits unfair settlements when claim eligibility is reasonably clear.

* Milliman guidelines are written recommendations of how to treat patients who have a specific ailment or injury. They're based on analyses of data collected from U.S. hospitals and are marketed as the current "best practices" in medicine.

2c. Claim #6033H02133 (Line 4; DOS 01/14/06; CPT RMBRD; Billed $11,731.38)

The above-referenced is an electronic inpatient claim related to a Utilization Management Appeal (Stage 2) denial for payable benefits on a hospital admission for epigastric pain, nausea, and vomiting on the basis of lacking medical necessity. Per notes, the patient was also post laparoscopic gastric bypass surgery.

This Stage 2 appeal was received on 03/27/06; however, the hospital progress notes were missing and therefore, OHP-NJ advised the facility on 04/19/06 that it was withdrawing the appeal until progress notes were received.

Nonetheless, this is an incomplete UM appeal that the Company provided for the examiners' review. Specifically, the examiners could not locate and the Company did not provide the Stage 2 appeal documents indicated by OHP-NJ as received on 05/22/06. Documentation related to all appeal level review is necessary in order for the examiner to establish a complete account of the appeal processes and measures assumed by all parties involved.

Based on the information stated above, it appears that OHP-NJ was not in compliance with **N.J.A.C. 11:2-17.12 (a)** and **(b)**.

STAGE 3 APPEALS (EXTERNAL)

2d. Claim #5169H01346 (Line 2; DOS 06/09/05; CPT RMBRD; Billed $7,123.50)

The above-referenced is an electronic inpatient claim related to a Utilization Management External Appeal (Stage 3) denial for lack of medical necessity. The External (Stage 3) Appeal was an attempt to obtain payable benefits for the member's acute inpatient care (room and board) acquired on 06/09/05 and prior to her gastroscopy on 06/10/05 on the basis of medical necessity.

The examiner is not rendering a determination regarding OHP-NJ's decision to uphold the appeal denial; however, it appears the UM appeal file provided for review is incomplete as examiner cannot locate all documentation related to the Stage 1 appeal in order to establish a complete account of the appeal processes and measures assumed by all parties involved.

Based on the information stated above, it appears that OHP-NJ was not in compliance with **N.J.A.C. 11:2-17.12 (a) and (b)**.

2e. Member #36718801, Pre-Certification for CPT 97110

The above-referenced is a Utilization Management External Appeal (Stage 3) related to a pre-certification denial for 10 additional skilled physical therapy (CPT 97110) visits on the basis of lacking medical necessity. It should be noted that this is in addition to the 23 visits previously approved due to medical necessity.

The examiner is not rendering a determination regarding OHP-NJ's decision to uphold the appeal denial; however, it appears the UM appeal file provided for review is incomplete as examiner cannot locate all documentation related to the Stage 2 and 3 (external) appeals. Documentation related to all appeal level review is necessary in order for the examiner to establish a complete account of the appeal processes and measures assumed by all parties involved.

Based on the information stated above, it appears that OHP-NJ was not in compliance with **N.J.A.C. 11:2-17.12(a) and (b)**.

2f. Member #421889303, Pre-Certification for CPT J2941

The above-referenced is a Utilization Management External Appeal (Stage 3) related to a pre-certification denial for growth hormone therapy (CPT J2941) on the basis of lacking medical necessity.

The examiner is not rendering a determination regarding OHP-NJ's decision to uphold the appeal denial; however, it appears the UM appeal file provided for review is incomplete as examiner cannot locate all documentation related to the Stage 2 appeal review. Documentation related to all appeal level review is necessary in order for the examiner to establish a complete account of the appeal processes and measures assumed by all parties involved.

Furthermore, it is noted that the receipt date reported by OHP-NJ and also identified on the form number for the Stage 2 appeal request from the provider/facility do not match the faxed date printed on it.

Based on the information stated above, it appears that OHP-NJ was not in compliance with **N.J.A.C. 11:2-17.12 (a)** and **(b)**.

2g. Member #98902701, Pre-Cert for CPT 30520, 31240, 31255, 31267 & 31287

The above-referenced is a Utilization Management External Appeal (Stage 3) related to a pre-certification denial for a partially approved nasal surgery - specifically CPT 30520, 31240, 31255, 31267, and 31287 on the basis of lacking medical necessity.

The examiner is not rendering a determination regarding OHP-NJ's decision to uphold the appeal denial; however, it appears the UM appeal file provided for review is incomplete as examiner cannot locate all documentation related to the Stage and 2 appeals. Documentation related to all appeals level review is necessary in order for the examiner to establish a complete account of the appeal processes and measures assumed by all parties involved.

Based on the information stated above, it appears that OHP-NJ was not in compliance with **N.J.A.C. 11:2-17.12(a)** and **(b)**.

2h. Member #781601801, Pre-Certification for CPT 70552

The above-referenced is a Utilization Management External Appeal (Stage 3) related to a pre-certification denial for an MRI with contrast (CPT 70552) on the basis of lacking medical necessity.

The examiner is not rendering a determination regarding OHP-NJ's decision to uphold the appeal denial; however, it appears the UM appeal file provided for review is incomplete as the examiner could not locate all documentation related to the Stage 3 appeal review. Documentation related to all appeal level review is necessary in order for the examiner to establish a complete account of the appeal processes and measures assumed by all parties involved.

Based on the information stated above, it appears that OHP-NJ was not in compliance with **N.J.A.C. 11:2-17.12 (a) and (b)** since the Company's failure to retain or provide appeal documents inhibited the examiners' attempts to reconstruct the final settlement.

F. CENSUS POPULATION PROMPT PAY ANALYSIS- UNITED HEALTHCARE OF NEW JERSEY

The examiners queried databases of mailed and electronic claims that United Healthcare, hereinafter UHC-NJ or the Company, received during the examining period (January 1, 2006 to December 31, 2006). In that time, the Company processed 63,440 claims. This total included 27,236 mailed and 36,204 electronic claims. Itemized

differently, the total contained 44,636 paid and 18,804 denied claims. These populations exclude all Medicare, Medicaid, federal employee health benefit plan (FEHBP) and ERISA claims.

The examiners reviewed the population to verify compliance with statutory and regulatory guidelines regarding prompt claim payments and denials. United Healthcare supplied the examiners with databases for each of the following: Paid Mandated benefits (1,553 claims), Paid Non-Mandated benefits (43,083 claims), Denied Mandated benefits (594 claims), and Denied non-Mandated benefits (18,210 claims).

In reviewing these claims, the examiner checked for compliance with statutes and regulations that govern the handling of claims, particularly **N.J.S.A. 26:2J-8.1** et seq. ("HINT" – the Health Insurance Network Technology Act). They also checked for compliance with **N.J.A.C. 11:22** et seq. (Prompt Payment of Claims), **N.J.S.A. 17B:30-13.1** and **N.J.A.C. 11:2-17.1** et seq. (Unfair Claim Settlement Practices Act), and NAIC Market Regulation Handbook Chapters 16 and 20.

The examiners note that HMOs must provide certain coverages that were once the subject of common policy exclusions. Each contract, member booklet, certificate or agreement for health care services delivered or issued in this State to any enrollee must set out the services and benefit to which the enrollee is entitled. These include all New Jersey mandated benefits, coverage and offers that conform to provisions in **N.J.S.A. 26:2J** et seq., and **N.J.S.A. 17B:27-54, 55,57,5, 59, 60, 62, 63** and **66**. HMOs must generally provide these coverages to the same extent as for any other covered illness or injury.

1. Population Review, Prompt Pay Exceptions, Mandated and Non-Mandated Exceptions

a. Population Review, Mailed Paid Claims

	Population	Exceptions	Exception Ratio
Mandated Mailed Paid	546	198	36.26%
Non-Mandated Mailed Paid	16,474	2,172	13.18%
Total	17,020	2,370	13.92%

The examiners queried populations of Mandated and Non-Mandated Benefit claims for the examining period (January 1, 2006 to December 31, 2006). As noted, United Healthcare's overall prompt pay exception rate was 13.92%.

b. Population Review, Electronic Paid Claims

	Population	Exceptions	Exception Ratio
Mandated Electronic Paid	1,007	198	19.66%
Non-Mandated Electronic Paid	26,609	2,582	9.70%
Total	27,616	2,780	10.07%

United Healthcare's population of 27,616 electronically paid claims contained 2,780 prompt pay exceptions. This resulted in an exception ratio of 10.07%, with a significant difference in ratios between mandated and non-mandated claims (19.66% and 9.70%, respectively).

c. Summary of Mailed and Electronic Paid Claim Population Review

As the preceding charts show, the examiners discovered an overall exception ratio of 13.92% on mailed claims and a 10.07% exception ratio on electronically submitted claims. The Company's prompt pay exception ratio was moderately lower for electronic claims than for mailed claims.

d. Population Review, Mailed Denied Claims

	Population	Exceptions	Exception Ratio
Mandated Mailed Denied	284	25	8.80%
Non-Mandated Mailed Denied	9932	303	3.05%
Total	10,216	328	3.21%

The examiners queried the entire population of denied mailed claims for the examining period (January 1, 2006 to December 31, 2006). As the examiners note above, United Healthcare's mailed denied claim exception ratio was 3.21%.

e. Population Review, Electronic Denied Claims

	Population	Exceptions	Exception Ratio
Mandated Electronic Denied	310	24	7.74%
Non-Mandated Electronic Denied	8,278	221	2.67%
Total	8,588	245	2.85%

The Company's population of 8,588 electronically denied claims contained 245 exceptions. This was a 2.85% exception ratio, with a significant difference in ratios between mandated and non-mandated claims (7.74% and 2.66%, respectively).

f. Summary of Mailed and Electronic Denied Claim Population Review

The results of this analysis indicate similar results between denied claims that claimants submitted through regular mail and those submitted electronically. The exception ratios were 3.21% and 2.85% respectively.

2. Population Review of Overall Settlement Delays and Applicable Interest Errors on Paid Mandated and Non-Mandated Claims

The examiners also ran queries of paid claim databases for interest payments on late claims. The results of those queries are as follows:

	Late Payments	No Interest	Exception Ratio
Non-Mandated Electronic	2,582	1,376	53.29%
Non-Mandated Mailed	2,172	1,363	62.75%

Mandated Electronic	198	111	56.06%
Mandated Mailed	198	118	59.59%
Total	5,150	2,968	57.63%

G. RANDOM SAMPLE PROMPT PAY ANALYSIS – UNITED HEALTHCARE (UHC-NJ)

The examiners randomly selected records from United Healthcare's (UHC-NJ's) overall population of claims in order to review specific files and UHC-NJ's overall compliance with prompt pay requirements outlined in **N.J.A.C. 11:22-1.5(a)-(c)**, **N.J.AC. 11:22-1.6(c)**, **N.J.S.A. 26:2J-8.1d(9)**, **N.J.A.C. 11:2-17.9(b)** and **N.J.S.A. 17B:30-13.1(d)**.

Specifically, **N.J.A.C. 11:22-1.5(a)1** permits 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** permits 40 days to investigate claims submitted manually. Additionally, **N.J.S.A. 26:2J-8.d1(9)** requires interest at 12% effective July 11, 2006 or 10% prior to that date pursuant to **N.J.A.C. 11:22-1.6(c)**. Lastly, **N.J.A.C. 11:2-17.9(b)** obligates a payer to request additional proofs to establish entitlement to benefits, and **N.J.S.A. 17B:30-13.1(d)** prohibits refusal to pay a claim without conducting a reasonable investigation based upon all available information.

The examiners' findings and applicability of the above-referenced requirements are outlined in the subsections that follow.

1. Failure to Maintain Auditable Records – Current Exam and Prior New Jersey Examination Finalized March 2007 – Improper General Business Practice

N.J.A.C. 11:22-1.5(d) requires a company to maintain an auditable record of when payments were transmitted to health care providers or covered persons, by U. S. mail or other means. Contrary to the above-stated regulation on the current examination, United Healthcare (UHC-NJ) did not provide claim databases to the examiners that included the date the Company mailed or electronically transferred checks or denials. Since **N.J.A.C. 11:22-1.5(c)** and **N.J.A.C. 11:22-1.6(a)** establish the date that a claim is paid or denied as the date that the Company places the payment or denial in the U.S. mail, the databases were unauditable as submitted, and not in compliance with state record retention requirements. Accordingly, the examiners cited as an improper general business practice UHC-NJ's failure to provide accurate U. S. mail or transmittal dates as an Improper General Business Practice.

In response to the examiners' comments relative to this persisting error, UHC-NJ provided a copy of its "Life Cycle of a Claim" procedures and two spreadsheets showing the results of a test conducted by UHC-NJ to confirm the mail dates on a random sample that it conducted. The Company disagreed with this error, stating the following:

> "As described in the "Life Cycle of a Claim" policy previously provided and pertinent page attached here for ease of reference, United (UHC-NJ) prints

checks on a schedule. The schedule is based on provider's name as identified in the "CHK NAME" field, and is based on the first letter. It is important to note that functionality has been added to Unet that will allow review of a particular claim and decide whether it should override the standard practice considering prompt pay laws. By reviewing the policy along with the mail dates provided, the mail date can be confirmed. We have confirmed this on the attached in all instances except for three which we are still reviewing."

The examiners reviewed UHC-NJ's written schedule as described in the "Life Cycle of a Claim" and the accompanying spreadsheets that purportedly contained confirmation on the requested dates, but found that UHC-NJ did not include any documentation in support of the dates included in the spreadsheets.

In deeming UHC-NJ's records unauditable, the examiners rely on **N.J.A.C. 11:22-1.5(c)**, which explains that payment of a claim is considered to have been made:

1. On the date a draft or other valid instrument equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope: or
2. If not paid pursuant to (c)1 above, on the date of delivery of a draft or other valid instrument equivalent to payment.

Based on UHC-NJ's lack of documentation to support the actual date the payment was placed in the United States mail, the examiners concluded that the results of a test performed by UHC-NJ and its "Life Cycle of a claim" procedures do not constitute proof that its records are auditable. Therefore, UHC-NJ continues to conduct business contrary to **N.J.A.C. 11:22-1.5(d)** for failing to maintain auditable records of when payments were transmitted to health care providers or covered persons.

2. Delayed Settlements and Failure to Pay Interest as Required – 7 Files in Error (Improper General Business Practice)

As outlined above, **N.J.A.C. 11:22-1.5(a)1** permits 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** permit 40 days to investigate claims submitted manually. Additionally, **N.J.S.A. 26:2J-8.1d(9)** requires interest at 12% effective July 11, 2006 or 10% prior to that date pursuant to **N.J.A.C. 11:22-1.6(c)**. The examiners found seven delayed claims in which UHC-NJ failed to pay the correct amount of interest. UHC-NJ failed to properly calculate interest on 100% of all delayed claims reported below. These seven errors, in conjunction with a 57.63% interest exception error as summarized in Section V.F above, designates this error as an improper general business practice. Notably, the examiners cited UHC-NJ for failure to pay interest as an improper general business practice in a March 2007 examination. This error was not corrected despite UHS-NJ's assurances of compliance in the final stages of that examination.

The randomly selected files in error are highlighted below.

2.a Claim #097849243101/Member ID 00967881811

The referenced claim with a date of service of 9-06-04 was a claim received on 10-21-04. On 11-04-04, UHC-NJ paid $185.80. In a discussion with UHC-NJ regarding

the facts of this claim, UHC-NJ stated that UNET (UHC-NJ's claim system) used an incorrect fee schedule to process the claim. As a result, UHC-NJ reversed the initial payment and paid $353.76 on 5-31-06 (check mailed on 6-01-06). In addition, UHC-NJ paid $52.44 in interest; the examiners' computations show that the interest payment should have been $53.39, an underpayment of $0.95.

UHC-NJ's failure to use the correct fee schedule to effectuate a fair and equitable settlement is an unfair claim settlement practice and not in compliance with **N.J.S.A 17B:30-13.1(f)**. This fee schedule error affected all claims in which it was applied. Furthermore, the UHC-NJ's interest payment is inconsistent with **N.J.A.C. 11:22-1.6(c)**; the claim processor utilized an incorrect number of days delayed which caused the interest error.

UHC-NJ agreed that the interest amount was incorrect for claim #097849243101.

2b. Claim # 074711379301/Member ID 00826504412

The referenced claim with a date of service of 7-28-03 was an electronic claim received on 8-07-03. On 8-11-03, UHC-NJ denied the claim with an NI denial code (according to your plan, benefits are only available when a network physician or health care provider is used). At the request of the New Jersey Department of Banking and Insurance, UHC-NJ re-processed the claims that had been incorrectly denied with the NI denial code. On 7-11-06UHC-NJ re-opened the referenced claim and paid $105 (check mailed on 7-12-06). In addition, UHC-NJ paid $29.51 in interest; the examiners' computations show that the interest payment should have been $29.92.

UHC-NJ's initial denial of the referenced claim does not appear to be in compliance with **N.J.A.C. 11:2-17.8(i)**. Furthermore, UHC-NJ's interest payment does not appear to be in compliance with P.L. 2005, c.352.

2c. Claim #100258600201/Member ID 00957921030

The referenced claim with dates of service from 10-05-04 through 11-03-04 was a paper claim received on 11-30-04. On 12-14-04, UHC-NJ paid $1,250. In a discussion with UHC-NJ regarding the facts of this claim, UHC-NJ stated that UNET used an incorrect fee schedule to process the claim. As a result, UHC-NJ paid an additional $400 on 3-08-06 (check mailed on 3-09-06); UHC-NJ also paid $45.90 in interest. The examiners' computations show that the interest payment should have been $46.47.

UHC-NJ's failure to use the correct fee schedule to effectuate a fair and equitable settlement appears to be an unfair claim settlement practice and not in compliance with **N.J.S.A.17B:30-13.1(f)**. Furthermore, UHC-NJ's interest payment does not appear to be in compliance with **N.J.A.C. 11:22-1.6(c)**.

UHC-NJ agreed with the examiner's findings for claim #100258600201.

2d. Claim #103647955201/Member ID 00947257547

The referenced claim with a date of service of 1-06-05 was a paper claim received on 1-24-05. On 2-08-05, UHC-NJ denied the claim with a NI denial code

(according to your plan, benefits are only available when a network physician or health care provider is used). At the request of the New Jersey Department of Banking and Insurance, UHC-NJ re-processed the claims that had been incorrectly denied with the NI denial code. On 7-07-06, UHC-NJ re-opened the referenced claim and paid $444.60 (check mailed on 7-10-06). In addition, UHC-NJ paid $58.94 in interest; the examiners' computations show that the interest payment should have been $59.04 based on a 10% interest rate.

UHC-NJ's initial denial of the referenced claim does not appear to be in compliance with **N.J.A.C. 11:2-17.8(i)**. Furthermore, UHC-NJ's interest payment does not appear to be in compliance with **N.J.A.C. 11:22-1.6(c)**.

2.e Claim #105015675101/Member ID 00841388799

The referenced claim with a date of service of 2-15-05 was an electronic claim received on 2-18-05. On 3-02-05, UHC-NJ approved the payment of the claim with a D1 adjustment code (thank you for using a network physician or other health care professional. We have applied the contracted fee); however, a payment was not issued. On 1-30-06, UHC-NJ paid $40 (check mailed on 1-31-06). In addition, UHC-NJ paid $3.33 in interest; the examiners' computations show that the interest payment should have been $3.43.

The initial processing of the referenced claim without a payment does not appear to be in compliance with **N.J.A.C. 11:2-17.8(i)**. Furthermore, UHC-NJ's interest payment does not appear to be in compliance with **N.J.A.C. 11:22-1.6(c)**; the claim processor utilized an incorrect number of days delayed which caused the interest error.

UHC-NJ agreed with the examiner's findings for claim #105015675101.

2f. Claim #105288893201/Member ID 00830617937

The referenced claim with a date of service of 1-25-05 was an electronic claim received on 2-23-05. On 7-26-05, UHC-NJ paid $166.25 (check mailed on 7-27-05). In addition, UHC-NJ paid $5.61 in interest; the examiners' computations show that the interest payment should have been $5.65. The claim was adjusted on 6-20-06 per UHC-NJ's notes.

UHC-NJ's interest payment does not appear to be in compliance with **N.J.A.C. 11:22-1.6(c)**.

2.g Claim #108152456501/Member ID 00801672499

The referenced claim with a date of service of 1-27-05 was a paper claim received on 4-04-04. On 5-30-06, UHC-NJ approved the payment of the claim with a 51 adjustment code (the plan benefit for these services was determined by using the amount approved by Medicare. This physician or health care professional has agreed to accept that amount). On 5-30-06, UHC-NJ paid $20.81 in interest; however, the allowed amount of Oxford's exposure ($201.20) was not paid as of 2-11-09. The examiners determined that the interest payment as of 2-11-09 should be $95.05 as of February 20, 2009.

The processing of the referenced claim without a payment does not appear to be in compliance with **N.J.A.C. 11:2-17.8(i)**. Furthermore, UHC-NJ's interest payment does not appear to be in compliance with P.L. 2005, c.352.

3. Unfair Claim Underpayments due to use of Incorrect Fee Schedule (Improper General Business Practice)

During the random sample review the examiners discovered that UHC-NJ utilized an erroneous fee schedule that contained underpayments. The examiners cited this error as an improper general business practice because this error consistently recurred whenever a provider submitted the applicable CPT code for payment. The two files discovered in the random review are as follows.

3.a Claim #097849243101/Member ID 009678818110 ($406 Claim Underpayment and $8.57 Interest Underpayment)

The referenced claim with a date of service of 9-06-04 was a paper claim received on 10-21-04. On 11-04-04, UHC-NJ paid $185.80. In a discussion with UHC-NJ regarding the facts of this claim, UHC-NJ stated that UNET (UHC-NJ's claim system) used an incorrect fee schedule to process the claim. As a result, UHC-NJ reversed the initial payment and paid $592.19 on 5-31-06 (check mailed on 6-01-06).

UHC-NJ's failure to use the correct fee schedule to effectuate a fair and equitable settlement constitutes an unfair claim settlement practice and is not in compliance with **N.J.S.A 17B:30-13.1(f)**.

3b. Claim #100258600201/Member ID 00957921030 ($400 Claim Underpayment and $0.578 Interest Underpayment)

The referenced claim with dates of service from 10-05-04 through 11-03-04 was a paper claim received on 11-30-04. On 12-14-04, UHC-NJ paid $1,250. In a discussion with UHC-NJ regarding the facts of this claim, UHC-NJ stated that UNET used an incorrect fee schedule to process the claim. As a result, UHC-NJ paid an additional $400 on 3-08-06 (check mailed on 3-09-06).

UHC-NJ's failure to use the correct fee schedule to effectuate a fair and equitable settlement constitutes an unfair claim settlement practice and is not in compliance with **N.J.S.A. 17B:30-13.1(f)**.

4. Non-Par Small Group-Claim Underpayments due to Failure to Pay at 80th PHCS Percentile (Improper General Business Practice)

4a. Claim #142178325801, Line 1, DOS 07/26/06, CPT 77334-26, Billed $345, Paid $157.50

According to **N.J.A.C. 11:21-7.13**, out-of-network claims for small employer groups shall be paid at the 80th percentile of PHCS Fee Schedules or on actual charges. The above-referenced is a non-par small employer group claim that the company paid incorrectly. It appears UHC-NJ owes the provider an additional $29.50 payment.

A review of the PHCS Fee Schedule released by Ingenix during this date of service reveals the 80th percentile for this procedure code within the provider's geographic area (07753) as $187. Therefore, the correct allowable amount for this procedure by UHC-NJ should have been for $187 and not $157.50.

Based on the information stated above, it appears the UHC-NJ was not in compliance with **N.J.A.C. 11:21-7.13**.

4b. Claim #158235942301, Line 1, DOS 03/30/07, CPT 72194-26, Billed $335, Paid $132.30

According to **N.J.A.C. 11:21-7.13**, out-of-network claims for small employer groups shall be paid at the 80th percentile of PHCS Fee Schedules or on actual charges. The above-referenced is a non-par small employer group claim that appears to have been paid incorrectly. It appears UHC-NJ owes the provider an additional $187.70 payment.

A review of the PHCS Fee Schedule released by Ingenix during this date of service reveals the 80th percentile for this procedure code within the provider's geographic area (07834) as $320. Therefore, the correct allowable amount by UHC-NJ should have been for $320 and not $132.30.

Based on the information stated above, it appears the UHC-NJ was not in compliance with **N.J.A.C. 11:21-7.13**.

4c. Claim #161156275001, Line 1, DOS 04/30/07, CPT 88305, Billed $165, Paid $88

According to **N.J.A.C. 11:21-7.13**, out-of-network claims for small employer groups shall be paid at the 80th percentile of PHCS Fee Schedules or on actual charges. The above-referenced is a non-par small employer group claim that appears to have been paid incorrectly. It appears UHC-NJ owes the provider an additional $77.00 payment.

A review of the PHCS Fee Schedule released by Ingenix during this date of service reveals the 80th percentile for this procedure code within the provider's geographic area (07701) as $220. It should be noted that this rate is greater than the billed amount and as providers cannot be reimbursed for more than what was billed, the correct allowable amount by UHC-NJ should have been for the billed amount ($165) and not $88.

Based on the information stated above, it appears the UHC-NJ was not in compliance with **N.J.A.C. 11:21-7.13**.

4d. Claim #141697203601, Line 1, DOS 08/04/06, CPT 99213, Billed $155, Paid $98.65

According to **N.J.A.C. 11:21-7.13**, out-of-network claims for small employer groups shall be paid at the 80th percentile of PHCS Fee Schedules or on actual charges.

The above-referenced is a non-par small employer group claim that appears to have been paid incorrectly. It appears UHC-NJ owes the provider an additional $51.35 payment.

A review of the PHCS Fee Schedule released by Ingenix during this date of service reveals the 80th percentile for this procedure code within the provider's geographic area (10017) as $150. Therefore, the correct allowable amount by UHC-NJ should have been $150 and not $98.65

Based on the information stated above, it appears the UHC-NJ was not in compliance with **N.J.A.C. 11:21-7.13**.

4e. Claim #144118131601, Line 1, DOS 09/06/06, CPT 99213, Billed $120, Paid $87

According to **N.J.A.C. 11:21-7.13**, out-of-network claims for small employer groups shall be paid at the 80th percentile of PHCS Fee Schedules or on actual charges. The above-referenced is a non-par small employer group claim that appears to have been paid incorrectly. It appears UHC-NJ owes the provider an additional $3.00 payment.

A review of the PHCS Fee Schedule released by Ingenix during this date of service reveals the 80th percentile for this procedure code within the provider's geographic area (08822) as $90. Therefore, the correct allowable amount by UHC-NJ should be $90 and not $87.

Based on the information stated above, it appears the UHC-NJ was not in compliance with **N.J.A.C. 11:21-7.13**.

4f. Claim #161189585201, Line 1, DOS 05/02/07, CPT 99213, Billed $115, Paid $65.45

According to **N.J.A.C. 11:21-7.13**, out-of-network claims for small employer groups shall be paid at the 80th percentile of PHCS Fee Schedules or on actual charges. The above-referenced is a non-par small employer group claim that appears to have been paid incorrectly. It appears UHC-NJ owes the provider an additional $49.55 payment.

A review of the PHCS Fee Schedule released by Ingenix during this date of service reveals the 80th percentile for this procedure code within the provider's geographic area (10065) as $150. It should be noted that this rate is greater than the billed amount and as providers cannot be reimbursed for more than what was billed, the correct allowable amount by UHC-NJ should have been for the billed amount ($115) and not $65.45.

Based on the information stated above, it appears the UHC-NJ was not in compliance with N.J.A.C. 11:21-7.13.

4g. Claim #149954691401, Line 1, DOS 09/26/06, CPT 99214, Billed $250, Paid $200

According to **N.J.A.C. 11:21-7.13**, out-of-network claims for small employer groups shall be paid at the 80th percentile of PHCS Fee Schedules or on actual charges. The above-referenced is a non-par small employer group claim that appears to have been paid incorrectly. It appears UHC-NJ owes the provider an additional $15 payment.

A review of the PHCS Fee Schedule released by Ingenix during this date of service reveals the 80th percentile for this procedure code within the provider's geographic area (10087) as $215. Therefore, the correct allowable amount by UHC-NJ should have been for $215 and not $200.

Based on the information stated above, it appears the UHC-NJ was not in compliance with **N.J.A.C. 11:21-7.13**.

4h. Claim #160031093901, Line 1, DOS 04/18/07, CPT 71260-26, Billed $295, Paid $244.85

According to **N.J.A.C. 11:21-7.13**, out-of-network claims for small employer groups shall be paid at the 80th percentile of PHCS Fee Schedules or on actual charges. The above-referenced is a non-par small employer group claim that appears to have been paid incorrectly. It appears UHC-NJ owes the provider an additional $8.15 payment.

A review of the PHCS Fee Schedule released by Ingenix during this date of service reveals the 80th percentile for this procedure code within the provider's geographic area (11725) as $253. Therefore, the correct allowable amount by UHC-NJ should have been for $253 and not $244.85.

Based on the information stated above, it appears the UHC-NJ was not in compliance with **N.J.A.C. 11:21-7.13**.

4i. Claim #148316846501, Line 3, DOS 10/13/06, CPT 78306, Billed $1,042, Paid $864.86

According to **N.J.A.C. 11:21-7.13**, out-of-network claims for small employer groups shall be paid at the 80th percentile of PHCS Fee Schedules or on actual charges. The above-referenced is a non-par small employer group claim that appears to have been paid incorrectly. It appears UHC-NJ overpaid the provider by $314.86.

A review of the PHCS Fee Schedule released by Ingenix during this date of service reveals the 80th percentile for this procedure code within the provider's geographic area (10065) as $550. However, UHC-NJ reported this claim line in the sampled population as procedure code 78000 and processed it in the system for $864.86 under a revenue code.

Based on the information stated above, it appears that UHC-NJ was not in compliance with **N.J.A.C. 11:21-7.13**.

5. Unfair Denial on Otherwise Clean Claims and Failure to Specify on Denial Notice Applicable Policy Provisions in Support of Claim Denial (2 Files in Error)

5a. Claim #129154853501 (CPT 76091 – Radiology Services)

The referenced claim with a date of service of 11-17-05 was an electronic claim initially received on 2-10-06 (or after 85 calendar days) and was denied with a 7Y adjustment code (additional information requested). On 2-20-06, the provider re-submitted the claim, and the claim was denied with an UP adjustment code (Your provider did not submit this claim within their contracted time frame). The same claim was re-submitted again on 3-27-06 and was paid on 3-27-06 with a GA adjustment code (according to your contract, claims must be submitted within the timely filing limit. After reviewing your appeal, it was determined that the information submitted meets the requirements).

Denial of a clean claim is inconsistent with N.J.A.C. 11:2-17.8(i). Moreover, and contrary to **N.J.A.C. 11:2-17.8(a)**, UHC-NJ failed to specify any policy provisions, conditions and exclusions that support the language of this denial.

5b. Claim #134445194701 (CPT 49568–Implantation of mesh or other prosthesis for open incisional)

The referenced claim with a date of service 1-31-06 was an electronic claim received on 5-03-06 (or after 92 calendar days) from a participating provider. On 5-03-06, UHC-NJ denied the claim with an UP denial code (Your provider did not submit this claim within their contracted time frame).

Denial of a clean claim is inconsistent with N.J.A.C. 11:2-17.8(i).

6. Miscellaneous Claim Handling Errors

6a. Claim #123208603602 (CPT 58322 – Artificial Insemination) – Improper General Business Practice

The referenced claim with a date of service of 11-21-05 was an electronic claim received on 11-23-05 and was manually adjudicated. On 12-07-05, UHC-NJ paid the claim ($67.58) with a D-1 adjustment code (thank you for using a network physician or other health care professional. We have applied the contracted fee. The patient is not responsible for the difference between the amount charged by the physician or health care professional). On 5-11-06, UHC-NJ reversed the initial payment and reprocessed the claim with a QG adjustment code (we have reprocessed this claim using additional information received about the discount). In fact, UHC-NJ paid a higher reimbursement amount ($93.53) with interest ($0.99). In a discussion regarding the facts of the referenced claim, UHC-NJ explained that the initial payment was reversed because UNET, UHC-NJ's claim system, had been using an incorrect fee schedule to reimburse the treating provider and other providers within the same fee region.

UHC-NJ's failure to use the correct fee schedule to effectuate a fair and equitable settlement constitutes an unfair claim settlement practice and is not in compliance with **N.J.S.A 17B:30-13.1(f)**.

6b. Claim #130852336601 (line 4; CPT 64483)-Unfair Recoupment

Claim 130852336601 with a date of service of 2/24/06 is comprised of two CPT codes: 76005 (fluoroscopic guidance of a needle) and 64483 (injection of an anesthetic agent or steroid). Originally the Provider billed eight units to CPT code 64483 at a total cost of $1,080. Because UHC-NJ's policies and procedures prohibit paying on more than one unit of CPT code 64483 per day, the claim was restated to have seven units on one line – which were denied as exceeding the daily allowance – and another line of one unit which was paid in full at $135 on 4/6/06. Had the Provider billed the $1,080 to one unit of CPT code 64483, the maximum allowable amount is $160.72. As a result, the original claim was underpaid by $25.72 ($160.72 – 135). On 7/12/06, UHC-NJ re-analyzed claim 130852336601 and determined that the amount due the Provider was $80.36 (one half of $160.72) and requested a recoupment of $54.64. The examiner could find no justification for the recoupment.

Based on the information cited above, it appears that UHC-NJ was not in compliance with the requirements of **N.J.S.A. 26:2J-8.1(10)**. UHC-NJ did not provide adequate documentation that justified the recoupment request.

UHC-NJ agreed with the examiner's finding for claim #130852336601.

H UNITED HEALTHCARE - BEHAVIORAL HEALTH (UBH)

1. Incorrect Denials – Coordination of Benefits

1a. Member ID #155963074 / FLN #0620595283 (CPT 99283 – Emergency department visit for the evaluation and management of a patient)

The referenced claim with a date of service of 11-28-05 was a paper claim received on 5-08-06 from a non-participating provider. On 5-12-06, UBH denied the claim with a UW denial code (Medicare did not approve this service and indicates you are not responsible for the expense). In fact, the review of the EOB from the primary carrier shows that the entire charge amount ($199) was applied to the member's deductible. In a discussion with the examiners regarding the facts of this claim, UBH stated that the provider appealed the denial of the referenced claim on 7-27-06. On 8-18-06, UBH paid the claim with no interest.

UBH's initial failure to pay for an emergency department visit does not appear to be in compliance with **N.J.A.C. 11:2-17.8(i)**. Furthermore, UBH was not in compliance with P.L. 2005, c.352 for failing to pay the applicable interest amount.

UBH agreed with the examiner's findings for member #155963074.

I. CENSUS POPULATION PROMPT PAY ANALYSIS-ORTHONET

Similar to Sections B and F above, the examiners attempted to analyze the electronic population of paid and denied claims in order to determine Orthonet's compliance with New Jersey prompt pay laws. In response to the examiners' records requests, Orthonet stated that it does not maintain auditable electronic records that permit measurement of payment and denial time frames. Accordingly, the examiners cited Orthonet for failure to comply with **N.J.A.C. 11:22-1.5(d)**, which requires a carrier and its agent to maintain an auditable record as to when a claim payment is issued to providers or covered members. Please also see Section III.C above where the examiners cited the Companies for failure to facilitate this examination.

The examiners findings relative to randomly selected manual and individual electronic review is presented in the sections that follow.

1. Claim Submission Filing Error (1 File in Error) – Improper General Business Practice as Outlined above in OHC-NJ and UHC-NJ Claims

1a. Claim #2006052599901978 / Member ID 36752401 (CPT 97530 – Occupational Therapy Visit)

OrthoNet denied this claim with a D-99 denial code (Filing deadline has passed) in a manner that is inconsistent with **N.J.A.C. 11:2-17.8(i)** because the claim was clean.

2. Failure to Request Additional Information on Explanation of Benefit Form Necessary to Cure Informational Deficiencies on Denied Claims (4 Claims in Error)

2a. Claim #2006031411000002 (CPT 27818 – Closed treatment of trimalleolar ankle fracture)

The referenced claim with a date of service of 2-05-06 was a paper claim received on 2-24-06. On 3-17-06 (or after 21 calendar days), OrthoNet denied the claim with a D13B denial code (Need Medical Documentation). However, the explanation of benefits (EOB) sent to the member and the remittance advice (RA) sent to the provider did not specify what additional information OrthoNet needed to process the claim.

Accordingly, OrthoNet's EOB and RA did not comply with **N.J.A.C. 11:22-1.6(a) 2.** This regulation states that, "Where missing information is a reason for denying ... a claim, the (EOB) shall identify with specificity the additional information ... that is required and the carrier shall engage in good faith effort to expeditiously obtain such additional information ..."

2b Claim #2006072703300033 (CPT 95904 – Nerve conduction, amplitude and latency/velocity study nerve)

The referenced claim with a date of service of 11/25/2005 was a paper claim received on 4/27/2006. On 8/2/2006 (or after 97 calendar days), OrthoNet denied the

claim with a D20 denial code (Additional information requested and not received). However, the EOB sent to the member and the Remittance advice sent to the provider did not specify what additional information OrthoNet needed to process the claim.

Accordingly, OrthoNet's EOB and RA did not comply with **N.J.A.C. 11:22-1.6(a) 2**. This regulation states that, "Where missing information is a reason for denying ... a claim, the (EOB) shall identify with specificity the additional information ... that is required and the carrier shall engage in good faith effort to expeditiously obtain such additional information ..." Additionally, the EOB and RA were not sent within 40 calendar days as required by **N.J.A.C. 11:22-1.5(b)**.

2c Claim #2006032399901226 (CPT 97014 – Application of a modality to one or more areas)

The referenced claim with a date of service of 10-18-2005 was an electronic claim received on 3/23/2006. On 4-04-06 (or after 12 calendar days), the Company denied the claim with a D13B denial code (Need Medical Documentation). However, the EOB sent to the member and the Remittance advice sent to the provider did not specify what additional information OrthoNet needed to process the claim.

Accordingly, OrthoNet's EOB and RA did not comply with **N.J.A.C. 11:22-1.6(a) 2**. This regulation states that, "Where missing information is a reason for denying ... a claim, the (EOB) shall identify with specificity the additional information ... that is required and the carrier shall engage in good faith effort to expeditiously obtain such additional information ..."

2d Claim #2006062999900297 (CPT 17000 – Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement)

The referenced claim with a date of service of 6-16-06 was an electronic claim received on 6-29-06. On 7-12-06 (or after 13 calendar days), OrthoNet denied the claim with a D13F denial code (Need Medical Documentation). However, the EOB sent to the member and the Remittance advice sent to the provider did not specify what additional information OrthoNet needed to process the claim. On 7-25-06, additional information was received from the provider; on 8-16-06 (or after 35 calendar days), OrthoNet paid the claim with an A8C adjustment code (reviewed by medical director) under claim # 2006081103300004.

Accordingly, OrthoNet's EOB and RA did not comply with **N.J.A.C. 11:22-1.6(a)(2)**. This regulation states that, "Where missing information is a reason for denying ... a claim, the (EOB) shall identify with specificity the additional information ... that is required and the carrier shall engage in good faith effort to expeditiously obtain such additional information ..." Additionally, the Company did not pay the referenced claim within 30 calendar day as required by **N.J.A.C. 11:22-1.5(b)**.

3. Failure to Send Explanation of Benefit to Member (2 Files in Error)

3a. OHP-NJ Claim #5137N68419 (line 2; CPT G0151), OHP-NJ Claim #6142622300 (line 2; CPT G0151) and OrthoNet Claim #2006052699900044

(line 1; CPT G0151), OHP-NJ Claim #6174411462 (line 2; CPT G0151) and OrthoNet Claim #2006062999900151 (line 1; CPT G0151)

All the referenced claims have the same date of service, provider and member. While the original claim was submitted to OHP-NJ, OHP-NJ forwarded the original claim and all subsequent claims to OrthoNet for processing.

On OHP-NJ's claim 5137N68419, the referenced claim line (2) with a date of service of 4/20/05 was received on 5/17/05. On 6/7/05, the claim was denied with a Z545 denial code (claim forwarded to OrthoNet LLC for processing). On OHP-NJ claim #6142622300, the referenced claim line (2) was received on 5/22/06 and denied on 5/31/06 with a Z545 denial code. On OrthoNet claim number 2006052699900044, the referenced claim line (1) was received on 5/26/06 and denied on 6/13/06 with an NZ denial code (this procedure is being processed by Oxford). On OHP-NJ claim 6174411462, the referenced claim line (2) was received on 6/23/06 and denied on 7/5/06 with a Z545 denial code. On OrthoNet Claim 2006062999900151, the referenced claim line (1) was received on 6/29/06 and denied on 7/11/06 with an NZ denial code.

Based on the examiner's review, it appears that OrthoNet did not send an EOB to the member, contrary to **N.J.S.A. 11:22-1.6(a)**.

3b. Oxford Claim #5350500163 (line 5; CPT G0155) and OrthoNet Claim #2005122099900130 (line 6; CPT G0155)

Both referenced claims have the same date of service, provider and member. While the original claim was submitted to OHP-NJ, OHP-NJ forwarded the claim to OrthoNet for processing.

On OHP-NJ claim #5350500163, the referenced claim line (2) with a date of service of 11/14/05 was received on 12/16/05. On 12/31/05, the claim was denied with a D9M denial code (Medicare is the primary insurer). On OrthoNet claim #2005122099900130, the referenced line (6) with a date of service of 11/14/05 was received on 12/20/05. On 1/10/06, the claim was denied with an NZ denial code (this procedure is being processed by Oxford).

Based on the examiner's review, it appears that OrthoNet did not send an EOB to the member, contrary to **N.J.S.A. 11:22-1.6(a)**.

J. APPEALS ON ORTHONET BUSINESS

1. Failure to Justify Denial Reason Which Caused Appeal

1a. Claim #2006052599901341/Member ID 36595401 / Provider ID ES417

The referenced claim with a date of service of 3/2/2006 was an electronic claim received on 3/21/2006. On 4/3/2006, OrthoNet processed the claim as follows:

- CPT code 95903 (Nerve conduction, amplitude and latency/velocity study, with F wave study) denied with a D-26 denial code (auto insurance liable).
- CPT code 95904 (Nerve conduction, amplitude and latency/velocity study, sensory) denied with a D-26 denial code.
- CPT code 95861 (Needle electromyography) denied with a D-26 denial code.
- CPT code 95934-50 (H-reflex, amplitude and latency study – bilateral procedures) denied with a D-26 denial code.
- CPT code 99243 (Office consultation for a new or established patient) denied with a D-26 denial code.

On 6-07-06, the medical director reviewed OrthoNet's initial determination. As a result of the medical director's review, OrthoNet reprocessed the claim on 6-14-06 as follows:

- CPT code 99243 was reversed and paid.
- CPT codes 95903, 95904, and 95934 were reversed and denied with a D13A denial code (not substantiated by medical documentation).

On 10-27-06, the provider appealed the D13A denial and submitted the patient's treatment summary. On 11-21-06, OrthoNet responded to the appeal and upheld its initial determination.

Based on the above, OrthoNet was not in compliance with **N.J.S.A. 17B:30-13.1(d)** for initially denying the referenced claim without conducting a reasonable investigation. Additionally, it appears that OrthoNet used an incorrect denial reason (D-26) and was not, therefore, in compliance with **N.J.A.C. 11:22-1.6(a)(1)**. Finally, the remittance advice (RA) sent to the provider on 6-14-06 was not in compliance with **N.J.A.C. 11:22-1.6(a)(2)** for failing to specify what additional information OrthoNet needed to process the claim.

1b. Claim #2006011699900010/ Member ID 572801601/ Provider ID ANC 1055

The referenced claim with a date of service of 12-07-05 was an electronic claim received on 1-25-06. OrthoNet processed the claim as follows:

- CPT code 99203-25 (Office visit for the evaluation and management of a new patient) was paid
- CPT code 20605-RT (Arthrocentesis, aspiration and/or injection) was paid.
- CPT code J0702-RT,26 (Injection, betamethasone acetate and betamethasone) was paid.
- CPT code 29540-51,59 (Strapping; ankle and/or foot) was denied with a D-11 denial code (included in primary procedure fee).

On 2-07-06, the medical director reviewed OrthoNet's initial determination. As a result of the medical director's review, OrthoNet reprocessed the claim on 2-17-06 as follows:

- CPT J0702-RT,26 was reversed and denied with a D13A denial code (not substantiated by medical documentation).

- CPT 29540-51,59 was reversed and paid.

The provider appealed the D13A denial and submitted a treatment summary of the patient. On 3-13-06, OrthoNet responded to the appeal and upheld its initial determination.

Based on the above, OrthoNet was not in compliance with **N.J.S.A. 17B:30-13.1(d)** for initially denying the referenced claim without conducting a reasonable investigation. Additionally, it appears that the initial bundling of CPT 29540-51,59 was inappropriate and not in compliance with **N.J.A.C. 11:2-17.8(i)**. Finally, the remittance advice (RA) sent to the provider on 2-17-06 was not in compliance with **N.J.A.C. 11:22-1.6(a)(2)** for failing to specify what additional information OrthoNet needed to process the claim

K. APPEALS ON UHC-NJ BUSINESS

1. Unfair Denial of Medically Necessary Claims (2 Files in Error)

1a Claim #1239010769 / Provider ID 221487258

The referenced claim with dates of service from 7-12-05 through 7-15-05 was received on 12-14-05. On 12-22-05, UHC-NJ denied the claim with an I9 denial code (according to our record, a network healthcare facility was used. Under the plan, notification was required but not received). On 3-03-06, UHC-NJ received an appeal from the provider, in which the provider wrote:

> "The underlying focus of the pre-authorization requirement is to assure your company that medically necessary charges are processed for payment. The charges for this patient are certainly medically necessary."

On 3-30-06, UHC-NJ responded to the provider's appeal and upheld its initial denial:

> "We reviewed your appeal of our decision to deny reimbursement for the 7-12-05 claim. The inpatient hospital confinement requires prior notification. Because the information provided does not show that prior notification was obtained, no payment can be made."

On 6-15-06, a second appeal was received. On 7-24-06, UHC-NJ reversed its initial determination and paid the claim. However, the applicable interest was not paid.

1b Claim #s 1327796731 & 1350023222 / Provider ID 223763567

Claim 1327796731 with a date of service of 4-06-06 was an electronic claim received on 4-10-06 and was paid on 4-11-06. Claim 1350023222 with a date of service of 5-05-06 was also an electronic claim received on 5-10-06 and was paid on 5-11-06. On 6-21-06, however, UHC-NJ received an appeal from the provider because the chemotherapy drugs were not being paid at 100% of the allowable amount as stipulated

in the member's health benefit plan. In fact, the provider made the following statement in the appeal letter to UHC-NJ:

> "J codes are processing at 50%; leaving the patient responsible for the other 50%. This is not a pharmacy benefit. We are providing chemotherapy."

On 6-05-06, UHC-NJ reprocessed the payments of the chemotherapy drugs at 100% of the allowable amount. However, the applicable interest was not paid on claim 1327796731.

The initial payment of the chemotherapy drugs at 50% of the allowable amount does not appear to be a fair and equitable settlement as stipulated in **N.J.S.A. 17B:30-13.1(f)**. Furthermore, UHC-NJ's failure to pay the applicable interest does not appear to be in compliance with **N.J.A.C. 11:22-1.6(c)**.

UHC-NJ agreed with the examiner's findings for claim #1327796731.

2. Unfair Denial (1 File in Error)

2a. Claim #1326966872/ Provider 223538225

The referenced claim with dates of service from 10-20-05 through 12-30-05 was a paper claim received on 3-31-06 (or 91 calendar days after the last date of service). On 4-08-06, UHC-NJ denied the claim with an UP denial code (your provider did not submit this claim within their contracted time frame). On 4-17-06, the provider filed an appeal to dispute the denial of the claim. On 4-24-06, UHC-NJ upheld the initial denial as outlined in a response to the provider as follows:

> "We reviewed the information and determined that the original claim was processed correctly."

On 5-18-06, UHC-NJ reversed its initial denial, and the claim was paid on 5-22-06. However, the applicable interest was not paid.

The initial denial of this claim is inconsistent with **N.J.A.C. 11:2-17.8(i)** because this claim was clean.

3. Unfair Denial due to Improper Bundling (1 File in Error)

3a. Claim #1295609909 / Provider ID 223055577

The referenced claim with a date of service of 1-11-06 was an electronic claim received on 2-24-06. On 2-25-06, UHC-NJ processed the referenced claim as follows:

- CPT code 21015 (Radical resection of tumor, soft tissue of face or scalp) was paid.
- CPT code 13121 (Repair, complex, scalp, arms, and/or legs) was denied with an I4 denial code (this is not a separately reimbursable service).

On 2-28-06, the provider appealed UHC-NJ's denial of CPT code 13121. On 3-31-06, in response to the provider's appeal, UHC-NJ wrote:

"13121 is an integral part of CPT procedure 21015. As a result, a separate charge for 13121 is not eligible for benefits under the plan."

On 4-25-06, the provider filed a second appeal disputing the bundling of CPT 13121. On 5-11-06, a clinician entered the following notes in UHC-NJ's Online Routing System (the internal appeal system):

"Overturn. Clinical supports CPT 13121 as being a separate procedure performed."

On 5-15-06, UHC-NJ reversed the initial denial and paid CPT 13121. However, the applicable interest was not paid.

This claim was handled contrary to **N.J.S.A. 17B:30-13.1(f)**. Furthermore, UHC-NJ's failure to pay the applicable interest does not appear to be in compliance with **N.J.A.C. 11:22-1.6(c)**.

L. APPEALS ON UNITED BEHAVIORAL HEALTH (UBH)

1. Utilization Management Appeals-1st Level – Misstating Maximum Time Period for Exercising Appeal Rights

1a. Claim #1466430193, Member #135469908

On 7/14/06, the referenced member was denied substance abuse inpatient rehab benefit coverage. UBH's denial letter stated that "The rationale, based on UBH Level of Care Guidance for substance abuse inpatient rehabilitation care, is that there is no evidence of imminent risk of harm to self or others..." UBH's case notes dated July 07/11/06, stated the member was considered to be "serious and imminent risk of harm to self or others due to psychiatric illness"

UBH's erroneous denial of benefits for failure to meet qualifying guidelines that were clearly included in the member's history is inconsistent with **N.J.S.A. 17B:30-13.1(d)**, which prohibits a carrier from denying benefits without conducting a reasonable investigation based on all available information.

Moreover, the examiners found that in the "New Jersey Appeal Rights and Instructions" portion of the denial letter, in the section titled "The Second level Internal Appeal Review Process-(Stage 2 Appeal)", UBH misstates the timeline for the member to file a second level appeal. The letter states "This request must be made within sixty (60) calendar days of the date you received notification from UBH of the outcome of your first level appeal." It also lacks a timeline under the Urgent/Expedited Process section.

The letter further erroneously states "UBH will notify you and your health care provider of the appeal resolution in writing within twenty (20) working or thirty (30) calendar days of the receipt of your request, whichever is more expeditious."

UBH's misstated timelines are inconsistent with NJDOBI's internet communication entitled "How to File a Utilization Management Appeal" which suggests a 90-day period for a provider to submit an internal, stage 2 appeal. Moreover, the language above was systems generated. As such, this incorrect language was utilized on a systemic basis.

UBH agreed with the examiner's findings related to the misstated timelines for claim #1466430193.

1b Member ID #156567193 / Provider ID #155345768 (CPT 90806 – Individual psychotherapy)

The referenced member was diagnosed with a biologically-based mental illness and was seen by a Licensed Clinical Social Worker (LCSW) from 4-14-05 through 4-27-06. The social worker filed a total of 10 claims; the first claim was received on 4-23-05, and the last claim was received on 5-08-06 (as illustrated in the table below). UBH denied all 10 claims with a I7 denial code (According to our records, a network physician or other healthcare professional was used. Under the plan, notification was required but not received. Therefore, we have declined payment for the service because requirements of the plan were not met.). On 6-07-06, UBH received an appeal from the provider disputing the denial of the claims. On 6-13-06, UBH overturned its initial denial and paid the 10 claims on 6-15-06 and 8-22-06; however, no interest has been paid.

VI. RECOMMENDATIONS

OHP-NJ and UHC-NJ 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 OHP-NJ and UHC-NJ establish procedures to monitor compliance with these measures.

The examiners acknowledge that during the examination, OHP-NJ and UHC-NJ stated that based on some of the findings in this report, they had in whole or in part, implemented some of the recommendations. For the purpose of obtaining proof of compliance and for OHP-NJ and UHC-NJ 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 unless otherwise noted.

On claims that should be reopened for supplemental payments, the claim payment should be sent to the insured 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 files and recommended a further Company review. Subsequently, our review showed that we (owe additional interest relating to a previously submitted claim or claims/improperly denied a prior mandated benefit claim/improperly paid your claim at the out-of-network rate/failed to pay interest on your claim/[other as described where warranted]). We are providing details regarding the claim or claims in question in the enclosed Explanation of Benefits. (We have mailed the check associated with this amount separately/we have included payment in this correspondence). If you have any questions regarding this payment, please contact us at (toll free number) or write us at the address listed on the Explanation of Benefits."

RECOMMENDATION:

1) OHP-NJ and UHC-NJ should re-adjudicate all claims cited in error and reimburse members and providers the re-adjudicated dollar amount and appropriate interest. OHP-NJ and UHC-NJ should provide the Commissioner with a list of all claims that were re-adjudicated in Excel format, including the following columns:

   i. Member/Provider Last Name
   ii. Member/Provider First Name
   iii. Claim Number
   iv. Date Re-adjudicated
   v. Re-adjudicated amount
   vi. Interest paid
   vii. Date check mailed

In addition, the Companies must provide a plan of correction that identifies each error type and the method by which OHP-NJ and UHC-NJ plans to correct the underlying error.

2) Pursuant to **N.J.S.A. 26:2J-8.1(1)** and P.L. 2005, C. 352, the Companies must cease the practice of issuing recoupment demands prior to referring a fraud investigation to the New Jersey Office of Insurance Fraud Prosecutor. Such investigations must be complete within the context of **N.J.S.A. 17:33A-1 et seq.** and the Companies' fraud prevention and detection plans within the context of **N.J.A.C. 11:16-1 et seq.** Specifically, the Company must reopen all recoupment files cited in error in Section V.D.1 and remediate invalid recoupments as identified in this report.

3) Pursuant to **N.J.S.A. 26:2S-6b(1)**, the Companies must cease the practice of utilizing medical coders to determine medical necessity reported herein as applicable to third party utilization audits.

4) The Companies must develop and implement a method or procedure to assure that all claims are auditable as required by **N.J.A.C. 11:22-1.5(d)**. At a minimum, the Companies' records must preserve information as to the actual claim payment mailed date.

5) The Companies should remind all personnel who process claims 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 electronic claims within 30 days following receipt by the payer of required documentation in support of an initial claim submission. The Companies should also remind all claims personnel 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 mailed claims within 40 days following receipt by the payer of required documentation in support of an initial claim submission.

6) The Companies should remind all personnel who process claims that **N.J.S.A. 26:2J-8.1(12)** requires interest at 12% effective July 11, 2006 or 10% prior to that date pursuant to **N.J.A.C. 11:22-1.6(c)**. This reminder should also state that **N.J.A.C. 11:2-17.9(b)** obligates a payer to request additional proofs to establish entitlement to benefits, and that **N.J.S.A. 17B:30-13.1(d)** prohibits refusal to pay a claim without conducting a reasonable investigation based upon all available information.

7) In order to comply with **N.J.A.C. 11:2-17.8(i)** and relevant provider agreements, the Companies should issue written instructions to all applicable personnel stating that health care professionals who deliver care under an assignment of benefits are permitted to submit claims within the maximum, statutory period allowable, calculated from the last date of treatment. Subject to any viable agreements during the post-adoption, recommendation compliance phase of this examination, the Company should research it entire paid claim population from calendar year 2007 to the present to identify and remediate all claims denied for this reason. A list of all remediated claims should be provided to the Commissioner and include claim number, amount paid, payee and date of payment.

8) The Companies must cease the practice of not providing members with an Explanation of Benefit and/or Remittance Advice upon the denial of a claim.

9) OHP-NJ and UHC-NJ should establish training programs to ensure that employees understand New Jersey insurance laws identified in this report. The Companies should provide a summary of all items addressed.

10) OHP-NJ and UHC-NJ should establish standards and procedures to conduct reasonable investigations of all claims prior to adjudication.

11) OHP-NJ and UHC-NJ should establish procedures for timely update of the PHCS Fee schedules. Oxford should reopen all claims cited in section V.D.12 of this report in order to pay any additional amounts owed. The Company should also research it entire paid claim population from calendar year 2007 to the present to identify and remediate all underpaid claims. A list of all remediated claims should be provided to the Commissioner and include claim number, amount paid, payee and date of payment.

12) OHP-NJ and UHC-NJ should modify all communications and literature regarding appeal timelines in a manner that is consistent with DOBI Bulletins.

13) OHP-NJ and UHC-NJ should establish standards for proper documentation of all files to comply with New Jersey statues and regulations.

VERIFICATION PAGE

I, Clifton J. Day, am the Examiner-in-Charge of the Market Conduct Examination of Oxford Health Plans of New Jersey and United Healthcare of New Jersey conducted by examiners from RSM McGladrey, Inc and market conduct examiners from 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 Oxford Health Plans of New Jersey and United Healthcare of New Jersey as of May 8, 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.

April 23, 2010
Date

Clifton J. Day
Clifton J. Day, MPA, CFM, CSM
Examiner-In-Charge
New Jersey Department
of Banking and Insurance

APPENDIX A

N.J.S.A. 17B:30-13.1. Unfair claim settlement practices

No person shall engage in unfair claim settlement practices in this State. Unfair claim settlement practices which shall be unfair practices as defined in N.J.S.A.17B:30-2, shall include the following practices:

Committing or performing with such frequency as to indicate a general business practice any of the following:

a. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

b. Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

c. Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

d. Refusing to pay claims without conducting a reasonable investigation based upon all available information;

e. Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

f. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

g. Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

h. Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application;

i. Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;

j. Making claims payments to insureds or beneficiaries not accompanied by statement setting forth the coverage under which the payments are being made;

k. Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

l. Delaying the investigation or payment of claims by requiring an insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

m. Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage;

n. Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

N.J.S.A §26:2J-8.1 Health maintenance organization to receive, transmit transactions electronically; standards, states in part:

"... (10) With the exception of claims that were submitted fraudulently or submitted by health care providers that have a pattern of inappropriate billing or claims that were subject to coordination of benefits, no payer shall seek reimbursement for overpayment of a claim previously paid pursuant to this section later than 18 months after the date the first payment on the claim was made. No payer shall seek more than one reimbursement for overpayment of a particular claim. At the time the reimbursement request is submitted to the health care provider, the payer shall provide written documentation that identifies the error made by the payer in the processing or payment of the claim that justifies the reimbursement request. No payer shall base a reimbursement request for a particular claim on extrapolation of other claims, except under the following circumstances:

(a) in judicial or quasi-judicial proceedings, including arbitration;

(b) in administrative proceedings;

(c) in which relevant records required to be maintained by the health care provider have been improperly altered or reconstructed, or a material number of the relevant records are otherwise unavailable; or

d) in which there is clear evidence of fraud by the health care provider and the payer has investigated the claim in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), and referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).

(11) (a) In seeking reimbursement for the overpayment from the health care provider, except as provided for in subparagraph (b) of this paragraph, no payer shall collect or attempt to collect:

(i) the funds for the reimbursement on or before the 45th calendar day following the submission of the reimbursement request to the health care provider; ...

N.J.S.A §26:2J-18.1 Examination of HMO by Commissioner of Insurance and Banking, states in part:

"... The Commissioner of Banking and Insurance may conduct an examination of a health maintenance organization in accordance with the procedures provided in P.L.1993, c.236 (C.17:23-20 et seq.) as often as he deems necessary in order to protect the interests of providers, contract holders, members, and the residents of this State. An organization shall make its relevant books and records available for examination by the Commissioner of Banking and Insurance, ...

N.J.A.C. 11:2-17.8(a) Rules for fair and equitable settlements and reasonable explanations applicable to all insurance, states that in part:

"No insurer shall deny or offer to compromise a claim because of a policy provision, including any concerning liability, a condition, or an exclusion without providing specific reference to such language and a statement of the facts that make that language operative."

N.J.A.C. 11:2-17.8(i) Rules for fair and equitable settlements and reasonable explanations applicable to all insurance, states that in part:

"No insurer shall deny payment of a claim when it is reasonably clear that either full or partial benefits are payable."

N.J.A.C. § 11:2-17.12 Examinations

(a) Each insurer's claim files are subject to examination and inspection by the Commissioner or by his duly appointed designees pursuant to N.J.S.A. 17:23-20 et seq., 17:29B-5, and 17B:30-16.

(b) Detailed documentation and/or evidence shall be contained in each claim file in order to permit the Commissioner or his designated examiners or investigators to reconstruct the company's activities relative to the claims settlement. Such documentation shall include but is not necessarily limited to all investigative reports, payment vouchers, transactions, notices, memoranda and work papers. With respect to automobile damage claims, file documentation also shall include the name, address, telephone number and license number of any auto body repair facility that has been utilized by the insurer in the adjustment of the loss or repair of the automobile. All such documentation shall be properly dated and, for investigative reports, notes, memoranda and work papers, the parties preparing such documents shall be identified.

(c) Every insurer shall maintain records of all pertinent communications relating to a claim. The records must identify the date of the communication and the parties, and describe the substance of the communication.

N.J.A.C. § 11:4-28.7(e)(2), "the covered person shall only be liable for the copayment, deductible and coinsurance under the secondary plan if the covered person has no liability for a copayment, coinsurance or deductible under the primary plan and the total payments by both the primary and secondary plans are less than the provider's billed charges."

N.J.A.C. § 11:24B-5.2(c)6 Provisions setting forth pre-authorization requirements, states in part: "No provider agreement form shall contain ... A provision that states 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."

N.J.A.C. § 11:22-1.5 Prompt payment of claims

(a) A carrier and its agent shall remit payment of clean claims pursuant to the following time frames:

1. Thirty calendar days after receipt of the claim where the claim is submitted by electronic means or the time established for the Federal Medicare program by 42 U.S.C. § 1395u(c)2(B), whichever is earlier; or

2. Forty calendar days after receipt of the claim where the claim is submitted by other than electronic means.

(b) Carriers and their agents shall pay claims that are disputed or denied because of missing information or documentation within 30 or 40 calendar days of receipt of the missing information or documentation, as applicable, pursuant to (a) above.

(c) Payment of a claim shall be considered to have been made:

1. On the date a draft or other valid instrument equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope; or

2. If not paid pursuant to (c)1 above, on the date of delivery of a draft or other valid instrument equivalent to payment.
(d) A carrier or its agent shall maintain an auditable record of when payments were transmitted to health care providers or covered persons whether by United States mail or otherwise.

N.J.A.C §11:22-1.6 Denied and disputed claims, states in part:
"...(a) A carrier or its agent shall either deny or dispute a claim, in full or in part, that has not been processed according to N.J.A.C. 11:22-1.5. If only a portion of a claim is disputed or denied, the carrier or its agent shall remit payment for the uncontested portion in accordance with N.J.A.C. 11:22-1.5. The pending of a claim does not constitute a dispute or denial. The carrier or its agent shall, within 30 or 40 calendar days of receipt of the claim, whichever is applicable, notify both the covered person when he or she will have increased responsibility for payment and the provider of the basis for its decision to deny or dispute, including:
1. The identification and explanation of all reasons why the claim was denied or disputed;"

N.J.A.C §11:22-1.6 Denied and disputed claims, states in part:
"... (a)(1)(iv) ... A carrier or its agent shall not deny or dispute a claim for reasons other than those identified in the first review after the claim is entered, unless information or documentation relevant to the claim is received after the first review and such documentation leads to additional reasons to deny or dispute which were not present at the time of that review.

N.J.A.C. § 11:21-7.13 Paying Benefits, states in part:

(a) In paying benefits for covered services under the terms of the small employer health benefits plans provided by health care providers not subject to capitated or negotiated fee arrangements, small employer carriers shall pay covered charges for medical services, on a reasonable and customary basis or actual charges, and, for hospital services, based on actual charges. Reasonable and customary means a standard based on the Prevailing Healthcare Charges System profile for New Jersey or other state when services or supplies are provided in such state, incorporated herein by reference published and available from the Ingenix, Inc., 12125 Technology Drive, Eden Prairie, Minnesota 55344."

1. The maximum allowable charge shall be based on the 80th percentile of the profile.
2. Carriers shall use the profile effective as of July 1993, and shall update their databases within 60 days after receipt of periodic updates released by the Prevailing Healthcare Charges Systems.

N.J.A.C. § 11:24-1.2 (Definitions relative to Health Maintenance Organizations)
"Emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious

jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency exists where: there is inadequate time to effect a safe transfer to another hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or the unborn child.

N.J.A.C. § 11:24-8.3 Utilization management determinations

(a). The HMO shall have written policies and procedures that address responsibilities and qualifications of staff who render determinations to authorize admissions, services, procedures or extensions of stay.

(b). All determinations to deny or limit an admission, service, procedure or extension of stay shall be rendered by a physician. The determination shall be directly communicated by the physician to the provider or, if this is not possible, the provider shall be supplied with the physician's name, telephone number, and where he or she can be reached. The physician shall be available immediately in urgent or emergency cases and on a timely basis for all other cases as required by the medical exigencies of the situation. The physician shall be under the clinical direction of the medical director responsible for medical services provided to the HMO's New Jersey members. Such determinations shall be made in accordance with clinical and medical necessity criteria developed pursuant to N.J.A.C. 11:24-8.1(b) and the evidence of coverage.

(c). All determinations shall be made on a timely basis, as required by the exigencies of the situation.

(d). An HMO shall not retroactively deny reimbursement for a covered service provided to a member by a provider who relied upon the written or oral authorization of the HMO or its agents prior to providing the service to the member, except in cases where there was material misrepresentation or fraud.

(e). A member or provider acting on behalf of a member shall receive upon request a written notice of any determination to deny coverage or authorization for services required in this subchapter or in the evidence of coverage, which shall be subject to appeal in accordance with N.J.A.C. 11:24-8.5, 8.6 and 8.7. The written notice of determination shall include an explanation of the appeal process.

N.J.A.C. § 11:24-8.6 Formal internal utilization management appeal process (Stage 2), states in part:

(b) Each HMO shall establish and maintain a formal internal appeal process (stage 2 appeal) whereby any member or any provider acting on behalf of a member with the member's consent, who is dissatisfied with the results of the stage 1 appeal, shall have the opportunity to pursue his or her appeal before a panel of physicians and/or other health care professionals selected by the HMO who have not been involved in the utilization management determination at issue.

(c) The formal internal utilization management appeal panel shall have available consultant practitioners who are trained or who practice in the same specialty as would typically manage the case at issue or such other licensed health care professional as may be mutually agreed upon

by the parties. In no event, however, shall the consulting practitioner or professional have been involved in the utilization management determination at issue. The consulting practitioner or professional shall participate in the panel's review of the case, if requested by the member and/or provider.

(d) All 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.

(e) All stage 2 appeals shall be concluded as soon as possible after receipt by the HMO in accordance with the medical exigencies of the case, which in no event shall exceed 72 hours in the case of appeals from determinations regarding urgent or emergent care (including all situations in which the member is confined as an inpatient) and, except as set forth in (e) below, 20 business days in the case of all other appeals.

N.J.A.C. § 11:24-8.7 External appeal process (Stage 3), states in part:

(b) To initiate an external appeal, a member and/or provider shall, within 60 days from receipt of the written determination of the stage 2 internal appeal panel under N.J.A.C. 11:24-8.6(f), file a written request with the Department. The request shall be filed on the forms automatically provided to the member in accordance with N.J.A.C. 11:24-8.6(f), and shall include both the fee specified in (c) below and a general release executed by the member for all medical records pertinent to the appeal...

(i) The IURO shall complete its review and issue its recommended decision as soon as possible in accordance with the medical exigencies of the case which, except as provided for in this subsection, in no event shall exceed 30 business days from receipt of all documentation necessary to complete the review. The IURO may, however, extend its review for a reasonable period of time as may be necessary due to circumstances beyond its control, except that in no event shall it render its determination later than 90 days following receipt of a completed application. In the event the IURO needs to extend its review period, it shall, prior to the conclusion of the 30 business day review, provide written notice to the member and/or provider, to the Department, and to the HMO setting forth the status of its review and the specific reason for the delay.

1. Notwithstanding (i) above, if the appeal involves care for an urgent or emergency case, the IURO shall complete its review within no more than 48 hours following its receipt of the appeal.

(k) Within 10 business days of the receipt of the determination of the IURO as set forth in (j) above, the HMO shall submit a written report to the IURO, member and provider if the provider made the appeal on behalf of the member with the member's consent, and the Department

indicating whether the HMO will accept and implement or reject the recommendations of the IURO in whole or in part.

N.J.A.C. 11:24B-5.2(c)6 and N.J.A.C. 11:4-42.8(a):
prohibit an Organized Delivery Service and an HMO, respectively, from denying a claim due to lack of precertification or preauthorization where the claim may otherwise be eligible for payment based on medical necessity.

N.J.A.C. 11:24B:5.2(c)(6)(i) states:
"No provider agreement form shall contain a provision that states 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 preauthorized. There may be a provision that allows payment to be reduced up to, but not exceeding, 50 percent of what would otherwise have been paid had pre-certification or pre-authorization been obtained for a medically necessary service, but only if the actual percentage reduction is set forth in the provider agreement;"

Title 42 C.F.R. § 411.101 Definitions – Large group health plan (LGHP) means a GHP that covers employees of either –

(1) A single employer or employee organization that employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year; or

(2) Two or more employers, or employee organizations, at least one of which employed at least 100 full-time or part-time employees 50 percent or more of its regular business days during the previous calendar year.

Subpart F – ESRD Beneficiaries: Title 42 C.F.R. § 411.162(a) Medicare benefits secondary to group health plan benefits, states in part:

(a) General Provisions –

(1) Basic Rule. Except as provided in § 411.163 (with respect to certain individuals who are also entitled on the basis of age or disability), Medicare is secondary to any GHP (including a retirement plan), with respect to benefits that are payable to an individual who is entitled to Medicare on the basis of ESRD, for services furnished during any coordination period determined in accordance with paragraphs (b) and (c) of this section.

(2) Medicare benefits secondary without regard to size of employer and beneficiary's employment status. The size of employer and employment status requirements of the MSP provisions for the aged and disabled do not apply with respect to ESRD beneficiaries.

Subpart G – Aged Beneficiaries: Title 42 C.F.R. § 411.172(a) Medicare benefits secondary to group health plan benefits, states in part:

(a) Conditions that the individual must meet. Medicare Part A and Part B benefits are secondary to benefits payable by a GHP for services furnished during any month in which the individual—

(1) Is aged;

(2) Is entitled to Medicare Part A benefits under § 406.10 of this chapter; and

(3) Meets one of the following conditions:
(i) Is covered under a GHP of an employer that has at least 20 employees (including a multi-employer plan in which at least one of the participating employers meets that condition), and coverage under the plan is by virtue of the individual's current employment status.

Subpart H – Disabled Beneficiaries: Title 42 C.F.R. § 411.204(a)(1) & (3)(i) Medicare benefits secondary to LGHP benefits, states in part:

(b) Medicare benefits are secondary to benefits payable by an LGHP for services furnished during any month in which the individual –
(1) Is entitled to Medicare Part A benefits under § 406.10 of this chapter;
(2) Is covered under an LGHP; and
(3) Has LGHP coverage by virtue of his or her own or a family member's current employment status.

(c) Individual entitled to Medicare on the basis of disability who are also eligible for, or entitled to, Medicare on the basis of ESRD. If a disabled individual is, or could upon filing an application become, entitled to Medicare on the basis of ESRD, the coordination of benefits rules of subpart F of this part apply.

P.L. 2005, c.352 includes Section 7 of P.L.1999, c.154 (C.26:2J-8.1), which has been amended to read in part:

(9) An overdue payment shall bear simple interest at the rate of 12% per annum. The interest shall be paid to the health care provider at the time the overdue payment is made.

Definitions:

P.L. 2005, c.352 (C.17B:30-50 Definitions relative to processing health claims)

- "Medical necessity" or "medically necessary" means or describes a health care service that a health care provider, exercising his prudent clinical judgment, would provide to a covered person for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that is: in accordance with the generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the covered person's illness, injury or disease; not primarily for the convenience of the covered person or the health care provider; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered person's illness, injury or disease.

Bulletin 07-23 issued by the New Jersey Department of Banking and Insurance (the Department) on December 7, 2007, states in part:

"...some organized delivery systems (ODS) are 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 acknowledgment of prior notice (collectively "administrative procedures"). Such denial violated N.J.A.C. 11:24B:5.2(c)6, which permits a penalty of no greater

than 50% of what would otherwise have been paid to the network provider had the administrative procedures been satisfied, provided such penalty is specified in the provider agreement.

The purpose of this bulletin is to remind ODSs and the insurance companies, health service corporations and health maintenance organizations that contract with ODSs of the maximum penalty that can be levied on provider claims for medically necessary covered services for failure to comply with the ODS' or carrier's administrative procedures. In order to avoid enforcement action by the Department, ODSs that are not in compliance with N.J.A.C 11:24B:5.2(c)6 are advised to submit for the Department's approval a Plan of Correction (POC) describing how the ODS intends to come into compliance, including remediation with interest of all improperly denied claims, on or before February 1, 2008."