# Market Conduct Examination

## Horizon Healthcare of New Jersey Inc.
## (A Health Maintenance Organization)

NEWARK, NEW JERSEY

**STATE OF NEW JERSEY**
**DEPARTMENT OF BANKING AND INSURANCE**

Office of Consumer Protection Services

Market Conduct Examination and Anti-Fraud Compliance Section

**Report Adopted: May 20, 2008**

# MARKET CONDUCT EXAMINATION

of

## Horizon Healthcare of New Jersey, Inc.

## (A Health Maintenance Organization)

located in

**NEWARK, NEW JERSEY**

as of

**May 6, 2006**

**BY EXAMINERS**

of the

**STATE OF NEW JERSEY**
**DEPARTMENT OF BANKING AND INSURANCE**

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

**REPORT ADOPTED:**
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# I. INTRODUCTION

This is a report of the Market Conduct activities of Horizon Healthcare of New Jersey, Incorporated (hereinafter referred to as “Horizon” or “the Company”). Authority for this exam is found under **N.J.S.A. 26:2J-18.1** and **N.J.S.A. 17B:30-16**, made applicable to the operations of a health maintenance organization (hereinafter “HMO”) by **N.J.S.A. 26:2J-15b** 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, Veronica Schmitt, Tia Hammond, William Sonntag, and Anthony Cecere.

## A. SCOPE OF EXAMINATION

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**, **N.J.A.C. 11:2-17.6(b) and N.J.A.C. 11:22** et seq., made applicable to the operations of HMOs by **N.J.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 review period for this examination was January 1, 2004 to December 31, 2004 for all random sample and population review datasets. The examiners completed their fieldwork at the Company’s Newark, New Jersey offices from August 15, 2005 to January 27, 2006. 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 benefits laws, and reviewed randomly selected mandated benefit claims. Finally, the examiners reviewed Horizon’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 that the Company handled in error. Each file mishandled or not handled in accordance with applicable statutes is an error, and the examiners cited all such errors in the report. Some files contained one error and others contained several. Even though a file may contain multiple errors, the examiners counted the file only once in calculating the error ratios; however, any file that contains more than one error will be cited more than once in the report. The examiners count a file in error when a company mishandles it or treats an insured 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.

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 Horizon with the opportunity to respond to the examiners' findings and to provide comments on the statutory errors or mishandlings reported herein. On those errors and exceptions with which the Company disagreed, the examiners evaluated the individual merits of each response and considered all comments. In some instances, the examiners did not cite the files due to the Company's explanatory responses. In others, the errors or exceptions remained as cited in the examiners' inquiries.

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

## C. COMPANY PROFILE

Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ), a non-profit organization, is headquartered in Newark, New Jersey. Established in 1932 as Associated Hospitals of Essex County, New Jersey, Blue Cross began service in 1933. In 1936 the plan went statewide and changed its name to Hospital Service Plan of New Jersey (HSP). In 1942 Blue Shield was established as Medical Surgical Plan of New Jersey to cover medical and surgical services.

In 1973, HSP sponsored New Jersey's first Health Maintenance Organization (hereinafter, "HMO") in Trenton. This new HMO was called Medigroup. Today, Horizon HMO is offered by Horizon Healthcare of New Jersey, a subsidiary of Horizon Blue Cross Blue Shield of New Jersey.

Blue Cross and Blue Shield merged in 1986. In 1998 BCBSNJ changed its name to Horizon Healthcare Services, Inc., conducting business as Horizon Blue Cross Blue Shield of New Jersey. The company provides health coverage to approximately 3.1 million people.

Horizon offers managed care, Medicare and traditional indemnity health plans for individuals and groups. The Company also processes claims for subscribers of other Blue Cross Blue Shield Plans and for programs such as Federal Employees Health Benefits Program (FEP).

In addition, Horizon provides HMO coverage through its wholly owned, for-profit Horizon Healthcare subsidiaries. The for-profit subsidiaries owned through Horizon Healthcare Holding Company, a downstream holding company, include: Horizon Healthcare Dental Services, Inc., conducting business as Direct Dental Network, Horizon Healthcare Administrators, Inc., and Horizon Healthcare Insurance Agency, Inc.

Magellan Behavioral Health (formerly Green Spring of New Jersey) performs utilization review management services as a vendor for Horizon. Magellan handles contract holder claims for behavioral health and substance abuse treatment.

## D. IDENTIFYING MANDATED BENEFIT CLAIMS

This examination focused in part on how Horizon 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 10 mandated benefits in Company datasets because they equate to specific Current Procedural Terminology (hereinafter "CPT") codes, International Classification of Diseases (hereinafter "ICD") codes, or Healthcare Common Procedure Coding System (hereinafter "HCPCS") codes. The examiners then acquired random samples from the resulting populations of those 10 mandated benefits.

**Please See Appendix A for 10 Mandated Benefits Examined by Codes**

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

## A. INTRODUCTION

The examiners reviewed Horizon's Provider Appeals, Utilization Management Appeals and Consumer Complaints for compliance concerning claim processing turnaround time and other procedural requirements. The applicable laws include **N.J.S.A. 17B:30-13.1** and **N.J.A.C. 11:22-1.8** (Provider Appeals), **N.J.A.C. 8:38-8.1 et seq.** (Utilization Management Appeals), **N.J.A.C. 11:2-17.6(d)** and **N.J.A.C. 8:38-3.7(a)4** (Consumer Complaints). These laws provide various guidelines and mandates on turn-around time.

The Company processed 11 Provider Appeals, 649 Utilization Management Appeals and 667 Complaints representing 1,327 transactions during the period January 1, 2004 though December 31, 2004.

The examiners requested all 11 Provider Appeals that the Company opened in 2004 in order to evaluate the Company's Provider Appeal process. They found ten in error, which was an error ratio of 91%, an Improper General Business Practice. They also requested specimen copies of provider contracts, amendments, manuals and materials relating to provider appeals. Horizon supplied copies of its Physician, Specialty Provider and Network Hospital Agreements. The Company included copies of its Administrative Policy Manual's "Participating Provider Claim Appeals Process," and its Managed Care Network Office Manual - 2004's section on "Provider Inquiries, Complaints and Appeals."

The examiners also reviewed the Utilization Management and Complaint databases supplied by the Company. The Utilization Management data included Stage 1 and 2 Appeals, while the Complaint information included complaints that the Company received directly and those that DOBI forwarded for handling.

## B. PROVIDER APPEALS

### 1. Failure to Describe an Internal Appeal Mechanism in the Provider Contract - One File in Error

**N.J.A.C. 11:22-1.8(a)** requires a company to describe its internal appeals mechanism in the participating provider contract. During the examining period,

Horizon complied with this regulation by publishing its internal appeals mechanism in a provider contract appendix entitled, "Provider Claim Payment Appeal Process." The National Association of Insurance Commissioners (NAIC) Market Conduct Examiners' Handbook contains Standard 7, which also recommends that the examiners confirm that an HMO has procedures for appeals in compliance with regulations. Contrary to these guidelines, however, Horizon refused to process a provider's written appeal in claim number 04247E0013230, relying on a reason that the Company failed to describe in its appeals mechanism. Advising the provider that, "Unfortunately, the appeal does not qualify for handling under the participating Provider Claim Appeal Process," the Company explained, "Your appeal does not include all necessary documentation required for review." The examiners found that since the Company had not listed this in its Provider Claim Payment Appeal Process as a reason to refuse an appeal, its handling was not in compliance with **N.J.A.C. 11:22-1.8(a).**

The examiners also noted that by refusing to process the appeal, the Company avoided its responsibility under **N.J.A.C. 11:22-1.8(a)** to provide appeal-related information to the appellant. Such information includes, but is not limited to, the names and titles of the persons participating in the internal review [**N.J.A.C. 11:22-1.8(a)2i**], and a detailed explanation of the contractual basis for the decision [**N.J.A.C. 11:22-1.8(a)2iii**].

In addition, Horizon advised the examiners that the Company's request for documentation was, in any case, erroneous. In response to an examiner's inquiry, the Company wrote, "Claim #04247E0013230 denied procedure code 93325 requesting additional information. The claim was then adjusted under claim #04323A02253 to retract the request for additional information."

## 2. Failure to Include Required Elements in Written Decisions of Provider Claim Appeals – 5 Files in Error, Improper General Business Practice.

**N.J.A.C. 11:22-1.8(a)2** lists what elements a company must include in a written decision to respond to a provider claim appeal. They are as follows:

- **i.** The names, titles and qualifying credentials of the persons participating in the internal review;
- **ii.** A statement of the participating providers' 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

In addition, the NAIC Market Conduct Examiners' Handbook contains Standard 7, which recommends that the examiners confirm that an HMO has procedures for appeals in compliance with regulations. Contrary to these rules, Horizon failed to include at least one of the above-listed requirements in five out of

11 appeals that providers submitted to the Company during the examining period. This was a 45% error ratio, and an Improper General Business Practice. The Company agreed with three of the five errors cited. The two claims in which Horizon disagreed with examiners' findings are as follows:

On claim number 04229E0012370, the examiners cited the Company's written appeal decision to a provider. They found that the decision did not contain a detailed explanation of the medical basis for the decision, or a description of the evidence, which are the requirements of **N.J.A.C. 11:22-1.8(a)2iii** and **iv.** Horizon disagreed with this finding, writing, "The medical basis for the decision is the American Society of Anesthesiologists (ASA) Guide, which was referenced in our letter to the provider." The examiners found, however, that the Company referenced the Guide's title without explaining how its contents applied. This was not in compliance with the regulation's requirement that the Company explain the medical basis for the decision, and a description of the evidence that supported that decision.

Horizon also disagreed with the examiners' finding that it had not complied with **N.J.A.C. 11:22-1.8(a)2iv** in its decision of the appeal for claim number 04365A01365. In that decision, the Company reversed its claim denial and issued an adjusted payment, but did not respond to the appeal letter with evidence of the payment. This left the claimant without information specific to the benefit determination, including information with which to decide whether to appeal further. Horizon disagreed with this finding, writing, "The appeal for (member's name) was adjusted for payment and, therefore, did not require supporting evidence." However, since the regulation's requirement of supporting documentation did not make an exception for appeal decisions that favor the member, the examiners found that the regulation required a copy of the adjusted payment to accompany the written appeal decision.

In addition, the examiners found that the Company's response indicated typical handling of such an appeal, and it was therefore an Improper General Business Practice.

**Please See Appendix B for a list of the 5 Appeal Decisions in Error**

### 3. Failure to Communicate a Written Decision to a Provider within 10 Business Days of Receipt of an Appeal – Four Files in Error

**N.J.A.C. 11:22-1.8(a)2** requires a company to communicate the results of an internal appeal review to a provider/appellant within 10 business days of receipt of an appeal. In addition, the NAIC Market Conduct Examiners' Handbook contains Standard 7, which recommends that examiners confirm that an HMO has procedures for appeals in compliance with regulations. Horizon was not in compliance with these rules in four appeal files out of a total of 11, for a 36.4% error ratio.

Horizon disagreed with the examiners' findings in one of the four files in error. In the appeal for claim number 04140A01116, the Company stated that it had received the appeal on October 29, 2004 and communicated the results of its review

on November 9, 2004, for an eight-day turnaround. However, the examiners noted the Company's date stamp on the appeal. It read, "Received Oct 25 2004 Provider Service Executive Inquiry." Based on the date stamp, the examiners calculated a turnaround of 11 business days.

**Please See Appendix C for a List of the Four Appeals in Error**

### 4. Failure to Submit to DOBI the Number of Provider Appeals Received and How They Were Resolved - Three Files in Error

**N.J.A.C. 11:22-1.8(d)** requires an HMO to submit an annual report to the Department indicating the number and resolution of internal and external appeals that a company received. Contrary to this regulation, the examiners found that Horizon did not report three appeals that the Company received in 2004 but did not close until 2005. These were appeals for claim numbers 04365A00633, 04365A01439 and 04365A01365. The Company agreed with the examiners' findings in the three files, and agreed to follow the prescribed format for the Annual Report in the future.

## C. UTILIZATION MANAGEMENT APPEALS

### 1. Failure to Respond to Utilization Management Appeals within Required Time Frames - 8 Exceptions

**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 an HMO to respond to a Stage Two Appeal within 20 business days. The examiners queried the database of Utilization Management cases that the Company provided, and found a 1.07% exception ratio as illustrated in the following chart:

| | Population | Exceptions | Exception Ratio |
|---|---|---|---|
| **UM Stage 1** | 649 | 8 | 1.23% |
| **UM Stage 2** | 101 | 0 | 0.00% |
| **Totals** | 750 | 8 | 1.07% |

The Company agreed with the examiners' findings in this chart.

**Please See Appendix D for a List of the 8 Exceptions**

## D. CONSUMER COMPLAINTS

### 1. Failure to Respond to Direct and Department of Banking and Insurance Claim Complaints within Required Time Frames- 85 Exceptions

**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. In addition, **N.J.A.C. 8:38-3.7(a)4** requires a 30-calendar day response to directly received complaints. The examiners queried the database of Utilization Management cases that the Company provided, and found an overall exception ratio of 12.74% as follows:

| | Population | Exceptions | Exception Ratio |
|---|---|---|---|
| **Direct Complaints** | 556 | 82 | 14.74% |
| **DOBI Complaints** | 111 | 3 | 2.70% |
| **Totals** | 667 | 85 | 12.74% |

The Company agreed with the examiners' findings in this chart.

**Please See Appendix E for a List of the 85 Complaint Exceptions**

# III. PROVIDER CLAIM REVIEW

## A. INTRODUCTION

The examiners queried databases of mailed and electronic claims that Horizon received during the examining period (January 1, 2004 through December 31, 2004). In that time, the Company processed 1,402,942 claims. This total included 407,541 mailed and 995,401 electronic claims. Itemized differently, the total contained 985,880 paid and 417,062 denied claims. In arriving at the populations, the examiners requested the Company to exclude all Medicare, Medicaid, federal employee health benefit plan (FEHBP) and ERISA claims.

The examiners reviewed the population to verify compliance with statutory and regulatory guidelines regarding prompt claim payments and denials. Horizon supplied the examiners with databases for each of the following: Paid Mandated benefits (56,995 claims), Paid Non-Mandated benefits (928,885 claims), Denied Mandated benefits (19,012 claims), and Denied non-Mandated benefits (398,050 claims).

In reviewing these claims, the examiner checked for compliance with statutes and regulations that govern the handling of claims, particularly **N.J.S.A. 26:2J-8.1** et seq. ("HINT" – the Health Insurance Network Technology Act). They also checked for compliance with **N.J.A.C. 11:22** et seq. (Prompt Payment of Claims), **N.J.S.A. 17B:30-13.1** and **N.J.A.C. 11:2-17.1** et seq. (Unfair Claim Settlement Practices Act), and the NAIC Market Conduct Examiners' Handbook, Chapter XVII, *Conducting the Health Examination*. That chapter includes the requirements of 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, 55,57,5, 59, 60, 62, 63** and **66**. HMOs must provide these coverages to the same extent as for any other covered illness or injury.

## 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 ten mandated benefits that produced reliable populations because they equate to specific ICD, CPT, and HCPCS codes. This section reports results of randomly selected samples derived from these populations.

The examiners reviewed 109 denied mandated benefit claims from a population of 19,012, and a sample of 105 paid mandated benefit claims from a population of 56,995. The following chart displays all of the errors from Mandated Benefit claims that the examiners found during this review:

**Mandated Benefits**

| | Random Sample | Errors | Error Ratio |
|---|---|---|---|
| **Paid Mandated** | 105 | 20 | 19.05% |
| **Denied Mandated** | 109 | 41 | 37.61% |
| **Total** | 214 | 61 | 28.50% |

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 14.02% as follows:

**Mandated Benefits**

| | Random Sample | Error | Error Ratio |
|---|---|---|---|
| **Paid Mandated** | 105 | 18 | 17.14% |
| **Denied Mandated** | 109 | 12 | 11.01% |
| **Total** | 214 | 30 | 14.02% |

ii. Non-Mandated Benefits

The examiners' prompt pay review of Non-Mandated Benefit claims revealed an error ratio of 7.23%, as follows:

### Non-Mandated Benefits

| | Random Sample | Error | Error Ratio |
|---|---|---|---|
| **Paid Non-Mandated** | 116 | 5 | 4.31% |
| **Denied Non-Mandated** | 119 | 12 | 10.08% |
| **Total** | 235 | 17 | 7.23% |

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

### a. Population Review, Mailed Paid Claims

| | Population | Exceptions | Exception Ratio |
|---|---|---|---|
| **Mandated Mailed Paid** | 25,820 | 2,338 | 9.05% |
| **Non-Mandated Mailed Paid** | 230,774 | 34,153 | 14.80% |
| **Total** | 256,594 | 36,491 | 14.22% |

The examiners queried populations of Mandated and Non-Mandated Benefit claims for the examining period (January 1, 2004 through December 31, 2004). As noted, Horizon's overall prompt pay exception rate was 14.22%.

### b. Population Review, Electronic Paid Claims

| | Population | Exceptions | Exception Ratio |
|---|---|---|---|
| **Mandated Electronic Paid** | 31,175 | 3,924 | 12.59% |
| **Non-Mandated Electronic Paid** | 698,111 | 82,651 | 11.84% |
| **Total** | 729,286 | 86,575 | 11.87% |

Horizon's population of 729,286 electronically paid claims contained 86,575 prompt pay exceptions. This was an 11.87% exception ratio, with little difference in ratios between mandated and non-mandated claims (12.59% and 11.84%, respectively).

### c. Summary of Mailed and Electronic Paid Claim Population Review

As the preceding charts show, the examiners cited Horizon with an overall exception ratio of 14.22% on mailed claims and an 11.87% exception ratio on electronically submitted claims. The Company's prompt pay exception ratio was lower for electronic claims than for mailed claims, 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** | 9,137 | 687 | 7.52% |
| **Non-Mandated Mailed Denied** | 141,810 | 17,510 | 12.35% |
| **Total** | 150,947 | 18,197 | 12.06% |

The examiners queried the entire population of denied mailed claims for the examining period (January 1, 2004 through December 31, 2004). As the examiners note above, Horizon's mailed denied claim exception ratio was 12.06%.

e. Population Review, Electronic Denied Claims:

| | Population | Exceptions | Exception Ratio |
|---|---|---|---|
| **Mandated Electronic Denied** | 9,875 | 1,426 | 14.44% |
| **Non-Mandated Electronic Denied** | 256,240 | 35,844 | 13.99% |
| **Total** | 266,115 | 37,270 | 14.01% |

The Company's population of 266,115 electronically denied claims contained 37,270 exceptions. This was a 14.01% exception ratio, with little difference in ratios between mandated and non-mandated claims (14.44% and 13.99%, respectively).

f. Summary of Mailed and Electronic Denied Claim Population Review

The results of this analysis indicate similar results between denied claims that claimants submitted through regular mail and those they submitted electronically. The exception ratios were 12.06% and 14.01% respectively. The examiners found little difference between paid and denied mandated and non-mandated claims that were submitted electronically or by mail.

## C. EXAMINERS' FINDINGS – PAID CLAIMS

### 1. Failure to Pay Electronically Transferred Claims Within 30 Calendar Days – 18 Random Errors.

**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 of the claim. In addition, the NAIC Market Conduct Examiners' Handbook contains Standard 3, which recommends that examiners confirm the timely settlement of claims required by statutes, rules and regulations. Contrary to the above-stated regulations, Horizon failed to process 18 claims within the required time frame in the random sample of 175 paid electronic claims. This was a 10.28% error ratio.

**Please See Appendix F for a List of the 18 Claims in Error**

The examiners' queries of electronic paid claim databases for late handling of claims resulted in an 11.87% exception ratio, reported in section III.B.2.b above. That was 1.59 percentage points higher than the random error ratio of 10.28% in this sample.

The Company disagreed with the examiners' findings in one of the randomly selected claims. In claim number 0425A01362, the Company wrote, "The claim originally denied correctly for no referral because the referral that was on file, N15345276, was submitted with the name of the facility instead of the name of the rendering provider. Subsequently, there was an administrative decision to pay the claim and the claim was adjusted under #04252A01362... Therefore, Horizon does not agree that it is not in conformity with the mandate." However, the examiners found that the original claim could have been paid within the required time frame because the provider was cross-referenced under the name of the facility. The examiners found that the Company's failure to make the cross-reference when it processed the claim caused the delay.

## 2. Failure to Pay Mailed Claims within 40 Calendar Days – 7 Random Errors

**N.J.S.A. 26:2J-8.1d(1)** and **N.J.A.C. 11:22-1.5(a)2** require a company to pay mailed claims within 40 calendar days of receipt. In addition, the NAIC Market Conduct Examiners' Handbook contains Standard 3, which recommends that the examiners confirm the timely settlement of claims required by statutes, rules and regulations. Contrary to the above-stated requirements, Horizon failed to process seven claims in the random sample of 46 paid mailed claims within required time frames. This was a 15.22% error ratio, which was one percentage point higher than the exception ratio of 14.22% in the mailed paid claim database, reported in section III.B.2.a. above.

**Please See Appendix G for a List of the 7 Claims in Error**

The Company disagreed with the examiners' finding in claim number 04209A04710. Horizon wrote, "Claim #03237000534 was received on 8/25/03 and paid incorrectly on 9/4/03. The claim was paid within the 40-day turn-a-round time. The claim was then adjusted under claim #04209A04710 to reduce the amount of the payment..." The examiners found that since the Company erred in originally processing the claim it caused the delay, and the total turnaround time as it appears in Appendix G is correct.

## 3. Failure to Pay Interest on Overdue Claims – Six Random Sample Errors and 1,405 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 interest in the amount of ten percent per annum on overdue claims. Contrary to these requirements, Horizon failed to pay interest on six overdue claims in a random sample population of 34 claims that were either improperly denied or paid late. This was a 17.65% error ratio.

The Company repeated its disagreement with the examiners' findings in claim numbers 04252A01362 and 0436E0008609. The examiners review those positions, and their findings, in section III.C.1 above.

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

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

| | Late Payments | No Interest | Exception Ratio |
|---|---|---|---|
| **Non-Mandated Electronic** | 82,651 | 1,031 | 1.25% |
| **Non-Mandated Mailed** | 34,153 | 325 | 0.95% |
| **Mandated Electronic** | 3,924 | 24 | 0.61% |
| **Mandated Mailed** | 2,338 | 25 | 1.07% |
| **Total** | 123,066 | 1,405 | 1.14% |

## D. EXAMINERS' FINDINGS – DENIED CLAIMS

### 1. Failure to Deny Claims With Specific Reference to a Policy Provision – 47 Random Files in Error, 47,433 Database Exceptions, and 3 Improper General Business Practices.

N.J.S.A. **17B:30-13.1n** and N.J.A.C. **11:2-17.8(a)** require a company to provide a specific reference to the language of policy provisions and a statement of the facts which make the language operative when the company is denying claims due to a policy provision. In addition, the NAIC Market Conduct Examiners' Handbook contains Standard 9 which recommends that the examiners confirm that companies handle denied claims in accordance with policy provisions, HIPAA, and state law. Contrary to the above-stated rules, Horizon denied 47 claims from a random sample of 228 denied claims without providing the specific reference to applicable policy provisions and a statement of the facts that make that language operative. This was a 20.61% error ratio.

**Please See Appendix I for a List of the 47 Claims in Error**

The Company disagreed with the examiners' findings in three claims. In claim number 04089E9000126, the Company used Denial Code 1008, which printed the message, "Services are excluded from your benefit plan." The examiners found that this message lacked the specificity required by the statute and the regulation. In its disagreement, the Company wrote, "Members receive specific information regarding their benefit plan, including information on exclusions. And, since the message referenced clearly states that the services are excluded from the member's benefit plan, there is a direct connection to the policy provision. We therefore, disagree with the examiner's finding." However, the examiners found that the Company's reference to the benefit plan was too general, and did not meet the requirement of specificity.

The examiners asked Horizon to report the number of times that it had used message code 1008 during the examining period (January 1, 2004 to December 31, 2004). The Company reported that it had used the message 47,433 times. The frequency of such usage constitutes an Improper General Business Practice.

The Company also disagreed with the examiners' finding in claim number 04260000002. In that claim, the Company used Edit Code 175, which in turn printed denial message 8001. That message read, "Bill type invalid for type of claim submitted." The examiners again found that this message lacked specificity, as it did not reference applicable policy language. In disagreeing with this finding, Horizon wrote, "Horizon disagrees that use of edit code 175 is an Improper General Business Practice. Because there is no member liability, we are not explaining an adverse benefit determination to the member. The EOB, therefore, is only informational to the member. A similar message is sent to the provider who is responsible for taking the appropriate action." However, the examiners' review of the statue and the regulation revealed no exceptions for denial messages that were informational to the member, and no exceptions for messages sent to providers. The Company reported that it had used denial message 8001 a total of 897 times during the examining period. The frequency of such usage constitutes an Improper General Business Practice.

Horizon also disagreed with the examiners' finding in claim number 04012E0006060. In that claim, the Company used Edit Code 611 to deny a doctor's office visit. Edit Code 611 then printed a benefit denial on the EOB with message code 7003. This message read, "The Units on the authorization for these services have already been used." However, Horizon's authorization form number 3095 W0104, in use during the examining period, did not identify the benefit in "units," but rather as, "office visits." A member would therefore not be able to tell by comparing the EOB to the referral why the Company denied the benefit. For this reason, the examiners found that the message did not comply with the statute and regulation's requirement of specificity. In its disagreement, the Company wrote, "Horizon has attempted to follow the HCFA-1500 form. When the form is completed by the providers, item 24g states to enter the number of days or units. Since this field is used for multiple visits, units of supplies or anesthesia minutes, we have tried to simplify the wording by using units. Units is more generic than days. Days can only apply to visits, but units can apply to a broader range. Horizon disagrees that use of this denial explanation is unreasonable." The examiners found that this explanation did not address the difference that the Company created between its EOB and its referral form. They also reviewed form 1500 on the website of the Health Care Financing Administration (HCFA), but found no indication that HCFA intended item 24g to be used in conjunction with referrals. The examiners ran queries of denied claim databases, finding 2,154 claims in which the Company generated denial message 7003. The frequency of such usage constitutes an Improper General Business Practice.

In addition, the Company reported to the examiners that it experienced a software failure during the examining period (January 1, 2004 – December 31, 2004). During the period January 1 until August 31, 2004 three denial Edit Codes malfunctioned, and failed to print out any denial message on Member EOBs. The examiners found 39 of these errors in the denied random samples of 228 claims, which was a 17.11% error ratio. These claims appear on Appendix I.

The examiners also ran queries of the database populations to determine how often the Company issued EOBs with no denial explanation during the period of malfunction. The following chart displays the codes, the messages they were

intended to print out, and the number of Mandated and Non-mandated denied claims they effected:

| Edit Code | EOB Message | Mandated | Non-Mandated |
|---|---|---|---|
| 201 | Patient not enrolled on date(s) of service on claim. | 1,706 | 30,684 |
| 366 | Claim has been denied for Workman's Compensation. | 11 | 434 |
| 915 | The onset date of patient's condition is required. This information is required from the provider or the claim will be denied. | 714 | 4,726 |
| | **Totals** | 2,431 | 35,844 |

## 2. Failure to Deny Claims within 30 Calendar Days if Electronically Transferred or Within 40 Days if Mailed – 20 Files in Errors

**a**. **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 transferred claim within 30 calendar days from receipt. In addition, the NAIC Market Conduct Examiners' Handbook contains Standard 9, which recommends that the examiners confirm that companies handle denied and closed-without payment claims in accordance with policy provisions, HIPAA, and state law. The examiners found that Horizon did not conform to these rules in 14 randomly selected files in the population of 163 claims, which was an 7.36% error ratio. This was 6.65 percentage points less than the 14.01% exception ratio in the database population queries that the examiners report in section III.B.2.e above.

**Please See Appendix J for a List of the 12 Files in Error**

**b**. **N.J.S.A. 17B:30-13.1e** and **N.J.A.C. 11:22-1.6(a)** also require a company to deny a mailed claim within 40 calendar days of receipt. Contrary to this rule, Horizon failed to process eight denied claims within the required time frame in a random sample of 65 claims. This was a 12.31% error ratio. That compares with a 12.06% exception ratio in the database queries that the examiners report in section III.B.2.d above, which was a difference of 0.25 percentage points.

**Please See Appendix K for a List of the Eight Files in Error**

Horizon disagreed with the examiners' findings in one claim. In claim number 04153A02022, the Company kept a claim matter open by mistakenly sending a duplicate payment to a provider, and then debiting the provider's account for its error. The examiners counted the additional time it took to clear the debit from the account as part of the claim turnaround, as the benefit that the claim represented was not paid until the debit was cleared. In disagreeing, the Company responded to an examiner's inquiry by writing, "The claim was adjusted on 6/1/04 under claim number 04153A02022 to correct the members' claim history." However, the examiners found that since the correction was also an accounting change in addition to a claim history change, it should be counted in the overall turnaround time. The settlement period on this claim was 153 calendar days.

## 3. Failure to Effectuate Fair and Equitable Settlements of Claims in Which Liability Has Become Reasonably Clear – 23 Files in Error

**N.J.S.A. 17B:30-13.1d**, **N.J.S.A. 17B:30-13.1f** and **N.J.A.C. 11:2-17.8(i)** require a company to deny claims fairly after conducting reasonable investigations based upon all available information. In addition, the NAIC Market Conduct Examiners' Handbook contains Standard 9, which recommends that the examiners confirm that companies handle denied claims in accordance with policy provisions, HIPAA and applicable state law. Contrary to these rules, Horizon unfairly denied 23 claims in the random samples of 449 claims dispersed within the paid and denied random samples, which was a 5.12% error ratio.

**Please See Appendix L for a List of the 23 Claims in Error**

The Company disagreed with the examiners' findings in four claims. In claim number 04065E9005160, the Company agreed that it had denied the claim in error, but disagreed that the statutes and regulation applied. Horizon wrote, "The claim referenced above, 04065E9005160, was received on 3/4/04, with the same date of service as claim number 03275E00034310. The processor denied the entire claim as a duplicate, instead of the one service line. This was done in error; therefore, the action should not be taken to be unfair." After receiving this disagreement, the examiners reviewed the two statutes and the regulation, finding that they did not contain an exception for denials that were committed in error. Moreover, these requirements specify that a reasonable investigation must precede the denial. It is apparent that the processor denied these claims distinguishing between the service line and the duplicate claim submission.

The Company's disagreements with the examiners' findings in three other claims (numbers 03364E0008757, 04070E901070, and 04106E9006325), were similar to each other. In each case, Horizon agreed that it had denied a previous claim in error. It each case, it denied the random sample claim as a duplicate to the previously denied claim, an action that the examiners found to be unfair. The Company disagreed with this finding, writing in one inquiry response, "When a provider submits the exact same information on another claim with no additional comments or additional information it will deny as a duplicate. The originally received claim was processed prior to the receipt of #04070E9010170, therefore, Horizon does not agree that denying duplicate claims is an unfair claim denial." However, the examiners found that the Company's receipt of a second claim provided a second opportunity to review the erroneous denial and fairly pay the claim, which Horizon failed to do in all three random samples. For that reason, the examiners found that the duplicates were unfair denials within the meaning of **N.J.S.A. 17B:30-13.1d**, **N.J.S.A. 17B:30-13.1f** and **N.J.A.C. 11:2-17.8(i)**.

Among the 23 claims in error were seven that the Company denied when it failed to match them to existing referrals. These seven claims appear on both Appendices M and O, which list, respectively, claims denied unfairly for all reasons and claims denied unfairly when the Company miss-matched an existing referral (the examiners further reference the seven claims in Section III.F.2 below). All other denial reasons are outlined in Appendix M.

## E. EXAMINERS' FINDINGS – COORDINATION OF BENEFITS CLAIMS

### Introduction

**N.J.A.C. 11:4-28.1** was in effect during the examining period (January 1, 2004 to December 31, 2004), enabling a secondary carrier to take into consideration the benefits of the primary plan before issuing payment. On July 11, 2006 **N.J.S.A. 26:2J-8.1d(7)(b)** went into effect, prohibiting an HMO from denying a claim while seeking coordination of benefits (hereinafter "COB") information, unless good cause exists. The statute excludes as reason for "good cause" any routine request to determine if COB is in effect.

The examiners reviewed 31 randomly selected COB claims, and they queried Company databases for data relating to general claim populations.

During this period, Horizon denied 35,802 COB claims, which was 8.58% of the Company's population of 417,062 denied claims. The following chart displays the breakdown between Mandated and Non-Mandated claims:

| | Claim Population | COB Claim Population | Ratio |
|---|---|---|---|
| **Denied Mandated** | 19,012 | 1,939 | 10.20% |
| **Denied Non-Mandated** | 398,050 | 33,863 | 8.51% |
| **Totals** | 417,062 | 35,802 | 8.58% |

### 1. Making an untrue statement – 11 Random Errors

Standard 9 of the NAIC Market Conduct Examiners' health exam handbook requires the examiners to determine if denied claims are handled in accordance with state law. One such law, **N.J.S.A. 17B:30-4**, prohibits a Company from making any untrue statements. Contrary to this guideline, Horizon used a denial message for COB claims that the examiners found to be untrue. The Company advised claimants that their claims were denied because they did not respond to letters requesting COB information, but the Company failed to establish that it had produced the letters. This error was present in 11 of 31 randomly selected COB claims, for an error ratio of 35.5%. The Company provided copies of letters for the remaining 20 files.

**Please See Appendix M for a List of the Eleven Files in Error**

The Company disagreed with this cite. In response to an inquiry in which the examiners cited six of the claims, Horizon wrote, "Applicability of this law would imply that Horizon's errors indicate a general business practice. Because letters were available in the majority of cases, Horizon does not agree that this is a general business practice nor that the Company's inability to locate 6 letters rises to the level of making untrue statements per the statute." However, the examiners did not find a general business practice, finding more narrowly that the Company's failure to produce the eleven letters was evidence that they did not exist.

Also among the 11 errors was claim number 04170000662, in which the examiners found that Horizon intentionally misinformed a member regarding a claim denial. The Company used Denial Code 4006 to advise a member that it denied the claim because the member failed to respond to a letter from the Company requesting COB information. The denial message read in part, "This claim has been denied because Horizon did not receive your response to our coordination of benefits letter." But, unlike other COB letter denial messages, there was a second part to the message in which the Company also requested an Auto Insurance Carrier Explanation of Benefits (hereinafter "EOB").

In response to an examiner's inquiry, the Company acknowledged that it did not send a COB letter to the member. When the examiners found that the denial therefore contained an untrue statement, Horizon relied on the second part of the message to disagree with the cite. The Company wrote, "As stated in Horizon's response to Inquiry 180, EOB message 4006 is a two-part statement. The message is structured in such a way that it cannot be separated – the entire message is produced on the EOB because it is used for other denials in addition to edit 236. The second part of the message states, *'If the service(s) billed on this claim were covered by your auto insurance carrier, submit EOB to complete claim processing'*. Since this claim was related to an auto accident, this EOB message is applicable. For this reason, Horizon disagrees that the message referenced rises to the level of making an untrue statement for the purpose of this statute."

However, the examiners found that the Company was able to re-write the code to separate the two parts of the message. They also found that the message was misleading to the claimant because it caused her to believe she had done something to cause the denial. Since she did not cause the denial, the examiners found the message to be untrue within the meaning of **N.J.S.A. 17B:30-4**.

The examiners also queried the denied claim databases to determine the number of times Horizon used code 4006. The examiners found that the Company denied 224 claims in a population of 35,802 denied COB claims, yielding a ratio of 0.63%.

The examiners also reviewed the databases to determine global COB letter denial volume. Using all denial codes that triggered COB-specific denial messages to claimants, including 4006, the examiners' queries resulted in the following chart of denied claims, divided between Mandated and Non-Mandated claims:

| | COB Claim Population | Denied for No COB Letter Response | Ratio |
|---|---|---|---|
| **Mandated Denied** | 1,939 | 1,871 | 96.49% |
| **Non-Mandated Denied** | 33,863 | 31,044 | 91.68% |
| **Totals** | 35,802 | 32,915 | 91.94% |

Moreover, the examiners noted an anomaly when the Company reported claims it had denied for no letter response. In some examiner inquiry platforms, the

Company reported figures that were consistent with those of the examiners'. When the examiners relied on Company-provided "flags" to extract a population from the databases, however, the count was only 3,053. It increased to 35,802 after the examiners added claims that Horizon denied for a COB-specific reason, but failed to flag on the database. The following chart displays this anomaly:

| | COB Claim Population | Denied for No COB Letter Response | Ratio |
|---|---|---|---|
| **Examiners' Count** | 35,802 | 32,915 | 91.94% |
| **Company-Provided "Flags"** | 3,053 | 183 | 5.99% |
| **Difference** | 32,749 | 32,732 | |

Relying on this data, the examiners concluded that Horizon denied 32,732 claims for lacking letter responses, but in an anomalous manner that later masked their identity as COB claims on the Company's market conduct examination databases. In other words, if the examiners had relied upon data supplied by Horizon, they would have concluded that the population of denied COB claims was 3,053 and that the ratio of denial for no letter response was 5.99%. Instead, the population was ten times that number, and the ratio of denial for no letter response was 91.94%.

## 2. Failure to Document Randomly Selected Claim Files – 11 COB Errors and 1 Other Error.

N.J.A.C. **11:2-17.12(b)** requires an HMO to contain detailed documentation in each claim file in order to permit the examiners to reconstruct the Company's activities relative to the claim. In addition, Standard 6 of the NAIC Market Conduct Examiners' health exam handbook requires the examiners to determine if COB claim handling meets applicable state laws. Also, Standard 5 requires the examiners to determine whether the Company's files are adequately documented. Horizon failed to comply with these standards when it could not produce copies of its requests to members for COB status information in 11 files. The Company also could not produce a copy of a letter requesting medical records in one additional non-COB claim file. Again, the COB claim error ratio was 35.5% (eleven errors in thirty-one random selections).

**Please See Appendix N for a List of the Twelve Files in Error**

One randomly selected claim from this list, claim number 04327E0034129, was not a COB claim, but it is reported here in order to consolidate findings regarding this type of error. The Company agreed with the examiners' cite of this file, and with the eleven remaining files.

The examiners counted these claims only once in determining Horizon's overall error ratio, which was in accord with Chapter 1, Section B of this report, "Error Ratios".

## F. MISCELLANEOUS ERRORS

### 1. Untrue Statements in Non-COB Claims Communications-Four Randomly Selected Files in Error

Previously cited above, **N.J.S.A. 26:2J-15b** makes the unfair trade practice provisions of New Jersey insurance law applicable to HMOs. As the examiners reported, one unfair trade practice statute, **N.J.S.A. 17B:30-4,** prohibits HMOs from making untrue statements in any way. The examiners found that Horizon made factually incorrect and therefore untrue statements in claims communications in two denial code categories during the examining period (January 1, 2004 – December 31, 2004), contrary to the statute. These are addressed below.

a. In the first instance, involving two adjusted claims, Horizon wrote to providers stating that, "This claim has been adjusted because there has been a change in the allowance/rate of reimbursement for this claim." In each case, however, the reason for the adjustment was actually due to Company error in processing the initial claim submissions. In claim number 04187A01078, the Company erred in listing the primary care physician status of the provider, and so underpaid the original claim. In disagreeing that it subsequently used an untrue statement in explaining the adjustment, Horizon wrote, "The original adjudication was based on the PCP status in the system and as a result of correcting the PCP status, the rate of reimbursement changed." However, since the system status of providers was within the control of the Company, the examiners found Horizon to be at fault for the error, and obliged to comply with **N.J.S.A. 17B:30-4** in providing a correct explanation. In claim number 04084300051, the Company erred when it failed to deduct a co-payment, and had to adjust the original claim to retrieve the co-pay. The Company disagreed that it had made an untrue statement when, rather than explaining the error, it stated that the rate of reimbursement had changed. "The original adjudication of the claim did not account for the member's co-payment and the allowed amount was $55.00," the Company wrote. "The claim was subsequently adjusted to apply the $15.00 co-pay, which changed the allowed amount Horizon paid to the provider to $40.00. For this reason, the message is appropriate. Horizon disagrees with the examiner that the EOB message represents an untrue statement." The examiners found, however, that the reason for the adjustment was due to the Company's error in processing the original claim, and that no change in the rate of reimbursement had occurred.

b. The second instance in which Horizon made untrue statements occurred in two claims in the Denied Non-Mandated random sample. In claim number 04049E0009205, the Company made two untrue statements, and in claim number 03339E0000270, it made one. The following chart displays the statements:

| Claim Number | Untrue Statement | Correct Information |
|---|---|---|
| 04049E0009205 | The Company advised the provider, "The disposition of this claim/service is pending further review. Letter to follow containing further information." | The provider in the claim was a radiologist, and Horizon did not mail letters with further information to radiologists. |

| | | |
|---|---|---|
| 04049E0009205 | The Company advised the member, "This claim is being contested. Medical documentation has been requested from the provider. Until a final determination is made, you are not responsible for the charges. This documentation is required from the provider or the claim will be denied." | The Company did not request medical documentation from the provider. |
| 03339E0000270 | The Company advised the member, "The claim submitted requires additional information for processing. This information is required from the provider within 45 days of this notice or the claim will be denied." | The Company did not need or request additional information. |

Horizon disagreed with the examiners' findings in all three statements. In the first statement, the provider was a radiologist, and the examiners made their finding of an untrue statement after the Company advised them that it did not send requests for additional information to radiologists. The Company wrote, "The QBlue claims engine systemically generates additional information request letters to all providers except laboratories, radiologists, and institutions. These provider types are excluded because they are generally not able to submit the documentation required for a pre-existing condition review."

The Company wrote a disagreement to cover the examiners' findings in both untrue statements in claim number 04049E0009205. Horizon wrote, "We apologize for any confusion our response to Inquiry 137 may have created. However, neither this error, nor the fact that we used a generic message for both our member EOB and provider voucher, constitutes false statements. Misstatements made in error do not equate to false statements for the purpose of the statute." However, the examiners did not find an exception in **N.J.S.A. 17B:30-4** for incorrect information that results in untrue statements made in error. The examiners also found that each of the two statements was conspicuous because one advised a provider to expect a letter, and one advised a member that her provider's medical records were needed and subject to inspection when in fact no such request was made to the provider. This finding was central to the examiners' determination that the Company had made untrue statements.

In the third untrue statement, in claim number 03339E0000270, the Company explained, "The processor denied the claim in error. When this was realized, generation of the letter was halted. The processor should have adjusted the claim at that point, but failed to do so. As a result of receiving this inquiry, the claim is being adjusted and interest will be paid." After reviewing this explanation, the examiners then found that the EOB resulting from the processor's error contained an

incorrect and therefore untrue statement – that Horizon required additional information within 45 days or it would deny the claim. The Company disagreed with this finding, writing, "As noted in Inquiry 161, Horizon stated that the claim was denied in error, which generated the EOB message. Horizon does not agree that a misstatement made in error rises to the level of making untrue statements for the purposes of the statute." However, as noted above, the examiners were unable to find an exception in **N.J.S.A. 17B:30-4** for a company's informational errors that result in incorrect statements.

### 2. Failure to Pay a Mailed Claim within 40 Days of Receiving Requested Information- 1 File in Error

**N.J.S.A. 26:2J-8.1(d)** and **N.J.A.C. 11:22-1.5(b)** require a Company to pay a mailed claim within 40 days of receiving requested additional information. Contrary to this statute and regulation, the Company contested claim number 04049E0009205 on March 5, 2004, received the information it needed on August 22, 2005, but did not pay the claim until October 9, 2005. This was a 48-day turnaround, which was not in compliance with the statute and regulation. The Company agreed with this finding.

### 3. Failure to Notify a Provider of the Basis to Dispute a Claim- 1 File in Error

**N.J.A.C. 11:22-1.6(a)** and **(a)2** require a Company to advise a provider of the basis for its decision to dispute a claim. Contrary to these regulations, Horizon failed to notify the provider in claim number 04049E0009205 of the reason why it disputed the claim. The Company disagreed with this finding, writing, "The provider messages that are generated meet ANSI standards and are HIPAA compliant. These standards impose certain limitations regarding specificity."

However, the examiners were unable to locate any provision of HIPAA that prohibited an insurer from advising a provider why it was disputing a provider claim.

### 4. Failure to Document a Paid Claim File- 1 File in Error

As previously reported, **N.J.A.C. 11:2-17.12(b)** requires a company to contain detailed documentation in each claim file in order to permit the Commissioner or his designated examiners to reconstruct the company's activities relative to the claim. Contrary to this regulation, Horizon's claim system could not retrieve data regarding a claim whenever a processor erred by inputting a "clean claim date" that preceded the date of service. In claim number 04230001193, the Company could not respond to the examiners' inquiry for further information because a processor had committed this error. This result was not in compliance with the regulation since it caused the claim file to be devoid of documentation. Horizon agreed with this finding.

### 5. Failure to Pay Mandated Benefit Claims – 5 Random Files in Error.

The examiners list a total of five unfairly denied claims in Appendix M that were also mandated claims. Each of the five files therefore incurred an additional cite for the mandated benefit that Horizon failed to pay. Following the procedure in section I.B above for calculating error ratios, the examiners only counted the files once to establish the error ratios. These five claims are as follows:

| Claim Number | Mandate | Cite |
|---|---|---|
| 03364E0008757 | Childhood Screening | **N.J.S.A. 26:2J-4.10** and **N.J.A.C. 8:57-8.1** |
| 04050E0006863 | Childhood Screening | " |
| 04191E0017091 | Diabetes Supplies | **N.J.S.A. 26:2J-4.11** and **N.J.A.C. 8:38-5.4(a)2** |
| 04294E9001672 | Diabetes Supplies | " |
| 04283A02160 | Mammogram Examination | **N.J.S.A. 26:2J-4.4** |

The Company disagreed with the unfair denial cite in claim number 03364E0008757. The examiners discuss this disagreement above in section III.D.4. The Company agreed with the unfair denial cite in all four remaining files.

However, Horizon also disagreed with the additional cite in all five files for failure to pay the mandated benefit. In response to an inquiry, the Company stated that, "The original claim was denied in error, however, the claim was subsequently adjusted and payment made under claim numbers 05070A01724 and 05105A00832. Because the claim was adjusted to pay, Horizon does not agree that it did not conform to the mandate." In each case, however, the examiners found that Horizon unfairly denied the claim, and then made an adjustment only when claimants pointed out the Company's errors. A review of the statues and regulations revealed no exceptions for claims that are processed in this fashion.

## G. EXAMINERS' FINDINGS – REFERRALS

### Introduction

The examiners reviewed three samples of referrals. They chose a random sample of 105 from a database of 193,046 referrals that Horizon issued during the examining period (January 1, 2004 through December 31, 2004), calling that sample "Random #1." After they reviewed this sample, Horizon advised the examiners that it had erred by not reporting an additional 6,863 referrals, so the examiners made another random selection of 60 files from that population. They called this sample, "Random #2." Additionally, they took a select sample of 26 referrals from the Company's incoming mail during their visit to mail operations in Wall, New Jersey on September 26, 2005, calling that sample, "Select."

The examiners then compared these three samples to Horizon's claim history data to determine to what extent Horizon successfully matched referrals to specialty claims, thus enabling payment of those claims.

### 1. Failure to Effectuate Fair Settlements of Referred Claims in Which Liability Was Clear – Five Errors

The examiners cite **N.J.S.A. 17B:30-13.1d**, **N.J.S.A. 17B:30-13.1f** and **N.J.A.C. 11:2-17.8(i)** in section III.D.4 above in their review of denied claims. These laws require a company to deny claims only after conducting reasonable investigations based upon all available information. The laws also apply in cases in which an HMO fails to match referrals to specialty claims, and then denies the claims in error. In addition, the NAIC Market Conduct Examiners' Handbook contains Standard 9, which requires the examiners to confirm that companies handle denied claims in accordance with policy provisions, HIPAA, and state law.

Contrary to these rules, Horizon unfairly denied five specialty claims in the random samples, for an error rate of 2.26%, displayed as follows:

| Sample | Population | Sample Size | Errors | Error Ratio |
|---|---|---|---|---|
| Random #1 | 193,046 | 105 | 4 | 3.81% |
| Random #2 | 6,863 | 60 | 1 | 1.67% |
| Select | 26 | 26 | 0 | 0.00% |
| **Totals** | 199,935 | 191 | 5 | 2.62% |

**Please See Appendix O for a List of the Five Files in Error**

The Company agreed with the examiners' finding that each of the five files in error actually had a referral to authorize the claim payment.

The Company also failed to match seven specialty claims to their referrals in the denied random samples of Mandated and Non-mandated claims that the examiners report in section III.D.4 above. These seven claims appear in both Appendices M and O for comparative purposes, but they were only counted once to determine error ratios.

# IV. RECOMMENDATIONS

Horizon Healthcare 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 Horizon 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. PROVIDER APPEALS, UTILIZATION MANAGEMENT APPEALS AND CONSUMER COMPLAINTS

1. The Company should advise all personnel in writing who process Provider Appeals that <u>**N.J.A.C.**</u> **11:22-1.8(a)2i** through **iv** 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.

2. Horizon should remind all personnel in writing who process Provider Appeals that <u>**N.J.A.C.**</u> **11:22-1.8(a)2** requires the insurer to conduct an internal review and communicate the results in a written decision to the provider within 10 business days of appeal receipt.

3. The Company should advise all personnel in writing who prepare annual reports that <u>**N.J.A.C.**</u> **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. Horizon should submit a revised 2004 Annual Report to the Department and a copy to the Commissioner for review. The insurer should indicate in the Report that 11 Appeals were "Received"; six "Resolved in Favor of the Carrier"; five "Resolved against the Company"; and zero were "Not Settled at End of Year."

4. Horizon should advise all personnel in writing who process Utilization Management Appeals that <u>**N.J.A.C.**</u> **8:38-8.5** requires a company to respond to Stage 1 Utilization Management Appeals within five business days.

5. The Company should remind all personnel who process complaints that <u>**N.J.A.C.**</u> **11:2-17.6(d)** requires a company to respond to a Department of Banking and Insurance claim-related complaint within 15 working days; <u>**N.J.A.C.**</u> **8:38-3.7(a)4** requires a company to respond to directly received complaints within 30 calendar days.

## C. CLAIMS

6. Horizon should remind all personnel who process claims that <u>**N.J.S.A.**</u> **26:2J-8.1d(1)** and <u>**N.J.A.C.**</u> **11:22-5(a)1** require a company to pay electronic claims within 30 days following receipt by the payer of required documentation in support of an initial claim submission.

7. The Company should remind all its claims personnel that <u>**N.J.S.A.**</u> **26:2J-8.1d(1)** and <u>**N.J.A.C.**</u> **11:22-1.5(a)2** require a company to pay mailed claims within 40 days following receipt by the payer of required documentation in support of an initial claim submission.

8. Horizon should remind all personnel who process claims that <u>**N.J.S.A.**</u> **26:2J-8.1d(7)** and <u>**N.J.A.C.**</u> **11:22-1.6(c)** require a company to pay interest in the amount of ten percent per annum on overdue claims. See General Instructions for accompanying cover letter. Based on the six random errors and 1405 database exceptions, Horizon should review all claims that were paid late in order to determine the interest payments that are owed to members or providers. The Company must provide the examiners with a summary report that indicates: claim number, date of service, claim received date, amount paid, interest amount paid and date Company paid interest.

9. The Company should remind all its claims personnel that <u>**N.J.S.A.**</u> **17B:30-13.1n** and <u>**N.J.A.C.**</u> **11:2-17.8(a)** require a company to provide a specific reference to the language of policy provisions and a statement of the facts which make the language operative when denying claims.

10. The Company should remind all claims handling personnel that <u>**N.J.S.A. 17B:30-13.1e**</u> and <u>**N.J.A.C.**</u> **11:22-1.6(a)** require a company to deny an electronically transferred claim within 30 calendar days and a mailed claim within 40 calendar days.

11. The Company should remind all claims processing personnel that <u>**N.J.S.A.**</u> **17B:30-13.1d**, <u>**N.J.S.A.**</u> **17B:30-13.1f** and <u>**N.J.A.C.**</u> **11:2-17.8(i)** require a company to deny claims fairly after conducting reasonable investigations based upon all available information.

12. Horizon should remind all its claim personnel that <u>**N.J.S.A.**</u> **26:2J-15b** makes the unfair trade practice provisions of New Jersey insurance law applicable to HMOs. The unfair trade practice statute, <u>**N.J.S.A.**</u> **17B:30-4**, prohibits HMOs from making untrue statements in any way.

13. Horizon should remind its entire claim handling personnel that <u>**N.J.A.C.**</u> **11:2-17.12(b)** requires a company to contain detailed documentation in each claim file in order to permit the Commissioner or his designated examiners to reconstruct the company's activities relative to the claim.

14. Horizon should remind all personnel who process claims that <u>**N.J.S.A.**</u> **26:2J-8.1(d)** and <u>**N.J.A.C.**</u> **11:22-1.5(b)** require a Company to pay a mailed claim within 40 days of receiving requested additional information.14.

15. The Company should remind all its claims personnel that <u>**N.J.A.C.**</u> **11:22-1.6(a)** and **(a)2** require a Company to advise a provider of the basis for its decision to dispute a claim.

16. Horizon should remind all personnel who process claims that <u>**N.J.A.C.**</u> **11:2-17.12(b)** and <u>**N.J.A.C.**</u> **11:2-17.8(b)** require a company to document a denied claim file to permit the Commissioner or his designated examiners to reconstruct the company's activities relative to the clam settlement.

17. The Company should remind all personnel who process claims that <u>**N.J.S.A.**</u> **26:2J-4.10**, and <u>**N.J.A.C.**</u> **8:57-8.1** require an HMO to pay claims for childhood immunizations as recommended by the Advisory Committee on

Immunization Practices of the United States, and for screening by blood lead measurement for lead poisoning in children. The Company should also remind all personnel who handle claims that **N.J.S.A. 26:2J-4.11** and **N.J.A.C. 8:38-5.4(a)2** require an HMO to pay claims for equipment and supplies for the treatment of Diabetes. Horizon should also remind all personnel who handle claims that **N.J.S.A. 262J-4.4** requires a company to pay claims for one base mammogram examination for women who are at least 35 but less than 40 years old, and one mammogram every year for women age 40 and over.

# APPENDIX A:

Ten mandated benefits that equate to specific Current Procedural Terminology codes, International Classification of Diseases codes, or Healthcare Common Procedure Coding System codes:

| | Authority | Benefit, Coverage, or Offer | CPT and/or HCPCS | Diagnosis, ICDA |
|---|---|---|---|---|
| **1** | **NJSA 26:2J-4.1**<br>**NJAC 8:38-5.6** | Treatment of Wilm's Tumor | | **189.0** |
| **2** | **NJSA 26:2J-4.4** | Mammogram Examination Benefit | **76083**<br>**76085**<br>**76092** | |
| **3** | **NJSA 26:2J-4.8** | Certain Cancer Treatments-dose intensive chemo & autologous bone marrow transplants. | **38241** | |
| **4** | **NJSA 26:2J-4.10**<br><br>**NJAC 8:57-8.1** | Child Screening and Immunizations, Blood Lead, screening for hearing loss (PL 2001, c. 337), childhood immunization | **83655**<br>**90371**<br>**90700**<br>**90702**<br>**90708**<br>**90710**<br>**90716**<br>**92551** | |
| **5** | **NJSA 26:2J-4.11**<br>**NJAC 8:38-5.4(a)2** | Diabetes Treatment (Equipment, Supplies, Self-Mgmt. Education) | **A4206**<br>**A4210-11**<br>**A4220**<br>**A4230-32**<br>**A4244-47**<br>**A4250**<br>**A4253-54**<br>**A4256**<br>**A4258-59**<br>**A6257**<br>**E0607**<br>**E2100-01**<br>**G0108-09**<br>**S9140**<br>**S9141**<br>**S9455**<br>**S9460**<br>**S9465**<br>**S9470**<br>**97802-04**<br>**99078** | **250.0-250.9** |
| **6** | **NJSA 26:2J-4.13** | Prostate Cancer Screening for Men Age =>50; men =>40 with risk or family history | **84152**<br>**84153**<br>**84154**<br>**G0102**<br>**G0103** | |

# APPENDIX A (Continued)

| | Authority | Benefit, Coverage, or Offer | CPT and/or HCPCS | Diagnosis, ICDA |
|---|---|---|---|---|
| **7** | **NJSA 26:2J-4.14<br>Women's Health & Cancer Rights Act of 1998** | Re-constructive Breast Surgery, Surgery to Restore/ Achieve Symmetry, Prostheses | **19340<br>19342<br>19350<br>19357<br>19361<br>19364<br>19366<br>19367<br>19368<br>19369** | **174-174.9<br>175-175.0<br>175.9** |
| **8** | **NJSA 26:2J-4.20<br>Bulletin 01-06 (5/25/01)** | Coverage for Biologically-Based Mental Illnesses (Mental Health Parity Law PL 1999, c.106) | | **295-295.9<br>296-296.9<br>297-297.9<br>299-299.9<br>300.01<br>300.21<br>300.3** |
| **9** | **PL 2001, c236<br>Approved 8/31/2001 eff. 90 days after enactment - 11/30/2001<br>NJSA 26:2J-4.23<br>NJAC 8:38-5.4(a)5** | Repro Assist Tech - Diagnose/Treatment of Infertility–includes/not limited to: diagnosis, diagnostic testing, medications, surgery, in-vitro fertilization, embryo transfer, artificial insemination, 4 completed egg retrievals | **58321-22<br>58970<br>58974<br>58976<br>89250<br>89251 89252<br>89253<br>89254<br>89255<br>89258<br>89268<br>89272<br>89280<br>89281** | |
| **10** | **NJSA 26:2J-4.24** | Colorectal surgery Diagnosis/treatment | **G0104-07<br>G0120-22** | |

# APPENDIX B:

FAILURE TO INCLUDE REQUIRED ELEMENTS IN WRITTEN DECISIONS OF PROVIDER CLAIM APPEALS IN CONFORMITY WITH THESE PROVISIONS OF N.J.A.C. 11:22-1.8(a)2:

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

ii. A statement of the participating providers' 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 documentations which supports the decision; and

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

| Appeal of Claim Number | Response Date | Failed to Include |
|---|---|---|
| 04140A01116 | 11/9/2004 | iii, iv |
| 04303E9002611 | 12/30/2004 | iv |
| 04326E0018968 | 12/1/2004 | ii, iii, iv |
| 04093E0011311 | 5/18/2004 | i, ii, iii, iv |
| 04229E0012370 | 11/29/2004 | iii, iv |

# APPENDIX C:

FAILURE TO RESPOND TO A PROVIDER CLAIM APPEAL WITHIN 10 BUSINESS DAYS:

| Claim Number | Received | Responded | Turnaround |
|---|---|---|---|
| 04140A01116 | 10/25/2004 | 11/9/2004 | 11 |
| 04121E0008627 | 7/28/2004 | No response | n/a |
| 04093E0011311 | 5/12/2004 | 6/2/2004 | 15 |
| 04170E009792 | 7/28/2004 | No response | n/a |

# APPENDIX D:

FAILURE TO RESPOND TO STAGE 1 UTILIZATION MANAGEMENT APPEALS WITHIN FIVE BUSINESS DAYS:

| Database Sequence Number | Received | Responded | Turnaround |
|---|---|---|---|
| 15 | 2/24/2004 | 3/15/2004 | 15 |
| 246 | 9/22/2004 | 9/30/2004 | 7 |
| 254 | 6/4/2004 | 6/18/2004 | 11 |
| 295 | 5/26/2004 | 6/3/2004 | 6 |
| 361 | 2/19/2004 | 2/27/2004 | 7 |
| 415 | 3/8/2004 | 3/25/2004 | 14 |
| 450 | 8/31/2004 | 9/10/2004 | 8 |
| 536 | 12/6/2004 | 12/15/2004 | 8 |

# APPENDIX E:

DATABASE EXCEPTIONS: FAILURE TO RESPOND TO DIRECTLY RECEIVED COMPLAINTS WITHIN 30 CALENDAR DAYS AND TO DOBI COMPLAINTS WITHIN 15 CALENDAR DAYS:

| Sequence Number | Received | Respond | Turnaround | Sequence Number | Received | Respond | Turnaround |
|---|---|---|---|---|---|---|---|
| 4 | 5/23/03 | 1/5/04 | 227 | 112 | 1/27/04 | 4/13/04 | 77 |
| 5 | 6/27/03 | 1/23/04 | 210 | 116 | 1/27/04 | 5/21/04 | 115 |
| 17 | 12/23/03 | 3/31/04 | 99 | 117 | 1/21/04 | 2/28/04 | 38 |
| 18 | 11/19/03 | 5/27/04 | 190 | 121 | 11/14/03 | 1/7/04 | 54 |
| 21 | 12/9/03 | 3/5/04 | 87 | 124 | 1/16/04 | 3/3/04 | 47 |
| 25 | 12/26/03 | 1/26/04 | 31 | 125 | 12/11/03 | 6/17/04 | 189 |
| 34 | 1/27/04 | 3/3/04 | 36 | 129 | 1/26/04 | 3/3/04 | 37 |
| 36 | 2/2/04 | 3/22/04 | 49 | 133 | 1/23/04 | 4/1/04 | 69 |
| 44 | 11/26/03 | 2/18/04 | 84 | 136 | 1/13/04 | 4/6/04 | 84 |
| 46 | 2/4/04 | 4/6/04 | 62 | 148 | 9/22/03 | 1/10/04 | 110 |
| 49 | 2/2/04 | 3/8/04 | 35 | 155 | 3/9/04 | 4/12/04 | 34 |
| 50 | 11/19/03 | 1/7/04 | 49 | 158 | 9/17/03 | 1/10/04 | 115 |
| 54 | 1/29/04 | 4/23/04 | 85 | 168 | 6/9/04 | 7/22/04 | 43 |
| 56 | 12/30/03 | 6/11/04 | 164 | 185 | 2/25/04 | 6/10/04 | 106 |
| 58 | 10/20/03 | 2/18/04 | 121 | 193 | 3/15/04 | 5/7/04 | 53 |
| 63 | 12/26/03 | 2/24/04 | 60 | 209 | 4/29/04 | 6/17/04 | 49 |
| 70 | 12/4/03 | 1/8/04 | 35 | 220 | 3/15/04 | 6/28/04 | 105 |
| 71 | 12/5/03 | 2/19/04 | 76 | 221 | 9/5/03 | 6/16/04 | 285 |
| 72 | 3/23/04 | 4/23/04 | 31 | 227 | 3/4/04 | 7/15/04 | 133 |
| 78 | 3/22/04 | 5/18/04 | 57 | 228 | 3/4/04 | 4/23/04 | 50 |
| 79 | 12/8/03 | 1/9/04 | 32 | 232 | 4/23/04 | 6/10/04 | 48 |
| 80 | 11/21/03 | 1/12/04 | 52 | 233 | 3/9/04 | 4/15/04 | 37 |
| 82 | 12/17/03 | 6/18/04 | 184 | 239 | 8/21/03 | 1/13/04 | 145 |
| 84 | 1/23/04 | 2/23/04 | 31 | 249 | 3/23/04 | 4/28/04 | 36 |
| 85 | 12/8/03 | 2/26/04 | 80 | 250 | 4/6/04 | 6/18/04 | 73 |
| 89 | 1/14/04 | 4/13/04 | 90 | 252 | 4/1/04 | 5/5/04 | 34 |
| 97 | 1/12/04 | 3/25/04 | 73 | 253 | 3/17/04 | 4/27/04 | 41 |
| 100 | 1/5/04 | 2/5/04 | 31 | 256 | 5/6/04 | 6/7/04 | 32 |
| 102 | 1/7/04 | 3/31/04 | 84 | 257 | 4/2/04 | 5/5/04 | 33 |
| 108 | 1/27/04 | 3/2/04 | 35 | 260 | 10/10/03 | 4/6/04 | 179 |
| 109 | 1/8/04 | 2/24/04 | 47 | 261 | 2/4/04 | 3/16/04 | 41 |

# APPENDIX E (Continued)

| Sequence Number | Received | Respond | Turnaround |
|---|---|---|---|
| 263 | 2/13/04 | 4/21/04 | 68 |
| 289 | 3/25/04 | 4/30/04 | 36 |
| 295 | 5/5/04 | 6/7/04 | 33 |
| 303 | 9/4/03 | 2/6/04 | 155 |
| 304 | 4/13/04 | 5/18/04 | 35 |
| 309 | 5/7/04 | 6/21/04 | 45 |
| 311 | 3/25/04 | 4/30/04 | 36 |
| 313 | 2/6/04 | 3/9/04 | 32 |
| 314 | 3/25/04 | 4/30/04 | 36 |
| 335 | 9/13/04 | 10/18/04 | 35 |
| 348 | 10/22/04 | 12/6/04 | 45 |
| 419 | 6/15/04 | 7/20/04 | 35 |
| 422 | 5/21/04 | 6/28/04 | 38 |
| 425 | 6/10/04 | 7/15/04 | 35 |
| 428 | 6/28/04 | 8/9/04 | 42 |
| 436 | 7/7/04 | 8/9/04 | 33 |
| 446 | 5/5/04 | 6/10/04 | 36 |
| 457 | 5/26/04 | 7/9/04 | 44 |
| 474 | 6/7/04 | 9/8/04 | 93 |
| 490 | 6/1/04 | 8/9/04 | 69 |
| 506 | 7/28/04 | 8/30/04 | 33 |
| 665 | 9/29/04 | 11/1/04 | 33 |
| 667 | 5/27/04 | 7/9/04 | 43 |

# APPENDIX F:

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

| Claim Number | Date of Receipt | Date Paid | Calendar Day Turnaround |
|---|---|---|---|
| 04119A00477 | 11/10/2003 | 4/29/2004 | 171 |
| 04042A00422 | 8/28/2002 | 2/12/2004 | 533 |
| 04119A01076 | 6/5/2003 | 4/29/2004 | 329 |
| 04252A01362 | 7/9/2004 | 9/9/2004 | 62 |
| 04341A01310 | 10/10/2004 | 12/7/2004 | 58 |
| 04065A01499 | 1/22/2004 | 3/20/2004 | 58 |
| 04104A01413 | 12/11/2003 | 4/14/2004 | 125 |
| 04012A01738 | 9/26/2003 | 1/16/2004 | 112 |
| 04065A01843 | 1/9/2004 | 3/6/2004 | 57 |
| 04289A01924 | 8/1/2004 | 10/20/2004 | 80 |
| 04145A02179 | 2/29/2004 | 5/25/2004 | 86 |
| 04083A02240 | 3/10/2004 | 5/17/2004 | 68 |
| 04198A02342 | 3/11/2004 | 7/17/2004 | 128 |
| 03329E0020556 | 11/25/2003 | 1/16/2004 | 52 |
| 04042E9008687 | 2/9/2004 | 3/23/2004 | 43 |
| 04181A00496 | 5/7/2004 | 6/30/2004 | 54 |
| 04203A00706 | 5/28/2004 | 7/22/2004 | 55 |
| 03339E0000270 | 12/5/03 | 1/30/04 | 56 |

# APPENDIX G:

FAILURE TO PAY MAILED CLAIMS WITHIN 40 DAYS OF RECEIPT:

| Claim Number | Date of Receipt | Date Paid | Calendar Day Turnaround |
|---|---|---|---|
| 3328000720 | 11/24/2003 | 2/7/2004 | 75 |
| 04325A04499 | 12/22/2004 | 2/4/2005 | 44 |
| 04209A04710 | 8/25/2003 | 7/28/2004 | 338 |
| 040384A01954 | 7/22/2003 | 2/9/2004 | 202 |
| 3325001741 | 12/1/2003 | 2/5/2004 | 66 |
| 04065A01883 | 11/10/2003 | 3/6/2004 | 117 |
| 05143A00481 | 8/13/04 | 5/24/05 | 284 |

# APPENDIX H:

FAILURE TO PAY INTEREST ON CLAIMS PAID LATE:

| Claim Number | Date of Receipt | Date Paid | Calendar Day Turnaround |
|---|---|---|---|
| 04187A01078 | 5/13/2004 | 7/7/2004 | 55 |
| 4050E0006863 | 1/22/2004 | 4/26/2005 | 460 |
| 03364E0008757 | 12/30/2003 | 3/25/2004 | 86 |
| 04252A01362 | 7/9/2004 | 9/9/2004 | 62 |
| 04325A04499 | 12/22/2004 | 2/4/2005 | 44 |
| 0436E0008609 | 2/5/2004 | 3/13/2004 | 37 |

# APPENDIX I:

## FAILURE TO DENY CLAIMS WITH SPECIFIC REFERENCE TO POLICY PROVISION:

| Claim Number | Denial Reason | Comments |
|---|---|---|
| 4146000063 | Needs authorization | The actual reason was the member had not yet selected a PCP. |
| 04111A03247 | Blank message | In error, processor chose incorrect Edit Code. |
| 04005E0008542 | Edit Code 307 | This code did not print any message. |
| 04043E0013473 | Edit Code 205 | " |
| 04089E9000126 | Denial Code 1008 | "Services are excluded from your benefit plan." was too generic. |
| 4260000002 | Denial Code 8001 | "Bill type invalid for type of claim submitted" was not specific. |
| 04202E9005992 | Duplicate Claim | Should have been denied for pre-existing rather than duplicate. |
| 04012E0006060 | Units exhausted | Use of the word "Units" was not explanatory. |
| 4063000976 | Edit Code 201 | In software failure, printed no EOB message from 1/1 - 8/31/04 |
| 3351001807 | Edit Code 201 | " |
| 4163002335 | Edit Code 201 | " |
| 4229300096 | Edit Code 201 | " |
| 4043A02036 | Edit Code 201 | " |
| 04225E0000014 | Edit Code 201 | " |
| 03183E0004189 | Edit Code 201 | " |
| 04022E0009227 | Edit Code 201 | " |
| 04224E0002425 | Edit Code 201 | " |
| 04024E0006487 | Edit Code 201 | " |
| 04026E0008295 | Edit Code 201 | " |
| 03364E0008757 | Edit Code 201 | " |
| 04203E0013056 | Edit Code 201 | " |
| 04085E0015667 | Edit Code 201 | " |
| 4051E0011116 | Edit Code 201 | " |
| 04218E0012130 | Edit Code 201 | " |
| 04075E0025623 | Edit Code 201 | " |
| 04026E0025247 | Edit Code 201 | " |
| 4117E0025127 | Edit Code 201 | " |
| 04021E9000382 | Edit Code 201 | " |
| 04201E9005067 | Edit Code 201 | " |
| 4125300252 | Edit Code 201 | " |
| 04030E0009768 | Edit Code 201 | " |
| 03289E0004209 | Edit Code 201 | " |
| 04033E0006090 | Edit Code 201 | " |
| 04195E0002340 | Edit Code 201 | " |
| 04079E0013974 | Edit Code 201 | " |
| 03184E0011540 | Edit Code 201 | " |

| 04211E0013886 | Edit Code 201 | " |
|---|---|---|
| 04079E0010481 | Edit Code 201 | " |
| 04022E9005583 | Edit Code 201 | In software failure, printed no EOB message from 1/1 - 8/31/04 |
| 04098E9006020 | Edit Code 201 | " |
| 04204E9004519 | Edit Code 201 | " |
| 04009E9005124 | Edit Code 201 | " |
| 4041000817 | Edit Code 915 | " |
| 04240A1866 | Edit Code 915 | " |
| 04077E0013911 | Edit Code 915 | " |
| 04069A01521 | Edit Code 915 | " |
| 04070E0020076 | Edit Code 366 | " |

# APPENDIX J:

FAILURE TO DENY ELECTRONICALLY TRANSFERRED CLAIMS WITHIN 30 DAYS OF RECEIPT:

| Claim Number | Date of Receipt | Date Paid | Calendar Day Turnaround |
|---|---|---|---|
| 04154A03183 | 4/4/2004 | 6/15/2004 | 72 |
| 04092A03155 | 1/11/2004 | 4/2/2004 | 82 |
| 4149A03239 | 9/28/2003 | 5/29/2004 | 244 |
| 4269A05117 | 6/12/2003 | 9/28/2004 | 474 |
| 4050E0006863 | 1/22/2004 | 4/26/2005 | 460 |
| 04118E0009182 | 4/28/2004 | 6/9/2004 | 42 |
| 04075E0025623 | 3/14/2004 | 6/25/2004 | 103 |
| 04278A00348 | 10/5/2003 | 10/5/2004 | 366 |
| 03289E0004209 | 10/16/2003 | 3/17/2004 | 153 |
| 04036E0010438 | 12/11/2003 | 2/27/2004 | 78 |
| 04072E0010089 | 3/12/2004 | 6/4/2004 | 84 |
| 04156A02319 | 1/22/2004 | 6/5/2004 | 135 |

# APPENDIX K:

FAILURE TO DENY MAILED CLAIMS WITHIN 40 DAYS OF RECEIPT:

| Claim Number | Date of Receipt | Date Denied | Calendar Day Turnaround |
|---|---|---|---|
| 04187A01078 | 5/13/2004 | 7/7/2004 | 55 |
| 3360000041 | 12/15/2003 | 2/6/2004 | 53 |
| 3351001807 | 12/17/2003 | 3/18/2004 | 92 |
| 04259A00260 | 12/1/2003 | 9/16/2004 | 290 |
| 04153A02022 | 1/1/2004 | 6/2/2004 | 153 |
| 04133A02537 | 12/23/2003 | 5/13/2004 | 142 |
| 04058E9004549 | 12/28/2003 | 2/29/2004 | 63 |
| 04070E9010170 | 12/15/2003 | 3/14/2004 | 90 |

# APPENDIX L:

CLAIMS DENIED UNFAIRLY, ALL REASONS:

| Claim Number | Unfair Reason for Denial |
|---|---|
| 4146000063 | Horizon failed to identify the provider as the Primary Care Physician. |
| 04050E0006863 | “ |
| 04306E0032902 | “ |
| 03363E9000838 | “ |
| 03295E0015287 | “ |
| 04002E9002163 | “ |
| 04062E9006383 | “ |
| 04093E9003446 | “ |
| 04112E9004432 | “ |
| 04191E0017091* | Horizon erred when it failed to match the claim to a valid referral. |
| 04106E9006325* | “ |
| 04022E0010925* | “ |
| 03316E0013420* | “ |
| 04069E9003809* | “ |
| 04078E0018046* | “ |
| 04079E9004885* | “ |
| 04283A02160 | In a processing error, the Company adjusted the claim to deny it. |
| 03184E0011540 | Horizon erred when it failed to match the claim to correct eligibility data. |
| 03364E0008757 | Horizon denied this claim as a duplicate to a claim it agreed it had previously denied in error. |
| 04294E9001672 | Horizon erred when it denied the claim for missing COB information. |
| 04065E9005160 | Horizon erred when it denied the whole claim rather than one service line. |
| 03339E0000270 | Horizon erred when it denied the claim for missing unspecified information. |
| 04070E9010170 | Horizon duplicated this claim to the claim above, thereby repeating the unfair denial error. |

*These errors also appear in Appendix P.

# APPENDIX M:

MAKING UNTRUE STATEMENTS REGARDING COB LETTER RESPONSES:

| Claim Number | Claim Number | Claim Number |
|---|---|---|
| 04063E0012866 | 04343E0010807 | 04226001339 |
| 04071E9004343 | 04219000617 | 04111E9006033 |
| 04071E9004343 | 04245E0008998 | 04170000662 |
| 05006E9001074 | 04294E9001672 | |

# APPENDIX N:

FAILURE TO DOCUMENT CLAIM FILES

| | | |
|---|---|---|
| 04063E0012866 | 04343E0010807 | 04226001339 |
| 04071E9004343 | 04219000617 | 04111E9006033 |
| 04071E9004343 | 04245E0008998 | 04170000662 |
| 05006E9001074 | 04294E9001672 | 04327E0034129 |

# APPENDIX O:

CLAIMS DENIED UNFAIRLY, FAILURE TO MATCH REFERRALS TO SPECIALTY CLAIMS:

| Sample | Denied Claim | Existing Referral Number |
|---|---|---|
| Referral #1 | 04112E0010680 | N16470011 |
| Referral #1 | 04344E9005015 | N17404903 |
| Referral #1 | 04149E0028138 | N14797698 |
| Referral #1 | 04162E9004134 | N16546039 |
| Referral #2 | 04047E0027950 | 407215071647883 |
| Paid Mandated | 04191E0017091* | N15345376 |
| Denied Non-mandated | 04106E9006325* | N12884030 |
| Denied Non-mandated | 04022E0010925* | N12884030 |
| Paid Non-mandated | 03316E0013420* | N14716208 |
| Paid Non-mandated | 04069E9003809* | N14716208 |
| Paid Non-mandated | 04078E0018046* | N14716208 |
| Paid Non-mandated | 04079E9004885* | N14716208 |

*These errors also appear in Appendix M

# VERIFICATION PAGE

I, Dean Turner, am the Examiner-in-Charge of the Market Conduct Examination of Horizon Healthcare of New Jersey, 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 Horizon Healthcare of New Jersey, Inc. as of May 6, 2006.

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.<br>Examiner-In-Charge<br>New Jersey Department<br>of Banking and Insurance |