ORDER NO. E17- 117

STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

IN THE MATTER OF:

Proceedings by the Commissioner of Banking and Insurance, State of New Jersey, with respect to Horizon Healthcare of New Jersey, Inc. (NAIC No: 95529)	))))	CONSENT ORDER

TO: Horizon Healthcare of New Jersey, Inc.
Three Penn Plaza East
Newark, NJ 07105

This matter, having been opened by the Commissioner of Banking and Insurance, State of New Jersey, upon the filing of a Market Conduct Examination Report ("Report") containing the results of the examination of Horizon Healthcare of New Jersey, Inc., ("Horizon") performed by the Department of Banking and Insurance ("Department") pursuant to the authority provided at N.J.S.A. 17:23-20 et seq.; and

WHEREAS the Department filed a Report containing the results of the examination of Horizon's Medicaid claims settlement practices during the period October 1, 2016 to December 31, 2016, performed pursuant to N.J.S.A. 17:23-20 et seq., and

WHEREAS the market conduct examination revealed certain instances where Horizon's practices did not accord fully with various provisions of New Jersey insurance statutes or regulations. These instances, as fully set forth in the Report, are incorporated herein by reference; and

IT FURTHER APPEARING that, as a result of the Department's examination, Horizon has taken or will take corrective measures pursuant to the recommendations contained in the Report to address the instances of nonconformance set forth in the Report, and

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

NOW, THEREFORE, IT IS on the 12th day of DECEMBER 2017

ORDERED AND AGREED that the attached Report of Horizon will be adopted and filed as an official record of the Department; and

IT IS FURTHER ORDERED AND AGREED that Horizon will continue to monitor claims settlements activity in order to identify instances of nonconformance with New Jersey insurance statutes and regulations and the recommendations contained in the Report; and

IT IS FURTHER ORDERED AND AGREED that Horizon shall comply with New Jersey insurance statutes and regulations and the recommendations contained in the attached Report; and;

IT IS FURTHER ORDERED AND AGREED that pursuant to N.J.S.A. 17:23-24 d (1), within thirty days of the adoption of this Report, Horizon shall file an affidavit with the Department's Market Conduct Unit, stating under oath that its directors have received a copy of the adopted Report.

Pete L. Hartt
Director of Insurance

Consented to as to form, content and entry
Horizon Healthcare of New Jersey, Inc.

APPROVED JPS 12/11/17 LEGAL

By: [Signature]

Printed Name: Erhardt Preitauer

Title: SVP, Government Programs

Date: 12/11/17

State of New Jersey
DEPARTMENT OF BANKING AND INSURANCE
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RICHARD BADOLATO
Commissioner

PETER L. HARTT
Director

December 13, 2017

Honorable Richard Badolato
Commissioner of Insurance
State of New Jersey
Department of Banking and Insurance
20 West State Street
P.O. Box 329
Trenton, N.J. 08625

Dear Commissioner Badolato,

Pursuant to the authority provided in N.J.S.A. 26:2J-18.1, N.J.S.A. 17:23-22 and N.J.A.C. 11:24-2.12, and in accordance with your instructions, a market conduct examination of the business practices and affairs was conducted on:

Horizon Healthcare of New Jersey, Inc., NAIC Code 95529
Domiciled in Newark, NJ

hereinafter referred to as "Horizon" The field work for the Horizon examination was conducted in Pennington, N.J. The following report is respectfully submitted on behalf of the examination team. Through a deliberative process, I certify the accuracy of the findings presented herein.

Clifton J. Day, MPA, MCM, CPM, CSM
Chief of Market Regulation and Consumer Protection Services

MARKET CONDUCT EXAMINATION
(Exam Tracking Number NJ090-23)

of

HORIZON HEALTHCARE of NEW JERSEY, INC
(NAIC Number 95529, Group Number 1202)

Examination Office Address
1700 American Blvd, Pennington, New Jersey 08534

Domestic Office Address
3 Penn Plaza East, Newark, New Jersey 07105

as of

June 8, 2017

BY EXAMINERS

of the

STATE OF NEW JERSEY

DEPARTMENT OF BANKING AND INSURANCE

DIVISION OF INSURANCE

OFFICE OF CONSUMER PROTECTION SERVICES

MARKET REGULATION SECTION

MARKET CONDUCT EXAMINATIONS

REPORT ADOPTED: DECEMBER 12, 2017

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I. INTRODUCTION

This is a report of the Market Conduct activities of Horizon Healthcare of New Jersey, Inc. (hereinafter referred to as "Horizon" or the "Company"). Authority for this examination is found under **N.J.S.A. 26:2J-18.1** as applicable to a health maintenance organization ("HMO"), and **N.J.A.C. 11:24-2.12**, which requires an HMO to open its books and records for an examination. Market Conduct Examiners from the New Jersey Department of Banking and Insurance (hereinafter referred to as the "Department" or "DOBI") conducted this examination. The examiners present their findings, conclusions and recommendations in this report as a result of their market conduct examination of the Company. The Market Conduct Examiners were Examiner-in-Charge Robert Greenfield, Erin Porter, Richard Segin and Michael Wise.

A. Scope of Examination

The scope of the examination included managed care medical claims that Horizon processed on behalf of New Jersey's Medicaid program. The examiners evaluated the Company's compliance with market conduct-related provisions of laws and regulations applicable to HMOs. Overall, the purpose of this examination was to determine compliance with fair settlement practices mandated by **N.J.S.A. 17B:30-13.1**[1], prompt pay requirements outlined in **N.J.S.A. 26:2J-8.1d,** appeal rights requirements outlined in **N.J.A.C. 11:24-8.4** to **8.7,** and record viability, accuracy and auditability requirements specified in **N.J.A.C. 11:22-1.5(d)** and **N.J.A.C. 11:2-17.12(b)**.

The review period for this examination was October 1, 2016 through December 31, 2016. The examiners conducted this review at the Company's office located in Pennington, New Jersey, between March 13, 2017 and April 20, 2017. On various dates following the fieldwork, the examiners completed additional review work and report writing in Trenton, N.J.

The random selection process that the examiners used in this examination is in accordance with the National Association of Insurance Commissioners' (hereinafter referred to as "NAIC") Market Regulation Handbook, Chapters 14, 16 and 20.

B. Error Ratios

Error ratios are the percentage of files reviewed that a HMO handled in error. A file is counted as an error when it is mishandled or the covered person has been treated unfairly, even if no statute or regulation is applicable. If a file contains multiple errors, the examiners will count the file only once

[1] The unfair trade practice provisions of N.J.S.A. 17B:30-1 et seq. apply to HMOs pursuant to N.J.S.A. 26:2J-15b.

in calculating error ratios. However, any file that contains more than one error will be cited more than once in the report. In the event that the HMO corrects an error as a result of a consumer complaint or due to the examiners' findings, the error will be included in the error ratio. If the HMO corrects an error independent of a complaint or DOBI intervention, the error is not included in the error ratios.

There may be errors cited in this report that define practices as specific acts that a HMO commits with such frequency that it constitutes an improper general business practice. The examiners have identified all errors that constitute an improper general business practice.

The examiners sometimes find improper general business practices or HMO errors that may be technical in nature or which did not have an impact on a covered person. Even though such errors or practices are not in compliance with law, the examiners do not include these errors when determining error ratios. Whenever such business practices or errors do have an impact on the covered person, each file in error is counted in the error ratio. The examiners indicate in the report whenever they did not count particular files in the error ratio.

The examiners submitted written inquiries to Company representatives on the errors cited in this report. These inquiries provided Horizon the opportunity to respond to the examiners' findings and to provide exceptions to the statutory and/or regulatory errors or mishandling reported herein. In response to these inquiries, the Company agreed with some of the errors cited in this report. On those errors with which the Company disagreed, the examiners evaluated the individual merits of each response and gave due consideration to all comments. In some instances, the examiners did not cite the files due to the Company's explanatory responses. In others, the errors remained as cited in the examiners' inquiries. For the most part, this is a report by exception, i.e. it notes only the errors found by the examiners.

C. Company Profile

The corporate relationship between Horizon Healthcare Services, Inc., doing business as Horizon Blue Cross Blue Shield of New Jersey and the Company originated in October 1993, when Horizon Healthcare Services, Inc. and Mercy Health Plan (a subsidiary of Mercy Health System of Southeastern Pennsylvania) formed Mercy Health Plan of New Jersey. Two years later, 27,000 members were enrolled in the plan. In March 1999, the plan officially changed its name to Horizon/Mercy.

On June 1, 2004, Horizon Healthcare Services, Inc. acquired 100 percent of Horizon/Mercy. At that time, enrollment reached more than 265,000 members in the Medicaid and NJ FamilyCare programs in all 21 New Jersey counties.

On July 1, 2014, the Managed Long-Term Services and Supports program was launched. This managed care delivery system coordinates long-term services and program support for eligible Medicaid beneficiaries.

On January 1, 2017, the dual-eligible special needs plan was introduced. Horizon NJ TotalCare, a Medicare Advantage plan for beneficiaries eligible for both Medicare and Medicaid coordinates all covered Medicare and Medicaid managed care benefits in one health plan.

As of February 2017, Horizon covered 885,087 members, or 53 percent of the New Jersey's Medicaid recipients.

D. Executive Summary

This examination included a review of the Company's appeal process and claim settlement practices. The examiners reviewed 19 Independent Utilization Review Organization ("IURO") decisions conducted pursuant to the Independent Health Care Appeals Program at **N.J.S.A. 26:2S-12** and a total of 542 random and 50 select claims.

The error ratio in complying with IURO decisions was 74%. Failure to promptly pay claims whose denials were reversed by IURO decisions and failure to accurately assess and pay interest on claim denials overturned in IURO decisions are cited as improper general business practices.

The random claims review resulted in a 12% error ratio and the select claims review resulted in an error ratio of 30%. The examiners found several improper general business practices caused by both systemic and manual processing errors. Major findings include failure to link authorizations and provider referrals to corresponding claims, improper denial of multiple procedure codes, improper denial of radiology and mammogram claims, improper claim denials due to erroneous determinations that Medicare or another plan was primary, improper denial of emergency response devices, failure to pay interest on claims reprocessed after improper denial, failure to provide the specific reason for denial and improper denial of personal care assistant claims and wellness examinations. Detailed descriptions of all findings appear in the sections that follow.

II. PROVIDER APPEALS AND APPEAL MECHANISM

A. Introduction

Stage 1 and Stage 2 appeals are internal appeals of utilization management denials, i.e. denials of claims or prior authorization requests because the Company determined that the service is not medically necessary, submitted and decided by the Company. Where a Stage 2 appeal results in a determination that is adverse to the member or provider (retention of a denial or inappropriate compromise), the covered person or the provider acting on the covered person's behalf can file an appeal to an IURO. Such an appeal is referred to as an IURO appeal or an external appeal. The decision of the IURO is binding.

The examiners reviewed Horizon's process for compliance with **N.J.S.A. 26:2J-8.1** and **N.J.A.C. 11:24-8.4** to **8.7**.

During the period October 1, 2016 through December 31, 2016, the IUROs issued 57 decisions reversing Horizon's denials of medical, dental and pharmacy services for Medicaid members. Nineteen of the 57 reversals involved medical services. The examiners reviewed whether Horizon timely complied with the 19 IURO reversals involving medical services.

B. Error Ratios on Selected Appeals

The examiners calculated the error ratios by applying the procedure outlined in the introduction of this report. The examiners found that Horizon failed to timely comply and accurately adjudicate 14 of the 19 IURO reversals, for an error ratio of 74%.

Appeal Error Ratio Chart

Type of Appeal	Appeals Reviewed	Appeals in Error	Error Ratio
Stage 3- IURO Overturned	19	14	74%

C. Examiners' Findings

1. **Failure to Pay Internal and External Appeal Awards Promptly upon Receipt of Decision – 13 Appeals in Error with Interest Impact of $55,816.04 (Improper General Business Practice)**

N.J.S.A. 26:2S-12c and **N.J.A.C. 11:24-8.7(k)** provide that the IURO's determination shall be binding on the HMO and the member, and that the HMO shall provide benefits (including issuance of authorizations and payment of the claim) promptly and without delay. Additionally, **N.J.S.A. 17B:30-13.1b** requires a HMO to respond reasonably promptly upon receipt of

communications related to a claim. Lastly, **N.J.S.A. 17B:30-13.1f** requires a HMO to effectuate fair and equitable settlements on claims in which liability is reasonably clear.

Contrary to the above statutes and regulation, the examiners found 13 cases in which the Company failed to issue payment when the IURO overturned the final internal appeal decision. Horizon complied with the IURO reversals in these 13 cases only in response to the examiners' inquiries. While preparing these cases for payment, Horizon discovered 14 additional IURO reversals that were issued outside of the exam review period and were never processed for payment. Therefore, this error occurred on a total of 27 IURO reversals. The average number of days for payment from receipt date of the IURO reversal was 165 days for the 13 cases identified by the examiners; payment was therefore not prompt or equitable. The Company agreed that it failed to promptly comply with the IURO reversals.

Interest payments on the 13 cases identified by the examiners totaled $15,973.28, and interest on the 14 additional cases identified by the Company totaled $3,694.21. The total interest due under this error category was $19,667.69 ($15,973.28 + $3,694.21).

The examiners note that the 27 IURO reversals referenced above were part of a larger Horizon initiative to correct appeal payment errors on both internal and external IURO appeals. While Horizon did identify its failure to comply with 278 internal appeal reversals on January 3, 2017 (with late payment interest calculated at $36,148.35), its corrective methodology did not address the failure to comply with the 27 IURO reversals discussed above. In sum, Horizon failed to timely comply with a total 305 internal and external appeal decisions in which it was reversed between the period of September 19, 2016 to January 3, 2017 and paid a total of $55,816.04 ($36,148.35 + $19,667.69) in interest under this error category.

Due to the frequency of the above errors, the examiners cited delayed appeal compliance as an improper general business practice. Horizon advised that it has implemented procedures to identify overturned appeals and to issue payment or authorization promptly.

Please See Appendix A-1 for Files in Error

2. **Failure to Calculate and Pay Interest Accurately on External Appeal Awards – 13 Files in Error (Improper General Business Practice)**

Pursuant to **N.J.S.A. 26:2J-8.1d(9)**, an HMO must pay interest at a rate of 12% when a claim is paid after 30 days (claims submitted electronically) or 40 days (claims submitted by mail). Where an IURO decision reverses an HMO claim denial, interest accrues from 30 or 40 days after the HMO's initial

receipt of claim through the date the claim is paid. Contrary to this requirement, the examiners found that Horizon calculates interest from the IURO decision date to the date of payment, thus excluding the time period between receipt of claim to the IURO decision date. The examiners found this error on all 13 appeals cited in item II.C.1 above.

Horizon disagreed with this error based on language in **N.J.S.A. 26:2J-8.1e(1)**. This statute states that, "interest shall begin to accrue on the day the appeal was received by the payer." The examiners note that this statute applies only to payment appeals that are submitted to state sponsored payment arbitration and specifically excludes medical necessity appeals that are subject to the IURO appeal program in **N.J.S.A. 26:2S-11**. Notably, **N.J.S.A. 26:2S-11**, applicable to IURO appeals, does not specify the date that interest begins to accrue. **N.J.S.A. 26:2J-8.1d(9)** therefore applies and claims whose denial is overturned by the IURO are overdue 30 or 40 days from claim submission because the initial, adverse claim determination was erroneous. The examiners cited Horizon's interest calculation methodology as an improper general business practice.

Please See Appendix A-2 for Files in Error

3. **Failure to Accurately Adjudicate CPT Modifier 50 for Bilateral Procedures – 1 File in Error (Improper General Business Practice)**

While researching a response to an inquiry requesting status of payment on an IURO reversal not included in the 13 cases referenced above, Horizon discovered that it failed to properly adjudicate bilateral procedure claims that were billed with a modifier 50. Attaching a modifier 50 to the CPT code indicates that the procedure was performed bilaterally. However, contrary to **N.J.S.A. 17B:30-13.1d**, Horizon processed such claims as unilateral rather than bilateral procedures. The examiners cited this error as an improper general business practice because the systems error affected all electronically adjudicated claims during the period in error. Proper procedures for manual processing were in place.

Horizon advised that it would perform a sweep for impacted claims billed with modifier 50 and would pend these claims for consideration. The number of claims and providers impacted by this error and the amount of additional principal and interest payments required to be paid to remedy this error were unknown at the time of the examiners' inquiry.

Please See Appendix A-3 for File in Error

III. CLAIMS ADJUDICATION and RE-ADJUDICATION/ADJUSTMENTS

A. Introduction

The examiners manually reviewed 200 randomly selected adjudicated and 342 randomly selected re-adjudicated/adjusted claims submitted for services rendered to persons covered by the Medicaid program for the period October 1, 2016 through December 31, 2016. The examiners also randomly reviewed a stratified sample of 50 claims. This sample was designed to determine overall compliance within a particular benefit level or subpopulation. Files from this sample are designated as "select" files or as having originated from the "select sample." Including all sample types, the examiners manually reviewed a total of 592 claims.

During the period October 1, 2016 through December 31, 2016, Horizon processed 3,978,367 claims (consisting of 9,941,827 lines). Horizon's claims consisted of 3,350,028 paid adjudicated claims (consisting of 7,749,102 lines) and 478,930 denied adjudicated claims (consisting of 1,370,305 lines). In addition, the Company processed 90,548 paid re-adjudicated claims (consisting of 633,558 lines) and 58,861 denied re-adjudicated claims (consisting of 188,862 lines). The distribution of errors from these samples is shown below.

In reviewing these claims, the examiners checked for compliance with statutes and regulations which govern the handling of claims, particularly **N.J.S.A. 26:2J-1 et seq.**, **N.J.S.A.26:2S-1 et seq.**, and **N.J.S.A. 17B:30-13.1** (Unfair Trade Practices Act). The examiners also utilized the NAIC Market Regulation Handbook, Chapters 16 and 20, in developing the scope of review and in examining company claim documentation and records.

B. Error Ratios

The examiners calculated the following error ratios by applying the procedure outlined in the introduction of this report. Error ratios are itemized separately based on the review samples as indicated in the following chart.

1. Random Adjudicated Claims Error Ratios

Type of Claim	Files Reviewed	Files in Error	Error Ratio
Horizon Paid Adjudicated	50	0	0%
Horizon Denied Adjudicated	150	5	3%
Total Horizon Adjudicated Claims	200	5	3%

2. Random Re-adjudicated/Adjusted Claims Error Ratios

Type of Claim	Files Reviewed	Files in Error	Error Ratio
Horizon Paid Re-adjudicated	185	39	21%
Horizon Denied Re-adjudicated	157	28	18%
Total Horizon Re-adjudicated Claims	342	67	20%

3. Select Sample Error Ratios

Type of Claim	Files Reviewed	Files in Error	Error Ratio
Home Health Care	15	4	27%
Medicare EOP[2] Denials	20	7	35%
Authorization Denials	15	4	27%
Total Horizon Select	50	15	30%

C. Examiners' Findings– Claims Adjudication and Re-Adjudication/Adjustment

1. **Systemic Failure to Link Authorizations and Referrals to Corresponding Claims Resulting in Denials - 30 Random and 4 Select Files in Error, 8,518 Known and 7,263 Potential System-wide Errors with Interest Impact of $79,714.28 (Improper General Business Practice)**

In the absence of fraud or misrepresentation, **N.J.S.A. 17B:30-53(1)** provides that an HMO shall not deny reimbursement to a hospital or physician on the grounds of medical necessity if the HMO authorized health care services prior to rendering the service. In addition, **N.J.S.A. 17B:30-13.1d** states that an HMO shall not refuse to pay claims without conducting a reasonable investigation based upon all available information. Horizon failed to comply with these statutes on 8,518 claims and on possibly 7,263 additional claims as described below.

From the paid re-adjusted random samples, the examiners found that Horizon invalidly denied twenty eight random and four select sample claims because system errors did not link authorizations and referrals between the CareRadius authorization system and the Facets claim system. These errors occurred on several different CPT codes. The Company stated this error was discovered on February 2, 2017, during a periodic sweep of mismatched

[2] EOP refers to Explanation of Payment, these are claims that are denied because the member is also covered by Medicare and the claim did not include a Medicare EOP denying payment of the claim.

authorizations. The error affected a population of 8,316 claims, resulting in $77,957.84 in interest payments to providers. The Company agreed that these claims were denied in error and the examiners note that some claims were re-adjudicated prior to the market conduct examination. However, various systemic linkage problems with authorizations continued to occur throughout and beyond the examination review period. Although Horizon stated that it corrected defects in the applicable authorization matching script, the examiners found additional authorization errors as highlighted below.

On claim 163191234800 that was denied on November 16, 2016, the provider billed the service with CPT code modifier LT (procedures performed on the left side of the body) and Horizon erroneously denied payment for failure to obtain an authorization. In response to the examiners' inquiries on this error, Horizon advised that authorizations are assigned in the Care Management Platform at the CPT code level. However, that system does not recognize modifiers. This caused an improper claim denial because the authorization script was not able to match the authorization to the CPT code with a modifier.

In response to an inquiry, Horizon stated that this error was originally identified by the Company on October 5, 2016 with an unsuccessful corrective intervention on November 29, 2016. Ultimately, the Company advised that it resolved this issue on or about April 7, 2017, during the market conduct examination. The examiners requested the population of claims affected and Horizon provided a spreadsheet of 7,263 potentially impacted claims that are currently under review for re-adjudication.

In addition to the above errors, the examiners identified another authorization-denial issue after requesting an explanation of a denial of claim 16328H210400. Horizon denied this claim under denial code "A01" (Invalid Number of Units for Site Specific Modifier). The Company responded that a system configuration error driven by clinical edit engine McKesson's ClaimCheck caused the inappropriate denial. The Company has since upgraded to McKesson ClaimsXten and advised that denials of this nature will no longer occur. The Company re-adjusted a population of 202 claims and applied interest totaling $1,756.44 with adjustments as of April 27, 2017.

Please See Appendix B-1 for Files in Error

2. **Manual Failure to Link Authorizations to Corresponding Claims Resulting in Potential Overpayments - 1 Select File in Error, 2,042 Potentially Impacted Claims Overall (Improper General Business Practice)**

Pursuant to **N.J.S.A. 17B:30-13.1c**, HMOs are required to adopt and implement reasonable standards for the prompt investigation of claims arising

under insurance policies. Horizon failed to comply with this statute on 1 select claim file and 2,042 claims overall as described below.

Specifically on file 16281E123900, the Company advised that it overpaid the provider's claim because of a manual error in which a claim processor erroneously linked an authorization from a prior approval period to a current billing period. This error resulted in an apparent overpayment of $2,871.24 that Horizon intends to recover through recoupment.

In response to an inquiry regarding the cause and frequency of this error type, the Company stated that the claims processing system allows claims handlers to override warning messages that alert a potentially mismatched authorization. Invalid overrides caused otherwise ineligible claims to be processed for payment.

In terms of error frequency, Horizon identified a total of 2,042 claims that were affected by this error. The examiners cited this error as an improper general business that is inconsistent with **N.J.S.A. 17B:30-13.1c** because Horizon's claim investigation failed to recognize erroneous authorizations.

Please See Appendix B-2 for File in Error

3. **Unfair Denial of Radiology Claims including Mammograms Due to Claim System Errors – 3 Random Files in Error, 2,039 Claims Overall (Improper General Business Practice)**

During review of random files 16292E323701, 16301F126401, and 16286G508001, the examiners found that Horizon issued denials for "No Precert/Authorization or Referral". In response to the examiners' inquiry, the Company stated there was an error in an internal claim system file containing information regarding the provider's eligibility as a participating provider. When these claims were sent to Horizon's radiology vendor, the claims system incorrectly identified these providers as non-participating, thus resulting in denial. This system programming error caused erroneous denials that impacted 205 different radiology CPT codes that do not require authorizations when performed by a participating provider. The Company was unaware of this issue at the time of the examiners' inquiry and advised that a sweep for impacted claims would be performed. These erroneous denials are contrary to **N.J.S.A. 17B:30-13.1d**, which requires a reasonable investigation based upon all available information.

In order to evaluate the overall frequency of this error, the examiners requested the Company to provide a list of all claims denied due to this error. In response, Horizon provided a list of 2,039 erroneously denied claims. The examiners reviewed this population and found that 732 claims were mammogram examinations with CPT codes 77051, 77052, G0202, G0204, and

G0206. All claims were submitted by eligible, participating providers and these services do not require prior authorization. The examiners also cited these denials as violations of **N.J.S.A. 17B:30-13.1d**.

As of May 2, 2017, Horizon indicated that it re-adjusted and paid interest in the amount of $543.87 on 117 of the 2,039 claims referenced above. The Company continued to reprocess the remaining claims during the post-field phase of this examination. However, Horizon advised the examiners that it failed to properly apply interest to a subset of these claims, resulting in further corrective action.

Lastly, while resolving the provider eligibility programming error that caused these denials, Horizon discovered another error type involving authorization and referral requirements which caused an unspecified number of erroneous denials. Horizon advised that it would conduct another corrective sweep to identify and adjust claims affected by this additional error type. Statistics were unavailable while the examiners wrote the examination report.

Please See Appendix B-3 for Files in Error

4. **Improper Denial of Claims for Explanation of Payment (EOP) Requests – 2 Random and 7 Select Files in Error, 6,031 Claims in Error Overall with $40,227.43 in Interest (Improper General Business Practice)**

The examiners found several instances in which Horizon's claims system and manual claims processors erroneously determined the Company to be a secondary payer. Where this occurred, Horizon either pended or denied the claim, stating that an Explanation of Benefit ("EOB")[3] from a primary carrier was required in order to coordinate benefits with that carrier. The examiners found two error types: 1) denials where manual claims processors failed to code claims as EOB compliant, e.g., the provider properly submitted an EOB from a primary carrier, but Horizon failed to recognize receipt; and 2) denials where only Medicaid covered the service that was provided. Both error types are addressed below.

a. Failure to Recognize EOB from Other Carrier - 1 Random and 7 Select Files in Error

Contrary to **N.J.S.A. 17B:30-13.1d**, Horizon incorrectly denied claim 163549005000 for denial reason "Z11- Clm Pend: EOB from prim carrier req" because the provider did in fact submit an EOB with this claim. In response to the examiners' inquiries, Horizon attributed this error to a failed manual processing function that requires claims personnel to activate a claim "flag"

[3] Horizon uses the terms Explanation of Benefit and Explanation of Payment interchangeably.

that allows the system to recognize receipt of an EOB. Horizon described this process as "prone to error". Horizon applied a plan of correction on March 6, 2017 that replaced manual processing with systems processing.

The examiners also observed many similar claim denials utilizing the phrase "Resubmit with EOB from Medicare". On these, the examiners provided the Company with a list of 20 select claims for review and comment. After review, the Company agreed that seven of the 20 claims (35%) were denied in error; all seven were paper claims. Horizon responded that this issue was remediated pursuant to the March 6, 2017 corrective action plan referenced above.

To determine the frequency of this error, the examiners requested the total population of impacted claims. The Company performed a sweep of paper claims denied for no EOB. Horizon continued the process of reviewing and re-adjusting claims at the time the examination report was being written. As of April 28, 2017, the Company adjusted 2,576 claims and paid $6,505.59 in interest. Due to the frequency of error, the examiners cited this as an improper general business practice.

b. Incorrect EOP Denials- Services Only Covered by Medicaid- 1 Random File in Error

Contrary to **N.J.S.A. 17B:30-13.1d**, Horizon incorrectly denied claim 16315F601301 for denial reason "ZDF- Resubmit with EOB from primary carrier". Horizon explained this was a claim for a self-directed service which was covered only by Medicaid and was manually denied inappropriately for no EOP and then paid after a corrective sweep on February 27, 2017 that identified the error. Horizon advised that the claims processing system is configured to not require an EOP when Medicaid is the only payer or the member does not have other insurance coverage. On this particular claim, an employee manually applied this erroneous denial code.

The examiners requested a list of impacted claims and were provided a population of 3,455 claims that were adjusted through April 27, 2017 (indicating that the erroneous EOP denials continued to occur throughout the market conduct examination and was not an isolated manual processing error) with $33,721.84 paid in interest. The examiners cited this error as an improper general business practice due to the frequency of this error.

Please See Appendix B-4 for Files in Error

5. **Improper Denial and Failure to Pay Interest on Emergency Response Devices due to Claim Errors Relative to Taxonomy Codes – 24 Random Files in Error; 6,511 In Error Overall with Interest Impact of $2,577.52 (Improper General Business Practice)**

Contrary to **N.J.S.A. 17B:30-13.1d**, the examiners found that the Company improperly denied 24 re-adjusted claims from the random sample. As a result of the examiners' inquiries, Horizon indicated that these claims were erroneously denied under reason code "not covered under contract" when in fact the provider and services were covered under the contract. The Company further stated this was the result of a manual processing error by the claims team. Upon receipt of a claim, the Company enters the provider into the claims system with two distinct identification ("ID") or taxonomy numbers. One ID reflects services for physically installing an emergency response communication device in a home or other location. The second ID is the fee for the monthly service. The claims team manually misrouted these IDs to other, incorrect ID codes resulting in claim denial. This misrouting error occurred from September 2016 to December 2016.

In response to the examiners inquiries, Horizon advised that a total of 6,333 claims were impacted. To rectify the error, the Company implemented a system change on December 12, 2016 to allow for automated selection of taxonomy codes rather than manual selection. The Company re-adjudicated these claims and paid $969.89 in interest payments. The examiners found, however, that Horizon paid interest only on 2,682 of the 6,333 claims. Horizon agreed that it failed to pay interest on the remaining 3,651 claims (58% of this population) as of the date of the examiners' inquiry. As such, the Company failed to comply with **N.J.S.A. 26:2J-8.1d(9),** which requires a HMO to pay 12% interest when the payment exceeds either 30 days (claims submitted electronically) or 40 days (claims submitted by mail).

The examiners requested the amounts of additional interest payments Horizon failed to pay on the remaining 3,651 claims and further requested the Company to include erroneous denials resulting from "Z55" (provider not eligible by contract for payment) and "Z76" (Incorrect Provider/TIN Identification Number Submitted) denial codes as these were observed on the impacted claims. The Company provided a list of 3,829 claims resulting in $1,607.63 in interest due. Horizon has advised that this additional amount will be resolved through a settlement agreement with the provider, which is currently being executed. Due to the number of claims affected by this systemic error, the examiners cited these denials as an improper general business practices. The Company agreed with these findings.

Please See Appendix B-5 for Files in Error

6. **Failure to Issue Specific Denial Reasons – 2 Select Files in Error, 24 Denial Codes in Error with 46,710 Errors on Denial Codes R01 and ZAK (Improper General Business Practice)**

N.J.S.A. 17B:30-13.1n requires a HMO to provide a reasonable explanation of the contractual and legal basis for denying a claim; a denial reason that is ambiguous is neither reasonable nor factual in content and inhibits use of the appeals process. In addition, **N.J.A.C. 11:2-17.8(a)** requires that where a policy provision is the basis for a claim denial there must be a specific reference to policy language and a statement of fact which makes the policy language operative in the claim denial.

Claim numbers 162791343000 and 16277H131800 were denied for reason code (R01) "Authorization or Referral not Obtained and/or not the Member's PCP". Denial code ZAK includes the same language as code R01. This language includes the terms "or" and "and/or", along with multiple possible reasons for denial, which is inconsistent with the statute and regulation above. The examiners reviewed the call letter response data and determined the language quoted above was used a total of 46,710 times during the review period of October 2016 through December 2016 (Not Adjusted Oct01 = 3,034, Not Adjusted Oct02 = 4,229, Not Adjusted Oct03 = 3,816, Not Adjusted Oct04 = 4,028, Not Adjusted Nov01 = 4,152, Not Adjusted Nov02 = 2,916, Not Adjusted Nov03 = 3,028, Not Adjusted Nov04 = 3,021, Not Adjusted Dec01 = 4,623, Not Adjusted Dec02 = 3,793, Not Adjusted Dec03 = 3,592, Not Adjusted Dec04 = 6,478).

The examiners requested a list from the Company of all denial codes used on EOBs and found 22 other ambiguous codes (from a list of 1,560). The examiners determined these reason codes to be inconsistent with the above statute and regulation because they fail to provide a reasonable and specific explanation for denial. Specifically, 18 of the 24 reason codes include two or more subsequent, successive "or" reasons or conjunctions that do not satisfy the applicable reasonableness and factual notice requirements outlined above. A notice that requires the provider or member to determine which of the "or" arguments is applicable is unreasonable. Four of the 24 reason codes include one or more "/" references, a symbol reference to "or", which is objectionable for the same reasons as use of "or". Reason codes "RiskWhAmt" and "Referral Discrepancy" are unclear and vague and do not provide clarity as to the basis of denial or what specifically is being requested of the provider.

Please See Appendix B-6 for Files in Error

7. **Failure to Settle Claims Timely – 2 Random Files and 1 Select File in Error**

N.J.S.A. 26:2J-8.1d(1) requires a HMO to pay or deny a claim no later than the 30th day for a claim submitted by electronic means and the 40th day for a claim submitted by other than electronic means.

Contrary to the statute cited above, the Company failed to deny two random claims (162941345600 and 16322H825600) and one select claim (16279J293000) in a timely manner. The Company agreed with these errors.

Please See Appendix B-7 for Files in Error

8. Failure to Acknowledge Claim Timely - 1 Random File in Error

N.J.A.C. 11:2-17.6(b) states every HMO, upon receiving notification of claim shall, within 10 working days, acknowledge receipt of such notice unless payment is made within such period of time. This acknowledgement shall include the address and telephone number of the insurer claims office or authorized claims representative which will handle the claim.

Claim 163549005000 was received via paper on December 19, 2016 and input into the Company's system on January 9, 2017, which does not meet the 10 working day time limit for acknowledgement as outlined above. In response to examiners' inquiries, Horizon advised that while the claim was not input into the system promptly, the claim was being handled and the investigation was timely. However, the claim remains cited for untimely acknowledgement.

Please See Appendix B-8 for File in Error

9. Improper Systemic Denial of Complete Blood Count (CBC) CPT Code 85025 – 5 Random Files in Error, 26,638 Claims Overall (Improper General Business Practice)

Contrary to **N.J.S.A. 17B:30-13.1d**, Horizon improperly denied five random claims submitted under CPT code 85025 for complete blood count ("CBC").

The claims system listed the denial reason as "invalid procedure disallow". In response to the examiners' inquiries regarding the cause of this error, the Company stated that the denials were caused by a system configuration issue.

In order to determine the extent of this error, the examiners requested the Company to provide a list of claims where CPT code 85025 was improperly denied during the time period of this configuration error. The Company indicated that a total of 642 provider ID's and 26,638 claims were impacted. Corrective action to remediate erroneously denied claims ensued on January 24, 2017. The Company reviewed the prior 18 month period and reprocessed claims with interest payments. Although the Company identified this issue prior to the examiners' inquiry, the issue originated prior to system transition on April 1, 2016, possibly as far back as 18 months, and was not corrected until January 2017, after the review period of October 2016 to December

2016. Therefore this error has been included in the error ratio and cited as an improper general business practice due to frequency and time period affected.

Please See Appendix B-9 for Files in Error

10. Unfair Denial of Wellness Exam/EPSDT Benefits due to Claim System Errors – 1 Random File in Error; 248 Claims In Error Overall

The Early and Periodic Screening, Diagnostic and Treatment ("EPSDT") benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The examiners found that Horizon failed to provide this benefit as outlined below.

During a review of file 16334G710001, the examiners found that Horizon denied CPT code 99384 (Well Child Outpatient with encounter for contraceptive management) due to a system configuration error. In response to the examiners' inquiry, the Company stated the issue was discovered on January 5, 2017 after outreach from a provider. The error caused erroneous denials for CPT codes 99381, 99385, 99391-99395, 99460, 99461, and 99463 with a qualifying EPSDT diagnosis by applying an "X86" code incorrectly indicating that the physician was not the member's PCP or OBGYN. The Company advised that the error was remediated on January 12, 2017 after a system sweep for impacted claims.

In order to determine the overall frequency of this error, the examiners requested the Company to provide a list of all claims denied due to this configuration error. In response, Horizon provided a list of 248 claims denied between October 3, 2016 and January 5, 2017. Horizon re-adjudicated these claims. This configuration error affected 22 providers and resulted in $133.10 in interest.

The examiners found that Horizon failed to comply with **N.J.S.A. 17B:30-13.1d.** The examiners note that a provider notified Horizon of this error.

Please See Appendix B-10 for File in Error

11. Improper Denials of Home Health Care - PPP Personal Care Assistant – 5 Random Files in Error; 1,332 Claims In Error Overall (Improper General Business Practice)

During random file reviews, the examiners found several claims that Horizon originally denied for "No Precert/Authorization or Referral" for Home Health Care- PPP Personal Care Assistant, but subsequently paid as adjustments. The Company responded to the examiners' inquiry that the

claims were originally denied due to manual processing errors despite the existence of valid authorizations.

The Company further stated that its claim processing systems were updated retroactively on November 26, 2016 to no longer require authorizations for these services.

The examiners requested the total population of claims affected by this error. In response, Horizon provided a list of 1,475 claims for dates of service in 2016 that had already been addressed. A total of 1,332 claims out of the population of 1,475, or 90%, were processed in error and re-adjudicated. The examiners cited this error pursuant to **N.J.S.A. 17B:30-13.1d**, and as an improper general business practice.

Horizon stated that interest was not paid on these claims because an advance was previously made to the provider that covered costs for these services and because a positive balance was maintained.

Please See Appendix B-11 for Files in Error

12. Improper Systemic Denial of CPT Code S9083 at Urgent Care Centers – 5 Random Files in Error, 8,004 Claims In Error Overall (Not Counted in the Error Ratio)

Pursuant to **N.J.S.A. 17B:30-54**, Horizon is required to reimburse a hospital or physician for medically necessary urgent care services that are covered under a health benefits plan. Contrary to this statute, Horizon erroneously denied five random claims submitted under CPT code S9083 (global fee urgent care centers) for "GLB Disallow-global case". In response to the examiners' inquiries regarding the cause of this error, the Company stated that a system configuration issue caused denials of CPT code S9083 under place of service 20 (urgent care facility).

In order to determine the extent of this error, the examiners requested the Company to provide a list of claims including all erroneous denials caused by this system configuration failure. The Company responded with a spreadsheet indicating that a total of 8,004 claims submitted from 22 different providers were impacted. Horizon advised that the system configuration issue was resolved on November 7, 2016 and the claims were reprocessed, resulting in $953.27 in interest payments. The five randomly reviewed claims in this section are not included in the error ratios because the Company resolved this issue independently during the review period; the examiners found no evidence that deficiencies of this nature continued beyond that point of reconciliation.

Please See Appendix B-12 for Files in Error

IV. RECOMMENDATIONS

Horizon should inform all responsible personnel who handle the files and records cited as errors in this report of the remedial measures that follow. 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 additional errors may have occurred.

Various non-compliant practices were identified in this report. The Company is directed to take immediate corrective action to demonstrate its ability and intention to conduct business according to New Jersey law and regulations.

The examiners acknowledge that during the examination, the Company agreed and had voluntarily complied with, either in whole or in part, some of the recommendations outlined below. 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, Chief of Market Regulation, 20 West State Street, PO Box 329, Trenton, NJ 08625, within thirty (30) days of the date of the adopted report.

On claims to be reopened for supplemental payments, the claim payment should be sent to the insured or provider with a cover letter containing the following first paragraph (variable language is included in parentheses):

"During a recent examination, Market Conduct Examiners from the New Jersey Department of Banking and Insurance found errors in our claim payments and recommended a further review to determine if additional benefits and interest are payable. Our review indicated that we (improperly calculated interest/did not apply interest/improperly denied your claim) and are providing you with an updated (Explanation of Benefits/Remittance Advice). To correct this error, we are including a check for (insert amount) for the amount owed, as well as interest in the amount of (insert amount). If you have any questions regarding this process, please contact us at (toll free number) or write us at the address listed on the (Explanation of Benefits/Remittance Advice)."

B. Provider Appeals and Appeal Mechanism

1. The Company should issue written instructions to applicable personnel stating that pursuant to **N.J.S.A. 26:2S-12c** and **N.J.A.C. 11:24-8.7(k)**, the IURO's determination is binding on the HMO and the member. These instructions should emphasize that a HMO shall provide benefits (including payment of the claim) promptly and without delay.

   In order to comply with settlement fairness requirements outlined in **N.J.S.A. 17B:30-13.1f** with respect to IURO decisions, Horizon must provide documentation that it corrected the cause of delayed claim payments following IURO reversals. The Company must also research all IURO reversals issued in calendar year 2016 in order to identify and remediate any delayed authorizations or claim payments. Horizon must provide the Commissioner with a report of findings that include claim number, date of claim, date of IURO decision, date of authorization (if applicable), date of payment, CPT code and diagnosis code.

2. Horizon must issue written instructions to all appropriate staff stating that, pursuant to **N.J.S.A. 26:2J-8.1d(9)**, interest at 12% is required when the claim is paid after 30 days (claims submitted electronically) or 40 days (claims submitted by mail). Horizon should also instruct staff that interest on claims that are paid as a result of an IURO reversal accrues from 30 or 40 days of the claim receipt date to the claim payment date.

   Horizon should review all internal appeal and IURO decisions that reverse an adverse determination. This review should identify the following fields: date of initial claim, date of appeal award, date of payment, principal paid, and interest paid. Where the interest payment does not begin 30 or 40 days after the claim receipt, Horizon should calculate interest from that date to the payment date, deduct any interest already paid and then remit the balance to the provider. Upon conclusion, Horizon should submit a summary spreadsheet to the Commissioner that includes the above-stated fields.

3. To assure compliance with **N.J.S.A. 17B:30-13.1d**, Horizon must submit a report detailing all claims impacted by CPT modifier 50 for bilateral procedures. The report should include the total number of claims that were affected by this error, including original claim number, CPT code, amount denied, amount subsequently paid, date paid, receipt date and interest paid. See general instructions for language to be included in the cover letter sent with each payment. Horizon should also provide a summary of the action taken to correct this error.

C. Claims Adjudication and Re-Adjudication/Adjustment

4. Horizon must issue written instructions to all appropriate staff stating that, according to N.J.S.A. 17B:30-53(1), no payer shall deny reimbursement to a hospital or physician on the basis of medical necessity if the payer approved authorization for the health care services delivered prior to rendering the service. Horizon should also instruct staff that N.J.S.A. 17B:30-13.1d prohibits denial of claims without conducting a reasonable investigation based upon all available information.

   To assure compliance with N.J.S.A. 17B:30-53(1) and N.J.S.A. 17B:30-13.1d, Horizon must submit to the Commissioner a plan of correction that addresses the system configuration errors that caused denials of claims with authorizations. The Company should also provide an updated report on the 7,263 potentially impacted claims (modifier match logic) that were under further review during the examination. The report should include the total number of claims that were affected by this error, including original claim number, CPT code, amount denied, amount subsequently paid, date paid, receipt date and interest paid. See general instructions for language to be included in the cover letter sent with each payment.

5. The Company should provide written instructions to all appropriate employees that N.J.S.A. 17B:30-13.1c requires insurers to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies. To assure compliance, Horizon must provide an updated report of the universe of 7,851 potentially mismatched authorizations due to manual errors and provide original claim number, CPT code, amount of overpayment, and the date and amount of recoupment in the event of recoveries.

6. To further assure compliance with N.J.S.A. 17B:30-13.1d, Horizon must provide a plan of correction to assure that radiology and mammogram claims are properly adjudicated and not denied due to errors in processing authorizations. Horizon must also submit an updated report on the re-adjudication of the population of 2,039 claims impacted by system configuration errors with the 205 different radiology CPT codes referenced in this report. The report should include original claim number, CPT code, amount denied, amount subsequently paid, date paid, receipt date and interest paid. Horizon should also provide a summary of the action taken to correct this error.

7. The Company must demonstrate that it corrected processing errors that failed to identify and recognize Explanations of Benefits. Horizon must also demonstrate that its claims system no longer automatically denies claims that are eligible only through Medicaid. To assure compliance

with **N.J.S.A. 17B:30-13.1d**, Horizon must submit an updated report of re-adjudicated claims denied under this error type. The report should include original claim number, CPT code, amount denied, amount subsequently paid, date paid, receipt date and interest paid.

8. The Company should remind all appropriate employees that **N.J.S.A. 17B:30-13.1n** requires a HMO to provide a reasonable explanation of the contractual and legal basis for denying a claim. In addition, **N.J.A.C. 11:2-17.8(a)** requires a specific reason for denial. Horizon should amend or replace the external denial codes cited in this report to comply with these regulations. Specifically, Horizon must avoid conjunctive statements that utilize "or", "and/or", or "/" conditions in the reason for denial.

9. Horizon must provide a plan of correction demonstrating that it corrected taxonomy errors related to emergency response devices and the monthly fees associated with these devices. Horizon must submit an updated report of re-adjudicated claims denied under this error type. The report should include original claim number, CPT code, amount denied, amount subsequently paid, date paid, receipt date and interest paid.

10. The company should remind all appropriate staff that **N.J.A.C. 11:2-17.6(b)** states that every insurer, upon receiving notification of claim shall, within 10 working days, acknowledge receipt of such notice unless payment is made within such period of time.

11. Horizon should provide a corrective action plan that verifies the Company's activity that corrects and remediates inappropriate denials of CPT Codes, specifically those associated with laboratory services (complete blood count), wellness exams, home health care, personal care and urgent care services. Horizon must submit an updated report of re-adjudicated claims denied under this error type. The report should include original claim number, CPT code, amount denied, amount subsequently paid, date paid, receipt date and interest paid.

APPENDIX A – PROVIDER APPEALS AND APPEAL MECHANISM

1. **Failure to Pay Internal and External Appeal Awards Promptly upon Receipt of Decision – 13 Appeals in Error with Interest Impact of $55,816.04 (Improper General Business Practice)**

Appeal Number	IURO Determination Date	Overturned IURO Payment Date	Days to Pay Overturned Appeal
0001776848-AP0003	12/5/16	4/13/17	129
0001855609-AP0004	11/15/16	4/17/17	153
0001983984-AP0003	8/8/16	4/17/17	252
0002086088-AP0003	10/20/16	4/17/17	179
0002092437-AP0003	10/10/16	4/13/17	185
0002168334-AP0003	11/23/16	4/17/17	145
0002177822-AP0003	10/6/16	4/17/17	193
0002179741-AP0003	10/31/16	3/7/17	127
0002187039-AP0003	11/16/16	4/17/17	152
0002210591-AP0003	11/18/16	4/17/17	150
0002243342-AP0003	10/26/16	4/17/17	173
0002281415-AP0003	10/14/16	4/17/17	185
0002826136-AP0003	12/21/16	4/17/17	117

2. **Failure to Calculate and Pay Interest Accurately on External Appeal Awards – 13 Files in Error (Improper General Business Practice)**

Appeal	Appeal
0001776848-AP0003	0002179741-AP0003
0001855609-AP0004	0002187039-AP0003
0001983984-AP0003	0002210591-AP0003
0002086088-AP0003	0002243342-AP0003
0002092437-AP0003	0002281415-AP0003
0002168334-AP0003	0002826136-AP0003

0002177822-AP0003

3. **Failure to Accurately Adjudicate CPT Modifier 50 for Bilateral Procedures – 1 File in Error (Improper General Business Practice)**

Appeal
0002537911-AP0003

APPENDIX B – CLAIMS ADJUDICATION and RE-ADJUDICATION/ADJUSTMENTS

1. **Systemic Failure to Link Authorizations and Referrals to Corresponding Claims Resulting in Underpayments - 30 Random and 4 Select Files in Error, 8,518 Known and 7,263 Potential System-wide Errors with Interest Impact of $79,714.28 – (Improper General Business Practice)**

Claim	Claim	Claim	Claim	Claim
16313G409801	16295G829302	16348F557702	16292E384103*	16307E809201
16293J129401	16341F444702	16350J072402	16280I435803*	16322E812901
16358L620301	16291E004502	16314E202402	16280I436504*	16292E423601
16327G848701	16300F209402	16341E021702	16322I169102*	16328H210400
163157433901	16356E126302	16364E212101	16342I855702	16319I234800
16354G952301	16364H109902	16363F150401	16348F557702	16287G968002
16295F281002	16327F728502	16280F054401	16322E311501	

*Select Review

2. **Manual Failure to Link Authorizations to Corresponding Claims Resulting in Potential Overpayments - 1 Select File in Error, 7,851 Potentially Impacted Claims Overall – (Improper General Business Practice)**

Claim
16281E123900

3. **Unfair Denial of Radiology Claims including Mammograms Due to Claim System Errors – 3 Random Files in Error, 2,039 Claims Overall – (Improper General Business Practice)**

Claim
16292E323701
16301F126401
16286G508001

4. **Improper Denial of Claims for Explanation of Payment (EOP) Requests – 2 Random and 7 Select Files in Error, 6,031 Claims in Error Overall with $40,227.43 in Interest – (Improper General Business Practice)**

   a. Failure to Recognize EOB from Other Carrier - 1 Random and 7 Select Files in Error

Claim	Claim	Claim
163549005000	162781318900*	162781583300*

162771310600*	162781276100*	162781299300*
16278105500*	162801120500*	

*Select Review

b. Incorrect EOP Denials- Services Only Covered by Medicaid- 1 Random File in Error

Claim
16315F601301

5. **Improper Denial and Failure to Pay Interest on Emergency Response Devices due to Claim Errors Relative to Taxonomy Codes – 24 Random Files in Error; 6,511 In Error Overall with Interest Impact of $2,577.52 (Improper General Business Practice)**

Claim	Claim	Claim
16315H404401	16315G962201	16315H408601
16279I865801	16315G986701	16343G170201
16343G708901	16315H388501	16315H402401
16315H386801	16315H390001	16343G267101
16343G715201	16343G254901	16315G995301
16343G686401	16279H879201	16315G944501
16343G708701	16315H023001	16279I854901
16315H038501	16315H396801	16315G958601

6. **Failure to Issue Specific Denial Reasons – 2 Select Files in Error, 24 Denial Codes in Error with 46,710 Errors on Denial Codes R01 and ZAK (Improper General Business Practice)**

Select Files in Error

Claim	Claim
162791343000	16277H131800

External Denial Codes in Error

Denial Code	Denial Explanation
108	Invalid Procedure/Modifier/POS Combination
C03	RiskWhAmt
H66	Missing/Incomplete/Invalid Principle Diagnosis
I05	Invalid/Inappropriate/Deleted Code, Modifier or Description; Please Refile
I06	Itemized Bill, Dates of Service, Charges or Invoice Required; Please Refile
I07	Invalid/Inappropriate/Deleted Code, Modifier or Description
I15	Resubmit with appropriate Modifier and/or time units
IA4	NDC number, use during effective date, quantity or unit of measure is either missing, incomplete, or invalid
R01	Authorization or Referral not Obtained and/or not the Member's PCP
R02	Referral Discrepancy

R18	Resubmit with ICD9 principle procedure code or valid HCPCS or CPT code
R60	Dates and/or Services Outside Referral/Authorization
X05	Invalid/deleted/inappropriate code, modifier or description
X08	Diagnosis Invalid/Missing/Deleted/Requires 4th or 5th digit
Z95	Invalid/Deleted/Inappropriate Code, Modifier or Description
ZAK	Authorization or Referral not Obtained and/or not the Member's PCP
ZM3	No Precert/Authorization or Referral Obtained
ZRG	Procedure not valid for gender and/or diagnosis
ZS3	Dates and/or Services Outside Referral/Authorization
ZZ1	Specific documentation required for payment is missing/illegible/duplicate from another provider
ZZ2	Specific documentation required for payment is missing/illegible/duplicate from another provider
e82	This Service is not paid. The procedure exceeded max units allowed per date of service on this claim or another claim for same DOS.
p01	A required procedure code or modifier is missing or invalid on the current line or an associated claim line
04	Documentation or authorization is required to be submitted and/or reviewed

7. **Failure to Settle Claims Timely – 2 Random Files and 1 Select File in Error**

Claim	Date Received	Date Denied	Days Over 30/40
162941345600	10/20/16	12/7/16	8
16322H825600	11/17/16	12/20/16	3
16279J293000*	10/5/16	11/7/16	3

*Select Review

8. **Failure to Acknowledge Claim Timely - 1 Random File in Error**

Claim	Date Received	Date Claim Entered	Working Days Over 10
163549005000	12/19/16	1/9/17	3

9. **Improper Systemic Denial of Complete Blood Count (CBC) CPT Code 85025 – 5 Random Files in Error, 26,638 Claims Overall (Improper General Business Practice)**

Claim
16351F007201
16351G817501
16354H167601
16366E545301
16362H611901

10. **Unfair Denial of Wellness Exam/EPSDT Benefits due to Claim System Errors – 1 Random File in Error; 248 Claims In Error Overall**

Claim
16334G710001

11. **Improper Denials of Home Health Care - PPP Personal Care Assistant – 5 Random Files in Error; 1,332 Claims In Error Overall (Improper General Business Practice)**

Claim	Claim	Claim
16293E806101	16279G064801	16293E831201
16293E301501	16277F115801	

12. **Improper Systemic Denial of CPT Code S9083 at Urgent Care Centers – 5 Random Files in Error, 8,004 Claims In Error Overall (Not Counted in the Error Ratio)**

Claim
16279J957801
16279J959901
16288H845601
16301G978701
16301G993401

V. VERIFICATION PAGE

I, Robert Greenfield, 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 June 08 2017.

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.

July 13, 2017
Date

Robert Greenfield
Examiner in Charge
New Jersey Department of Banking
and Insurance