ORDER NO. E16-95

STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

IN THE MATTER OF:

Proceeding by the Commissioner of Banking and Insurance, State of New Jersey, to fine, suspend and/or revoke CareCentrix of New Jersey, Inc. and CareCentrix, Inc.	))))	CONSENT ORDER

TO: CareCentrix of New Jersey, Inc.
CareCentrix, Inc.
20 Church Street
Suite 1200
Hartford, CT 06103

This matter, having been opened by the Commissioner of Banking and Insurance ("Commissioner"), State of New Jersey, upon information that CareCentrix of New Jersey, Inc. and CareCentrix, Inc. (collectively "CareCentrix"), may have violated various provisions of the insurance laws of the State of New Jersey; and

WHEREAS, CareCentrix of New Jersey, Inc. is a licensed organized delivery system authorized to transact business since December 16, 2011 pursuant to N.J.S.A. 17:48H-13; and

WHEREAS, CareCentrix, Inc. is a certified organized delivery system authorized to transact business since September 18, 1998 pursuant to N.J.S.A. 17:48H-5; and

WHEREAS, N.J.S.A. 17:48H-33.1d(1) provides that an organized delivery system shall remit payment for every insured claim no later than the 30th day following receipt of the claim or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42 U.S.C. 1395u(c)(2)(B), whichever is earlier, if the claim is submitted by

electronic means, and no later than the 40th day following receipt if the claim is submitted by other than electronic means, provided the claim is an eligible claim for a health care service provided by an eligible health care provider to a covered person under the health benefits plan contract or policy, the claim has no material defect or impropriety, there is no dispute regarding the amount claimed, the organized delivery system has no reason to believe that the claim has been submitted fraudulently and the claim requires no special treatment that prevents timely payment being made on the claim under the terms of the health benefits plan contract or policy; and

WHEREAS, N.J.S.A. 17:48H-33.1d (7) provides that an overdue payment of a claim by an organized delivery system shall bear simple interest at the rate of 10% per annum; and

WHEREAS, N.J.S.A. 17:48H-33.1d(2) provides that if all or a portion of a claim is denied because the claim is an ineligible claim, the claim is incomplete because the required substantiating documentation has not been submitted, the diagnosis coding, procedure coding or any other required information to be submitted with the claim is incorrect, the amount claimed is disputed or the claim requires special treatment that prevents timely payment from being made on the claim under the terms of the health benefits plan contract or policy, the organized delivery system shall advise within 30 days of all reasons for denial where all or a portion of the claim is denied, of what substantiating documentation or other information is required to complete adjudication of a claim denied for absence of required substantiating documentation, of the amount disputed where there is a disputed amount claimed, and of the special treatment to which a claim is subject where a claim is denied because it requires special treatment; and

WHEREAS, N.J.A.C. 11:22-1.6(a)1 requires that an organized delivery system notify providers within 30 or 40 days of receipt of a claim of its decision to deny or dispute the claim,

including the identification and explanation of all reasons why the claim was denied or disputed and further states that an organized delivery system 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 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 ; and

WHEREAS, N.J.S.A. 26:2S-9.2 requires that an organized delivery system shall reimburse participating providers in accordance with their contractual fee schedules; and

WHEREAS, N.J.S.A. 17B:30-13.1c defines an unfair claim settlement practice to include failing to adopt and implement reasonable standards for the prompt investigations of claims arising under insurance policies; and

WHEREAS, N.J.S.A. 17B:30-13.1d defines an unfair claim settlement practice to include refusing to pay claims without conducting a reasonable investigation based upon all available information; and

WHEREAS, N.J.S.A. 17B:30-13.1f defines an unfair claim settlement practice to include not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonable clear; and

WHEREAS, N.J.S.A. 17B:30-13.1n defines an unfair claim settlement practice to include 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; and

IT APPEARING that, Horizon Healthcare Services, Inc. ("Horizon") entered into an agreement with CareCentrix for the provision of durable medical equipment, orthotics and

prosthetics, home infusion services, home health services, medical foods and diabetic and medical supplies to Horizon commercial members effective July 1, 2015 (the "Agreement"); and

IT FURTHER APPEARING that, under the Agreement CareCentrix contracts with the providers of the above services, providers submit claims to CareCentrix, CareCentrix applies mutually agreed upon systems edits to said claims and sends valid claims to Horizon, Horizon processes the claims and remits payment to CareCentrix, and CareCentrix then pays the providers consistent with Horizon's processing; and

IT FURTHER APPEARING that, the Department has received complaints from providers about CareCentrix's improper denial of claims, failure to promptly pay claims, inaccurate explanation of benefit and remittance advice forms and failure to pay interest on late claims with respect to services provided to Horizon commercial members on and after July 1, 2015; and

IT FURTHER APPEARING that, between July 1, 2015 and March 28, 2016, CareCentrix and Horizon had IT systems related issues that resulted in multiple errors in the processing of certain provider claims under the Agreement, including failure to recognize modifiers used with certain HCPCS codes, failure to recognize some revenue codes used by home health providers, failure to recognize more than one taxonomy code per claim on certain claims, improper and inconsistent direction to home health care providers on how to submit private duty nursing claims and failure to pay more than one home infusion administration per day for the same patient and service, which resulted in approximately 4,500 improper claim denials under insured commercial plans totaling approximately $1.8 million, and also failed to accurately pay interest on certain claims that were paid late; and

IT FURTHER APPEARING that, the various claim processing errors described above are violations of N.J.S.A. 17:48H-33.1d(1), (2) and (7), N.J.S.A. 26:2S-9.2, N.J.S.A. 17B:30-13.1 c, d, f and n and N.J.A.C. 11:22-1.6(a)1; and

IT FURTHER APPEARING that, the claims processing errors have been corrected and appropriate payment, including interest, remitted to affected providers; and

IT FURTHER APPEARING THAT, CareCentrix asserts that Horizon and CareCentrix have engaged in a good faith effort to resolve any and all difficulties with provider claims that have arisen under the Agreement, and that they have continued to address and resolve all such issues with provider claims under the Agreement, and

NOW, THEREFORE, IT IS on this 27th day of SEPTEMBER 2016

ORDERED AND AGREED that, CareCentrix will pay a penalty of four hundred thousand dollars ($400,000), upon its execution of this Consent Order. The payment shall be made through a certified check, attorney trust account check, money order or electronic funds transfer made payable to "State of New Jersey – General Treasury" and shall be sent to Gale Simon, Assistant Commissioner, Department of Banking and Insurance, 20 West State Street, P. O. Box 329, Trenton, NJ 08625-0329; and

IT IS FURTHER ORDERED AND AGREED that CareCentrix will submit a monthly claim report in the format required by Appendix B to N.J.A.C. 11:22-1 for twelve months to Clifton Day, Manager of Market Conduct and Market Analysis, Department of Banking and Insurance, 20 West State Street, P.O. Box 329, Trenton, NJ 08625-0329, by the 45th day after the last day of the reporting month, starting with a report for claims processed in October 2016 and ending with a report for claims processed in September 2017; and

IT IS FURTHER ORDERED AND AGREED that the provisions of this Consent Order represent a final agency decision and constitute a full and final resolution of the matters addressed herein.

Peter L. Hartt
Director of Insurance

Consented to as to Form, Content and Entry:

CareCentrix, Inc.
CareCentrix of New Jersey, Inc.

9/20/16
Date