COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, APRIL 9, 2008

COMMONWEALTH OF VIRGINIA

2008 APR -9 P 12: 37

At the relation of the

STATE CORPORATION COMMISSION

v.

CASE NO. INS-2008-00069

GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.,

Defendant

SETTLEMENT ORDER

Based on a market conduct examination conducted by the Maryland Insurance Administration and provided to the Bureau of Insurance ("Bureau") as agreed to by the Defendant, it is alleged that the Defendant, duly licensed by the State Corporation Commission ("Commission") to transact the business of insurance in the Commonwealth of Virginia, in certain instances, has violated §§ 38.2-510 A 5, 38.2-510 A 6, and 38.2-3407.1 B of the Code of Virginia by failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed, by failing to make prompt, fair and equitable settlements of claims in which liability has become reasonably clear, and by failing to pay interest at the legal rate of interest from the date of fifteen (15) working days from the Defendant's receipt of proof of loss to the date that the claim was paid.

The Commission is authorized by §§ 38.2-218, 38.2-219, and 38.2-1040 of the Code of Virginia to impose certain monetary penalties, issue cease and desist orders, and suspend or revoke the Defendant's license upon a finding by the Commission, after notice and opportunity to be heard, that the Defendant has committed the aforesaid alleged violations.

The Defendant has been advised of its right to a hearing in this matter, whereupon the Defendant, without admitting any violation of Virginia law, has made an offer of settlement to the Commission wherein the Defendant has tendered to the Commonwealth of Virginia the sum

of ten thousand dollars ($10,000), waived its right to a hearing, and agreed to comply with the Corrective Action Plan provided to the Bureau on February 26, 2008, which is attached and made a part of this Order.

The Bureau of Insurance has recommended that the Commission accept the offer of settlement of the Defendant pursuant to the authority granted the Commission in § 12.1-15 of the Code of Virginia.

THE COMMISSION, having considered the record herein, the offer of settlement of the Defendant, and the recommendation of the Bureau of Insurance, is of the opinion that the Defendant's offer should be accepted.

IT IS THEREFORE ORDERED THAT:

(1) The offer of the Defendant in settlement of the matter set forth herein be, and it is hereby, accepted;

(2) The Defendant shall comply with the attached Corrective Action Plan by December 31, 2008, and shall document such compliance to the Bureau. Compliance may be verified by the Bureau; and

(3) The papers herein be placed in the file for ended causes.

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to Jimmy W. Riggs, Assistant General Auditor, CareFirst BlueCross BlueShield, Box 2-755, 10455 Mill Run Circle, Owings Mills, Maryland 21117-4208; and the Bureau of Insurance in care of Deputy Commissioner Jacqueline K. Cunningham.

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MIA DENIED CLAIMS MARKET CONDUCT EXAM REVIEW

[redacted] ACTION PLAN
(UPDATES IN RED 02/26/08)

DECEMBER 19, 2007

Booker T. Carter, Jr.
Vice President – Claims and Cost Containment

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Background:

- MIA conducted focused audit of denied claims processed in MD during 2004.
- To address findings both short-term (stop-gap) measures and long-term action steps were developed. All stop-gap measures are effective with claims paid subsequent to 10-1-07.

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MIA DENIED CLAIMS AUDIT SUMMARY OF VIOLATIONS

MIA VIOLATION (Note: Violations start with #4)	Category of Violations	Short Definition of Violations	Status of Action Plan
Finding 4	Prompt Processing	Processing claims in excess of 30 days of receiving them.	No adjustment necessary. We follow state regulations.
Finding 5	Interest Penalty	Failure to pay interest on claims paid in excess of 30 days after receiving them or in excess of 30 days after additional information was received.	SOP's completed, adjust calculation of interest.
Finding 6	Adjusted Claims Payment	Failing to pay claims within 30 days after receipt of the requested additional information.	Timely processing requirements iterated.
Finding 7	Clean Claims Payment	Failure to pay a clean claim.	Refresher training completed.
Finding 8	Small Employer Group PT	Failure to properly process physical therapy claims.	Refresher training completed.
Finding 9	Multiple Claim Number	Assigning new claim numbers to denied and paid claims that were related and determined to be a single claim.	Status is open. This is a system constraint and provider billing problem. Expect recommendations by September 30, 2008.
Finding 10	Inappropriate Denials	Inappropriately denying claims for reasons, including, but not limited to, pre-existing, no authorization, onset date and premium not paid.	Refresher training completed.
Finding 11	Undisputed Claim	Failing to pay the undisputed portion of the claim.	Reviewing billing practice changes and system changes needed. Targeted completion date is September 30, 2008.
Finding 12	Small Employer Group Chiropractic Benefit	Failing to properly process chiropractic claims.	Refresher training completed.
Finding 13	Reimbursement for Hospital Emergency Facility Benefit	Failing to reimburse a hospital emergency facility the EMTALA[1] screening fees billed.	Reviewing billing practice changes needed. Will provide retraining to providers by September 30, 2008.

[1]Emergency Medical Treatment And Labor Act

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No/Incomplete Inpatient Authorization on File

Finding: Original claim was rejected and CF did not adjust the claim after receipt of a subsequent or updated authorization when added to the Managed Care file.

ACTION STEPS TAKEN/TO BE TAKEN

- A weekly report was created to identify original rejected inpatient claims to review for subsequent receipt of the authorization for claims rejected 10-1-07 forward.
- A weekly report is generated when there is any type of update to the Managed Care authorization inpatient system.
- The reports are researched to determine if as a result of the authorization update an adjustment or interest is applicable.
- A quality review of the reports will be implemented to audit the process on a monthly basis beginning February 2008. This will assist in the evaluation of human error as the report is manual, until ultimate system solutions are in place. **(In Progress)**
- A systems change request was submitted for automated recycle of claims denied for authorizations and referrals not on file.
- Customer Service Departments will review SOPs by 1-11-08 and provide training on revised SOPs by January 31, 2008. **(Completed)**
- **Quality Assurance (QA) review of compliance began in February, 2008.**

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No Outpatient Pre-Treatment Plan/Extended Plan on File

Finding: Claims were not adjusted timely when original claim denied and Pre-Treatment Plan subsequently received or extended.

ACTION STEPS TAKEN/TO BE TAKEN

A weekly report is generated for new and updates to Pre-Treatment Plan type services.

- This report requires manual research of claims identified for adjustment and any applicable interest. **(In Progress)**
- A robot, identifies on a weekly basis any claims rejected for the previous week and systemically recycles these claims for proactive search of any newly loaded or updated treatment plans in the Managed Care file. This addresses any delay in receipt or processing of the treatment plan within five days of the claim rejection. Continued evaluation for existing robotic solution will be completed by February 2008. **(In Progress)**
- In addition, a monthly report is generated that contains monthly updated information to the Managed Care file as another fail safe for potential updates missed on the weekly reports.
- Customer Service will review SOPs by 1-11-08 and provide training on revised SOPs by January 31, 2008. **(Competed)**
- **Quality Assurance (QA) review of compliance began in February, 2008.**

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No Outpatient Pre-Treatment/Extended Plan on File (cont'd)

Finding: Claims were not adjusted timely when original claim denied and Pre-Treatment Plan subsequently received or extended.

ACTION STEPS TAKEN/TO BE TAKEN (con't)

- A quality review of the reports will be implemented to audit the process on a monthly basis beginning February 2008. This will assist in the evaluation of human error as the report is manual, until ultimate system solutions are implemented. **(In Progress)**
- SEGO Mandate compliance system changes were identified. Implementation date of changes to be determined by February 2008. Though no adjudication errors were identified a system change was submitted to properly reflect benefit maximums based on the most recent MIA interpretation of the mandate. **(Not Yet Completed)**
- These reports combined with robotics will be used until ultimate system solutions are in place.
- Customer Service Department will review SOPs by 1-11-08 and provide training on revised SOPs by January 31, 2008. **(Completed)**
- **Quality Assurance (QA) review of compliance began in February, 2008.**

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Referrals > FLEXX

Finding: Claims were not adjusted timely when original claim denied and subsequent referral was received.

ACTION STEPS TAKEN/TO BE TAKEN

- Claims are recycled for a period of one year through a robotics adjustment process to determine if there is a referral now on file.
- If the referral is now on file, the robot will adjust the claim against the referral.
- A weekly report is now generated for claims rejected which the Robot could not successfully adjust. A claims processor will manually complete the adjustment process.
- Customer Service will review SOPs for enhancements by 1-11-08 and provide training on revised SOPs by January 31, 2008. **(Completed)**
- **Quality Assurance (QA) review of compliance began in February, 2008.**

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Pre-Existing > FLEXX

Finding: Claims were denied when Pre-Existing information was determined to be available to make a coverage decision at the time of original receipt.

ACTION STEPS TAKEN/TO BE TAKEN

- Central Medical Review (CMR) SOPs have been updated to include instructions on how to advise the adjustment staff on the appropriate Julian date to use when adjusting claims that have been rejected for records. This will allow the correct interest to be paid based on the receipt of the necessary additional information. Claims processing guidelines were modified February 2007 and SOPs were updated May 2007.
- The Central Appeals Unit (CAU) database was updated to allow clear indication based on review if interest should be paid related to overturned appeal determinations. This change was implemented mid 2006 and SOPs were created accordingly for the CAU and adjustment staff.
- Claims staff received enhancement training surrounding pre-existing in 2nd quarter through 3rd quarter 2007.
- Customer Service Department will review SOP by 1-11-08 and provide training on revised SOPs by January 31, 2008. **(Completed)**
- **Quality Assurance (QA) review of compliance began in February, 2008.**

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Business Policy Process Evaluation

Finding: Multiple Claim Numbers - Assigning new claim numbers to denied and paid claims that were related and determined to be a single claim.

ACTION STEPS TAKEN/TO BE TAKEN

- CF is required to identify each claim submitted by providers and members with the actual receipt date & will need to evaluate if any modifications can be made to minimize this occurrence by 3rd quarter 2008.

Finding: Reimbursement for Hospital Emergency Facility Benefit- Failing to reimburse hospital emergency facility the EMTALA[1] screening fees when billed in conjunction with inpatient services and claim denied for no approved authorization on file.

ACTION STEPS TAKEN/TO BE TAKEN

- Existing provider billing practices will need to be reviewed by Business Policy Department to recommend process changes. (ie: billing requirements and compliance with CMS billing standard review necessary) by 3rd quarter 2008.

[1]Emergency Medical Treatment And Labor Act

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Business Policy Process Evaluation (con't)

Finding: Timely Filing – Rejecting a claim for timely filing when not applicable.

ACTION STEPS TAKEN/TO BE TAKEN

- CF implemented new timely filing timeframes for consistency across all platforms 2nd quarter 2007.

Finding: Claim rejected for premium not paid by Group. MIA requested CF to make a decision to reject based on termination or allow benefits while awaiting receipt of premium – CARE.

ACTION STEPS TAKEN/TO BE TAKEN

- Business Policy Department and Medical Underwriting will need to evaluate for any changes by 3rd quarter 2008.

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Total Claims Preliminarily Identified for Review

- CF required to conduct self-audit for period 2004- September 2007 & make any necessary corrections/requirements.
- CF objective is to review claims which have been previously denied and subsequently adjusted to pay to determine if any penalty interest was applicable and that it was applied correctly upon adjustment.
- CF objective is to review claims denied and adjusted and remain denied for the same or different denial reason to determine if any additional adjustment is necessary.
- CF will complete sampling of preliminary report extracts for validation of targeted claims volume for review by 01/15/08. **(In Progress)**
- Based upon preliminary findings a timetable for completion of retro review/adjustments will be determined. **(In Progress)**

ACTION TO BE TAKEN

113,144 FLEXX Virginia jurisdictions claim records preliminarily identified for the 2004 – 9/30/07 period to be reviewed for possible adjustment and payment of interest.

(Note: This represents less than one-tenth of 1% of CF claims processed for this period)

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Additional Updates

- Met with MIA to review action plan which they deemed very satisfactory.
- MIA agreed to review sample findings to determine cost effectiveness of low volume adjustments. MIA determination on which categories of denied claims will be reviewed for possible adjustment will likewise be applied to the VBOI categories of denied claims.
- MIA agreed to schedule periodic meetings to proactively identify and address issues encountered.