ORDER NO. E15-12

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 AmeriChoice of New Jersey, Inc., NAIC No. 95497	))))	CONSENT ORDER

TO: UnitedHealthcare Community Plan of New Jersey
333 Thornall St.
9th Floor
Edison, NJ 08837

This matter, having been opened by the Commissioner of Banking and Insurance ("Commissioner"), State of New Jersey, upon the filing of a Market Conduct Examination Report (the Report) containing the results of the January 1, 2011 to December 31, 2012 examination of Medicaid Health Maintenance Organization claim practices of AmeriChoice of New Jersey, Inc. (the Company) 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 market conduct examination revealed certain instances, as fully set forth in the Report, where the Company's practices did not accord fully with various provisions of New Jersey insurance statutes or regulations; and

WHEREAS the Company's claim practices contained certain instances where the frequency of error was such as to constitute an improper general business practice; and

WHEREAS, based on the documentation and information submitted by the Company, the Department is satisfied that the Company has taken or will take corrective measures pursuant to the recommendations of the Report.

NOW, THEREFORE, IT IS on this 8th 15th day of January, 2015

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

IT IS FURTHER ORDERED AND AGREED that the Company 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 the Department will commence a reevaluation of the Company within twenty-four (24) months of the date of this Consent Order to determine if the Company has complied with the recommendations contained in the attached Report and if there is a need to reexamine the Company; and

IT IS FURTHER ORDERED AND AGREED that in the event a reevaluation and reexamination determines that the Company has not fully implemented the recommendations and complied with New Jersey insurance statutes and regulations, the Company will be subject to appropriate penalties and administrative sanctions; and

IT IS FURTHER ORDERED AND AGREED that pursuant to N.J.S.A. 17:23-24d(1), within 30 days of the adoption of the Report, the Company 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.

Peter Hartt
~~Acting~~ Director of Insurance

Consented to as to form, content and entry

Name

Date: 1/8/15

MARKET CONDUCT EXAMINATION

of

AMERICHOICE
OF NEW JERSEY, INC

located in

NEWARK, NEW JERSEY

as of

February 3, 2014

BY EXAMINERS

of the

STATE OF NEW JERSEY

DEPARTMENT OF BANKING AND INSURANCE

OFFICE OF CONSUMER PROTECTION SERVICES

MARKET CONDUCT EXAMINATIONS and ANTI-FRAUD COMPLIANCE SECTIONS

REPORT ADOPTED: JANUARY 21, 2015

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I. INTRODUCTION

This is a report of the Market Conduct activities of AmeriChoice of New Jersey, Inc. (hereinafter referred to as AmeriChoice or the Company). This review was limited to coverage that AmeriChoice provides under a contract with the New Jersey Division of Medical Assistance and Health Services (DMAHS) for New Jersey residents who are eligible for Medicaid health programs. Authority for this examination is found under **N.J.S.A. 26:2J-18.1** and **N.J.S.A. 17B:30-16**, made applicable to the operations of a health maintenance organization by **N.J.S.A. 26:2J-15b**. Also, **N.J.A.C. 11:24-2.12** requires an HMO to open its books and records for an examination. Market Conduct Examiners of the New Jersey Department of Banking and Insurance (hereinafter 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 Clifton J. Day, Marleen Sheridan, Monica Koch, Robert Greenfield, Ralph Boeckman, William Sonntag, Richard Segin, Erin Porter and Michael Wise.

A. Scope of Examination

The scope of the examination included managed care claims that AmeriChoice processed on behalf of New Jersey's Medicaid program. These included medical provider, institutional provider, dental, behavioral health, prescription and vision claims. The examiners also reviewed Special Needs claims that were dually eligible under Medicaid and Medicare. Overall, the purpose of this examination was to determine compliance with fair settlement practices mandated **by N.J.S.A. 17B:30-13.1**, prompt pay requirements outlined in **N.J.S.A. 26:2J-8.1d**, appeal rights notification requirements outlined in **N.J.A.C. 11:24B-3** and **N.J.A.C. 11:24-8.4**, 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 January 1, 2011 through December 31, 2012. The examiners conducted this review at the Company's office located in Newark, New Jersey, between May 13, 2013 and November 8, 2013. 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 NAIC) Market Regulation Handbook, Chapters 14, 16 and 20.

B. Error Ratios

Error ratios are the percentage of files reviewed which an insurer handles in error. A file is counted as an error when it is mishandled or the insured is treated unfairly, even if no statute or regulation is applicable. If a file contains multiple errors, the examiners will count the file only once 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 insurer 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 insurer 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 an insurer commits so frequently 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 insurer errors that may be technical in nature or which did not have an impact on a consumer. Even though such errors or practices would not be 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 consumer, each of the files in error will be counted in the error ratio. The examiners indicate in the report whenever they did not count particular files in the error ratio.

For purposes of the database analyses conducted in this review, the examiners define an exception as a file or record in a database that does not meet specified criteria as set forth in electronic queries. These include, but are not limited to, time studies that measure the difference between date received and date paid or denied, and interest calculations based on principal amount paid and total days beyond maximum settlement periods. An examiner has not conducted an in-depth review on these records, as the examiners relied on the Company's data.

The examiners submitted written inquiries to Company representatives on the errors cited in this report. These inquiries provided AmeriChoice 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.

C. Company Profile

AmeriChoice of New Jersey, Inc. (conducting business as United Healthcare Community Plan New Jersey) is licensed as a health maintenance organization (HMO) and offers its enrollees a variety of managed care programs and products through contractual arrangements with health care providers. The Company is a wholly owned subsidiary of AmeriChoice Corporation ("AmeriChoice"). AmeriChoice is a wholly owned subsidiary of UnitedHealth Group Incorporated ("UnitedHealth Group"). UnitedHealth Group is a publicly held company trading on the New York Stock Exchange. UnitedHealthCare Services, Inc. (UHS), an HMO management corporation and an affiliate of the Company, provides services to the Company under the terms of a management agreement.

The Company was incorporated on October 17, 1994, as an HMO and operations commenced in February 1996. The Company is identified as an HMO by the State of New Jersey Department of Banking and Insurance. The Company has entered into contracts with physicians, hospitals, and other health care provider organizations to deliver health care services for all enrollees. As of December 1, 2013, the company had 385,000 members. At year-end 2012, assets were $440,402,018, liabilities were $302,607,672, and statutory premium was $1,714,452,062.

During the review period, the Company had a contractual relationship with the DMAHS, to provide health care services to Medicaid and FamilyCare (a program for uninsured children and adults) eligible beneficiaries in New Jersey. The contract was effective through December 31, 2013, and was subject to annual renewal provisions thereafter.

II. INAUDITABILITY OF ELECTRONIC RECORDS

A. Introduction

Pursuant to **N.J.A.C. 11:22-1.5(d)** and **N.J.A.C. 11:2-17.12**, an insurer is required to maintain an auditable record of claim transactions and records in a manner that permits the Department to reconstruct a company's claim settlement activities. Contrary to these requirements, the examiners found errors that reflect the Company's inability to maintain auditable claim records. These errors are outlined below.

1. Electronic Datasets

The examiners attempted to conduct an electronic review of all Medicaid claims that AmeriChoice processed during calendar year 2012. In response to the examiners' data call requests, the Company provided several spreadsheets that contained paid and denied claims that providers submitted either electronically or by mail. Specific coverage lines included professional provider and facility claims, institutional provider and facility claims, as well as behavioral health, vision, dental and prescription claims. The examiners also requested dataset claims on all Dually Eligible Special Needs Policies (DSNPs) that were dually eligible through Medicare and Medicaid (but deemed primary through Medicaid).

In response to the call letter that outlined specific data fields and formats, and after two pre-examination conference calls, the Company provided a series of datasets via spreadsheets or databases with scheduled due dates of March 26, 2013, April 1, 2013 and April 15, 2013. Contrary to **N.J.A.C. 11:22-1.5(d)** and **N.J.A.C. 11:2-17.12**, AmeriChoice was unable to provide accurate datasets upon first, second and in some instances, a third submission, which occurred on dental, behavioral health, prescription drug and vision datasets.

As an example on dental claims, the Company provided the examiners with two paid and two denied claim databases on April 15, 2013. Upon review, the examiners noted that the claim receipt date was omitted from these datasets. This field was essential for conducting a paid and denied time study to determine compliance with maximum settlement periods outlined in **N.J.S.A. 26:2J-8.1d** (30 days for paid claims submitted electronically or 40 days for claims submitted by mail). In response to a request for a corrected version, AmeriChoice submitted a revised dataset on April 23, 2013. Although that dataset did include date of receipt, the data extraction included zero values on all claims previously designated as paid. As such, the examiners were again unable to conduct this time study. AmeriChoice submitted revised dental datasets on July 8, 2013; however, the denied datasets included a nominal number of paid claims, and the paid datasets

included a nominal number of denied claims. The examiners were unable to conduct an accurate population-wide time study on dental claims due to these data inconsistencies.

Similar to dental claims, AmeriChoice was unable to provide viable population-wide data on behavioral health claims after three attempts, the first on April 15, 2013, the second on April 23, 2013 and the third on July 8, 2013. The first dataset omitted date of receipt, while the second and third datasets omitted decimals in the amount paid column. Without decimals, the examiners were unable to determine, for example, if the integer 34329 was in reality $343.29, $34,329 or $3,432.9. This error impeded the ability to determine actual amount billed, allowed, principal paid and interest paid. Additionally, the July 8, 2013 datasets did not distinguish between mailed or electronic claim submissions. Consequently, the examiners were unable to distinguish between a 30 calendar day and 40 calendar day settlement requirement.

Similar errors included either omitted or invalid date formats that occurred on prescription drug, vision, institutional and professional claims. On DSNP claims, the first dataset included an inaccurate claim receipt date. Rather than recording the initial date of claim submission, the Company provided the date that staff members deemed these claims to be ineligible under Medicare and eligible under Medicaid. Consequently, this dataset did not include the time that elapsed between receipt date and date of eligibility determination. AmeriChoice ultimately provided a corrected Medicaid DSNP dataset that included all required information.

Contrary to **N.J.A.C. 11:22-1.5(d)** and **N.J.A.C. 11:2-17.12**, AmeriChoice failed to maintain an auditable record of claim transactions and records in a manner that permits the Department to reconstruct the Company's claim settlement activities. AmeriChoice agreed with this error in response to examiner inquiries and during formal discussions with the Department.

2. Correspondence to Members

While conducting the claim denial review, the examiners found that AmeriChoice could not readily retrieve denial letters or similar correspondence on the randomly selected denied claims. In response to an inquiry, the Company explained that such correspondence are imaged and maintained in a Portable Document Format (PDF) that cannot be indexed or otherwise searched by claim or member number, or any other information that would locate a specific denial letter in a timely manner. AmeriChoice further explained that each PDF file contains multiple documents that require a manual review by a date that would coincide with the claim denial date and the PDF creation date. The examiners observed such a file and, due to the

laborious nature of this search process, decided to review a random sample of only 18 denial letters.

Contrary to **N.J.A.C. 11:22-1.5(d)** and **N.J.A.C. 11:2-17.12,** AmeriChoice's claim denial correspondence retention methodology impeded the examination process, resulted in an incomplete review and hindered the examiners' ability to reconstruct claim denials selected for review.

3. Waiver of Authorizations for Medical Day Care and Personal Care Assistant Benefits

On April 23, 2013, the examiners met with Company staff to discuss examination methodology and the datasets that AmeriChoice utilizes to process claims. During that meeting, the Company advised that system's limitations required claim processors to waive the need for authorization approval and tracking on Medical Day Care (MDC) and Personal Care Assistant (PCA) benefits. This waiver occurred during the period May 2011 through September 2012. The Company reinstituted authorization requirements by adding macro language to the claims processing system. Errors in that language, however, caused claims to systematically auto-deny or pend, even where a valid authorization was recorded in the claims processing system. Contrary to **N.J.A.C. 11:22-1.5(d)** and **N.J.A.C. 11:2-17.12**, the examiners were therefore unable to conduct an authorization quality and time study since authorizations were waived prior to September 2012, and frequently denied after September 2012 even when recorded as approved. AmeriChoice advised that this error was corrected in late 2012 and early 2013.

III. PROVIDER APPEALS AND APPEAL MECHANISM

A. Introduction

The examiners reviewed AmeriChoice's internal appeal process and appeal mechanism for compliance with **N.J.A.C. 11:24-3.7** (Complaint and Appeal System), **N.J.A.C. 11:24-8.4** (Appeals of Adverse Benefit Determinations), **N.J.A.C. 11:24-8.5** (Informal Internal Utilization Management Appeals Process – Stage 1), **N.J.A.C. 11:24.8.6** (Formal Internal Utilization Management Appeal Process – Stage 2) and **N.J.A.C. 11:24-8.7** (External Appeal Process).

During the period January 1, 2011 through December 31, 2012, AmeriChoice received a total of 31,076 administrative appeals (13,174 for 2011 and 17,902 for 2012), 7,742 internal Stage 1 and Stage 2 utilization management appeals (1,333 for 2011 and 6,409 for 2012) and 218 external IURO appeals.

B. Statistical Comparison Between Administrative and Utilization Management Appeal Determinations

The examiners attempted to conduct a statistical comparison between the outcome (claim determination/denial upheld versus overturned/reprocessed for payment) of administrative appeals and internal and external utilization management appeals; however, data inconsistencies (empty Resolution fields that designated the appeal as upheld or overturned) in the administrative/prompt pay appeal database made this analysis impossible. The examiners were, however, able to analyze the standalone utilization management datasets to compare appeal determination rates between Stage 1 and Stage 2 appeals over time (2011 and 2012) as follows.

The examiners queried the internal utilization management appeals datasets and found that AmeriChoice overturned the initial determination on 34.05% of all 2011 Stage 1 appeals. The Company overturned 27.78% of all 2011 Stage 1 appeals when a member or provider filed a Stage 2 appeal. The combined 2011 Stage 1 and 2 appeal overturn rate was 33.46%. For 2012, AmeriChoice overturned the initial determination on 23.06% of all Stage 1 appeals. The Company overturned 19.45% of all 2012 Stage 1 appeals when a member or provider filed a Stage 2 appeal. The combined 2012 Stage 1 and 2 appeal overturn rate was 22.28%. The examiners note that the Stage 1 and Stage 2 overturned appeal frequency decreased from 33.45% in 2011 to 22.28% in 2012. This represents a 33.41% decrease in the need to overturn a previously denied or compromised claim or utilization management determination. The combined Stage 1 and Stage 2 overturn rate for 2011 and 2012 was 24.21%. The following chart itemizes these results by year and stage.

Utilization Management Appeal Results

Appeal Year	Type of Appeal	Appeal Population	Appeals Overturned	Percent Overturned
2011	Stage 1	1,207	411	34.05%
2011	Stage 2	126	35	27.78%
	Subtotal	1,333	446	33.46%
2012	Stage 1	5,026	1,159	23.06%
2012	Stage 2	1,383	269	19.45%
	Subtotal	6,409	1428	22.28%
	Overall Total	7,742	1,874	24.21%

C. Error Ratios on Randomly Selected Appeals

The examiners calculated the error ratios by applying the procedure outlined in the introduction of this report. As indicated in the chart below, the examiners randomly selected and reviewed a total of 22 administrative appeals, 75 informal internal Stage 1 appeals, 62 formal internal Stage 2 appeals and 24 external appeals that were heard by an Independent Utilization Review Organization. Overall, the examiners found a total of 53 appeals processed in error, for a random sample error ratio of 29%.

Appeal Error Ratio Chart

Type of Appeal	Appeals Reviewed	Appeals in Error	Error Ratio
Administrative	22	3	14%
Internal Stage 1	75	22	29%
Internal Stage 2	62	24	39%
External IURO	24	4	17%
	183	53	29%

D. Examiners' Findings

1. Unfair Extension of Urgent Appeal Response Deadline (4 Random Sample Files in Error - General Business Practice)

Pursuant to **Article 5, Section 5.15.2B7** of the New Jersey Medicaid contract, a servicing carrier must comply with **N.J.A.C. 11:24 et seq.** when extending appeal response deadlines established in **N.J.A.C. 11:24-8.5** and **N.J.A.C. 11:24-8.6**. The former requires a servicing carrier to respond within no more than 72 hours on Stage 1 urgent or emergency care appeals, and within 10 calendar days on all other Stage 1 appeals. The latter requires a

carrier to respond within no more than 72 hours on Stage 2 urgent or emergency care appeals, and within 20 business days on all other Stage 2 appeals. Pursuant to **Article 4, Section 4.6.4C.4**, a servicing carrier may extend a Stage 2 appeal response deadline by up to 14 calendar days if the enrollee requests the extension, or if AmeriChoice obtains permission from the State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services (DMAHS).

Contrary to **N.J.A.C. 11:24-8.5, N.J.A.C. 11:24-8.6** and **Articles 4** and **5** as outlined above, the examiners found that AmeriChoice unilaterally extended the response deadline by 14 days on four files reviewed from the random sample. AmeriChoice agreed with this error on one appeal and disagreed on the remaining three appeals, stating that medical necessity issues validated response extensions. However, the Company's responses to examiner inquiries failed to document any request for DMAHS approval or enrollee extension requests. Consequently, the Company's application of Articles 4 and 5 was defective and indicative of a general business practice. The following narrative illustrates this error.

Case Number R2310708001 - Stage 1 Appeal

On August 12, 2011, the enrollee's out-of-network provider requested preauthorization on case number R2310708001 to obtain out-of-network services for an infant. Services requested included evaluation of swallowing function and oral pharyngeal feeding due to low infant weight and failure to thrive. The provider further indicated that no in-network providers were available due to appointment backlogs of one month. On August 15, 2011, the Company denied the authorization, stating that use of an out-of-network provider was not medically necessary.

In response, the enrollee submitted a Stage 1 appeal on August 18, 2011. That same day, a Company Reviewer entered the following in the appeals processing system: "Appealing denial for oral and pharyngeal feeding ... Network providers have very lengthy wait list and (member) can't wait ..." On August 19, 2011, AmeriChoice deemed this appeal to be urgent, thus invoking a 72 hour response period. An Appeals Coordinator wrote to the member on August 19, 2011, advising that a response would be provided within 72 hours. On the same day, however, a Resolution Analyst issued written notice to the enrollee stating that, "...we need more time to review your appeal. We need 14 more days to request additional information ... We only ask for extra time if it may help your case." Based on file documentation, AmeriChoice, not the enrollee, made the decision to extend the response period beyond 72 hours. Additionally, AmeriChoice failed to seek a response extension approval from DMHAS. As such, the Company failed to comply with **N.J.A.C. 11:24-8.5** and **Articles 4** and **5**.

Please See Appendix A-1 for Files in Error

2. **Improper Denial of Authorization and Failure to Disclose Member/Provider Obligations when Requesting Authorization (1 File in Error/$3,749 in Denied Benefits)**

On case number K0190314001, the member's provider submitted a Stage 1 Appeal to AmeriChoice on January 17, 2012 in response to a previous preauthorization denial for a motorized wheelchair. On January 24, 2012, the AmeriChoice medical director determined that the appeal should be denied and that the initial adverse determination should be upheld. The medical director issued a written denial to the appeal on January 24, 2013 that included the following three reasons for denial: 1) "Deny, as per evidence-based guidelines (Milliman) A-0253 ... your doctor does not document why you cannot walk with a Cane or Walker or Scooter; 2) "The prescription for the wheelchair does not specify the different parts that are essential; 3) "There is no description of the physical layout. All these items must be submitted to review the appeal ..." Below, the examiners provide a partial illustration as to how the Company evaluated the first reason for denial.

With respect to the company's position regarding the efficacy of a cane, walker or scooter as an alternative to a motorized wheelchair, the examiners reviewed the provider's appeal documentation which AmeriChoice received on January 17, 2012. Within that documentation, the examiners found a 4-page clinical assessment designated as Power Mobility Device Evaluation (PMDE) that describes the member's medical condition. This assessment was signed by the member's physician. Page 1, Section 1 of the PMDE assessment addresses medical conditions that limit a patient's mobility within the home. The provider selected the following conditions that limit the member's mobility: Parkinson's Disease, COPD, Degenerative Joint Disease, Diabetes. Moreover, Section 2, page 1 of the PMDE assessment addresses symptoms of the conditions selected in Section 1 of the PMDE. The provider identified the following symptoms experienced by the member: Abnormal Gait, Tremor, Walking Limitations, Weakness, Fatigue. Additionally, page 2 of the PMDE indicates that the member's physical limitations include upper body weakness due to tremor and Parkinson's, upper body pain due to disc herniation, limited upper body range of motion due to tremor and Parkinson's, lower body weakness due to severe spastic bi-lateral leg weakness, lower body pain due to disc herniation.

Based on the information presented above with respect to denial reason 1 and the file materials submitted for review relative to reasons 2 and 3 above, the provider appears to have adequately addressed all three reasons that AmeriChoice relied upon in its denial of this service. The provider satisfied all clinical and medical necessity requirements specified in the Company's health benefit plan, specifically, Milliman Guidelines. Since the

provider's documentation complied with all Milliman Guidelines, the Company's continued refusal to recognize this authorization as medically necessary is inconsistent with **N.J.S.A. 17B:30-50**, which defines medical necessity and generally accepted standards of medical practice. Notably, this statute requires a carrier to process authorization requests in accordance with medical necessity requirements outlined in its health benefit plan.

As indicated above, AmeriChoice asserts that Milliman Guidelines require a description of the physical layout of the member's home to assure safety. The company's internal notes and written communications indicate that this function rests primarily with the provider, or secondarily with the member. AmeriChoice assumed no role in making this determination as evidenced by its denial language and file documents. As such, AmeriChoice imposed obligations and settlement conditions on the member that must be fulfilled as a prerequisite to payment. Where such obligations exist, **N.J.S.A. 17B:30-51a(1)** requires an insurer to post conspicuously on its Internet website all clinical criteria and guidelines used to determine medical necessity. Contrary to this statute, AmeriChoice failed to post or otherwise convey the member's or provider's obligation to submit a physical description of the member's home as a condition for approval for this type of service.

Lastly, the examiners note that both the initial authorization denial and the appeal denial failed to comply with **N.J.A.C. 11:24-8.4(e)**. This regulation requires insurers to provide the "... reason(s) for the adverse benefit determination ... (and) ... a description of the standard used by the HMO in the denial." AmeriChoice's authorization denial letters stated that Milliman criteria utilized in the adverse determination were available *upon request*. Failure to state these standards at the time of denial is inconsistent with this regulation and may impede subsequent appeal efforts.

AmeriChoice disagreed with this error by referencing the neurological portion of the provider's overall medical evaluation. The Company stated that, "... the member's muscle strength was normal... Despite a tremor, the member should be able to manually propel a wheelchair..." Inconsistent with this assertion, the examiners found that the neurological assessment did not include reference to muscle strength; this section was limited to sensation (deemed to be normal) and Gait and Stance (abnormal, shuffling gait, right leg spasticity, tremor). The examiners note that the Musculoskeletal System section of the report identified bilateral tremor, with no reference to normal strength.

Please See Appendix A-2 for File in Error

3. **Improper use of Contract Language to Deny Authorization for Hospital Readmission (1 File in Error - Improper General Business Practice/$147,133 in Denied Services)**

Pursuant to **N.J.S.A. 17B:30-50**, a carrier is required to process authorization requests in accordance with medical necessity requirements outlined in its health benefit plan. Contrary to this statute on External appeal number 226-5/12, AmeriChoice issued an authorization denial stating that, "You were readmitted in less than 7 days with the same diagnosis. The request for a separate inpatient stay is denied based on the facility's contract with the Health Plan." The examiners reviewed the hospital's contract with AmeriChoice and found this reason to be an incomplete and misleading reference to contract language that in fact permits additional inpatient stays within a seven day period of discharge. Specifically, the contract (form number A/C AP-DRG w/Fixed OP State Specific entitled New Jersey Medicaid State Specific Payment Appendix) states that benefits are payable if the provider "...submit[s] a corrected claim for the first admission, by adding in the claim information of the second admission..." Since the reason for denying this authorization was inconsistent with the terms of the provider contract, AmeriChoice failed to comply with **N.J.S.A. 17B:30-50**. The Company also failed to comply with **N.J.S.A. 17B:30-54**. This statute requires a payer to reimburse a hospital according to the provider contract relative to all medically necessary emergency or urgent health care services. The following illustrates this error.

The provider submitted Stage 1 and Stage 2 internal appeals. On the former, the Company upheld the initial claim decision based exclusively on the initial authorization denial (readmission within seven days from release). On the latter, however, AmeriChoice upheld the Stage 1 appeal, but invoked medical necessity concerns not identified in the initial authorization denial. In response to the Stage 2 denial, the provider filed an External IURO appeal that reversed the internal Stage 1 and Stage 2 decisions. Notably, the external IURO panel relied on the same medical necessity documentation that the provider submitted at the time of claim. AmeriChoice disagreed with these errors, stating that "... providers should be well aware of the terms or provisions of agreements entered into with the Plan." The examiners note that such agreements do not negate the Company's obligation to apply a health benefit plan in accordance with applicable contract language.

The examiners cited this error as an improper general business practice since the Company's position applies universally to all similar situations. The examiners were unsuccessful at quantifying the frequency of this error because the reason code associated with this authorization denial equates to "Time limit for filing has expired."

Please See Appendix A-3 for File in Error

4. **Unfair Authorization Denial due to Conflicting Utilization Management Determinations among Three Separate Medical Directors (1 File in Error/$3,013.15 in Denied Benefits)**

N.J.S.A. 26:2S-6a specifies that a health benefit plan must ensure that "...the treatment policies, protocols, quality assurance activities and utilization management decisions ... shall be based on generally accepted standards of health care practice." Contrary to this statute on Stage 1 appeal number K0121117001, two separate medical directors reached different medical necessity determinations based on the same clinical documentation maintained in the file record. Consensus in terms of generally accepted health care standards was therefore absent. In addition, **N.J.S.A. 17B:30-50** specifies that a carrier is required to process authorization requests in accordance with medical necessity requirements outlined in its health benefits plan. Contrary to this statute, two separate medical directors that processed an initial authorization request failed to consistently apply medical necessity standards outlined in the health benefits plan. These errors are illustrated below.

Upon receipt, a Company medical director initially denied an authorization request for a Specialty Lift Chair at 9:14 am on November 8, 2011. As an alternative, that same medical director approved a Lift Chair Device for use with existing furniture. At 8:54 am on November 9, 2011, however, a different medical director approved the Specialty Lift Chair authorization request in entirety. The examiners note that the approving medical director did not rescind the prior medical director's partial disapproval the previous day. Consequently, AmeriChoice's claim system automatically processed the first authorization determination (denial of Specialty Lift Chair) that was entered into the claims processing system as not medically necessary on November 9, 2011.

Only upon receipt of the Stage 1 appeal did another medical director reverse the initial denial, stating in a letter to the member that additional information validated medical necessity of the Specialty Lift Chair. Inconsistent with this assertion, the file revealed that the provider did not submit additional clinical information. Notably, AmeriChoice deemed the device as medically necessary at appeal Stage 1 based on the same clinical documentation that resulted in the initial, pre-appeal authorization denial. Such inconsistency is contrary to **N.J.S.A. 26:2S-6a** and **N.J.S.A. 17B:30-50** as outlined above. AmeriChoice neither disagreed nor agreed with this finding.

Please See Appendix A-4 for File in Error

5. **Improper Diagnosis Related Group (DRG) Downcoding Resulting in Claim Underpayment (3 Random Appeals in Error/$35,548 in Underpaid Benefits and $6,838 in Interest Penalties)**

Pursuant to **N.J.S.A. 17B:30-53c**, a payer is prohibited from changing a hospital's or physician's billed diagnostic code without providing a written justification for doing so. The examiners found three administrative appeals that resulted from the Company downcoding the provider's Diagnosis Related Group (DRG). Contrary to the above statute and regulation, the Company failed to issue the required explanation for downcoding. The company disagreed with this error by providing the reason for downcoding at the time of this exam. The Company did not, however, provide evidence that it provided these explanations at the time of denial. Moreover, a review of the Explanation of Benefits form to the provider/member revealed denial code 45: "Charges exceed our fee schedule or max allowable amount." This language fails to justify or explain why the submitted DRG was downcoded.

Since these errors caused underpayments, all three providers filed an internal appeal pursuant to **N.J.S.A. 26:2J-8.1e(1)**. This statute requires a carrier to "... establish an internal appeal mechanism to resolve any dispute raised by a health care provider..." The Company's internal appeal panel affirmed the initial denial on all three claims. Consequently, all three providers submitted arbitration requests pursuant to **N.J.S.A 26:2J-8.1e(2)**. This statute specifies that, "Any dispute regarding the determination of an internal appeal conducted pursuant to (**N.J.S.A. 26:2J-8.1e(1)**) ... may be referred to arbitration..." The arbitration organization reviewed all pertinent records and overturned AmeriChoice's internal appeal denials on two of the three payment arbitrations. On the third, the provider withdrew the appeal when AmeriChoice agreed to an informal compromise.

As indicated above, AmeriChoice's initial claim denial and subsequent internal appeal denials were incorrect. Based on the payment arbitration decisions, AmeriChoice possessed all information necessary to pay these claims within 30 days or 40 days from receipt. When such denials are reversed in excess of these settlement periods, any resulting payment is overdue and inconsistent with **N.J.S.A. 26:2J-8.1d(1)**. This statute requires settlement within 30 days on claims received electronically and within 40 days on claims submitted by mail, respectively. Lastly, and contrary to **N.J.S.A. 26:2J-8.1d(9)**, AmeriChoice failed to pay the correct amount interest on one of these claims, contrary to **N.J.S.A. 26:2J-8.1d(9)**. Total amount of interest actually paid was $6,838.

Please See Appendix A-5 for Files in Error and Interest Paid/Underpaid

6. **Failure to Consider Entirety of Medical Records when Denying Appeals (8 Appeals in Error)**

Pursuant to **N.J.S.A. 17B:30-50**, a carrier is required to process authorization requests in accordance with medical necessity requirements outlined in the applicable health benefit plan. Moreover, **N.J.S.A. 26:2S-6a** specifies that a health benefit plan must ensure that "... the treatment policies, protocols, quality assurance activities and utilization management decisions ... shall be based on generally accepted standards of health care practice." Contrary to **N.J.S.A. 26:2S-6a**, AmeriChoice failed to apply such generally accepted standards when the Company inappropriately upheld six Stage 1 appeals that were overturned at Stage 2; the decision to pay these claims at appeal Stage 2 was based on the same documentation relied upon by the medical director who denied benefits at the Stage 1 appeal. Similarly, the examiners found one Stage 1 appeal that overturned the initial denial based on information already maintained in the claim file. Lastly, the examiners found one Stage 2 appeal in which the Company inappropriately upheld the Stage 1 appeal and the initial claim denial. As a result, the member filed an External, IURO appeal that reversed the internal Stage 1 and Stage 2 appeals. Notably, the IURO panel relied on the same medical necessity documentation reviewed by the internal, Stage 1 and Stage 2 staff.

None of the providers on the eight appeals referenced above submitted additional information that was not already in the company's possession either at the initial claim determination or the Stage 1 and 2 appeals. AmeriChoice agreed with the examiners on three of these appeals. On the remaining five, the company disagreed, stating essentially that variability in medical record interpretation is not uncommon.

Please See Appendix A-6 for Files in Error

7. **Delayed Appeal Resolution due to Inclusion of Previously Unidentified Utilization Management Factors (2 Appeals in Error)**

N.J.S.A. 17B:30-52a(3) states in part that a payer must respond to a provider or hospital prior authorization request within 15 days from the date of request. Contrary to this requirement, the examiners found two authorization requests in which AmeriChoice provided either an incorrect or incomplete response to the provider that was resolved or finalized only upon receipt of an appeal. In both cases, the appeal determination that corrected or clarified the authorization determination exceeded the maximum 15 day period outlined above. To the extent that these delays caused a protracted resolution period, AmeriChoice also failed to comply with **N.J.S.A. 17B:30-49a**. This statute requires a payer to make health benefits available in a prompt manner.

On Stage 1 appeal number R0391301001, AmeriChoice received an authorization request for Aged, Blind and Disabled (ABD) home services on

January 12, 2011. The Company denied this request on January 13, 2011, stating that the billed services were not covered under the contract. In response to a Stage 1 appeal, the Company upheld the initial authorization denial 23 days later, on February 4, 2011; however, AmeriChoice modified the authorization denial reason from a non-covered benefit to failure to meet medical necessity standards outlined in Milliman Guidelines. AmeriChoice's initial, pre-appeal denial on January 13, 2011 was defective and therefore incomplete. Since the correct determination occurred 8 days beyond the maximum 15 day response period, AmeriChoice failed to comply with **N.J.S.A. 17B:30-52a(3)**.

On Stage 2 appeal number K0591759001, AmeriChoice initially denied a February 20, 2012 preauthorization request for an infant Cranial Remolding Band on February 21, 2012, for lack of medical necessity. The denial stated that the provider failed to document that repositioning interventions were utilized for two or more months as a prerequisite to a Cranial Remolding Band pursuant to Milliman Guidelines. The provider submitted a Stage 1 appeal and documented such repositioning; however, AmeriChoice upheld the denied authorization on March 2, 2012, stating that the provider failed to submit cranial measurements. Notably, this criterion was omitted from the initial denial. In response, the provider submitted a Stage 2 appeal on March 13, 2012, along with the required measurements. Inconsistent with the prior two reasons for denial, AmeriChoice upheld the Stage 1 determination because the provider did not document yet another previously undisclosed Milliman criteria that required the provider to rule out "... underlying neuromuscular influencers, or known underlying neuromuscular influencers." Contrary to **N.J.S.A. 17B:30-52a(3)**, AmeriChoice did not complete and communicate its final denial until March 28, 2012, or 37 days after the initial authorization request, for a delay of 22 days. In response to the examiner's inquiries, the Company stated that it "...has no information available to dispute the findings of the examiner."

Please See Appendix A-7 for Files in Error

8. Failure to Conclude Non-Urgent Stage 1 and Stage 2 Appeals within Maximum Allowable Period (3 Appeals in Error)

Pursuant to **N.J.A.C. 11:24-8.6(d)**, a payer is required to conclude a non-urgent Stage 2 appeal within 20 business days from receipt. According to **N.J.A.C. 11:24-8.5**, a payer is required to conclude a non-urgent Stage 1 appeal within 10 calendar days from date of receipt, and an urgent Stage 1 appeal within 72 hours from receipt.

Contrary to **N.J.A.C. 11:24-8.6(d)** on non-urgent appeal number R0410737001, AmeriChoice received a Stage 2 appeal on January 4, 2012, but did not conclude the appeal until 35 business days later, on February 22,

2012. The examiners cited a 15 business day delay beyond the maximum allowable 20 business day period. The examiners also found that the Company failed to acknowledge this appeal within the maximum 10 business day period mandated by **N.J.A.C. 11:24-8.6(c)**. AmeriChoice issued the acknowledgement letter 17 working days beyond the 10 working day maximum period, on February 10, 2012. AmeriChoice attributed this delay to errors in the initial case set-up and administrative process.

Contrary to **N.J.A.C. 11:24-8.5** on appeal number S0101437001, AmeriChoice received a non-urgent Stage 1 appeal on September 30, 2011, but did not conclude the appeal until 80 calendar days later, on December 19, 2011. The examiners cited a 70 day delay beyond the maximum allowable 10 calendar day period. AmeriChoice agreed with these findings.

Contrary to **N.J.A.C. 11:24-8.5** on appeal number S1941054001, the Company received an urgent Stage 1 appeal on July 11, 2011, but did not conclude the appeal until 29 calendar days later, on August 3, 2011. The examiners cited a 26 day delay beyond the maximum allowable period of three days (72 hours). AmeriChoice agreed with these findings.

Please See Appendix A-8 for Files in Error

9. Failure to Respond to In-Patient Authorization Request within Maximum Timeframes (1 Stage 1 Appeal in Error)

N.J.S.A. 17B:30-52a(2) states that a payer must communicate a denied authorization request when a member is currently receiving inpatient services no later than 24 hours from the date of the request. Contrary to this statute on appeal number S0461723003, AmeriChoice received such an authorization request on December 17, 2011 but did not provide a disapproval response until 12 days later, on December 29, 2010, for a delay of 11 days after the maximum 24 hour period. The examiners note that this claim was ultimately paid on February 28, 2011 as a result of a Stage 1 appeal. The Company agreed with this error.

Please See Appendix A-9 for File in Error

10. Failure to Provide Written Request for Additional Information Necessary to Adjudicate Authorization Requests (2 Files in Error)

Where a payer requires additional information necessary to approve or deny a request for authorization, **N.J.S.A. 17B:30-52a(4)** requires the payer to do so in writing. Contrary to this statute, AmeriChoice failed to request information in writing on two Stage 1 appeals. The Company agreed with this finding on both appeals, but did provide a telephone log on claim number S1851701001 that referenced an oral request for additional information.

Please See Appendix A-10 for Files in Error

11. Failure to Provide Adequate Explanation of Reason for Authorization Denials (19 Files in Error - Improper General Business Practice)

N.J.A.C. 11:24-8.4(e)2 requires insurers to provide the "... reason(s) for the adverse benefit determination ... (and) ... a description of the standard used by the HMO in the denial."

Contrary to the above regulation, the examiners found a total of nineteen appeals in which AmeriChoice failed to reference the specific reason for denying an authorization. As an example on Stage 2 appeal number S02881432001, the initial denial and Stage 1 denial appeal letters stated "The request is denied. Treatment requested is beyond the scope of the benefit plan ... The criteria used to make this determination, is available upon a member's request or at the request of a provider appealing on behalf of a member." Notably, this language fails to state the standards or criteria that AmeriChoice used to make this determination. Moreover, disclosure of these standards is required at the time the adverse determination is communicated to the member, not upon the member's or provider's request at a later date. AmeriChoice disagreed with this error, stating to the effect that the adequacy of such disclosures is subject to interpretation. Since this language appears on standardized denial form letter, the examiners cited this error as an improper general business practice.

Please See Appendix A-11 for Files in Error

12. Failure to Include Office of Managed Care (OMC) Address on Authorization Denial Letters (19 Files in Error - Improper General Business Practice)

According to **N.J.A.C. 11:24-8.4(e)3** and **N.J.A.C. 11:24-8.6(e)**, a carrier is required to notify members that the New Jersey Department of Banking and Insurance is available to assist persons with claims and internal and external appeals. Such notification must include the Department's mailing address and telephone number. AmeriChoice failed to include this information on its form letter denials. Since the Company used this form letter on all claims and appeals, the examiners cited this error as an improper general business practice.

Please See Appendix A-12 for Files in Error

IV. CLAIMS ADJUDICATION

A. Introduction

Based on electronic records that AmeriChoice provided to the examiners, the Company reported that it processed (paid or denied) a total of 33,789,457 claim events for the period January 1, 2012 through December 31, 2012. The examiners define a claim event as one discreet date of service for a particular type or level of treatment or service associated with a unique Current Procedural Technology (CPT) code. These claim events include professional, institutional, dental, behavioral health, vision and prescription claims, as well as special needs claims that were dually eligible through Medicare (but deemed primary through Medicaid).

As indicated in Section II above, the examiners attempted to conduct a population-wide or census time study on all 33,789,457 claim events among all products to determine the Company's compliance with prompt pay requirements specified by **N.J.S.A. 26:2J-8.1d(1).** Based on data deficiencies, the examiners were unable to analyze institutional, professional, behavioral, vision, prescription and dental product lines for the reasons outlined in Section II.A.1 above.

The examiners were, however, able to electronically analyze 13,997,574 professional paid and denied claim events and 1,083,698 special needs paid and denied claim events that were dually eligible through Medicare (hereinafter referred to as DSNP). The results of this review appear in Section IV.B below.

B. Census Population Prompt Pay Review

The examiners queried the above-referenced databases of mailed and electronic claims that the Company processed during calendar year 2012. During that period, datasets revealed that AmeriChoice processed 11,257,992 paid professional claim events, 2,739,582 denied professional claim events, 659,093 paid DSNP claim events and 424,605 denied DSNP claim events.

The examiners reviewed these populations to verify compliance with statutory and regulatory guidelines regarding prompt claim payments and denials. In reviewing these claims, the examiners checked for compliance with statutes and regulations that govern a carrier's claims handling practices. Specifically, the examiners checked for compliance with **N.J.S.A. 26:2J-8.1d(1)** (Prompt Payment of Claims), **N.J.S.A. 26:2J-8.1d(9)** (interest of 12% on delayed settlements), **N.J.S.A. 17B:30-13.1** and **N.J.A.C. 11:2-17** (Unfair Claim Settlement Practices Act). The examiners also utilized the NAIC Market Regulation Handbook, Chapters 16 and 20, in developing the scope of review.

1. Professional Claims Population Review, Prompt Pay Exceptions

a. Paid Claim Population Review, Mailed and Electronic Claims

	Population	Exceptions	Exception Ratios
Electronic	10,462,479	2,082,799	20%
Mailed	795,513	85,902	11%
Total	11,257,992	2,168,701	19%

The examiners queried the population of Professional paid claims for calendar year 2012. As noted in the chart above, the electronic prompt payment claim population exception rate was 20%, while the mailed prompt payment claim population exception rate was 11%. AmeriChoice delayed settlement on 19% of all paid claims processed in 2012.

b. Denied Claim Population Review, Mailed and Electronic Claims

	Population	Exceptions	Exception Ratios
Electronic	2,105,331	58,202	3.0%
Mailed	634,251	605	0.1%
Total	2,739,582	58,807	2.0%

The examiners queried the population of Professional denied claims for calendar year 2012. As noted in the chart above, the electronic denied claim population exception rate was 3%, while the mailed denied claim population exception rate was 0.1%. AmeriChoice delayed settlement on 2% of all denied claims processed in 2012.

c. Combined Paid and Denied Claim Population Review, Mailed and Electronic Claims

	Population	Exceptions	Exception Ratios
Electronic Paid	10,462,479	2,082,799	20%
Mailed Paid	795,513	85,902	11%
Electronic Denied	2,105,331	58,202	3%
Mailed Denied	634,251	605	0.1%
Overall Totals	13,997,574	2,227,508	16%

As the above chart indicates, AmeriChoice settled a total of 2,227,508 claims beyond the 30 or 40 day periods specified by **N.J.S.A. 26:2J-8.1d(1)**. AmeriChoice delayed settlement on 16% of all paid and denied claims processed in 2012.

d. Interest Underpayment Population Review, Mailed and Electronic Claims

	Paid Claim Population	Days >30/40	% in Error	Correct Interest	Interest Paid	Interest Underpayment
Electronic	10,462,479	2,082,799	20%	$1,398,573	$276,589	$1,121,984
Mailed	795,513	85,902	11%	$108,727	$25,847	$82,880
Total	11,257,992	2,168,701	19%	$1,507,300	$302,436	$1,204,864

As the above chart indicates, AmeriChoice's datasets revealed that it underpaid interest by $1,121,984 on 20% of its electronic claims, and $82,880 11% on its mailed claims. Contrary to **N.J.S.A. 26:2J-8.1d(9)**, the total interest underpayment was $1,204,864. The examiners developed these values by conducting a time study, calculating the amount of interest owed, and comparing that value with the interest amount populated in the Company's datasets. The values in error are the difference between interest amount calculated and interest amount reported as paid. Total database interest in error was $1,204,864.

2. Dual Eligible Special Needs Population Review, Prompt Pay

a. Paid Claim Population Review, Mailed and Electronic DSNP Claims

	Population	Exceptions	Exception Ratios
Electronic	620,732	391,446	63%
Mailed	38,361	7,519	20%
Total	659,093	398,965	61%

The examiners queried the population of DSNP paid claims for calendar year 2012. As noted in the chart above, the electronic prompt payment claim population exception rate was 63%, while the mailed prompt payment claim population exception rate was 20%. AmeriChoice delayed settlement on 61% of all paid claims processed in 2012.

b. Denied Claim Population Review, Mailed and Electronic DSNP Claims

	Population	Exceptions	Exception Ratios
Electronic	330,682	211,708	64%
Mailed	93,923	20,632	22%
	424,605	232,340	55%

The examiners queried the population of DSNP denied claims for calendar year 2012. As noted in the chart above, the electronic denied claim

population exception rate was 64%, while the mailed denied claim population exception rate was 22%. AmeriChoice delayed settlement on 55% of all denied claims processed in 2012.

c. Combined Paid and Denied DSNP Claim Population Review, Mailed and Electronic Claims

	Population	Exceptions	Exception Ratios
Electronic Paid	620,732	391,446	63%
Mailed Paid	38,361	7,519	20
Electronic Denied	330,682	211,708	64%
Mailed Denied	93,923	20,632	22%
Overall Totals	1,083,698	631,305	58%

As the above chart indicates, AmeriChoice settled a total of 631,305 claims beyond the 30 or 40 day periods specified by **N.J.S.A. 26:2J-8.1d(1)**. AmeriChoice delayed settlement on 58% of all paid and denied claims processed in 2012.

d. Interest Underpayment DSNP Population Review, Mailed and Electronic Claims

	Paid Claim Population	Days >30/40	% in Error	Correct Interest	Interest Paid	Interest Underpayment
Electronic	620,732	391,446	63%	$248,444	$1,122	$195,404
Mailed	38,361	7,519	20%	$6,872	$53,040	$5,750
Total	659,093	398,965	61%	$255,316	$54,162	$201,154

The examiners extracted all 398,965 DSNP paid delayed claims and calculated interest at 12 percent based on receipt date, paid date and principal amount paid. Contrary to **N.J.S.A. 26:2J-8.1d(9)**, AmeriChoice either underpaid interest or failed to pay interest on 61% of all delayed claims. Total database interest in error was $201,154.

C. Random Sample Claim Review

The examiners randomly selected and manually reviewed in detail a total of 985 claim events from the total population of 33,789,457 claim events that AmeriChoice processed during calendar year 2012. The examiners tested for compliance with statutes and regulations that govern the handling of claims, including **N.J.S.A. 26:2J-8.1(d)**, **N.J.S.A. 17B:30-13.1** and **N.J.A.C. 11:2-17** (Unfair Claim Settlement Practices Act), **N.J.S.A. 26:2S-9.2b** (Compliance with Provider Contract and Fee Schedules) other statutes and

regulations that appear throughout this report, and standards outlined in the NAIC Market Regulation Handbook.

D. 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.

Paid Error Ratio Chart

Type of Claim	Files Reviewed	Files in Error	Error Ratio
Professional	215	85	39.53%
Institutional	47	26	55.31%
Dental	40	0	00.00%
Vision	20	1	05.00%
Behavioral Health	18	5	27.77%
Prescription	10	0	00.00%
Dual Eligible Special Needs	65	20	31.76%
Overall Totals	415	137	33.01%

Denied Error Ratio Chart

Type of Claim	Files Reviewed	Files in Error	Error Ratio
Professional	191	74	38.74%
Institutional	130	75	57.69%
Dental	32	0	00.00%
Vision	40	0	00.00%
Behavioral Health	11	0	00.00%
Prescription	15	0	00.00%
Dual Eligible Special Needs	151	40	26.49%
Overall Totals	570	189	33.15%

Combined Paid and Denied Error Ratio Chart

Type of Claim	Files Reviewed	Files in Error	Error Ratio
Overall Paid	415	137	33.01%
Overall Denied	570	189	33.15%
Combined Total	985	326	33.09%

E. Examiners' Findings – Paid and Denied Claims

1. Failure to Pay Electronic Claims within 30 days and Failure to Pay Mailed Claims within 40 Days from Receipt (137 Random Sample Claims in Error - Improper General Business Practice).

N.J.S.A. 26:2J-8.1d(1) requires a company to pay a mailed claim within 40 days from receipt, and an electronically submitted claim within 30 days from receipt. Contrary to these requirements, the examiners found a total of 137 (21 mailed claims and 116 electronic) paid claim events from the random sample that AmeriChoice settled beyond the 30 and 40 day periods referenced above.

On electronic claims, delays ranged from a low of 1 day to a high of 471 days beyond 30. The average settlement delay on 116 electronic claims cited as delayed was 50.3 days beyond the maximum 30 day period. On mailed claims, delays ranged from a low of 3 days to a high of 335 days beyond 40. The average settlement delay on all 21 mailed claims cited as delayed was 53.7 days beyond the maximum 40 day period. The examiners cited delayed claim payments as an improper general business practice.

Please See Appendix B-1 for Files in Error

2. Failure to Pay Required Interest on Delayed Claim Payments (55 Random Sample Claims in Error - Improper General Business Practice).

Pursuant to N.J.S.A. 26:2J-8.1d(9), an insurer is obligated to pay interest at a rate of 12% when settlement exceeds either the 30 day (claims submitted electronically) or 40 day (claims submitted by mail) maximum settlement periods. Contrary to this statute, the examiners found 55 claims out of 137 delayed settlements (40.14%) where AmeriChoice incorrectly calculated interest. On seven delayed claims, AmeriChoice overpaid interest by a total of $23.66. On 48 delayed claims, AmeriChoice underpaid interest by a total of $900.51; the average interest underpayment on these claims was $18.38. The examiners cited interest miscalculations as an improper general business practice due to the high frequency of error.

Please See Appendix B-2 for Files in Error

3. Failure to Deny Electronic Claims within 30 days and Failure to Deny Mailed Claims within 40 Days from Receipt (175 Random Sample Claims in Error - Improper General Business Practice).

Pursuant to N.J.S.A. 26:2J-8.1d(1) AmeriChoice is required to process a mailed claim within 40 days from receipt, and an electronically submitted claim within 30 days from receipt. Contrary to these requirements, the

examiners found a total of 175 claim events (24 mailed and 151 electronic) from the random sample that AmeriChoice denied beyond the 30 and 40 day periods referenced above.

On electronic claims, delays ranged from a low of 1 day to a high of 385 days beyond 30. The average settlement delay on 151 electronic claims cited as delayed was 20.5 days beyond the maximum 30 day period. On mailed claims, delays ranged from a low of 1 day to a high of 118 days beyond 40. The average settlement delay on all 24 mailed claims cited as delayed was 14.5 days beyond the maximum 40 day period. The combined average delay among all electronic and mailed claims was 19.7 days. The examiners cited delayed claim payments as an improper general business practice due to the high frequency of error.

Please See Appendix B-3 for Files in Error

4. **Improper Denial due to Compatibility Errors between CareOne and Diamond Systems (8 Random Files in Error - System Errors)**

Pursuant to **N.J.A.C. 11:2-17.8(i)** and **N.J.S.A. 17B:30-13.1f**, an insurer may not deny a claim when it is reasonably clear that benefits are payable. Contrary to this regulation and statute, the examiners found eight randomly selected claims in which AmeriChoice invalidly denied a claim because the Company's claim processing platform (Diamond System) failed to recognize a valid authorization number that represented approval for the service billed. On seven claims, AmeriChoice paid the claim when the provider called to question the denial. On one claim, the Company paid the claim with interest in response to an examiner inquiry. AmeriChoice confirmed that this error occurred on an intermittent basis during the review period. The Company was unable at the time of the exam to provide a population of claims that were affected by this error. See recommendations section.

Please See Appendix B-4 for Files in Error

5. **Improper Denial due to Incorrect Classification as Delayed Claim Submission (5 Random Sample Claims in Error)**

Pursuant to **N.J.S.A. 45:1-10.1**, a carrier may deny a professional provider claim that is submitted greater than 180 days from the last date of service. In addition, **N.J.S.A. 26:2H-12.12** specifies that a carrier may deny a health care facility claim that is submitted greater than 180 days from the last date of service. Lastly, **N.J.A.C. 11:2-17.8(i)** and **N.J.S.A. 17B:30-13.1f** specify that a carrier may not deny a claim when reasonably clear that benefits are payable. Contrary to these requirements, the examiners found 5 institutional claims (submitted by both facilities and professional providers) that AmeriChoice received within 180 days but erroneously coded as received

beyond the maximum 180 day submission period. As a result, AmeriChoice erroneously denied these claims in error.

Please See Appendix B-5 for Files in Error

6. **Improper Denial due to Manual Processing Error (4 Random Files in Error)**

The examiners found four claims that AmeriChoice incorrectly denied due to random processing or input errors that caused claim denials when benefits were due. On claim number 68084940, the company paid the claim in response to the examiner's inquiries. On the remaining three, AmeriChoice paid the claim when the provider called to complain about the denial. The examiners cited these errors pursuant to **N.J.A.C. 11:2-17.8(i)** and **N.J.S.A. 17B:30-13.1(d)**, for failure to pay when reasonably clear that benefits were due. The Company agreed with these errors in response to the examiners' inquiries.

Please See Appendix B-6 for Files in Error

7. **Miscellaneous Denial Errors (3 Random Files in Error)**

On claim number 55559658, the claim system applied an incorrect provider identification number that caused an automatic denial for pediatric daycare benefits. On claim number 69872780, the claim processor denied institutional benefits under the assumption that the maximum benefit was reached when that was in fact not the case. On claim number 62512472, the claims system incorrectly denied institutional benefits for lack of a prior authorization when the Company did in fact authorize services. AmeriChoice paid these claims upon appeal. The examiners cited these errors pursuant to **N.J.A.C. 11:2-17.8(i)** and **N.J.S.A. 17B:30-13.1(d)**, for failure to pay when reasonably clear that benefits were due. Contrary to **N.J.S.A. 26:2J-8.1d(9)**, AmeriChoice failed to include interest when it reprocessed claim number 62512472 upon appeal. The Company issued interest upon receipt of the examiners' inquiry.

Please See Appendix B-7 for Files in Error

V. FRAUD PREVENTION AND DETECTION

A. Introduction

Pursuant to **N.J.S.A. 17:33A-9**, an insurer is required to notify the New Jersey Bureau of Fraud Deterrence and the New Jersey Office of the Insurance Fraud Prosecutor upon establishing a belief of insurance fraud as defined at **N.J.S.A. 17:33A-4a-e.** This statute prohibits persons or corporations from presenting or causing to be presented any written or oral statement relative to a claim for benefits, knowing that the statement contains any false or misleading information concerning any fact or thing material to the claim. This statute also prohibits the preparation or making of any oral or written statement for the purpose of obtaining an insurance policy, knowing that the statement contains false or misleading information concerning any fact or thing material to an insurance application or contract. Lastly, **Article 7.38.4** of the Medicaid contract requires a contractee (AmeriChoice) to establish a Special Investigation Unit (SIU) for purposes of detecting and preventing fraud, waste and abuse.

During the review period, AmeriChoice's SIU investigated a total of 130 providers (believed either to have overbilled or fraudulently billed for services never provided) and members (theft of prescription pads, illegally selling controlled substances acquired through prescription benefits, etc.). Of these, the Company issued recoupment demands on nine providers. The examiners selected all nine recoupment demands for review, while also randomly selecting and reviewing an additional 35 SIU investigations from the remaining 121 investigations, for a total sample of 44 files. Of these, the examiners found 1 file in error, for an error ratio of 2.2%. The examiners' findings follow.

1. **Failure to Allow Medical Provider 45 Days to Resolve Recoupment Demands (1 File in Error)**

Pursuant to **N.J.S.A. 26:2J-8.1d(11)(a)(i)**, a carrier is prohibited from requiring a recoupment reimbursement within 45 calendar days after notice to the health care provider. Contrary to this statute on Case Number 570, the examiners found one recoupment letter dated August 17, 2011 in which AmeriChoice's demand letter required payment within 30 calendar days.

Please see Appendix C-1 for File in Error

VI. RECOMMENDATIONS

AmeriChoice 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.

Various non-compliant practices were identified in this report, some of which may extend to other jurisdictions. 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. When applicable, corrective action for other jurisdictions should be addressed.

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. For the purpose of obtaining proof of compliance and for AmeriChoice 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 and 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 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, the Market Conduct Examiners of 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. INAUDITABILITY OF ELECTRONIC RECORDS

1. AmeriChoice must provide written instruction to all appropriate staff stating that **N.J.A.C. 11:22-1.5(d)** and **N.J.A.C. 11:2-17.12** require an insurer to maintain an auditable record of claim transactions, records, communications and documentation in a manner that permits the Department to reconstruct a company's claim settlement activities.

2. AmeriChoice must provide the Commissioner with a written plan of correction that addresses the electronic data deficiencies outlined in Section II.A.1 through 3 of this report, including but not limited, to the Company's inability to:

a) efficiently search for and identify denial letters, explanations of benefits and other pertinent correspondence;

b) recreate data sets that accurately depict denied claims as actually denied and paid claims as actually paid;

c) consistently populate claim receipt, paid and denied dates;

d) accurately populate currency fields with proper decimal placement;

e) consistently include amount paid on paid datasets;

f) consistently separate paid claims from denied claims when extracting paid and denied claim datasets;

g) consistently identify claims submitted electronically or by mail;

h) properly and consistently record appeal resolutions, i.e., Upheld or Overturned.

C. PROVIDER APPEALS AND APPEAL MECHANISM

3. Pursuant to **N.J.A.C. 11:24-8.5** and **N.J.A.C. 11:24.8.6**, and in accordance with **Article 4, Section 4.6.4C.4** of the standard Medicaid contract, AmeriChoice must cease its practice of unilaterally extending Stage 1 and Stage 2 appeal response deadlines. To assure compliance, AmeriChoice must issue written instructions stating that extensions must be either requested by the member or effectuated only upon prior approval by the State of New Jersey, Department of Human Services, Division of Medical Assistance and

Health Services (DMAHS). These instructions should also specify that only Stage 2 extensions are permissible under **Article 4** of the Medicaid contract.

4. In order to comply with **N.J.A.C. 11:24-8.5**, AmeriChoice must issue written instructions to all appropriate staff, specifying that a carrier is required to render a decision within no more than 72 hours on Stage 1 urgent appeals, and within 10 calendar days on all other Stage 1 appeals. These instructions must also state that **N.J.A.C. 11:24-8.6(d)** requires a carrier to respond within no more than 72 hours on Stage 2 emergency care appeals, and within 20 business days on all other Stage 2 appeals.

5. The Company should remind all appropriate staff that:

a) **N.J.A.C. 11:24-8.6(c)** requires a carrier to acknowledge a non-urgent Stage 2 appeal within 10 working days from receipt;

b) **N.J.A.C. 11:24-8.6(d)** requires a payer to conclude a non-urgent Stage 2 appeal within 20 business days from receipt.

c) **N.J.A.C. 11:24-8.5** requires a payer to conclude a non-urgent Stage 1 appeal within 10 calendar days from receipt, and an urgent Stage 1 appeal within 72 hours from receipt.

6. AmeriChoice must issue written instructions to all appropriate staff, stating that **N.J.A.C. 11:24-8.4(e)3**, **N.J.A.C. 11:24-8.6(e)** and **N.J.A.C. 11:24-8.7(b)** require a carrier to notify members that the New Jersey Department of Banking and Insurance is available to assist persons with claims and internal and external appeals. Such notification must also include the DOBI's mailing address and telephone number.

D. AUTHORIZATION AND CLAIM ADJUDICATION

7. In order to comply with **N.J.S.A. 17B:30-50**, the Company must provide written instructions to all appropriate staff, stating that a payer is required to process all authorization requests in accordance with the medical necessity requirements outlined in its health benefit plan. These instructions must also include reference to **N.J.S.A. 26:2S-6a**, which requires a carrier to ensure that all treatment protocols, policies, quality assurance and utilization management decisions are based on generally accepted standards of health care practices.

To the extent that three separate medical directors issued different utilization determinations on appeal number K0121117001, the Company should conduct a process and/or decision analysis to identify and correct any ambiguities that would increase the likelihood of disparate utilization management determinations among medical directors.

8. In order to comply with **N.J.S.A. 17B:30-50**, AmeriChoice must cease its practice of automatically denying authorizations, and claims as applicable, where a member is readmitted within seven days with the same diagnosis. The Company must provide written instruction to all appropriate staff, stating that such readmissions are valid when the provider submits an authorization request that corrects the initial authorization.

9. In order to comply with **N.J.S.A. 17B:30-51a(1)**, the Company may not require members or providers to satisfy conditions as a prerequisite to approval or payment unless those conditions are conspicuously posted on the carrier's website.

10. The Company must issue written instructions to all appropriate staff, emphasizing that **N.J.A.C. 11:24-8.4(e)** requires insurers to provide the "... reason(s) for the adverse benefit determination ... (and) ... a description of the standard used by the HMO in the denial." Advising a member or provider that the applicable standard is available upon request is an insufficient explanation of an adverse benefit determination.

11. In order to comply with **N.J.S.A. 17B:30-53c**, AmeriChoice should remind all appropriate staff members that a carrier is prohibited from changing a hospital's or physician's billed diagnostic code without providing a written justification for doing so.

12. AmeriChoice must develop and implement procedures that reduce the likelihood of delays when finalizing authorization determinations. Such a delay is reported, for example, in Section III.D.9 above. Improvement can be achieved by assuring that authorization staff review the entirety of all records submitted by providers and/or members.

In addition, AmeriChoice should issue written instructions to all appropriate staff, indicating that:

a) **N.J.S.A. 17B:30-52a(3)** requires a payer to respond to a provider or hospital authorization request within 15 days from the request;

b) **N.J.S.A. 17B:30-52a(2)** requires a payer to communicate a denied authorization request when a member is currently receiving inpatient service no later than 24 hours from the date of the request;

c) where a payer requires additional information necessary to approve or deny a request for authorization, **N.J.S.A. 17B:30-52a(4)** requires the payer do so in writing.

13. The Company should issue written instructions to all appropriate staff, indicating that **N.J.A.C. 11:24-8.4(e)2** requires insurers to provide the reason

for an adverse benefit determination, as well as a description of the standard used by the HMO to support the denial.

14. AmeriChoice must issue written instructions to all personnel who process claims stating that **N.J.S.A. 26:2J-8.1d(1)** requires a company to pay clean electronic claims within 30 days following receipt by the payer of required documentation in support of an initial claim submission. These instructions should include a statement that, pursuant to **N.J.A.C. 11:2-17.9(b)**, AmeriChoice is obligated to utilize this time period in order to develop a final claim determination within 30 days.

15. The Company must issue written instructions to all claims personnel stating that **N.J.S.A. 26:2J-8.1d(1)** also requires a company to pay clean mailed claims within 40 days following receipt by the payer of required documentation in support of an initial claim submission. These instructions should include a statement that, pursuant to **N.J.A.C. 11:2-17.9(b)**, AmeriChoice is obligated to utilize this time period in order to develop a final claim determination within 40 days. AmeriChoice should further include reference to **N.J.A.C. 11:22-1.6**, which makes the foregoing applicable to denied claims.

16. AmeriChoice must issue written instructions to all personnel who process claims, stating that **N.J.S.A. 26:2J-8.1d(9)** requires an carrier to pay interest at a rate of 12% on all clams paid beyond 30 days for claims received electronically and 40 days for claims received by mail.

17. Due to the significantly higher prompt pay error ratios on DSNP claims outlined in Section IV.B.2 above, AmeriChoice must conduct a process analysis to determine the cause for delays and incorrect interest payments. The results of this analysis, including corrective intervention, should be provided to the Commissioner.

18. In order to comply with **N.J.S.A. 26:2J-8.1d(9)**, AmeriChoice must develop and submit to the Commissioner upon completion, a plan of correction that addresses interest calculation errors and failure to pay interest where warranted. The Company should also reopen all 48 claims listed in Appendix B in which interest was underpaid. The amount owed should be issued to the provider in accordance with General Instruction listed in Section VI.A above. A list of all final payments, including amount paid and actual calculation, should be provided to the Commissioner.

19. AmeriChoice should provide training or written instruction on the Unfair Claim Settlement Practices law (**N.J.S.A. 17B:30-13.1 et seq.**) and regulation (**N.J.A.C. 11:2-17.1 et seq.**). Such instruction should specifically provide descriptions of and reference to, the following:

a) **N.J.S.A. 17B:30-13.1d**. This statute prohibits claim denial without conducting a reasonable investigation based on all available information. See also **N.J.A.C. 11:2-17.7** and **N.J.A.C. 11:2-17.8**. Please refer to IV.E Item 6 and 7 for illustrations on the applicability of this statute;

b) **N.J.S.A. 17B:30-13.1f**. This statute requires a good faith effort to effectuate prompt, fair and equitable settlements where liability is reasonably clear. See also **N.J.A.C. 11:2-17.8** and **N.J.A.C. 11:2-17.9**. Please refer to Section IV.E Items 4 and 5 for illustrations on the applicability of this statute.

20. In order to comply with written denial reason disclosure requirements outlined in **N.J.A.C. 11:24-8.4(e)**, AmeriChoice should cease its practice of advising members that Milliman criteria utilized for denial are available upon request. The Company must include those criteria and any established standards with the denial notice, along with the facts that support adverse determinations.

21. AmeriChoice must submit to the Commissioner a plan of correction, and/or actions taken to date, that addresses systems errors between CareOne and the Diamond System that resulted in intermittent claim denials throughout 2012. The Company should also provide the total number of claims that were affected by this error, including claim number, CPT code, amount denied, amount subsequently paid, date paid, receipt date and interest paid.

22. The Company should remind all appropriate staff that **N.J.S.A. 45:1-10.1** and **N.J.S.A. 26:2H-12.12** require a carrier to accept for adjudication all claims submitted within 180 days from the last date of service.

E. FRAUD PREVENTION AND DETECTION

23. AmeriChoice should remind all appropriate SIU staff that, pursuant to **N.J.S.A 26:2J-8.1d(11)(a)(i)**, a carrier is prohibited from requiring a recoupment reimbursement within 45 calendar days after notice to the health care provider.

APPENDIX A – PROVIDER APPEALS AND APPEAL MECHANISM

1. **Unfair Extension of Urgent Appeal Response Deadline (4 Random Sample Files in Error - General Business Practice)**

Case Number	Appeal Stage	Appeal Type	Date Appeal Received	Date Closed	Response Delay
R2310708001	1	Urgent	08/18/11	09/01/11	11*
R0821404001	2	Urgent	03/21/12	03/29/12	3*
298-6/12	External	Standard	05/17/12	06/25/12	26**
S2211323002	1	Urgent	08/06/12	08/22/12	13*

* Calendar Days beyond 72 hours/3 days
**Business Days beyond 20 business days

2. **Unfair Denial of Authorization and Failure to Disclose Member/Provider Obligations when Requesting Authorization (1 File in Error/$3,749 in Denied Benefits)**

Case Number	Appeal Stage	Date Appeal Received	Date Closed
K0190314001	1	01/17/12	01/24/12

3. **Improper Use of Contract Language to Deny Authorization for Hospital Readmission (1 File in Error - Improper General Business Practice/$147,133 in Denied Benefits)**

Case Number	Appeal Stage
226-5/12	External

4. **Unfair Authorization Denial due to Conflicting Utilization Management Determinations among Three Separate Medical Directors (1 File in Error/$3,013.15 in Denied Benefits)**

Claim Number	Appeal Stage
K0121117001	1

5 **Improper Diagnosis Related Group (DRG) Downcoding Resulting in Clam Underpayment (3 Random Appeals in Error/$35,548 in Underpaid Benefits and $6,838 in Interest Penalties)**

Company Appeal Number	Provider DRG Code	Provider DRG Billed	Company DRG Downcode	Company DRG Paid	Appeal DRG Award	Final Appeal Award	Actual Interest Owed	Actual Interest Paid	Total Interest Error
NJ12-000444	710	$11,735.34	714	$7,241.19	710	$4,494.15	$1,129.22	$238.70	$89152
NJ12-000347	468	$99,520.80	297	$4,494.15	468	$28,000.90	$4,418.77	$4,418.77	$000.00
NJ12-000231	551	$6,807.75	813	$3,754.42	551	$3,053.33	$1,290.35	1290.35	$000.00
Totals						$35,548.38	$6,838.34		

6. **Failure to Consider Entirety of Medical Records when Denying Appeals (8 Appeals in Error)**

Case Number	Appeal Stage	Claim Number	Appeal Stage
S3490826002	2	S1530834001	2
K0181137002	2	R0341533001	1
R3481614004	2	R0410737001	2
S1041207001	2	169-4/12	3

7. **Delayed Appeal Resolution due to Inclusion of Previously Unidentified Utilization Management Factors (2 Appeals in Error)**

Case Number	Appeal Stage	Claim Number	Appeal Stage
K0591759001	2	R0391301001	1

8. **Failure to Conclude Non-Urgent Stage 1 and Stage 2 Appeals within Maximum Allowable Period (3 Appeals in Error)**

Case Number	Appeal Stage	Claim Number	Appeal Stage
R0410737001	2	S0101437001	1
S1941054001	1		

9. Failure to Respond to In-Patient Authorization Request within Maximum Timeframes (1 Stage 1 Appeal in Error)

Case Number	Authorization Receipt Date	Authorization Response Date	Days Delayed Beyond 24 Hours	Appeal Stage
S0461723003	12/17/2010	12/19/2010	11	1

10. Failure to Provide Written Request for Additional Information Necessary to Adjudicate Authorization Requests (2 Files in Error)

Case Number	Appeal Stage	Claim Number	Appeal Stage
S1851701001	1	K2501644001	1

11. Failure to Provide Adequate Explanation of Reason for Authorization Denials (19 Files in Error - Improper General Business Practice)

Claim Number	Appeal Stage	Claim Number	Appeal Stage
S0450913002	2	K0871256001	2
S2211323002	1	R1861311002	1
298-6/12	3	R0311213002	2
S02881432001	2	R0410737001	2
003-1/12	3	R2781810001	2
K0591759001	2	R2700925001	2
S2211323002	1	S1091003002	2
S2121004002	2	K0190314001	1
S3460814002	1	R3202113001	1
S3032031001	1		

12. Failure to Include Office of Managed Care (OMC) Address on Authorization Denial Letters (19 Files in Error - Improper General Business Practice)

Claim Number	Appeal Stage	Claim Number	Appeal Stage
R1151545002	1	S1090742001	1
R2611653001	1	K0591759001	2
K1781654001	1	R0951643001	1
R2700925001	2	S2211323002	1
S1091003002	2	S2121004002	2
S1861311002	2	S3460814002	2

R3121208003	2	R2130846002	2
R1041332003	2	R1881421001	2
R2561459001	2	K0921259001	2
R0821404001	2		

APPENDIX B – AUTHORIZATIONS AND CLAIMS ADJUDICATION

1. Failure to Pay Electronic Claims within 30 days and Failure to Pay Mailed Claims within 40 Days from Receipt (137 Random Sample Claims in Error - Improper General Business Practice)

Claim Number	Review Sample	Date Received	Date Paid	Mailed or Electronic	Days Over 30 or 40
55897355	Institutional	3/13/2011	3/7/2012	Electronic	330
56797991	Institutional	3/31/2012	5/16/2012	Electronic	16
55032664	Adult Daycare	1/20/2012	2/22/2012	Electronic	3
67116518	Adult Daycare	10/30/2012	12/5/2012	Electronic	6
69124614	Adult Daycare	12/19/2012	3/11/2013	Electronic	52
69849949	Adult Daycare	1/5/2013	3/13/2013	Electronic	37
70604246	Adult Daycare	1/16/2013	4/3/2013	Electronic	47
55781083	Adult Daycare	2/24/2012	3/30/2012	Electronic	5
57893790	Adult Daycare	3/26/2012	5/2/2012	Electronic	7
67114642	Adult Daycare	10/28/2012	12/5/2012	Electronic	8
67180269	Adult Daycare	10/24/2012	11/28/2012	Electronic	5
67521739	Adult Daycare	11/9/2012	12/19/2012	Electronic	10
68855920	Adult Daycare	12/13/2012	1/30/2013	Electronic	18
69121819	Adult Daycare	12/16/2012	2/1/2013	Electronic	17
69902956	Adult Daycare	1/5/2013	3/11/2013	Electronic	35
69987320	Adult Daycare	1/9/2013	4/5/2013	Electronic	56
55569798	Adult Daycare	2/15/2012	3/21/2012	Electronic	5
62116378	Adult Daycare	6/23/2012	7/27/2012	Electronic	4
67112298	Adult Daycare	10/24/2012	11/28/2012	Electronic	5
68858598	Adult Daycare	12/15/2012	2/11/2013	Electronic	28
69403742	Adult Daycare	12/29/2012	4/5/2013	Electronic	67
69900493	Adult Daycare	12/21/2012	2/13/2013	Electronic	24
60285683	Pediatric Daycare	5/19/2012	6/22/2012	Electronic	4
62563533	Pediatric Daycare	7/16/2012	8/17/2012	Electronic	2
68102910	Pediatric Daycare	11/25/2012	12/28/2012	Electronic	3
56100414	Pediatric Daycare	3/8/2012	4/13/2012	Electronic	6
55451614	Pediatric Daycare	2/12/2012	3/21/2012	Electronic	8
55559670	Pediatric Daycare	2/11/2012	3/28/2012	Electronic	16
55733236	Pediatric Daycare	2/23/2012	3/28/2012	Electronic	4
56016880	Pediatric Daycare	3/5/2012	4/11/2012	Electronic	7
56016892	Pediatric Daycare	3/5/2012	4/11/2012	Electronic	7
56091862	Pediatric Daycare	3/8/2012	4/13/2012	Electronic	6
69557844	Pediatric Daycare	1/4/2013	3/11/2013	Electronic	36

56830913	Pediatric Daycare	3/31/2012	5/9/2012	Electronic	9
59836924	Pediatric Daycare	5/11/2012	6/20/2012	Electronic	10
60247938	Pediatric Daycare	5/19/2012	6/22/2012	Electronic	4
60569675	Pediatric Daycare	5/23/2012	6/27/2012	Electronic	5
61617984	Pediatric Daycare	6/14/2012	7/20/2012	Electronic	6
65196318	Pediatric Daycare	9/8/2012	10/10/2012	Electronic	2
68828994	Pediatric Daycare	12/16/2012	2/16/2013	Electronic	32
69125324	Pediatric Daycare	12/19/2012	2/6/2013	Electronic	19
56730245	Pediatric Daycare	3/23/2012	4/27/2012	Electronic	5
56435487	Pediatric Daycare	3/24/2012	4/27/2012	Electronic	4
56817584	Pediatric Daycare	3/30/2012	5/9/2012	Electronic	10
56413274	Pediatric Daycare	3/21/2012	4/27/2012	Electronic	7
56816693	Pediatric Daycare	3/30/2012	5/9/2012	Electronic	10
57960300	Institutional	4/5/2012	5/18/2012	Electronic	13
59732486	Institutional	4/30/2012	6/20/2012	Electronic	21
61655414	Institutional	6/17/2012	8/1/2012	Electronic	15
61954082	Institutional	6/20/2012	8/3/2012	Electronic	14
59678442	Institutional	5/5/2012	6/22/2012	Electronic	18
59864213	Institutional	5/13/2012	7/4/2012	Electronic	22
55303500	Institutional	2/8/2012	3/21/2012	Electronic	12
58040670	Institutional	4/6/2012	5/23/2012	Electronic	17
61623310	Institutional	6/15/2012	7/27/2012	Electronic	12
44931565	Institutional	4/21/2011	5/30/2012	Electronic	375
54811650	Institutional	1/17/2012	2/17/2012	Electronic	1
60704071	Institutional	9/7/2011	6/8/2012	Electronic	245
68372151	Institutional	12/7/2012	1/16/2013	Electronic	10
57266031	Institutional	3/30/2012	5/16/2012	Electronic	17
58064520	Institutional	4/7/2012	5/23/2012	Electronic	16
58901184	Institutional	4/18/2012	6/1/2012	Electronic	14
61655775	Institutional	6/17/2012	9/19/2012	Electronic	64
44982401	Institutional	4/24/2011	5/30/2012	Electronic	372
70044686	Institutional	1/12/2013	2/13/2013	Electronic	2
56015544	Institutional	3/6/2012	8/22/2012	Electronic	139
59204794	Institutional	4/26/2012	6/13/2012	Electronic	18
44954730	Institutional	4/22/2012	5/30/2012	Electronic	8
66572049	Personal Care	2/20/2012	10/24/2012	Electronic	217
67969932	Personal Care	11/17/2012	1/2/2013	Electronic	16
56389595	Personal Care	3/21/2012	4/25/2012	Electronic	5
60143148	Personal Care	5/13/2012	6/15/2012	Electronic	3
62194118	Personal Care	6/26/2012	10/10/2012	Electronic	76
60603342	Personal Care	5/24/2012	6/27/2012	Electronic	4

62194119	Personal Care	6/26/2012	10/10/2012	Electronic	76
70740193	Personal Care	1/25/2013	3/27/2013	Electronic	31
55584654	Personal Care	2/17/2012	3/21/2012	Electronic	3
55376334	Personal Care	2/10/2012	3/14/2012	Electronic	3
56013171	Personal Care	2/29/2012	7/13/2012	Electronic	105
61612568	Personal Care	6/14/2012	7/20/2012	Electronic	6
69423847	Personal Care	12/29/2012	3/11/2013	Electronic	42
72525556	Personal Care	1/12/2013	3/20/2013	Electronic	37
56198781	Personal Care	3/15/2012	4/18/2012	Electronic	4
56065209	Personal Care	3/7/2012	4/11/2012	Electronic	5
66920864	Personal Care	10/22/2012	11/28/2012	Electronic	7
64705850	Personal Care	8/25/2012	9/26/2012	Electronic	2
61702415	Personal Care	3/31/2012	6/22/2012	Electronic	53
60304613	Personal Care	5/20/2012	6/22/2012	Electronic	3
55650554	Personal Care	2/11/2012	10/24/2012	Electronic	226
69107013	Professional	7/24/2012	12/26/2012	Electronic	125
62520766	Professional	7/13/2012	1/18/2013	Electronic	159
58015715	Professional	4/5/2012	4/3/2013	Electronic	333
54828875	Professional	1/18/2012	2/17/2012	Electronic	0
69450227	Professional	8/22/2011	1/4/2013	Electronic	471
67568893	Professional	8/19/2011	11/21/2012	Electronic	430
60676639	Professional	5/28/2012	6/29/2012	Electronic	2
55167062	Professional	1/23/2012	7/18/2012	Electronic	147
68792272	Professional	12/15/2012	4/3/2013	Electronic	79
56088386	Professional	3/8/2012	4/13/2012	Electronic	6
73178401	Professional	6/5/2012	3/15/2013	Electronic	253
60545255	DSNPS	5/18/2012	6/20/2012	Electronic	3
66905284	DSNPS	10/20/2012	11/21/2012	Electronic	2
68478597	DSNPS	12/3/2012	1/16/2013	Electronic	14
69253179	DSNPS	12/16/2012	2/1/2013	Electronic	17
59077336	DSNPS	4/22/2012	5/25/2012	Electronic	3
61292930	DSNPS	6/6/2012	7/11/2012	Electronic	5
67463245	DSNPS	9/10/2012	11/14/2012	Electronic	35
69449548	DSNPS	12/24/2012	2/13/2013	Electronic	21
59045030	DSNPS	4/12/2012	5/23/2012	Electronic	11
62380651	DSNPS	7/7/2012	8/8/2012	Electronic	2
67939065	DSNPS	11/16/2012	12/26/2012	Electronic	10
68078668	DSNPS	11/16/2012	12/26/2012	Electronic	10
68858397	DSNPS	12/5/2012	2/1/2013	Electronic	28
76881135	DSNPS	9/13/2012	5/22/2013	Electronic	221
86004591	Behavioral	3/18/2011	7/6/2011	Electronic	80

60189023	Behavioral	6/8/2011	11/2/2011	Electronic	117
60757382	Institutional	5/29/2012	7/18/2012	Mailed	10
60219083	Institutional	5/14/2012	7/11/2012	Mailed	18
70806764	Personal Care	1/22/2013	4/12/2013	Mailed	40
72059687	Personal Care	2/11/2013	4/12/2013	Mailed	20
63506118	Personal Care	3/9/2012	8/8/2012	Mailed	112
72418698	Personal Care	12/21/2012	2/27/2013	Mailed	28
60221152	Professional	5/14/2012	1/30/2013	Mailed	221
71236312	Professional	1/18/2012	3/26/2012	Mailed	28
70607838	Professional	7/13/2012	3/22/2013	Mailed	212
68762253	Professional	12/11/2012	1/25/2013	Mailed	5
64109731	Professional	2/8/2012	8/31/2012	Mailed	165
2707277	Vision	2/23/2012	5/1/2012	Mailed	28
69337442	DSNPS	12/19/2012	2/6/2013	Mailed	9
60968110	DSNPS	6/4/2012	7/20/2012	Mailed	6
67527811	DSNPS	10/22/2012	12/5/2012	Mailed	4
68856433	DSNPS	12/11/2012	1/25/2013	Mailed	5
68240254	DSNPS	11/21/2012	1/4/2013	Mailed	4
68852961	DSNPS	12/7/2012	1/23/2013	Mailed	7
60191975	Behavioral	11/23/2011	2/10/2012	Mailed	39
71125970	Behavioral	1/17/2012	2/29/2012	Mailed	3
86091100	Behavioral	6/10/2011	9/7/2011	Mailed	49

2. **Failure to Pay Required Interest on Delayed Claim Payments (55 Random Sample Claims in Error-Improper General Business Practice).**

Claim Number	Allowed Amount	Date Received	Date Paid	Days Over 30 or 40	Interest Company Paid	Correct Interest Owed	Interest in Error
72059537	155.00	2/11/2013	2/20/2013	n/a	$17.58	$0.00	$17.58*
86091100	7,836.00	6/10/2011	9/7/2011	49	$131.39	$126.23	$5.16*
86004591	3,520.00	3/18/2011	7/6/2011	80	$94.90	$92.58	$2.32*
56435487	1,605.35	3/24/2012	4/27/2012	4	$3.15	$2.10	$1.05*
66920864	31.04	10/22/2012	11/28/2012	7	$0.21	$0.07	$0.14*
71125970	80.00	1/17/2012	2/29/2012	3	$0.13	$0.08	$0.05*
56198781	31.04	3/15/2012	4/18/2012	4	$0.07	$0.04	$0.03*
58064520	100.00	4/7/2012	5/23/2012	16	$0.52	$0.53	-$0.01
70806764	46.50	1/22/2013	4/12/2013	40	$0.60	$0.61	-$0.01
72525556	46.56	1/12/2013	3/20/2013	37	$0.55	$0.57	-$0.02
68478597	31.04	12/3/2012	1/16/2013	14	$31.16	$31.18	-$0.02
56816693	1,605.35	3/30/2012	5/9/2012	10	$5.25	$5.28	-$0.03
57960300	5.99	4/5/2012	5/18/2012	13	$0.00	$0.03	-$0.03

66572049	85.00	2/20/2012	10/24/2012	217	$6.02	$6.05	-$0.03
56817584	963.21	3/30/2012	5/9/2012	10	$5.25	$5.30	-$0.05
58040670	3,034.50	4/6/2012	5/23/2012	17	$16.91	$16.96	-$0.05
69849949	235.50	1/5/2013	3/13/2013	37	$2.79	$2.85	-$0.06
69403742	314.00	12/29/2012	4/5/2013	67	$6.80	$6.88	-$0.08
54811650	269.00	1/17/2012	2/17/2012	1	$0.00	$0.09	-$0.09
69423847	46.56	12/29/2012	3/11/2012	42	$0.55	$0.64	-$0.09
69124614	546.00	12/19/2012	3/11/2013	19	$3.22	$3.43	-$0.11
70604246	471.00	1/16/2013	4/3/2013	47	$7.14	$7.26	-$0.12
55569798	392.50	2/15/2012	3/21/2012	5	$0.50	$0.65	-$0.15
55781083	392.50	2/24/2012	3/30/2012	5	$0.50	$0.65	-$0.15
59864213	2,178.60	5/13/2012	7/4/2012	22	$15.60	$15.75	-$0.15
56100414	642.14	3/8/2012	4/13/2012	6	$1.06	$1.26	-$0.20
62194119	62.08	6/26/2012	10/10/2012	15	$0.08	$0.31	-$0.23
67969932	46.56	11/17/2012	1/2/2013	16	$0.00	$0.24	-$0.24
55451614	963.21	2/12/2012	3/21/2012	8	$2.22	$2.52	-$0.30
56016892	963.21	3/5/2012	4/11/2012	7	$1.89	$2.22	-$0.33
58901184	79.67	4/18/2012	6/1/2012	14	$0.00	$0.37	-$0.37
69987320	1,099.00	1/9/2013	4/5/2013	56	$19.88	$20.30	-$0.42
59204794	76.25	4/26/2012	6/13/2012	18	$0.00	$0.45	-$0.45
72059687	155.00	2/11/2013	4/12/2013	20	$1.48	$1.02	-$0.46
55733236	1,605.35	2/23/2012	3/28/2012	4	$1.60	$2.10	-$0.50
55559670	1,605.35	2/11/2012	3/28/2012	16	$7.90	$8.45	-$0.55
56091862	1,926.42	3/8/2012	4/13/2012	6	$3.18	$3.78	-$0.60
69557844	321.07	1/4/2013	3/11/2013	36	$3.17	$3.80	-$0.63
56016880	2,247.49	3/5/2012	4/11/2012	7	$4.41	$5.11	-$0.70
60757382	220.82	5/29/2012	7/18/2012	10	$0.00	$0.72	-$0.72
59678442	123.56	5/5/2012	6/22/2012	18	$0.00	$0.73	-$0.73
56015544	18.12	3/6/2012	8/22/2012	139	$0.07	$0.83	-$0.76
62194118	34.00	6/26/2012	10/10/2012	76	$0.04	$0.85	-$0.81
57266031	213,048.00	3/30/2012	5/16/2012	17	$1,187.48	$1,190.93	-$3.25
44954730	1,435.02	4/22/2012	5/30/2012	7	$0.00	$3.30	-$3.30
60219083	222,936.00	5/14/2012	7/11/2012	18	$1,315.69	$1,319.29	-$3.60
61954082	1,116.22	6/20/2012	8/3/2012	14	$0.00	$5.12	-$5.12
59732486	11,581.07	4/30/2012	6/20/2012	21	$7.82	$14.92	-$7.10
55303500	42,872.00	2/8/2012	3/21/2012	12	$154.62	$168.69	-$14.07
60189023	1,068.00	6/8/2011	11/2/2011	117	$0.00	$41.08	-$41.08
61655414	8,720.25	6/17/2012	8/1/2012	15	$0.00	$42.89	-$42.89
61655775	5,193.00	6/17/2012	Sep-12	64	$0.00	$109.27	-$109.27
44931565	1,113.48	4/21/2011	5/30/2012	375	$0.00	$136.90	-$136.90
55897355	1,514.00	3/13/2011	3/7/2012	330	$0.00	$163.81	-$163.81

44982401	2,943.15	4/24/2011	5/30/2012	372	$0.00	$359.95	-$359.95

* Interest was overpaid.

3. **Failure to Deny Electronic Claims within 30 days and Failure to Deny Mailed Claims within 40 Days from Receipt (175 Random Sample Claims in Error-Improper General Business Practice).**

Claim Number	Review Sample	Date Received	Date Denied	Mailed/ Electronic	Days Over 30 or 40
61961505	Adult Daycare	6/17/2012	7/20/2012	Electronic	3
62654757	Adult Daycare	6/7/2012	7/25/2012	Electronic	18
64204202	Adult Daycare	5/8/2012	8/22/2012	Electronic	76
69253811	Adult Daycare	12/16/2012	1/16/2013	Electronic	1
69965996	Adult Daycare	1/6/2013	3/13/2013	Electronic	36
70066044	Adult Daycare	1/12/2013	4/5/2013	Electronic	53
70154455	Adult Daycare	8/29/2012	1/23/2013	Electronic	117
56055530	Adult Daycare	3/3/2012	4/4/2012	Electronic	2
56691987	Adult Daycare	3/19/2012	4/25/2012	Electronic	7
58100527	Adult Daycare	4/4/2012	5/11/2012	Electronic	7
60886347	Adult Daycare	2/19/2012	6/13/2012	Electronic	85
60887311	Adult Daycare	3/22/2012	6/13/2012	Electronic	53
56014092	Adult Daycare	3/5/2012	4/11/2012	Electronic	7
56269635	Adult Daycare	3/8/2012	4/13/2012	Electronic	6
62015100	Adult Daycare	4/13/2012	6/27/2012	Electronic	45
68513975	Adult Daycare	12/8/2012	1/25/2013	Electronic	18
68854758	Adult Daycare	9/6/2012	12/26/2012	Electronic	81
70066046	Adult Daycare	1/12/2013	3/20/2013	Electronic	37
56343909	Adult Daycare	3/14/2012	4/18/2012	Electronic	5
56414592	Adult Daycare	3/21/2012	4/25/2012	Electronic	5
62089020	Adult Daycare	5/5/2012	6/29/2012	Electronic	25
63955535	Adult Daycare	8/3/2012	9/5/2012	Electronic	3
66827456	Adult Daycare	8/29/2012	10/24/2012	Electronic	26
70154443	Adult Daycare	8/15/2012	1/23/2013	Electronic	131
72524168	Adult Daycare	1/11/2013	3/20/2013	Electronic	38
56680411	Adult Daycare	3/25/2012	4/30/2012	Electronic	6
55752850	Adult Daycare	2/25/2012	4/6/2012	Electronic	11
54671331	Pediatric Daycare	1/10/2012	2/10/2012	Electronic	1
54914178	Pediatric Daycare	1/21/2012	2/22/2012	Electronic	2
55324101	Pediatric Daycare	2/3/2012	3/7/2012	Electronic	3

55400820	Pediatric Daycare	2/10/2012	3/15/2012	Electronic	4
55558377	Pediatric Daycare	2/15/2012	3/21/2012	Electronic	5
55559658	Pediatric Daycare	2/11/2012	3/14/2012	Electronic	2
55668523	Pediatric Daycare	2/20/2012	3/27/2012	Electronic	6
55830372	Pediatric Daycare	2/22/2012	3/27/2012	Electronic	4
55859155	Pediatric Daycare	2/27/2012	4/4/2012	Electronic	7
55925291	Pediatric Daycare	3/1/2012	4/4/2012	Electronic	4
59780605	Pediatric Daycare	5/8/2012	6/13/2012	Electronic	6
71259985	Pediatric Daycare	1/28/2013	4/2/2013	Electronic	34
54891990	Pediatric Daycare	1/20/2012	2/22/2012	Electronic	3
55244320	Pediatric Daycare	2/3/2012	3/5/2012	Electronic	1
55451607	Pediatric Daycare	2/12/2012	3/16/2012	Electronic	3
55668523	Pediatric Daycare	2/20/2012	3/30/2012	Electronic	9
55761711	Pediatric Daycare	2/24/2012	3/28/2012	Electronic	3
55859155	Pediatric Daycare	2/27/2012	4/4/2012	Electronic	7
55978566	Pediatric Daycare	3/3/2012	4/5/2012	Electronic	3
62538301	Pediatric Daycare	7/13/2012	8/15/2012	Electronic	3
62538312	Pediatric Daycare	7/13/2012	8/15/2012	Electronic	3
55105319	Pediatric Daycare	1/28/2012	2/29/2012	Electronic	2
57981239	Pediatric Daycare	4/4/2012	5/10/2012	Electronic	6
67985529	Institutional	11/21/2012	1/9/2013	Electronic	19
68849882	Institutional	12/14/2012	1/23/2013	Electronic	10
60818897	Institutional	6/2/2012	7/20/2012	Electronic	18
62512372	Institutional	7/13/2012	8/17/2012	Electronic	5
59248505	Institutional	5/3/2012	6/20/2012	Electronic	18
56154831	Institutional	3/9/2012	4/20/2012	Electronic	12
58374158	Institutional	4/11/2012	5/23/2012	Electronic	12
69391868	Institutional	12/28/2012	3/27/2013	Electronic	59
58454787	Institutional	4/13/2012	6/1/2012	Electronic	19
58414061	Institutional	4/13/2012	5/30/2012	Electronic	17
70913235	Institutional	1/25/2013	3/1/2013	Electronic	5
56745038	Institutional	3/27/2012	5/11/2012	Electronic	15
55367146	Institutional	2/10/2012	3/28/2012	Electronic	17
70166659	Institutional	1/15/2013	3/1/2013	Electronic	15
68139347	Institutional	11/28/2012	1/16/2013	Electronic	19
58901578	Institutional	4/18/2012	5/25/2012	Electronic	7
69183557	Institutional	12/20/2012	1/30/2013	Electronic	11
58398582	Institutional	4/12/2012	5/23/2012	Electronic	11
69912814	Institutional	1/7/2013	2/8/2013	Electronic	2
69463131	Institutional	12/31/2012	2/6/2013	Electronic	7
68842409	Institutional	12/17/2012	1/25/2013	Electronic	9

58408618	Institutional	4/12/2012	5/25/2012	Electronic	13
68346280	Institutional	12/6/2012	1/11/2013	Electronic	6
69151639	Institutional	12/16/2012	1/23/2013	Electronic	8
55940384	Institutional	3/3/2012	4/11/2012	Electronic	9
69196540	Institutional	12/20/2012	2/6/2013	Electronic	18
66087742	Institutional	10/5/2012	11/9/2012	Electronic	5
64901291	Institutional	7/16/2012	9/12/2012	Electronic	28
61954609	Institutional	6/20/2012	8/1/2012	Electronic	12
62448157	Institutional	7/12/2012	8/17/2012	Electronic	6
68848855	Institutional	12/14/2012	1/23/2013	Electronic	10
67516507	Institutional	11/10/2012	12/19/2012	Electronic	9
69196951	Institutional	12/20/2012	1/30/2013	Electronic	11
69360874	Institutional	12/27/2012	2/6/2013	Electronic	11
69872780	Institutional	1/6/2013	2/8/2013	Electronic	3
60563759	Institutional	5/23/2012	7/13/2012	Electronic	21
59108881	Institutional	4/27/2012	6/15/2012	Electronic	19
64615683	Institutional	8/25/2012	9/26/2012	Electronic	2
59798181	Institutional	5/9/2012	7/4/2012	Electronic	26
60564402	Institutional	5/23/2012	7/18/2012	Electronic	26
69179303	Institutional	12/19/2012	1/28/2013	Electronic	10
60967504	Institutional	6/7/2012	7/27/2012	Electronic	20
70752006	Institutional	1/26/2013	2/27/2013	Electronic	2
55182688	Institutional	2/1/2012	3/7/2012	Electronic	5
67527854	Institutional	10/17/2012	11/23/2012	Electronic	7
59238956	Institutional	5/3/2012	6/22/2013	Electronic	385
69373991	Institutional	12/28/2012	2/6/2013	Electronic	10
58414061	Institutional	4/13/2012	5/30/2012	Electronic	17
60978206	Institutional	6/8/2012	7/25/2012	Electronic	17
72553602	Institutional	2/25/2012	3/20/2013	Electronic	359
69463506	Institutional	12/31/2012	2/5/2013	Electronic	6
55658860	Institutional	2/20/2012	3/27/2012	Electronic	6
70270523	Institutional	1/17/2013	2/22/2013	Electronic	6
56835197	Institutional	4/1/2012	5/2/2012	Electronic	1
67508978	Institutional	11/8/2012	12/24/2012	Electronic	16
55786394	Institutional	2/26/2012	4/4/2012	Electronic	8
67465636	Professional	11/4/2012	12/12/2012	Electronic	8
70225095	Professional	1/16/2013	3/22/2013	Electronic	35
69132818	Professional	12/16/2012	1/31/2013	Electronic	16
68228785	Professional	12/1/2012	1/2/2013	Electronic	2
68228491	Professional	12/1/2012	1/16/2013	Electronic	16
70013482	Professional	1/9/2013	3/13/2013	Electronic	33

62161729	Professional	6/28/2012	8/1/2012	Electronic	4
68816235	Professional	12/16/2012	2/1/2013	Electronic	17
56140324	Professional	3/9/2012	4/18/2012	Electronic	10
55582827	Professional	2/15/2012	3/21/2012	Electronic	5
58081153	Professional	4/8/2012	5/14/2012	Electronic	6
58081153	Professional	4/8/2012	5/14/2012	Electronic	6
56388057	DSNP	3/18/2012	4/25/2012	Electronic	8
59209101	DSNP	4/26/2012	5/30/2012	Electronic	4
60704519	DSNP	5/23/2012	7/11/2012	Electronic	19
62370114	DSNP	7/3/2012	8/10/2012	Electronic	8
67527854	DSNP	10/17/2012	11/23/2012	Electronic	7
68392503	DSNP	11/7/2012	12/19/2012	Electronic	12
69454473	DSNP	12/28/2012	2/20/2013	Electronic	24
56041762	DSNP	3/7/2012	4/25/2012	Electronic	19
67930322	DSNP	11/17/2012	12/26/2012	Electronic	9
68081955	DSNP	11/24/2012	1/4/2013	Electronic	11
68482802	DSNP	12/5/2012	1/16/2013	Electronic	12
69449853	DSNP	12/24/2012	2/22/2013	Electronic	30
62370719	DSNP	7/5/2012	8/15/2012	Electronic	11
60535775	DSNP	5/3/2012	6/20/2012	Electronic	18
66938355	DSNP	10/21/2012	11/21/2012	Electronic	1
61332440	DSNP	6/10/2012	7/25/2012	Electronic	15
58473243	DSNP	4/12/2012	5/17/2012	Electronic	5
60543454	DSNP	5/17/2012	6/20/2012	Electronic	4
56341795	DSNP	3/12/2012	4/18/2012	Electronic	7
58098454	DSNP	3/31/2012	5/9/2012	Electronic	9
59046237	DSNP	4/19/2012	5/23/2012	Electronic	4
60538214	DSNP	5/14/2012	6/15/2012	Electronic	2
60929513	DSNP	6/3/2012	7/6/2012	Electronic	3
61288559	DSNP	6/6/2012	7/15/2012	Electronic	9
62430205	DSNP	7/8/2012	8/15/2012	Electronic	8
67935086	DSNP	11/13/2012	12/19/2012	Electronic	6
68392503	DSNP	11/7/2012	12/19/2012	Electronic	12
68855419	DSNP	12/13/2012	1/30/2013	Electronic	18
69449894	DSNP	12/24/2012	5/10/2013	Electronic	107
69900526	DSNP	12/21/2012	2/13/2013	Electronic	16
69894450	DSNP	12/29/2012	2/20/2013	Electronic	23
69832026	DSNP	12/18/2012	2/5/2013	Electronic	19
70858444	DSNP	12/19/2012	2/20/2013	Electronic	33
68191247	Adult Daycare	11/27/2012	1/11/2013	Mailed	5
69508582	Pediatric Daycare	12/31/2012	3/1/2013	Mailed	20

69171662	Institutional	12/17/2012	2/6/2013	Mailed	11
59692579	Institutional	5/2/2012	6/20/2012	Mailed	9
68275797	Institutional	11/29/2012	1/11/2013	Mailed	3
67133296	Institutional	10/25/2012	12/5/2012	Mailed	1
69171662	Institutional	12/17/2012	2/8/2013	Mailed	13
69891879	Institutional	11/23/2012	1/25/2013	Mailed	23
60646818	Institutional	5/22/2012	7/11/2012	Mailed	10
61296319	Institutional	6/6/2012	7/20/2012	Mailed	4
59664824	Institutional	5/1/2012	6/27/2012	Mailed	17
69261667	Institutional	12/20/2012	2/20/2013	Mailed	22
61996604	Institutional	6/15/2012	8/1/2012	Mailed	7
70210288	Professional	1/15/2013	3/20/2013	Mailed	24
69259194	Professional	12/17/2012	5/24/2013	Mailed	118
68190946	Professional	11/27/2012	1/11/2013	Mailed	5
68761312	Professional	12/10/2012	1/29/2013	Mailed	10
69894789	DSNP	12/28/2012	2/20/2013	Mailed	14
68854831	DSNP	12/7/2012	1/23/2013	Mailed	7
68478328	DSNP	11/29/2012	1/11/2013	Mailed	3
69337447	DSNP	12/19/2012	2/6/2013	Mailed	9
68250416	DSNP	11/27/2012	1/9/2013	Mailed	3
70743007	DSNP	12/24/2012	2/8/2013	Mailed	6
68855501	DSNP	12/10/2012	1/25/2013	Mailed	6

4. **Improper Denial due to Compatibility Errors between CareOne and Diamond Systems (8 Random Sample Claims in Error-System Errors)**

Claim Number	Random Sample	Claim Number	Random Sample
55757641	Adult Daycare	60136159	Personal Care
62355384	Personal Care	68469612	Personal Care
67064928	Personal Care	56742190	Institutional
68763286	Pediatric Daycare	55940384	Institutional

5. **Improper Denial due Incorrect Classification as Delayed Claim Submission (5 Random Sample Claims in Error)**

Claim Number	Date of Service	Date of Receipt	Days Elapsed	Days Allowed
67516501	06/11/12	11/12/12	154	180
61296319	01/07/12	06/06/12	151	180
69992465	10/09/12	01/09/13	92	180
70830844	10/10/12	01/28/12	110	180

67108470	06/28/12	10/23/12	117	180

6. **Improper Denial due to Manual Processing Error (4 Random Files in Error)**

Claim Number	Random Sample	Claim Number	Random Sample
68762589	Institutional	68084940	Institutional
59692579	Institutional	68275797	Institutional

7. **Miscellaneous Denial Errors (3 Random Files in Error)**

Claim Number	Claim Number	Claim Number
55559658	69872780	62512472

APPENDIX C – FRAUD PREVENTI0ON AND DETECTION

1. **Failure to Allow Medical Provider 45 Days to Resolve Recoupment Demands (1 File in Error)**

Case Number	Letter Date
570	August 17, 2011

VII. VERIFICATION PAGE

I, Clifton J. Day, am the Examiner-in-Charge of the Market Conduct Examination of AmeriChoice 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 AmeriChoice of New Jersey, Inc., Inc. as of February 3, 2014.

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.

September 9, 2014
Date

Clifton J. Day
Clifton J. Day, MPA, CPM, CSM
Chief of Market Regulation and
Consumer Protection, New Jersey
Department of Banking and
Insurance

LAST PAGE