Market Conduct Examination

UnitedHealthcare of New Jersey Inc.
(A Health Maintenance Organization)

NEW YORK, NEW YORK

STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

Office of Consumer Protection Services

Market Conduct Examination Section

Report Adopted: March 6, 2007

MARKET CONDUCT EXAMINATION

of

UnitedHealthcare of NEW JERSEY INC

(A Health Maintenance Organization)

located in

NEW YORK, NEW YORK

as of

July 28, 2004

BY EXAMINERS

of the

STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

OFFICE OF CONSUMER PROTECTION SERVICES
MARKET CONDUCT EXAMINATION SECTION

REPORT ADOPTED: MARCH 6, 2007

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I. INTRODUCTION

A. SCOPE OF EXAMINATION

This is a report of the Market Conduct and Anti-Fraud Compliance activities of UnitedHealthcare of New Jersey, Inc., (hereinafter referred to as "UHC" or "the Company"). Authority for this examination is found under **N.J.S.A. 26:2J-18.1** and **N.J.S.A. 17B:30-16**, made applicable to the operations of a health maintenance organization (hereinafter "HMO") by **N.J.S.A. 26:2J-15b** and **N.J.A.C. 8:38-13.5(a)**. Under the provisions of **N.J.S.A. 26:2J-18.1** and **N.J.A.C. 8:38-2.12(a)**, an HMO is required to open its books and records for an examination. Market Conduct Examiners of the New Jersey Department of Banking and Insurance (DOBI) conducted the examination. The examiners present their findings, conclusions and recommendations in this report as the result of their market conduct examination of the Company. The Market Conduct Examiners were Examiner-in-Charge Dean Turner, Anthony Cecere, Robert Guice, Tia Hammond, Denise Banks and Michael Buchinski.

The scope of the examination included health coverage sold in New Jersey. The main purpose of this examination was to determine whether the Company complied with laws that impose mandated benefit coverages and time constraints on HMO claims processing operations. **N.J.S.A. 26:2J-8.1** and **N.J.A.C. 11:22 et seq**., made applicable to the operations of HMO's by **N.J.A.C. 8:38-13.5(a)**, define time constraint limits. **N.J.S.A. 26:2J-4.1 et seq**., **N.J.S.A. 17B:27-54 et seq**. and **N.J.A.C. 8:38-5.1 et seq**. define mandated benefits. The examination also entailed a review of the Company's fraud prevention and detection plan and training records for claim processors. **N.J.S.A. 17:33A-15, N.J.A.C. 11:16-6.3 et seq**. and **N.J.A.C. 11:22-3.10** et seq. define these requirements.

The review period for this examination was July 1, 2002 to June 30, 2003 for all random sample and population review datasets. The examiners completed their fieldwork at the Company's New York City offices from March 10, 2004 to April 30, 2004. They composed this report on various dates thereafter.

There were several areas in this examination. The examiners reviewed prompt payment of claims, and performed electronic reviews of paid and denied claims for turnaround timeframes. They also performed electronic studies of turnaround timeframes in the Company's responses to complaints, utilization management appeals and provider appeals. The examiners also reviewed the Company's compliance with mandated benefit laws, and reviewed randomly selected mandated benefit claims. Finally, the examiners reviewed UHC's provider contracts for conformity with provider appeal laws, and for consistency with Department-approved format.

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 the Company's on-line systems.

In accordance with **N.J.S.A. 26:2J-8.1** (Health Insurance Network Technology – "HINT" – legislation), a "clean" claim was defined in the examination as one that is:

1. Submitted by an eligible provider for a covered person
2. Free of defect or impropriety
3. Not in dispute as to the amount billed
4. Not suspect of being fraudulent
5. Not in need of special treatment

The random selection process that the examiners used in this examination is in accordance with the National Association of Insurance Commissioners' (hereinafter "NAIC") Market Conduct Examiners' Handbook.

B. ERROR RATIOS

Error ratios are the percentage of files reviewed which the Company handled in error. Each file mishandled or not handled in accordance with applicable statutes is in error, and the examiners cited all such errors in the report. Some files contained one error and others contained several. Even though a file may contain multiple errors, the examiners counted the file only once in calculating the error ratios; however, any file that contains more than one error will be cited more than once in the report. The examiners count a file in error when a company mishandles it or treats an insured unfairly, even if no statute or regulation is applicable. For the purpose of calculating the error ratios, the examiners counted only one error per file. In the event that the Company corrects an error because of a consumer complaint or due to the examiners' findings, the examiners included it in the error ratio. If a company corrected an error independent of a complaint or DOBI intervention, the examiners did not include the error in the error ratios.

For the purpose of the 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 computer queries. The file or record has not been reviewed in depth by an examiner.

There are errors cited in this report that define practices as specific acts that a carrier commits so frequently that it constitutes an improper general business practice. Whenever the examiners found that the errors cited constitute an improper general business practice, they have stated this in the report that follows.

The examiners sometimes find a business practice of a Company that may be technical in nature. Although such practice would not comply with law, the examiners would not count each of these files as an error in determining the error ratios. The examiners indicate in the report that follows whenever they did not count a particular file in the error ratio.

The examiners submitted written inquiries to company representatives on the errors and exceptions cited in this report. This provided UHC the opportunity to respond to the examiners' findings and to provide comments on the statutory errors or mishandling reported herein. Considering those errors and exceptions with which the Company disagreed, the examiners evaluated the individual merits of each response and reviewed all comments. In some instances, the examiners did not cite the files due to the Company's explanatory responses. In others, the errors or exceptions remained as cited in the examiners' inquiries. For the most part, this is a report by exception, in that findings reported are files in error.

C. COMPANY PROFILE

UnitedHealthcare of New Jersey, Inc. is 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. The Company applied for and was granted authority to operate as a New Jersey HMO by the New Jersey Departments of Health and Senior Services, and the New Jersey Department of Banking and Insurance. It commenced operations on May 7, 1987.

The Company's main office is in Minnetonka, Minnesota. The Company has approximately 33,000 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.

As of December 2003, UnitedHealthcare of New Jersey, Inc. had approximately 8,845 providers in its network, providing services to 64,167 members. This results in a doctor-to-member ratio of approximately 1 to 8.

D. IDENTIFYING MANDATED BENEFIT CLAIMS

This examination focused in part on how UHC 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, an examination can create a reliable claim population 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, an examination has access to data that is less reliable.

The examiners were able to identify 12 mandated benefits in Company datasets because they equate to specific codes from Current Procedural Terminology (hereinafter "CPT") or International Classification of Diseases (hereinafter "ICD")

manuals. The examiners then acquired random samples from the resulting populations of those 12 mandated benefits.

Please See Appendix A for 12 Mandated Benefits Examined by Codes

II. UTILIZATION MANAGEMENT APPEALS, CONSUMER COMPLAINTS, AND PROVIDER APPEALS

A. INTRODUCTION

The examiners evaluated UHC's Utilization Management Appeals, Consumer Complaints and Provider Appeals, reviewing for compliance with claim settlement turnaround guidelines and other procedural requirements identified below. Applicable laws included **N.J.A.C. 8:38-8.1 et seq.** (Utilization Management Appeals), **N.J.S.A. 17B:30-13.2**, **N.J.A.C. 11:2-17.6(d)** and **N.J.A.C. 8:38-3.7(a)4** (Complaints), and **N.J.A.C. 11:22-1.8(a)** (Provider Appeals). These laws set forth requirements for timely responses.

During the period July 1, 2002 though June 30, 2003 UHC processed eight Utilization Management Appeals, 63 Complaints, and 351 Provider Appeals, representing a total of 422 such transactions.

B. PROVIDER APPEALS

In order to complete the review of the Company's Provider Appeal process, the examiners requested 80 randomly selected Provider Appeal files and found 80 in error for an error ratio of 100%. They also requested specimen copies of Provider Contracts, the 2001 Physician and Health Care Administrative Manual (hereinafter "Manual"), and the Health Care Professional Administrative Addendum 2002-2003 edition (hereinafter "Addendum"). The examiners' findings are as follows:

1. Failure to Provide a Description of the Appeals Mechanism in the Participating Provider Agreement (Improper General Business Practice)

N.J.A.C. 11:22-1.8(a) requires the Company to describe a Provider Appeal Mechanism in its Participating Provider Contract. Contrary to this regulation, the Company did not describe the appeal mechanism in the Contract, but referred to sections of the Manual and the Addendum instead. This was not consistent with the regulation, which requires a company to place a description in the Contract itself.

The examiners then reviewed the description of the Provider Appeals Mechanism in the Manual and the Addendum, but found the language there to be inconsistent and ambiguous. For example, the Manual contains instructions to file appeals within two different time limits. On page 34, it indicates an appellant has 12 months to file for a claim adjustment, and in the next paragraph (titled, "How to appeal a claim"), it indicates an appellant has 90 days from the date of the Explanation of Benefits (hereinafter "EOB"). The examiners found this language to be ambiguous and potentially inconsistent, and therefore not in compliance with **N.J.A.C. 11:22-1.8(a)**, which requires a company to describe its Provider Appeal Mechanism in the provider Contract.

The Company disagreed with this finding. In response to an inquiry, the Company wrote, "The Administrative Manual and prior versions of the Manual describing the internal appeal mechanisms were considered part of the New Jersey provider agreements during the examination period." The examiners found, however, that **N.J.A.C. 11:22-1.8(a)** was clear in its requirement that descriptive language must appear in the Participating Provider Contract.

The examiners found that the Manual and the Addendum were also ambiguous and potentially inconsistent in providing an address for mailing Provider Appeals. Page 51 of the Manual contains a New York City address, Page 34 instructs the reader to submit appeals to another address on the back of the membership identification card, and Page 50 of the Addendum contains a Utah address. Two of these references, on page 51 of the Manual and on page 50 of the Addendum, were at odds because they were both New Jersey-specific. The examiners found that these instructions were not in compliance with the regulation.

The Company disagreed with this finding, writing in response to an inquiry, "We expect the physician to refer to the patient's ID card for the appropriate service center for that patient. However, to comply with New Jersey State Regulations, in the New Jersey Regulations section, an appeal address is given." The Company did not explain why it provided three different addresses for Provider Appeals and did not distinguish in those appeals which appeal was intended to be in compliance with New Jersey regulations since all were New Jersey appeals.

The examiners also note that **N.J.A.C. 11:22-1.8(a)** does not provide an appeal option for claims that claimants file pursuant to **N.J.A.C. 8:38-8.5** through **8.7** (Utilization Management appeals), or pursuant to **N.J.A.C. 8:38A-3.6** and **3.7** (Independent Utilization Review Organizations). However, **N.J.A.C. 11:22-1.8(a)** does provide appeal options for all other types of claims, including those that are still open in a company's processing system. The regulation therefore provides a mechanism to appeal an open claim based on prompt pay laws. Contrary to the regulation, however, UHC used language in its Manual and Addendum that would restrict appeals to claims that have already been paid or denied, leaving other claims that are unresolved beyond the periods provided in the prompt payment regulations, and still active in the Company's processing system, without an appeal mechanism. Pages 25, 34, and 51 of the Manual, and Page 50 of the Addendum, limit appeals to, "Disagreement with payment determination", and "Denied claim." The examiners

found that the language did not comply with the regulation because by omission, it may be interpreted to exclude open claims.

The Company disagreed with this finding. Responding to an inquiry, the Company wrote, "It was not and is not UnitedHealthCare's intent or policy to restrict the type of appeals a provider may appeal. The 2002/2003 Addendum has two sections that explain a provider's right to appeal. The section, Claim Adjustments, speaks to those claims which have been submitted but are not yet paid." The examiners found, however, that the language of the Claim Adjustments section read, "We require that requests for adjustment(s) be submitted within 12 months from the date of the initial claim determination," language that restricts adjustment considerations to processed claims only. For that reason, the examiners found that failure to provide a description of the appeals mechanism in the Provider Contract was not in accord with **N.J.A.C. 11:22-1.8(a)**.

2. Failure to Provide a Description of an External Alternate Dispute Resolution Mechanism in the Participating Contract (Improper General Business Practice)

N.J.A.C. 11:22-1.8(b)2 requires a carrier to offer an external Alternate Dispute Resolution (hereinafter "ADR") mechanism to participating health care providers. This mechanism enables providers to obtain a review of an adverse decision from a company's internal appeals process. The regulation requires a company to describe the ADR mechanism in its Participating Provider Contract. Contrary to this regulation, however, UnitedHealthcare did not describe an ADR mechanism in its Contract, but referred to sections of the Manual and the Addendum instead. Because the regulation requires a company to place a description in the Contract itself, each issuance of the contract constituted an error, thus resulting in an improper general business practice.

The Company disagreed with this finding. Responding to an inquiry from the examiners, the Company wrote, "To communicate the appropriate appeals process, including ADR, this information was included in the 2001 Physician and Health Care Administrative Manual (page 34 and the New Jersey Regulatory section beginning on page 49)." But the examiners found, again, that the ADR mechanism must be described in the Participating Provider's Contract.

The examiners also found that neither the Manual nor the Addendum contained a description of an ADR mechanism. The Manual referred to the final internal decision letter for instructions about how to file an ADR appeal, and the Addendum referred the reader back to the Provider Contract. The examiners found that this was not in compliance with **N.J.A.C. 11:22-1.8(b)2**, which affirmatively requires a description of an ADR mechanism in the Provider Contract.

3. Failure to Maintain Required Claim Handling Documentation (Improper General Business Practice)

N.J.A.C. 11:2-17.12(b) and **(c)** require a company to maintain detailed documentation and/or evidence in each claim file in order to permit the examiners to reconstruct the Company's activities relative to the claims settlement. Contrary to this regulation, the Company failed to retain the provider appeal letter in all 80 randomly selected files that the examiners requested. The absence of the provider appeal letters prevented the examiners from evaluating the Company's compliance with the 10-business day turnaround time specified in **N.J.A.C. 11:22-1.8(a)2**. The Company agreed with this finding.

In addition to the above, **N.J.A.C. 11:22-1.8(a)2i** through **v** require the Company to maintain copies of the final internal decision letters in each Provider Appeal file. The provisions in this regulation call for each letter to contain the following documentation:

i. The names, titles and qualifying credentials of the persons participating in the internal review;

ii. A statement of the participating provider's grievance;

iii. The decision of the reviewers, along with a detailed explanation of the contractual and/or medical basis for such decision;

iv. A description of the evidence or documentation which supports the decision; and

v. If the decision is adverse, a description of the method to obtain an external review of the decision.

All 80 randomly selected files failed to comply with at least one of the above requirements, thus constituting an improper general business practice. The following table illustrates which documents were not present in the files reviewed:

Review	Files Reviewed	Files in Error	Error Ratio
Absent any documentation	80	4	5%
Screen print-outs only	80	28	35%
N.J.A.C. 11:22-1.8(a)2i Name title and credentials of person conducting review.	80	48	60%
N.J.A.C. 11:22-1.8(a)2ii Statement of provider's grievance.	80	80	100%
N.J.A.C. 11:2-17.12(a)2iii Decision supported by contractual and/or medical basis.	80	20	25%
N.J.A.C. 11:2-17.12(a)2iv Description of	80	21	26%

evidence or documentation that supports decision.			
N.J.A.C. 11:2-17.12(a)2v Statement advising how to obtain external review.	80	28	35%

In response to an inquiry, the Company agreed with the examiner's findings in this table. In response to the draft report, the Company advised the examiners that it would implement means to correct this error.

Please see Appendix B for Appeals in Error

4. Failure to Submit to DOBI the Number of Internal and External Provider Appeals and How They Were Resolved

N.J.A.C. 11:22-1.8(d) requires an HMO to submit an annual report to the Department indicating the number of internal and external appeals that the Company received, and how they were resolved. Contrary to this regulation, UHC failed to submit such a report to the Department during the examining period (July 1, 2002 to June 30, 2003). In response to an inquiry, the Company agreed with this finding, stating that, "Due to the lack of complete information the Company did not file the annual provider appeal report."

5. Failure to Respond to Stage 1 and Stage 2 Provider Appeals and Direct and Department of Banking and Insurance Claim Complaints within Required Time Frames (176 Exceptions)

The type of communication that an HMO receives determines which of several turnaround response guidelines apply. **N.J.A.C. 8:38-8.5** requires an HMO to respond to Stage One Utilization Management Appeals within five business days. **N.J.A.C. 8:38-8.6(d)** requires a response to a Stage Two Appeal within 20 business days. **N.J.A.C. 11:2-17.6(d)** requires a company to respond to a Department of Banking and Insurance claim-related complaint within 15 working days. **N.J.A.C. 8:38-3.7(a)4** requires a 30-calendar day response on directly received complaints. In addition, **N.J.A.C. 11:22-1.8(a)2** requires a company to respond to a Provider Appeal within 10 business days. After applying these guidelines, the examiners found the following exceptions in the datasets:

	Population	Exceptions	Exception Ratio
Complaints	63	9	14.29%
Provider Appeals	351	167	47.58%
Utilization Management	8	0	0.00%
Totals	422	176	41.71%

As this chart shows, provider appeals accounted for 94.89% (167/176 = 94.89%) of the exceptions, while accounting for 83.18% (351/422 = 83.18%) of the files. In agreeing with this finding, the Company wrote, "As we have advised the

Department on March 12, 2004, the New Jersey provider appeals were previously handled by the New York health plan. In late 2002- early 2003, due to staffing issues, the New York health plan developed a backlog that could not be managed well locally."

The Company agreed that it did not process nine of 63 complaints within required time frames, and that it processed all eight Utilization Management cases within required time frames.

III. PROVIDER CLAIM REVIEW

A. INTRODUCTION

The examiners queried databases of mailed and electronic claims that UHC received during the examining period (July 1, 2002 through June 30, 2003). In that time, the Company processed 672,106 claims. This total included 195,191 mailed and 476,915 electronic claims. Itemized differently, the total contained 518,098 paid and 154,008 denied claims. In arriving at the populations, the examiners requested the Company to exclude all Medicare/Medicaid, federal employee health benefit plans (FEHBP) claims as well as ERISA self-funded plans.

The examiners reviewed the population to verify compliance with statutory and regulatory guidelines regarding prompt claim payments and denials. UHC supplied the examiners with databases for each of the following: Paid Mandated benefits (31,157 claims), Paid Non-Mandated benefits (486,941 claims), Denied Mandated benefits (10,233 claims), and Denied non-Mandated benefits (143,775 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** (Unfair Claim Settlement Practices Act) and **N.J.A.C. 11:2-17.1** et seq. (Unfair Claim Settlement Practices). The examiners used the NAIC Market Conduct Examiners' Handbook, Chapter XVII, *Conducting the Health Examination*, as a guide in conducting this review. That chapter addresses the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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., **N.J.S.A. 8:38** et seq. and **N.J.S.A. 17B:27-54, 55,57,58, 59, 60, 62, 63** and **66**. HMOs must provide these coverages to the same extent as for any other covered illness or injury.

UHC utilizes two claims processing systems, one called "UNET" and one called "COSMOS." The UNET system requires data beyond a simple claim number in order to locate a specific claim, so in all cases for UNET claims in this section, the examiners have provided necessary additional identifying data. These include an "FLN" number, and a letter indicating the "Engine" of the claim.

B. ERRORS/EXCEPTION RATIOS

1. Random Sample Errors

a. Random Sample Review, all Errors on Paid and Denied Mandated Benefits.

The Introduction section of this report previously referred to Appendix A. This Appendix lists 12 mandated benefits that produced reliable populations because they equate to specific International Classification of Diseases (hereinafter "ICD"), Current Procedural Terminology (hereinafter "CPT"), or identifiable in-house codes. This section reports results of randomly selected samples derived from these populations.

The examiners reviewed 114 denied mandated benefit claims from a population of 10,233, and a sample of 109 paid mandated benefit claims from a population of 31,157. The following chart displays all of the errors from Mandated Benefit claims that the examiners found during this review:

	Population	Error	Error Ratio
Paid Mandated	109	3	2.75%
Denied Mandated	114	17	14.91%
Total	223	20	8.97%

b. Random Sample, Prompt Pay Errors Only on Mandated and Non-mandated Benefits

i. Mandated Benefits

"Prompt pay" laws include **N.J.S.A. 26:2J-8.1d(1)** and **N.J.A.C. 11:22-1.5(a)2**, which require a company to pay a mailed claim within 40 days, and **N.J.S.A. 26:2J-8.1d(1)** and **N.J.A.C. 11:22-1.5(a)1**, which require a company to pay an electronically submitted claim within 30 days. In addition, **N.J.S.A. 17B:30-13.1e** and **N.J.A.C. 11:22-1.6(a)** require a company to deny a claim within 30 days if electronic, or within 40 days if mailed. The following chart contains the results of the prompt pay review of Mandated Benefit claims. The Company's overall prompt pay error ratio in processing Mandated Benefit claims within the required time frames was 1.79%:

Mandated Benefits

	Population	Error	Error Ratio
Paid Mandated	109	3	2.75%
Denied Mandated	114	1	0.88%
Total	223	4	1.79%

ii. Non-Mandated Benefits

The examiners' review of non-mandated benefits was solely for claims processing turnaround time. The results of this prompt pay review revealed that the Company maintained an error ratio of 2.22%, as follows:

Non-Mandated Benefits

	Population	Error	Error Ratio
Paid Non-Mandated	115	1	0.87%
Denied Non-Mandated	110	4	3.64%
Total	225	5	2.22%

2. Population Review, Prompt Pay Errors, Mandated and Non-Mandated Errors

a. Population Review, Mailed Paid Claims

	Population	Exceptions	Exception Ratio
Mandated Mailed Paid	8,409	335	3.98%
Non-Mandated Mailed Paid	122,860	4,996	4.07%
Total	131,269	5,331	4.06%

The examiners queried populations of Mandated and Non-Mandated Benefit claims for the examining period (July 1, 2002 through June 30, 2003). As noted, UHC's overall prompt pay exception rate was 4.06%, with little difference in ratios between mandated and non-mandated claims.

b. Population Review, Electronic Paid Claims

	Population	Exceptions	Exception Ratio
Mandated Electronic Paid	22,748	666	2.93%
Non-Mandated Electronic Paid	364,081	8,686	2.39%
Total	386,829	9,352	2.42%

UHC's population of 386,829 electronically paid claims contained 9,352 prompt pay exceptions. This was a 2.42% exception ratio, with little difference in ratios between mandated and non-mandated claims.

c. Summary of Mailed and Electronic Paid Claim Population Review

As the preceding charts show, the examiners cited UHC with an overall exception ratio of 4.06% on mailed claims and a 2.42% exception ratio on electronically submitted claims. UHC held its prompt pay exception ratio to a slightly lower figure for electronic claims than for mailed claims (difference of 1.64) even though the Company processed three times the number of electronic claims.

d. Population Review, Mailed Denied Claims

	Population	Exceptions	Exception Ratio
Mandated Mailed Denied	4,761	87	1.83%
Non-Mandate Mailed Denied	59,161	1,056	1.78%
Total	63,922	1,143	1.79%

The examiners queried the entire population of denied mailed claims for the examining period (July 2, 2003 through June 30, 2003). As the examiners note above, UHC's mailed denied claim exception ratio was 1.79%, with little difference in ratios between mandated and non-mandated claims..

e. Population Review, Electronic Denied Claims:

	Population	Exceptions	Exception Ratio
Mandated Electronic Denied	5,472	71	1.30%
Non-Mandated Electronic Denied	84,614	1,120	1.32%
Total	90,086	1,191	1.32%

UHC's population of 90,086 electronically denied claims contained 1,191 exceptions. This was a 1.32% exception ratio, with virtually no difference in ratios between mandated and non-mandated claims..

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 they submitted electronically. The exception ratios were low; at 1.79% and 1.32% respectively. The examiners found no virtually no differences between paid and denied mandated and non-mandated claims that were submitted electronically or by mail.

C. EXAMINERS' FINDINGS, DENIED MANDATED BENEFITS

1. Improper Denial of Mandated Benefit Claims - 15 Random Files in Error

A number of provisions in law require claim denials to be fair and equitable, and require companies to pay claims when liability is clear. **N.J.S.A. 17B:30-13.1d** and **f** require a reasonable investigation before denying claims, and require fair and equitable claim settlements. **N.J.A.C. 8:38-13.5(a)** makes their provisions applicable to the operations of an HMO. **N.J.A.C. 11:2-17.8(i)** requires a company to pay a claim when it is reasonably clear that full or partial benefits are payable. In addition, Standard 9 of the NAIC Market Conduct Examination Handbook specifies that an examination should review the extent to which an HMO processes denied claims in accordance with policy provisions, HIPAA and state law. Contrary to the above stated regulations, UHC improperly denied 15 claims in the Denied Mandated Claims random sample. The sample size was 114, making the error rate 13.2%.

In all 15 errors, New Jersey statutes and regulations required companies to pay the claims because they are mandated benefits, so the denials were also not in compliance with these laws. **N.J.S.A. 26:2J-4.4** requires a company to cover medical services for mammograms, and 6 of the 15 claims were mammogram claims. **N.J.S.A. 26:2J-4.10** and **N.J.A.C. 8:57-8.3** require a company to cover medical services for childhood screening and immunization, and 4 errors were childhood screening and immunization claims. **N.J.S.A. 26:2J-4.20** and **Bulletin 01-06(5/25/01)** both require a company to cover medical services for biologically-based mental illness, and 3 errors resulted from this type of claim. **N.J.S.A. 26:2J-4.24** requires a company to cover medical services for colorectal surgery, and 2 of the 15 errors resulted from this type of claim. The examiners note that these errors are technical in nature and are not substantively related to denial of the mandate itself.

Please See Appendix C for a List of the 15 Claims in Error

The Company submitted a number of agreements and disagreements with these findings. In eleven of the claims, UHC agreed that the denials were in error, but did not agree to the cite. The Company reasoned that its stated policy of complying with mandated benefit laws should mitigate the errors. For example, regarding claim number 704673353, the Company wrote, "It was determined that a processor error was made on 6/04/03. Denial of benefits was not due to non-coverage of childhood screenings." The examiners found, however, that mandated benefit laws are applicable to both intentional and inadvertent erroneous denials. As such, the cited statutes and regulations are applicable on all files cited by the examiners.

A representative description of the company's disagreements include the following: In claim number **0720622850**, the Company disagreed with the examiners' citation of **N.J.S.A. 17B:30-13.1d** and **f**, **N.J.S.A. 26:2J-4.20**, and **Bulletin 01-06** (5/25/01). The claim was for a biologically based mental illness, and the provider submitted the claim within the required time frame. The Company denied it because the provider failed to mail the claim to an address the Company preferred. In disagreeing with these cites, the Company wrote, "We are submitting a copy of the 'Physician and Health Care Professional Administrative Guide 2002/2003' which provides details to the provider regarding claim submissions. Note that a copy of the administrative guide was provided to the Department, along with the pre-fieldwork materials. Please refer to page 2 of the administrative guide that clearly advises the provider to, 'Mail paper claims to the claims address on the patient's ID card.' Also, page 5 of the administrative guide gives an illustration of the patient ID cards, and advises the provider that the claims addresses are displayed on the card." But the examiners found that the claim was a "clean claim" within the meaning of **N.J.S.A. 26:2J-8.1d**, requiring payment. They also found that the provider was not contractually obliged to mail claims to a preferred address, and that the Company could easily have directed the claim, once received, to the proper business unit within the Company. Therefore, the examiners' findings are applicable to the statutes referenced above.

The Company also disagreed with the examiners' findings in claim numbers **0702862962** and **0621974528**. In both claims, the member's eligibility lapsed and UHC denied the claim. The employer groups then notified the Company that the

members' eligibility had been reinstated, retroactive to the lapse date, but UHC allowed the denial to stand. The examiners note that New Jersey Law and regulation required the Company to re-process these claims in a timely fashion when the employer groups notified the Company that eligibility was confirmed and that coverage was in effect. Specifically, **N.J.S.A. 26:2J-8.1d(6)** requires a company to pay claims within 30 days (if electronic) or 40 days (if mailed) following receipt by the payer of required documentation in support of an initial claim submission. In addition, **N.J.A.C. 11:22-1.5(b)** states, "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…" In disagreeing with these findings, the Company wrote, "When a member is retroactively added, the member/group can either notify the company to reprocess the claim, or the claim can be resubmitted." However, the examiners note that the above-referenced statute and regulation required the Company to pro-actively process these claims based on all information available to the Company, and without requiring the member to request reprocessing of the claim. Notwithstanding the Company's disagreement in response to field inquiries, the Company agreed to issue refunds in response to the draft report.

Please See Appendix D for a list of the 11 Claim Citation Disagreements

2. Failure to Provide a Reasonable Explanation for Denial - 3 Random Files in Error, 230 Exceptions (Improper General Business Practice)

N.J.S.A. 17B:30-13.1n requires a reasonable explanation of the basis in an insurance policy for a claim denial. **N.J.A.C. 11:2-17.8(a**) requires a company to refer to contract language when denying a claim, and to explain how the language is applicable to the denial. In addition, Standard 9 of the NAIC Market Conduct Examination Handbook specifies that an examination should review the extent to which an HMO processes denied claims in accordance with policy provisions, HIPAA and state law. Contrary to the above-stated regulations, UHC denied three claims in the Mandated Denied Claim random sample with denial codes that did not explain how the contract language was operative, and did not explain the basis in the policy for the denial. In the random sample of 114 claims, this represents an error rate of 2.63%. Two of the three files in error contained codes that were inherently non-descriptive, while one code was descriptive, but which was used incorrectly as described below. The claims were as follows:

CLAIM #	FLN	ENGINE	DENIAL CODE
0608979171	0608979171	Y	65
0646806085	0236505370	S	29
0667397018	0304805160	Q	07

In claim number 0608979171, UnitedHealthcare used denial code 65, which read, "According to your plan, there is a limited benefit for this expense. Payment is based on this limited benefit." Since the Company denied the claim in full, there was

no payment; therefore, this explanation was not descriptive. The examiners queried the denied mandated claim database, and found that UHC denied a total of 149 claims with code 65. Notably, this code did not generate a message in any of the 149 claims that explained how the contract language was operative, or the basis in the policy for the denial. The examiners cited this as an improper general business practice because this error occurred on all denials for which the Company used this code.

In claim number 0646806085, the Company used denial code 29, which read, "Your plan covers reasonable charges for covered health services. The reasonable charge is based on amounts charged by other physicians or health care professionals in the area for similar services or supplies. Benefits are not available for that portion of the charge that exceeds the reasonable charge determined for this service." Since the payment in this claim was zero, there was no reasonable charge that the Company was paying. The message, therefore, was also not descriptive. The examiners queried the denied mandated claim database, finding 81 that the Company denied using Code 29. This was an improper general business practice in the 81 claims.

In claim number 0667397018, the Company inadvertently used Code 07 to deny a claim that a provider had not submitted within the required time frame. That code printed the message that the claimant was ineligible at the time of service, when in actuality the provider did not submit the claim within the required time frame.

The Company agreed with the examiners' findings in these three claims.

3. Failure to Deny an Electronic Claim Within 30 Days of Receipt 1 File in Error

N.J.S.A. 17B:30-13.1e and **N.J.A.C. 11:22-1.6(a)** require a company to deny an electronically submitted claim within 30 days. In addition, Standard 9 of the NAIC Market Conduct Examination Handbook specifies that an examination should review the extent to which an HMO processes denied claims in accordance with policy provision, HIPAA and state law. Contrary to the above-stated regulations, UHC failed to process one claim (0638647193) from the mandated benefit claim random sample of 114 claims within the required time frame. This claim was received on December 10, 2002, and denied 46 days later, on February 24, 2002. UHC agreed with this error.

4. Failure to Pay Participating Provider Mandated Benefit Claims at In-Network Rate (5 Random Sample Files in Error, 10 Select Sample Files in Error)

Random Sample Findings

Standard 6 of the NAIC Market Conduct Examiners' Handbook specifies that an examination should review the extent to which a company to handles claims in accordance with state laws and regulations. **N.J.A.C. 8:38-15.3** requires an HMO to submit its provider contract to the Department of Banking and Insurance for approval. The contract that UHC submitted pursuant to that regulation requires the Company to pay participating provider claims consistent with contract language that reads, "We

will pay you for Medically Necessary Covered Services 100% of the schedule which is attached and made part of this Agreement. Our payments will be net of any applicable copayments, coinsurance, or deductibles." Contrary to this language and the regulation, the Company did not process five claims in the denied sample at the in-network benefit level. Instead, the Company erred in manually identifying the providers, and denied the claims as out-of-network, using Code NI.

Please See Appendix E for List of 5 Claims in Error from Random Sample

Database/Select Sample Finding

The random sample of 114 mandated denied claims contained nine that UHC denied with Code NI. Since five of those nine were in error as indicated above, for a 56% error ratio, the examiners reviewed the database of 10,233 denied mandated claims for further instances in which the Company used Code NI. They found that UHC denied 271 claims with that Code during the examining period (July 1, 2002 through June 30, 2003). A select sample of 50 claims from those 271 produced ten errors of the type outlined in the five errors above, which yielded an error rate of 20%.

The Company agreed with the examiners' findings in the select sample. In response to an inquiry, it wrote, "Remark Code NI was inappropriately used to process these claims and benefits were not issued."

Please See Appendix F for List of 10 Claims in Error from the Select Sample

D. EXAMINERS' FINDINGS, PAID CLAIMS

1. Failure to Maintain Auditable Records (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. In addition, Standard 6 of the NAIC Market Conduct Examiners' Handbook specifies that an examination should review the extent to which the Company's records are adequate, accessible, consistent and orderly, and in compliance with state record retention requirements. Contrary to the above-stated regulation, UnitedHealthcare 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 inauditable as submitted, and not in compliance with state record retention requirements. The Company's failure to provide U. S. mail or transmittal dates was an Improper General Business Practice. The following chart lists the databases, and each population:

Database	Population
Mandated Paid	31,157
Mandated Denied	10,233
Non-Mandated Paid	486,941
Non-Mandated Denied	143,775
Total	672,106

The Company provided the date that it received each claim, and the date that it closed each claim out of its processing systems, but this data did not report the actual time that it took to get the checks and denial notices transferred, or in the mail. **N.J.A.C. 11:22-1.5(a)** and **N.J.A.C. 11:22-1.6(a)** define those time frames as 30 days for electronic and 40 for mailed claims.

UnitedHealthcare disagreed with this finding. The Company explained that it did store all the dates that it mailed checks or denials, but for technical reasons it could not retrieve the data and place it on the databases. The Company advised the examiners that they could retrieve all the dates one-by-one, but the examiners confirmed their finding, pointing out that they did not have the staff to review the Company's population of 672,106 claims individually. In response to an inquiry, UHC wrote, "With all due respect, the regulation does not define what is 'an unauditable' process, and does not require that a specific form be prepared for the State. An audit normally does not mean 100% of the records, therefore, when the regulation says 'auditable' it means that a sample can be pulled for review." However, the examiners reviewed **N.J.A.C. 11:22-1.5(d)**, and did not find that it defines "audit" as a sample of a company's business. Instead, they found that the language of the regulation allows for an examination of a company's total business product by database analysis when necessary for an examination.

The examiners and the Company agreed to add two days to each closed date on the databases to arrive at working figures. This allowed the examiners to complete the queries that they needed to produce the charts in Section III, B, 2, a through f of this report.

2. Failure to Pay Electronically Submitted Claims Within 30 Days - 7 Files in Error

N.J.S.A. 26:2J-8.1d(1) and **N.J.A.C. 11:22-1.5(a)1** require a company to pay electronically transferred claims within 30 days of receipt. In addition, Standard 3 of the NAIC Market Conduct Examiners' handbook specifies that an examination should review the extent to which a Company settles claims in a timely manner as required by statutes, rules and regulations. Contrary to these rules, UHC failed to pay seven electronically submitted claims within 30 days.

Three of the errors occurred in the Non-Mandated Denied sample, in which the Company adjusted previously denied claims after receiving additional information. The sample size was 110, resulting in an error rate of 2.72%. Three of the errors occurred in the Paid Mandated sample of 109 claims, resulting in an error rate of

2.8%. One error occurred in the Non-Mandated Paid sample of 115 files, for a 0.9% error rate.

The Company acknowledged that processing errors caused delays in six of the seven claims. The claim numbers were **0560007856, 0563864133, 0585997058, 05909811262, 0618707942, and 0672882212**. In response to the examiners' inquiries, the Company often responded that, benefits were not issued due to claim processor error.

The company disagreed with the examiners' findings in claim number **0514075477**, but did not give a reason for its disagreement. The member's medical providers billed the Company for the professional and technical components of a chest x-ray, but the Company mistook one of the claims as a duplicate. This error resulted in a 122-day payment period.

Please See Appendix G for a List of the Seven Claims In Error

3. Failure to Pay Interest on Overdue Claims (3 Random Sample Files in Error and 6,345 Database Exceptions

N.J.S.A. 26:2J-8.1d(7) and **N.J.A.C. 11:22-1.6(c)** require a company to pay simple interest of 10% per annum on electronic claims not paid within 30 days and on mailed claims not paid within 40 days. In addition, Standard 6 of the NAIC Market Conduct Examiners' handbook specifies that an examination should review the extent to which a Company handles claim files in accordance with policy provisions, HIPAA and state law.

Contrary to these requirements, UHC failed to pay interest on three random sample claims that it paid late. Two of the errors occurred in the Mandated Benefit Paid sample of 109 claims. The third interest error occurred in the Non-Mandated Benefit sample of 115 claims, where the Company failed to pay one claim within the required time frame.

Please See Appendix H for a List of the 3 Claims in Error

As stated above in III, D, 2, the Company disagreed with the examiners' findings in claim number **0614075477** but did not give a reason, and agreed with the examiners' findings in claim numbers **0672882212** and **05909811262**. In response to examiner inquiries, the Company paid interest on all three claims.

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

Paid Claim Database	Late Payments	No Interest	Exception Ratio
Non-Mandated Electronic	8,686	3,619	41.66%
Non-Mandated Mailed	4,996	2,270	45.44%

Mandated Electronic	666	301	45.20%
Mandated Mailed	335	155	46.27%
Total	14,683	6,345	43.21%

As the above chart demonstrates, 43.21% of all late claims were identified by database queries as exceptions to the statute and regulation requiring payment of interest. Although the Company agreed with the statistics that the queries produced, it expressed reservations about their significance. In response to an inquiry, UHC wrote, "The Company does agree with the statistics represented above, based on the query criteria used during (a) May 26, 2003 conference call. However, these statistics do not capture whether or not interest payments made were in fact due. For example, if the Company reconsidered a denied claim because of a provider error, the claim will appear in the database as being paid late with no interest being paid. The Company's Galaxy system data captures only the original receipt date, and the paid date. The system does not provide the specifics of when additional information was received and why the interest was not paid." The examiners and the Company were in agreement that these findings are grounded in statistics rather than individual file examination. The examiners therefore presented these findings as "exceptions" to N.J.S.A. 26:2J-8.1d(7) and N.J.A.C. 11:22-1.6(c), rather than as "errors," as described in the introduction to this report.

IV. ANTI-FRAUD COMPLIANCE REVIEW

A. INTRODUCTION

N.J.A.C. 11:22-3.10 requires a company to implement an anti-fraud system which must be approved by the Department of Banking and Insurance's Division of Anti-Fraud Compliance. **N.J.A.C. 11:22-3.10(b)** requires this system to be capable, at a minimum, of the following:

1. Screening all claims, pre-payment and/or post-payment, for data patterns associated with fraudulent activity;
2. Responding to all audit-specific inquiries to facilitate fraud investigations;
3. Identifying phantom vendors, employees, patients and providers;
4. Identifying inappropriate or inconsistent charges;
5. Scanning provider claims for unnecessary and repetitive charges. The examiners asked the Company for a copy of the program they submitted to the Department for approval.

B. EXAMINERS' FINDINGS

The examiners conducted a review of the Company's fraud detection and prevention system, finding that it complied with provisions of **N.J.A.C. 11:22-3.10(b)** as follows:

1. Screening all claims for patterns of fraud - **N.J.A.C. 11:22-3.10(b)1**.

To achieve compliance with this requirement, the Company utilized a database tool during the examination period (7/1/02 – 6/30/03) called the "Integrity Database." This database listed medical providers who have been investigated for questionable billing practices. It contained pertinent information regarding the providers, including provider address, sources of information, information codes, investigator comments, and investigator case history experience. The Company used the database to identify medical providers who could have, based upon prior experience, submitted questionable claims.

2. Responding to all audit specific inquiries to facilitate fraud investigations - **N.J.A.C. 11:22-3.10(b)2**.

United Healthcare used an "SIU Database" to collect and retain all information pertaining to investigation-related materials. This was a case-tracking database that contained data on medical providers, members and incidents of fraud and misrepresentation that were previously investigated. The database served as a source of information to facilitate fraud investigation.

3. Identifying phantom vendors, employees, patients and providers - **N.J.A.C. 11:22-3.10(b)3**.

Another tool utilized by the Company to implement fraud detection and prevention initiatives was use of a software program called "Pro-View." This system is used to review past claim histories to determine the existence of irregular or suspicious claim patterns. In this system, the Company stores data in claims for services that providers previously rendered. UHC then categorizes providers by specialty and region, and then examine their billing practices to determine which they utilized most frequently, and whether there were any patterns of irregular or suspect billing. From this information, UHC develops a report that identifies any suspect billing patterns. In addition, the Company used another system called "Pro-Spect." This system identifies all existing and new providers who are added to the Company's network of physicians. Furthermore, "Pro-Spect" enables the Company to detect and combat fraudulent use of provider tax identification numbers. When non-contracted physicians in high-risk locations were new to the Company's system or were submitting any type of change, their names were processed through this system. It provided validation for any change requests submitted by providers. "Pro-Spect" also had the capability of identifying common fraud schemes, such as those involving the submission of phantom claims, the use of stolen member identification, or the use of non-existent provider addresses.

UHC also utilized an internal database called the "Red Folder Database" that contains information on questionable providers with a history of submitting suspicious billing. The Company explained that a provider's inclusion in the database was not used as an automatic denial of their claims, but rather as a "flag" to closely monitor the provider's billing.

4. Identifying inappropriate or inconsistent charges – **N.J.A.C. 11:22-3.10(b)4**

As described above, UHC used its "Pro-View" system to identify questionable charges submitted by providers. Had the system identified questionable billing, then it would have "flagged" the provider. Subsequently, any bills received by the Company from the provider would be identified and examined by Company representatives prior to payments.

5. Scanning provider claims for unnecessary and repetitive charges – **N.J.A.C. 11:22-3.10(b)5**

United Healthcare also utilized the "Pro-View" system to identify questionable charges that appear to be unnecessary and/or repetitive.

C. SOURCES OF INFORMATION

UnitedHealthcare also utilized several additional sources of information. The sources included the following:

- Tips from providers, enrollees, other insurers, and the general public.

- Referrals from United Healthcare claims representatives, medical management, medical claim review staff, and medical directors.
- Involvement with the National Healthcare Anti-Fraud Association.
- Local and federal law enforcement agencies, as well as the New Jersey Department of Banking and Insurance.

V. RECOMMENDATIONS

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

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

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

A. GENERAL INSTRUCTIONS

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

On claims reopened 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 you interest relating to a previously submitted claim or claims/improperly denied a prior mandated benefit claims/improperly paid your claim at the out-of-network rate/failed to pay interest on your claim). 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."

B. UTILIZATION MANAGEMENT APPEALS, COMPLAINTS, AND PROVIDER APPEALS

1. The Company should advise personnel in writing who produce Provider Contracts that **N.J.A.C. 11:22-1.8(a)** requires a company to describe the

Provider Appeal mechanism in the Provider Contract. A specimen copy of the revised contract should be provided to the Commissioner for review prior to implementation.

2. UnitedHealthcare should advise personnel in writing who produce Provider Contracts that **N.J.A.C. 11:22-1.8(b)2** requires a company to describe the external Alternate Dispute Resolution mechanism in the Provider Contract. A copy of the revised contract should be provided to the Commissioner for review prior to implementation.

3. The Company should advise all personnel in writing who process Provider Appeals that **N.J.A.C. 11:2-17.12(b)** and **(c)** require insurers to maintain detailed documentation in each claim file to permit reconstruction of the claims settlement process. Such documentation includes any Provider Appeal letters, final internal decision letters, and all documents that the Company processes as part of its Provider Appeal mechanism.

4. UnitedHealthcare should advise all personnel in writing who process Provider Appeals that **N.J.A.C. 11:22-1.8(a)2i** through **v** require companies to issue final internal decision letters that contain the following documentation:

   i. The names, titles and qualifying credentials of the persons participating in the internal review;

   ii. A statement of the participating provider's grievance;

   iii. The decision of the reviewers' along with a detailed explanation of the contractual and/or medical basis for such decision;

   iv. A description of the evidence or documentation which supports the decision;

   v. If the decision is adverse, a description of the method to obtain an external review of the decision.

5. The Company should advise all personnel in writing who prepare annual reports that **N.J.A.C. 11:22-1.8(d)** requires a company to submit an annual report to the New Jersey Department of Banking and Insurance indicating the number of internal and external appeals received and how they were resolved.

6. UnitedHealthcare should advise all personnel in writing who process Provider Appeals and Consumer Complaints that:

   i. **N.J.A.C. 8:38-8.5** requires a company to respond to Stage 1 Utilization Management Appeals within five business days.

   ii. **N.J.A.C. 8:38-8.6(d)** requires a company to respond to a Stage 2 Appeal within 20 business days.

   iii. **N.J.A.C. 11:2-17.6(d)** requires a company to respond to a Department of Banking and Insurance claim-related complaint within 15 working days.

   iv. **N.J.A.C. 8:38-3.7(a)4** requires a company to respond to directly received complaints within 30 calendar days.

v. **N.J.A.C. 11:22-1.8(a)**2 requires a company to respond to a provider appeal within 10 business days.

C. CLAIMS

7. UHC should remind all personnel who process claims that:

   i. **N.J.S.A. 17B:30-13.1d** and **f** require a reasonable investigation before denying a claim, and that **N.J.A.C. 8:38-13.5(a)** makes this provision applicable to the operations of an HMO;

   ii. **N.J.A.C. 11:2-17.8(i)** requires a company to pay a claim when it is reasonably clear that full or partial benefits are payable.

   iii. **N.J.S.A. 26:2J-4.4** requires the Company to cover medical services for mammograms, that **N.J.S.A. 26:2J-4.10** and **N.J.A.C. 8:57-8.3** require a company to cover medical services for childhood screening and immunization, that **N.J.S.A. 26:2J-4.20** and **Bulletin 01-06** (5/25/01) require a company to cover medical services for biologically-based mental illness, and that **N.J.S.A. 26:2J-4.24** requires a company to cover medical services for colorectal surgery.

   iv. **N.J.S.A. 26:2J-8.1d(6)** and **N.J.A.C. 11:22-5(a)1** and **2** require a company to pay claims within 30 days (if electronic) or 40 days (if mailed) following receipt by the payer of required documentation in support of an initial claim submission. The Company should also remind such personnel that **N.J.A.C. 11:22-1.5(b)** states, "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."

8. UHN must reopen and pay, with interest, the 15 mandated benefit claims that were erroneously denied as identified in Section III.C.1 of this report. The Company must provide a summary report that itemizes the disposition of each claim, including status (e.g., paid, compromised, ineligible and reason therefor), amount billed, amount paid, provider name.

9. UHN must reopen and pay with interest, the 5 random sample and 10 select sample claims that were paid at the out-of-network rate as identified in Section III.C.4 of this report. In addition, UHC must open and review all claims processed with remark code NI during the period July 1, 2002 through the present in order assure that these claims are paid at the in-network level. The Company should provide the same summary report that is described in recommendation 9 above.

10. Based on the high interest exception ratio outlined in Section III.D.3, UHC should review all claims that were paid late and where interest was not provided in order to determine if interest payments are owed to providers. The period reviewed should include July 1, 2002 through the present. The

Company should provide a summary report that lists all claims reviewed, disposition, amount owed, amount paid and date of payment.

11. The Company should remind all personnel who process claims that **N.J.S.A. 17B:30-13.1n** requires a reasonable explanation of the basis in an insurance policy for a claim denial, and that **N.J.A.C. 11:2-17.8(a)** requires a company to refer to contract language when denying a claim, and to explain how the language is operative.

12. UHC should remind all personnel who process claims that **N.J.S.A. 17B:30-13.1e** and **N.J.A.C. 11:22-1.6(a)** require a company to deny an electronically submitted claim within 30 days, and a mailed claim within 40 days.

13. The Company should remind all personnel who process claims that **N.J.A.C. 8:38-15.3** requires a company to submit its provider contract to the Department of Banking and Insurance for approval, and that the Company must adhere to the contract once approved by the Department. Since UHC's approved contract establishes a schedule of payments to participating providers, the Company must adhere to that schedule and not deny claims with Code "NI" when the provider is participating.

14. UHC should remind all personnel who process claims that **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. This information must appear on databases that the Company supplies to the Department and which recount the Company's total business activity during any given period of time.

15. United Healthcare should remind all personnel who process claims that **N.J.S.A. 26:2J-8.1d(7)** and **N.J.A.C. 11:22-1.6(c)** require a company to pay simple interest of 10% per annum on electronic claims not paid within 30 days, and on mailed claims not paid within 40 days.

APPENDIX A

MANDATED BENEFITS IDENTIFIED BY CODES			
Authority	**Mandated Benefit**	**CPT**	**ICD**
N.J.S.A. 26:2J-4.1 N.J.A.C. 8:38-5.6	Treatment of Wilm's Tumor		189.0
N.J.S.A. 26:2J-4.8	Benefits for certain Cancer Treatment – dose intensive chemotherapy & autologous bone marrow transplants	38241 38204 38205 38206 38207 38208 38209 38210 38211 38212 38213 38214 38215 38230 38241 38242	
N.J.S.A. 26:2J-4.4	Mammogram Examination Benefit	76092 76085 76090 76091 G0202 G0204 G0206	
N.J.S.A. 26:2J-4.9 N.J.A.C. 8:38-5.2(a) 3i	48 hrs in-patient coverage for Vaginal delivery	REV CODES 120 122 130 132 110 112 140 142 200 150 152 170- 179 160 PLACE OF SERVICE IH/21	V30.00 V30.1 V30.2 V31.00 V31.1 V31.2 V32.00 V32.1 V32.2 V33.00 V33.1 V33.2 V34.00 V34.1 V34.2 V35.00 V35.1 V35.2 V36.00 V36.1 V36.2 V37.00 V37.1 V37.2 72.0 72.1 72.2 72.3 72.4 72.5 72.51 72.52 72.54 72.6 72.7 72.71 72.79
N.J.S.A. 26:2J-4.9 N.J.A.C. 8:38-5.2(a) 3i	96 hrs in-patient coverage for vaginal delivery	REV CODES 120 122 130 132 110 112 140 142 200 150 152 170- 179 160 PLACE OF SERVICE IH/21	V30.01 V31.01 V32.01 V33.01 V34.01 V35.01 V36.01 V37.01 74.0 74.1 74.2 74.4 74.99
N.J.S.A. 26:2J-4.10 N.J.A.C. 8:57-8.1	Child Screening and Immunizations, Blood Lead, Screening for hearing loss (PL 2001, c.337) Childhood Immunization Insurance Coverage	83655 92551 90702 90708 90705 90706 90371 90633 90634 90669 90585 90586 90645 90646	984.9

APPENDIX A
MANDATED BENEFITS IDENTIFIED BY CODES
(continued)

Authority	Mandated Benefit	CPT	ICD
	Child Screening and Immunizations (continued)	90647 90648 90659 90660 90732 (no claims for children under age 2) 90675 90676 90680 90700 90701 90703 90704 90707 90712 90713 90716 90719 90720 90721 90723 90733 90744 90748 90471 90472 90473 90474 G0010 G0008 G0009 G0192 90287 90296 90288 90291 90371 90281 90283 90375 90376 90378 90379 90384 90385 90386 90389 90399 90393 90396 90780 90781 90782 90783 90784 C9105 J1670 J1563 92585 92586 92587 92588 92589 90657	
N.J.S.A. 26:2J-4.11 N.J.A.C. 8:38-5.4(a) 2	Coverage for Diabetes Treatment (Equipment, Supplies, Self-Management Education)	A4206 A4210 A4211 A4230 A4231 A4232 A4244 A4245 A4246 A4247 A4250 A4253 A4255 A4256 A4258 A4259 E0607 97802 97803 97804 99078 G0108 G0109 E2100 E2101 E0784 S8490 S9455	250.0 250.1 250.2 250.3 250.4 250.5 250.6 250.7 250.8 250.9 648.0 648.8 775.1
N.J.S.A. 26:2J-4.14 Women's Health & Cancer Rights Act of 1998	Re-constructive Breast Surgery, Surgery to Restore and Achieve Symmetry, Prostheses	11920 11921 11922 19316 19350 19357-19396 A4280 L8000 L8001	

APPENDIX A
MANDATED BENEFITS IDENTIFIED BY CODES
(continued)

Authority	Mandated Benefit	CPT	ICD
	Re-constructive Breast Surgery (continued)	L8002 L8010 L8015 L8020 L8030 L8035 L8039 L8220 L8600 S8420 S8421 S8422 S8423 S8424 S8425 S8426 S8427 S8428 S8429 REV CODE 274	
N.J.S.A. 26:2J-4.17	Treatment of Inherited Metabolic Diseases, including medical food and food products	E1399 B4150 B4151 B4152 B4153 B4154 B4155 B4156	270.1 270.2 270.3 270.4 270.5 270.6 270.7 270.8 270.9 271.0 271.1 271.2 271.3 271.4 271.5 271.6 271.7 271.8 271.9 272.0 272.1 272.2 272.3 272.4 272.5 272.6 272.7 272.8 272.9 273.0 273.1 273.2 273.3 273.4 273.5 273.6 273.7 273.8 273.9 274.0 274.1 274.2 274.3 274.4 274.5 274.6 274.7 274.8 274.9
N.J.S.A. 26:2J-4.20 Bulletin 01-06 (5/25/01)	Coverage for Biologically-Based Mental Illness (Mental Health Parity Law PL 1999, c.106)		295.00-295.05 295.10-295.15 295.20-295.25 295.30-295.35 295.40-295.45 295.50-295.55 295.60-295.65 295.80-295.85 295.90-295.95 V11.0 297.0 297.3 297.8 297.9 298.3 298.4 301.0 298.0 290.9 296.03 296.04 296.13 296.14 293.81 293.82 297.1 298.8 298.9 296.00-296.06 296.40-296.46 296.50-296.56 296.60-296.66 296.7 296.80 296.89 293.83 296.20-296.26

APPENDIX A
MANDATED BENEFITS IDENTIFIED BY CODES
(continued)

Authority	Mandated Benefit	CPT	ICD
	Biologically Based Mental Illness (continued)		296.30-296.36 296.82 311 295.70-295.75 300.01 300.21 300.3 301.4 299.00 299.01 299.10 299.11 299.80 299.81 299.90 299.91
N.J.S.A. 26:2J-4.23 N.J.A.C. 8:38-5.4(a) 5 PL 2001, c236 Approved 8/31/2001 eff. 90 days after enactment- 11/30/2001	Reproduction Assisting Technologies – Diagnosis and Treatment of Infertility - Shall include, but not limited to: diagnosis, diagnostic testing, medications, surgery, in vitro fertilization, embryo transfer, artificial insemination, 4 completed egg retrievals	58970 58974 58976 58321 58322 89252 55400 55870 58322 58323 58750 58752 58760 58770 58970 58974 58976 89250 89251 89252 89253 89254 89255 89256 89257 89258 89259 89260 89261 89264 89310 89325 89330	628.0 628.1 628.2 628.3 628.4 628.5 628.6 628.7 628.8 628.9 (Female) 606.0 606.1 606.2 606.3 606.4 606.5 606.6 606.7 606.8 606.9 (Male)
N.J.S.A. 26:2J-4.24	Coverage for the diagnosis and treatment of colorectal surgery	G0104 G0105 G0106 G0107 G0120 G0121 G0122 S0605 45330-45335 45337-45339 45340-45342 45345 45355 45378-45380 45381-45387 45300 45303 45305 45307-45309 45315 45317 45320-45321 45327 82270 82273 82274 74270 74280	

APPENDIX B

PROVIDER APPEALS IN ERROR

Sequence #	Cites*		Sequence #	Cites*
1	1		**192**	2, 4, 5, 6
3	1		**194**	2, 4, 5, 6
7	1		**197**	2, 6
9	1		**200**	2, 6
18	1		**202**	2, 6
19	1		**203**	2, 6
23	1		**204**	2, 6
27	2, 6		**207**	2, 6
28	2, 5, 6		**210**	1
29	1		**211**	1
41	2, 5, 6		**214**	1
49	2, 5, 6		**215**	1
56	2		**218**	2, 6
60	1		**220**	2, 6
65	2		**231**	1
72	1		**232**	2, 6
78	1		**234**	2, 4, 5
79	2		**244**	2, 6
81	2		**251**	2, 4, 6
86	2		**259**	2, 4, 6
87	1		**265**	2, 4, 5
91	1		**277**	2, 4
108	1		**283**	2, 4, 5
109	2, 5, 6		**284**	2, 4, 5
115	2, 5, 6		**290**	2, 4, 5
116	1		**292**	1
119	1		**297**	1
126	2, 5, 6		**299**	1
132	2, 4, 5		**302**	2, 6
136	1		**308**	1
151	2, 4, 5		**310**	2, 6
157	2, 4, 5		**313**	1
159	2, 4, 5		**315**	1
160	1		**316**	2, 6
162	1		**317**	2, 4, 5
169	2, 4, 5		**318**	2, 4, 5
174	2, 4, 6		**319**	2, 4, 5
183	2, 4		**322**	2, 6
187	1		**325**	2, 6
191	1		**344**	2, 6

*Citations Applicable to Provider Appeals in Appendix B

NUMBER	CITE	MEANING
1.	**N.J.A.C 11:2-17.12(b) & (c)**	Requires detailed documentation to be maintained in the claim file, and records of all communications pertinent to the claim.
2.	**N.J.A.C 11:22-1.8 (a) 2i**	Requires the internal review document to contain the names, titles and credentials of persons participating in the review.
3.	**N.J.A.C 11:22-1.8 (a) 2ii**	Requires the internal review document to contain the provider's grievance.
4.	**N.J.A.C 11:22-1.8 (a) 2iii**	Requires the internal review document to contain the reviewer's decision and an explanation of the contractual and/or medical reason for the decision.
5	**N.J.A.C 11:22-1.8 (a) 2iv**	Requires the internal review document to contain a description of the evidence that supports the decision.
6	**N.J.A.C 11:22-1.8 (a) 2v**	Requires the internal review document to describe the method to obtain an external review of an adverse decision.

APPENDIX C

MANDATED BENEFIT CLAIMS IMPROPERLY DENIED (15 FILES IN ERROR)

CLAIM #	FLN	ENGINE	CITE*
0589321475	0222140861	S	1,2,5
0608979171	0227305473	Y	1,2,3
0612040316	0228015724	S	1,2,4
0621974528	0621974528	S	1,2,5
0640945557	0235020431	G	1,2,3
0646806085	0236505370	S	1,2,3
0662084697	0303040642	S	1,2,6
0663093755	0303453682	S	1,2,3
0683915384	0308048920	S	1,2,3
0686549865	0308633992	S	1,2,3
0700046937	0311525763	S	1,2,4
0702862962	0312114719	S	1,2,4
0704673353	0312793441	S	1,2,6
0686039089	0308744844	F	1,2,4
0720622850	0316010049	C	1,2,5

*Citations Applicable to Denied Mandated Benefit Claims in Appendix C

NUMBER	CITE	MEANING
1	N.J.S.A. 17B:30-13.1d	Disallows the denial of a claim without conducting a reasonable investigation based upon all available information.
2	N.J.S.A. 17B:30-13.1f	Requires prompt, fair and equitable settlements of claims in which liability has become reasonably clear.
3	N.J.S.A. 26:2J-4.4	Mandates coverage for one baseline mammogram for women age 35 to 40 and one annual mammogram for women over 40.
4	N.J.S.A. 26:2J-4.10 and N.J.A.C. 8:57-8.3	Mandates coverage for childhood screening and immunization.
5	N.J.S.A. 26:2J-4.20 and Bulletin 01-06(5/25/01)	Mandates coverage for biologically based mental illness.
6	N.J.S.A. 26:2J-4.24	Mandates coverage for colorectal surgery.

APPENDIX D

IMPROPER DENIAL OF MANDATED BENEFIT CLAIMS (11 FILES IN ERROR)

CLAIM #	FLN	ENGINE
589321475	222140861	S
608979171	227305473	Y
612040316	228015724	S
640945557	235020431	G
683915384	308048920	S
662084697	303040642	S
663093755	303453682	S
686039089	308744844	F
686549865	308633992	S
700046937	311525763	S
704673353	312793441	S

APPENDIX E

FAILURE TO PAY PARTICIPATING PROVIDER MANDATED BENEFIT CLAIMS AT IN-NETWORK RATE (RANDOM SAMPLE)

CLAIM #	FLN	ENGINE
640945557	235020431	G
662084697	303040642	S
663093755	303453682	S
686549865	308633992	S
704673353	312793441	S

APPENDIX F

FAILURE TO PAY PARTICIPATING PROVIDER MANDATED BENEFIT CLAIMS AT IN-NETWORK RATE (SELECT SAMPLE)

CLAIM #	FLN	ENGINE
0611714646	0228082204	S
0625978790	0230868844	S
0641029504	0234614990	S
0681091946	0307791555	S
0699186610	0311561705	S
0699486267	0311515864	M
0707920655	0313453003	S
0708062058	0313423944	S
0717718902	0315522711	S
0727054278	0317584286	S

APPENDIX G

FAILURE TO PAY ELECTRONICALLY TRANSFERRED CLAIMS WITHIN 30 DAYS OF RECEIPT.

CLAIM NUMBER	FLN #	ENGINE	RECEIVED	CLOSED	TURNAROUND
0672882212	0305907460	C	2/28/03	4/8/02	405
0514075477	0218231692	S	7/1/02	10/31/02	122
0560007856	0214731660	S	5/27/02	8/3/02	68
0563864133	0215716554	D	6/6/02	9/3/02	93
0585997058	0221328885	S	8/1/02	10/29/02	69
0590911262	0222613819	S	8/14/02	4/6/02	601
0618707942	0229671060	G	10/23/02	1/30/03	99

Average Days to Settle: 208

APPENDIX H

FAILURE TO PAY INTEREST ON CLAIMS PAID LATE.

CLAIM NUMBER	FLN #	ENGINE	RECEIVED	CLOSED	TURNAROUND
0672882212	0305907460	C	2/28/03	4/8/02	405
0514075477	0218231692	S	7/1/02	10/31/02	122
0590911262	0222613819	S	8/14/02	4/6/02	601

Average Days to Settle: 376

VERIFICATION PAGE

I, Dean Turner, am the Examiner-in-Charge of the Market Conduct Examination of Oxford Health Plans (NJ), Inc. conducted by examiners of the New Jersey Department of Banking and Insurance. This verification is based on my personal knowledge as acquired in my official capacity.

The findings, conclusions and recommendations contained in the foregoing report represent, to the best of my knowledge, a full and true statement of the Market Conduct examination of Oxford Health Plans (NJ) Inc. as of June 6, 2003.

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

Date

Dean Turner, F.L.M.I.
Examiner-In-Charge
New Jersey Department
of Banking and Insurance