ORDER NO. E15-91

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 AmeriHealth Insurance Company of New Jersey (NAIC No. 60061)	))))	CONSENT ORDER

TO: AmeriHealth Insurance Company of New Jersey
1901 Market Street, 42nd floor
Philadelphia, PA 19103

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, 2013 to December 31, 2013 examination of the claim practices of AmeriHealth Insurance Company of New Jersey ("AmeriHealth") performed by the New Jersey 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 AmeriHealth's practices did not accord fully with various provisions of New Jersey insurance statutes or regulations; and

WHEREAS AmeriHealth'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 30th day of July, 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 may 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
~~Director of Insurance~~
Acting Commissioner

Date: 7-30-15

Consented to as to form, content and entry

Judith L Roman

Name

Date: 7/28/2015

MARKET CONDUCT EXAMINATION

of

AMERIHEALTH INSURANCE COMPANY of NEW JERSEY

and

AMERIHEALTH HMO, INC.

located in

CRANBURY, NEW JERSEY

as of

December 17, 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: AUGUST 5, 2015

TABLE OF CONTENTS

I. INTRODUCTION 1

A. Scope of Examination 1
B. Error Ratios 2
C. Company Profile 2

II. PROVIDER APPEALS AND APPEAL MECHANISM 4

A. Introduction 4
B. Error Ratios on Randomly Selected Appeals 4
C. Examiners' Findings 5

III. CLAIMS ADJUDICATION AND RE-ADJUDICATION/ADJUSTED 8

A. Introduction 8
B. Error Ratios 8
C. Examiners' Findings–Paid and Denied Adjudicated Claims 9
D. Examiners' Findings–Paid and Denied Re-Adjudicated/Adjusted Claims 10

IV. ADVERTISING AND MARKETING 21

V. RECOMMENDATIONS 22

A. General Instructions 22
B. Provider Appeals and Appeal Mechanism 23
C. Claims Adjudication and Re-Adjudication/Adjustment 23

APPENDIX A – PROVIDER APPEALS AND APPEAL MECHANISM 28

APPENDIX B – CLAIMS ADJUDICATION AND RE-ADJUDICATION/ADJUSTMENTS 29

VI. VERIFICATION PAGE ..... LAST PAGE

I. INTRODUCTION

This is a report of the Market Conduct activities of AmeriHealth Insurance Company of New Jersey and AmeriHealth HMO, Inc. (hereinafter referred to as "AmeriHealth", the "Company" or the" Companies" collectively, or individually as "AH" in the case of AmeriHealth HMO, Inc., or "AHIC" in the case of AmeriHealth Insurance Company of New Jersey). Authority for this examination is found under **N.J.S.A. 26:2J-18.1** as applicable to a health maintenance organization ("HMO"), and **N.J.A.C. 11:24-2.12**, which requires an HMO to open its books and records for an examination. Further authority for this examination is found under **N.J.S.A. 17B:30-16**, which permits the Commissioner to examine the business affairs of a health insurance company. Market Conduct Examiners from the New Jersey Department of Banking and Insurance (hereinafter referred to as the "Department" or "DOBI") conducted this examination. The examiners present their findings, conclusions and recommendations in this report as a result of their market conduct examination of the Company. The Market Conduct Examiners were Examiner-in-Charge Monica Koch, Marleen Sheridan, Ralph Boeckman, Richard Segin and Erin Porter.

A. Scope of Examination

The scope of the examination included various health benefit plans sold in New Jersey. The examiners evaluated the Company's compliance with market conduct-related provisions of Health Maintenance Organization and Insurance laws and regulations. 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. 17B:27-44.2d** and **N.J.S.A. 26:2J-8.1d,** appeal rights requirements outlined in **N.J.A.C. 11:24-8.4** to **8.7** and **N.J.A.C. 11:24A-3.5 to 3.7,** and record viability, accuracy and auditability requirements specified in **N.J.A.C. 11:22-1.5(d)** and **N.J.A.C. 11:2-17.12(b)**.

The review period for this examination was January 1, 2013 through December 31, 2013. The examiners conducted this review at the Companies' office located in Cranbury, New Jersey, between May 5, 2014 and October 17, 2014. On various dates following the fieldwork, the examiners completed additional review work and report writing in Trenton, N.J.

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

B. Error Ratios

Error ratios are the percentage of files reviewed 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.

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

Greater Delaware Valley Health Care was a HMO incorporated under the laws of Pennsylvania on February 18, 1976. On December 23, 1986, all issued and outstanding stock of the Greater Delaware Valley Health Care was acquired by AmeriHealth Integrated Benefits, Inc., a wholly owned subsidiary of AmeriHealth, Inc., which in turn is a wholly owned subsidiary of Independence Blue Cross (hereinafter referred to as "IBC"). The name was

changed to Delaware Valley HMO. Inc. on July 11, 1988, and the name was changed again to AmeriHealth HMO, Inc., on July 1, 1995. AmeriHealth HMO, Inc., became authorized to operate in New Jersey pursuant to **N.J.S.A. 26:2J-1** et. seq. (the "Health Maintenance Organization Act") on May 9, 1991. AmeriHealth HMO, Inc., provides health benefits plans to individuals, small groups and large groups in New Jersey residents and workers.

Independence Insurance Benefits Company was incorporated under the laws of New Jersey on April 4, 1994. On March 10, 1995 the name was changed from Independence Insurance Benefits Company to AmeriHealth Insurance Company of New Jersey. AmeriHealth Insurance Company of New Jersey was authorized to transact business pursuant to **N.J.S.A. 17B:18-42**, on June 16, 1995. AmeriHealth Insurance Company of New Jersey provides health benefits plans to individuals, small groups and large groups in New Jersey.

II. PROVIDER APPEALS AND APPEAL MECHANISM

A. Introduction

The examiners reviewed AmeriHealth's complaint process and internal and external utilization management appeal process for compliance with **N.J.A.C. 11:24-3.7, N.J.A.C. 11:24A-4.6, N.J.A.C. 11:24-8.4 to 8.7, N.J.A.C. 11:24A-3.5 to 3.7.**

For purposes of this report, an administrative appeal is a challenge to an adverse company action that is not based on medical necessity, such as a denial of a claim or a precertification request because the member is no longer covered or was not covered on the date of service. Stage 1 and Stage 2 appeals are internal appeals to the company of its utilization management denials, i.e. denials of claims or precertification requests because the service is not medically necessary. In individual health benefit plans there is one stage of internal appeal and in group health benefits plans there are two stages of internal appeal. After the internal appeal, covered persons or providers acting on their behalf can file an external appeal to an independent utilization review organization (hereinafter "IURO") under the New Jersey Independent Health Care Appeals Program. The decision of the IURO is binding.

During the period January 1, 2013 through December 31, 2013, AmeriHealth received a total of 2,296 administrative appeals, 349 Stage 1 appeals, 73 Stage 2 appeals, and 24 external appeals.

B. 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 87 administrative appeals, 50 Stage 1 appeals, 40 Stage 2 appeals and 22 external appeals. Overall, the examiners found a total of 11 appeals processed in error, for a random sample error ratio of 6%. For reference purposes, AH in the following charts refer to appeals processed by AmeriHealth HMO, Inc., and AHIC refers to appeals processed by AmeriHealth Insurance Company of New Jersey.

Appeal Error Ratio Chart

Type of Appeal	Appeals Reviewed	Appeals in Error	Error Ratio
1. Administrative			
AH	40	2	5%
AHIC	47	3	6%
Subtotals	87	5	5.7%
2. Internal			
Stage 1 AH	25	1	4%

Stage 1 AHIC	25	1	4%
Stage 2 AH	20	0	0%
Stage 2 AHIC	20	0	0%
Subtotals	90	2	2.2%
3. External			
External AH	12	2	17%
External AHIC	10	2	20%
Subtotals	22	4	18%
Overall Totals	199	11	5.5%

C. Examiners' Findings

1. **Failure to Pay Administrative Appeal Awards, Internal Appeal Awards and External Appeal Awards Promptly upon Notice of Decision – 7 Files in Error (4 AH and 3 AHIC Appeal Files)**

N.J.S.A. 26:2S-12c, **N.J.A.C. 11:24-8.7(k)**, applicable to an HMO and **N.J.A.C. 11:24A-3.6(j)2**, applicable to a health insurer, provide that the IURO's determination shall be binding on the carrier and the member, and the carrier shall provide benefits (including payment of the claim) without delay. The Companies failed to provide prompt coverage in the following cases after adverse decisions on administrative appeals, internal appeals and external appeals.

a. External (4 Appeals in Error)

Contrary to the above statute and regulations, the examiners found two AH and two AHIC appeals in which the Companies did not issue payment promptly when the external appeal decision overturned the final internal appeal decision. The average number of days from notice date of external appeal decision to date of payment on these appeals was 51 days; payment was therefore not prompt. The Company agreed with these errors.

Please See Appendix A-1a for Files in Error

b. Administrative Appeals (3 Appeals in Error)

The examiners reviewed 80 Administrative appeals and determined that, contrary to **N.J.A.C. 11:24-3.7(a)4,** applicable to an HMO, and **N.J.A.C. 11:24A-4.6(a)4,** applicable to an insurance company, the Companies did not pay two AH administrative appeals and one AHIC administrative appeal within the maximum 30 day period when the initial decision was overturned. Two of these were paid 6 days beyond 30 days. On the third, AH processed payment in the amount of $149.24, including interest, only after receiving an inquiry from the examiners. This payment was delayed a total of 285 calendar days beyond 30 days.

The Companies agreed with these findings and further advised that they notified all staff that appeal decisions require expedited processing.

Please See Appendix A-1b for Files in Error

2. **Failure to Conclude Stage One Appeals within Required Time Frame – 2 Files in Error (1 AH and 1 AHIC Appeal File)**

N.J.A.C. 11:24-8.5 and **N.J.A.C. 11:24A-3.5(j)1.ii** require carriers to conclude all non-urgent Stage 1 appeals within 10 calendar days from the date of receipt. AH received appeal number 209645 on January 15, 2013 and sent the resolution letter on January 29, 2013, four days beyond the required 10 days. AHIC received appeal number 213629 on May 17, 2013 but did not send a resolution letter to the member until May 29, 2013, two days beyond the required 10 days. AmeriHealth agreed with both errors.

These Files are also listed in Appendix A-2

3. **Unfair Denial of Benefits and Misrepresentation of Policy Provisions – 2 Files in Error (2 AHIC Files)**

N.J.S.A. 17B:27-46.1h require an insurance company to provide coverage for wellness physicals on an annual basis. Additionally, **N.J.S.A. 17B:30-13.1a** prohibits carriers from misrepresenting pertinent facts or insurance policy provisions. Lastly, **N.J.S.A. 17B:27-44.2d(1)** and **(9)** require payment by insurance companies within 30 days on claims received electronically, and within 40 days on claims received by paper, with payment of interest at 12% for late payments.

The examiners found two claims in which the Company erroneously denied benefits for annual physicals, incorrectly stating that members exhausted the allowable limits for routine physical examinations. Both members filed an administrative appeal. In response, the Company appeal reviewer determined that neither member exceeded the annual limitation on routine examinations.

In response to the reviewer's decision, AHIC overturned both denials and issued payment to each provider. Inconsistent with the appeal decision and contract benefits, however, the Company's explanatory notice to the members erroneously stated that these claims were paid as a "one time administrative exception." This statement is inconsistent with **N.J.S.A. 17B:30-13.1a** because such services were in fact covered benefits under the contract, and not paid merely as administrative exceptions.

Lastly, to the extent that these claims were payable upon initial submission, payment was made in excess of the maximum 30 day period set

by **N.J.S.A. 17B:27-44.2d(1)**. However, the Company failed to pay interest as required by **N.J.S.A. 17B:27-44.2d(9).**

Please See Appendix A-3 for Files in Error and Period of Delay

4. **Failure to Submit Written Report Timely – 1 AHIC Appeal File in Error**

N.J.A.C. 11:24-8.7 (k) and **N.J.A.C. 11:24A-3.7** requires HMOs and insurance companies to submit a written report to the covered person, the Department of Banking and Insurance and the IURO describing how the carrier will implement the IURO's decisions within 10 business days of the date the carrier first receives the decision of the IURO. On one AHIC appeal, the Company issued a written report 14 business days after receiving the IURO's decision, contrary to **N.J.A.C. 11:24A-3.7**.

This File in Error is listed in Appendix A-4

III. CLAIMS ADJUDICATION and RE-ADJUDICATION/ADJUSTED

A. Introduction

The examiners manually reviewed 270 randomly selected adjudicated and 306 randomly selected re-adjudicated/adjusted claims submitted under health insurance policies and HMO contracts for the period January 1, 2013 through December 31, 2013. The examiners also randomly reviewed a stratified sample of 398 denied claims. This sample was comprised of sub-populations at the benefit level and was designed to determine overall frequency of compliance within that benefit level or subpopulation. Files from this sample are designated as "select" files or as having originated from the "select sample."

During the period January 1, 2013 through December 31, 2013, AH adjudicated 766,068 claims and AHIC adjudicated 953,400 claims. AH's claims consisted of 548,238 paid and 184,527 denied adjudicated claims, as well as 23,772 paid and 9,531 denied re-adjudicated claims. AHIC's claims consisted of 726,910 paid and 191,725 denied claims, as well as 25,520 paid and 9,245 denied re-adjudicated claims. In arriving at these populations, the examiners requested the company to exclude all Medicaid, Medicare and self-funded plans. The distribution of errors from these samples is reflected below.

In reviewing claims, the examiners checked for compliance with statutes and regulations which govern the handling of claims, particularly **N.J.S.A. 26:2J-1 et seq.**, **N.J.S.A.26:2S-1 et seq.**, **N.J.S.A. 17B:27-44.2** and **N.J.S.A. 17B:30-13.1** (Unfair Trade Practices Act). The examiners also utilized the NAIC Market Regulation Handbook, Chapters 16 and 20, in developing the scope of review and in examining company claim documentation and records.

B. Error Ratios

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

1. Random Adjudicated Claims Error Ratios

Type of Claim	Files Reviewed	Files in Error	Error Ratio
AH Paid Adjudicated	75	0	0%
AH Denied Adjudicated	60	1	2%
Total AH Adjudicated Claims	135	1	1%

AHIC Paid Adjudicated	75	1	1%
AHIC Denied Adjudicated	60	0	0%
Total AHIC Adjudicated Claims	135	1	1%
Total Random Paid Adjudicated Claims	270	2	1%

2. Random Re-adjudicated/Adjusted Claims Error Ratios

Type of Claim	Files Reviewed	Files in Error	Error Ratio
AH Paid Re-adjudicated	85	12	14%
AH Denied Re-adjudicated	75	4	5%
Total AH Re-adjudicated Claims	160	16	10%
AHIC Paid Re-adjudicated	70	15	21%
AHIC Denied Re-adjudicated	76	1	1%
Total AHIC Re-adjudicated Claims	146	16	11%
Total Random Re-adjudicated Claims	306	32	11%

3. Select Sample Error Ratios

AH Denied

Type of Claim	Files Reviewed	Files in Error	Error Ratio
CPT 90658	34	26	76%
CPT 90744	126	22	17%
Mandated Benefits - Infertility	13	3	23%
Total AH Select	173	51	#

AHIC Denied

Type of Claim	Files Reviewed	Files in Error	Error Ratio
CPT 90658	33	15	45%
CPT 90744	74	4	5%
Mandated Benefits - Infertility	22	18	82%
Psychiatric Services	76	11	14%
Improper Deductible	20	7	35%
Total AHIC Select	225	55	#

Aggregate error ratio omitted because more than one error type occurred on some files.

C. Examiners' Findings–Paid and Denied Adjudicated Claims

1. **Failure to Settle Claims Timely – 2 Files in Error (1 Random AHIC and 1 Random AH)**

N.J.S.A. 26:2J-8.1d(1), as applicable to an HMO, and N.J.S.A. 17B:27-44.2d(1), as applicable to an insurance company, require an insurer to pay or deny a claim no later than the 30th calendar day for a claim submitted by electronic means and the 40th day for a claim submitted by other than electronic means.

Contrary to the statutes cited above, the Company failed to adjudicate two claims in a timely manner. Correct payment and interest was made on paid AH claim 7509201303533. The Company denied AHIC claim 3002071327013; interest was therefore not required. The Company agreed with both errors.

Please See Appendix B-1 for Random Files in Error

D. Examiners' Findings–Paid and Denied Re-Adjudicated/Adjusted Claims

2. Systemic Failure to Link Authorizations and Referrals to Corresponding Claims (9 Files in Error - 8 Random AH and 1 Random AHIC Claim - Improper General Business Practice)

N.J.S.A. 17B:30-53(1) provides that no payer shall deny reimbursement to a hospital or physician on the grounds of medical necessity in the absence of fraud or misrepresentation if the payer approved authorization for the health care services delivered prior to rendering the service. In addition, N.J.S.A. 17B:30-13.1d states that no person shall refuse to pay claims without conducting a reasonable investigation based upon all available information.

From the paid adjusted random samples, the examiners found that AmeriHealth invalidly denied eight AH claims and one AHIC claim because a systems error in the claim processing system (the PEGA tool) did not link authorizations and referrals to corresponding claims. The PEGA tool was designed to automate hold code steps that claims analysts previously performed manually. The Company agreed with this error, and further stated in response to an inquiry that technology staff would conduct further research to determine if the PEGA tool is functioning properly. AmeriHealth paid these claims after receiving notification from the provider or member that an authorization was on file for each claim.

Please See Appendix B-2 for Random Files in Error

3. Improper Denial and Delayed Resolution of Psychiatric Services Due to Claim System Errors – 15 Files in Error (4 Random AHIC and 11 Select AHIC Claims - Improper General Business Practice)

Contrary to N.J.S.A. 17B:30-13.1d as referenced above in item 2 above, the examiners found that the Companies improperly denied four random AHIC

adjusted claims and 11 select AHIC claims. Each claim was improperly denied under reason code "ineligible provider of service" when in fact the provider was eligible to provide the applicable service.

As a result of several inquiries, AmeriHealth indicated that these denials resulted from a claim processing design error that did not include diagnosis codes and service classes. Where a provider billed psychiatric office visits in conjunction with depression diagnosis codes, the claim system automatically adjudicated a denial because the system could not record the diagnosis code. Consequently, the system denied the claim under an ineligible provider reason code. The Company adjusted the four randomly selected claims and issued payments with correct interest when the member questioned the denial.

In response to the examiners' request, AHIC advised that a total of 76 additional insurance company claims were payable but nevertheless denied because of this system error. In order to determine the extent of this error, the examiners reviewed these claims and found that the Company re-adjudicated only 65 of the 76 affected claims; the remaining 11 claims remained in denied status. In response to the examiners' inquiries as to why the 11 claims remained unpaid, the Company explained that it was still investigating why the system continued to deny these claims. The examiners note that these 11 claims were payable for the same reason as the 65 that were re-adjudicated and paid. As such, the Company failed to comply with **N.J.S.A. 17B:30-13.1e,** which requires a carrier to affirm or deny coverage within a reasonable period of time after a claimant submits proof of loss statements. Due to the number of claims affected by this systemic error, the examiners cited these denials as improper general business practices. The Company agreed with these findings.

Please See Appendix B-3a for Random Files in Error
Please See Appendix B-3b for Select Files in Error

4. **Improper Systemic Denial of Influenza Vaccination CPT Code 90658 – 42 Files in Error (1 Random AH, 26 Select AH and 15 Select AHIC Claims - Improper General Business Practice)**

Contrary to **N.J.S.A. 17B:30-13.1d**, AH improperly denied claim 3206271338406 submitted under CPT code 90658 (influenza vaccination). In response to the examiners' inquiries regarding the cause of this error, the Company stated that a claims analyst erroneously assigned a JX code (not a valid service or CPT code) to claims with CPT code 90658.

In order to determine the extent of this error, the examiners requested that the Company provide a list of claims where CPT code 90658 was improperly denied. In response, the Company provided the examiners with two claim lists. The first list contained 21 denied claims where the CPT code was

adjudicated as an invalid service or CPT code (JX Code) as stated above. The second list contained 26 claims where CPT code 90658 was improperly denied using denial code CU, which states that "The provider of this service was not contracted to perform this service according to the provision of the provider's contract." Due to the frequency of these denials, the examiners conducted a select review of all 47 claims from both lists to determine if any were in fact denied erroneously.

From the JX code list of 21 denied claims, the examiners found that 15, or 71%, were erroneously denied. In many instances, the denied claims were resubmitted by the providers for re-adjudication and ultimately paid with interest upon receipt. The remaining six claims were adjudicated accurately.

From the CU code list, the examiners found that the Company erroneously denied all 26 claims. On June 27, 2014, the examiners issued an inquiry that cited the above statute on all 26 claims. In response, the Company corrected the coding error to reflect the proper provider's service code according to the provider's contract. On July 17, 2014, the Company adjusted all 26 claims and issued payments that totaled $260.00, plus an additional $42.74 in interest.

In order to confirm that hold codes JX and CU were the only two codes that improperly affected CPT code 90658, the examiners extracted all 370 claims from Company datasets that contained CPT code 90658. A select review of 20 of those claims revealed that no additional errors occurred. However, due to the number of claims improperly denied through assignment of JX and CU codes, the examiners cited these errors as an improper general business practice under **N.J.S.A. 17B:30-13.1d**. The Company agreed with these errors.

The Random File in Error is listed in Appendix B-4a
Please See Appendix B-4b for Select Files in Error

5. **Unfair Denial of Mandated Infertility Benefits – 22 Files in Error (1 Random AHIC, 3 Select AH and 18 Select AHIC Errors - Improper General Business Practice)**

Pursuant to **N.J.S.A. 17B:27-46.1x,** as applicable to an insurance company and **N.J.S.A. 26:2J-4.23,** as applicable to an HMO, coverage for expenses incurred in the diagnosis and treatment of infertility shall be provided under group health benefits plans covering more than 50 persons.

During the random file review of the adjusted denied claims, the examiners found one AHIC claim, 7501311302844, where the Company improperly denied a mandated infertility benefit with BE hold code "Benefit Exclusion-Not Covered." In response to the examiners' inquiry the Company stated that

the claim analyst failed to assign correct hold code BZ (Infertility Claims NJ Mandate) and incorrectly assigned code BE (Benefit exclusion not covered). This caused the claim system to deny this mandated benefit. The examiners cited this file pursuant to **N.J.S.A. 17B:27-46.1x** as described above.

In order to test the overall frequency that this mandated benefit was paid as required, the examiners queried the Companies' HMO and insurance denied claims datasets to extract specific infertility CPT Codes. These included 58970, 89250, 89272, 89268 and 89280. This yielded a select sample population of 118 AHIC claims and 13 AH claims. From these sample populations, the examiners randomly reviewed 22 AHIC and 13 AH denied infertility claims. The examiners found that the Companies improperly denied 18 AHIC infertility claims (or 82% of the 22 AHIC claims extracted) and three AH infertility claims (or 23% of the 13 AH claims extracted). Due to the excessive frequency of these errors, the examiners cited **N.J.S.A. 17B:27-46.1x** as an improper general business practice on AHIC, and **N.J.S.A. 26:2J-4.23** on AH. The examiners also cited failure to comply with **N.J.S.A. 17B:30-13.1d** as referenced in previous sections of this report.

Overall, the examiners found several denial reasons, including "Benefit Exclusion-Not Covered" Hold Code BE, Analyst's Error and Member's Group not reflecting the NJ Infertility Mandated Benefit. The examiners noted that the Company re-adjudicated 21 of the 22 AHIC claims only after the provider or member questioned the denial. On remaining AHIC claim number 7501311302844, the Company did not pay the mandated benefit when the examiners notified AmeriHealth of this error because, as the Company indicated in response to an inquiry, neither the provider nor the member requested payment. Since the company was aware that this mandated benefit claim remained unpaid even though benefits were due, the examiners further cited this claim pursuant to **N.J.S.A. 17B:30-13.1d** (refusal to pay a claims based on all available information), **N.J.S.A. 17B:30-13.1e** (failure to affirm or deny coverage within a reasonable period after receipt of notice of loss) and **N.J.S.A. 17B:30-13.1f** (failure to attempt settlement in good faith). The examiners noted similar instances where the Companies identified improper denials but failed to adjust these claims unless the member or provider requested an adjustment.

Please See Appendix B-5a for the Random File in Error
Please See Appendix B-5b for Select Sample Files in Error

6. **Unfair Denial of Mandated Childhood Hepatitis B Immunization Benefits due to Claim System Errors - 15 Files in Error (1 Random AH, 10 Select AH and 4 Select AHIC - Improper General Business Practice)**

Pursuant to N.J.S.A. 17B:27-46.1l, N.J.S.A. 17B:27A-7e(2), N.J.S.A. 17B:27A-19k(2) and N.J.S.A. 26:2J-4.10, HMOs and insurance companies are to cover childhood immunization against Hepatitis B in health benefits plans issued in the individual, small and large group markets.

During a review of AH file 3211201326246, the examiners found that AH denied CPT code 90744 (Childhood/Adolescent Hepatitis B Immunization) due to a systemic claim processing error. While the claim system should have been programmed to deny CPT code 90744 for any service related to employment screening and/or vacation travel, the Company incorrectly programmed the claim system to deny all claims that were submitted with CPT code 90744. The Company advised that it corrected this error by changing CPT 90744 from a non/covered/benefit exclusion, to eligible for payment as of August 1, 2013.

In order to test the overall frequency of this error, the examiners requested the Companies to provide a list of all CPT 90744 claims that were denied in calendar year 2013. In response, AmeriHealth provided a list of 365 claims that were denied within this time period. The examiners randomly reviewed a select sample of 200 claims from that list and found that eight claims remained denied under denial code BE (benefit exclusion-not covered).

The examiners also determined that the Company improperly denied an additional six claims with code 67 (referral required-not found). These claims were originally denied because the member did not select a Primary Care Physician (PCP). On one of these claims, however, a PCP was in fact designated upon submission of the claim. Another claim was denied due to a claim analyst's error. On four other claims, the Company failed to submit the claims for adjustments when the member contacted AmeriHealth to add the PCP. The examiners cited these denials as inconsistent with N.J.S.A. 17B:30-13.1d as referenced above. In response to the examiners' inquiries, AmeriHealth agreed with these errors.

Due to the overall frequency of denial errors on mandated benefit CPT Code 90744, the examiners cited failure to comply with N.J.S.A. 17B:27-46.1l, N.J.S.A. 17B:27A-7e(2), N.J.S.A. 17B:27A-19k(2) and N.J.S.A. 26:2J-4.10 as an improper general business practice. The examiners also cited these denials as contrary to N.J.S.A. 17B:30-13.1d as referenced above.

Please See Appendix B-6a for Random Files in Error
Please See Appendix B-6b for Select Files in Error

7. **Improper Application of Deductible due to Incorrect System Coding – 8 Files in Error (1 Random AHIC and 7 Select AHIC Claims - Improper General Business Practice)**

Pursuant to **N.J.S.A. 26:2S-9.2b,** an insurance company and a health maintenance organization are required to reimburse participating health care provider in accordance with the applicable fee schedule and contract. Moreover, **N.J.S.A. 17B:30-13.1a** prohibits carriers from misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue. The Companies failed to comply with these statutes as outlined below.

On AHIC claim 7505091300926, the examiners found that CPT code 99213 (office visit) was originally denied and then adjusted due to an internal error. In response to an inquiry, AHIC advised that under insurance benefit package 5BMZ, policies should have been coded with a $2,500.00 deductible per individual. However, the system was incorrectly coded with a $5,000.00 deductible per individual. This claim was adjusted and paid with the appropriate interest on April 12, 2014 after the provider/member requested the adjustment.

Additional inquiries revealed that this error originated effective January 1, 2013 when the 2013 benefit packages were programmed into the claim processing system. However, this error was not identified until August 7, 2013 and the system was not corrected until approximately seven months later, on March 12, 2014. Once the system was corrected, the Company conducted an audit to determine the number of claims affected. Based on AmeriHealth's response, additional payments were issued on 13,621 claims affected by the deductible coding error.

The examiners reviewed a select sample of 20 claims from the 13,621 claims provided. This review indicated that AmeriHealth continued to apply the incorrect $5,000.00 deductible on seven claims, or 35% of the select sample. The Company's intervention was insufficient to correct this error. The Company agreed with this error.

This Random File in Error is in Appendix B-7a
Please See Appendix B-7b for Select Files in Error

8. Improper Denials of Duplicate Claims - 2 Random AHIC Files in Error (Improper General Business Practice)

Contrary to **N.J.S.A. 17B:30-13.1d**, the Company automatically denied both an initial claim submission and a subsequent, duplicate claim submission, without first considering the initial claim as a valid request for payment. In response to the examiners' inquiry, AmeriHealth explained that its claim system applies "hard logic" in its auto adjudicating claim protocol. This protocol cannot differentiate between an initial claim submission and it's duplicate. Where the company erroneously denies a claim and the provider resubmits that same claim for payment, the company automatically denies the second and all subsequent bills without a determination of the eligibility of

the claim for payment. The end result is that any validly submitted claim that is erroneously denied initially will always be denied upon resubmission unless the provider contacts the company (either by phone call, complaint or appeal).

Please see Appendix B-8 for Random Files in Error

9. **Failure to Settle Claims Timely and Pay Required Interest on Re-adjudicated Claims – 21 Files in Error (6 Random AH, 2 Random AHIC, 3 Select AH and 10 Select AHIC Claims)**

N.J.S.A. 26:2J-8.1d(1) and **N.J.S.A. 17B:27-44.2d(1)** require an HMO and an insurance company to pay claims no later than the 30th calendar day for a claim submitted by electronic means and the 40th day for a claim submitted by other than electronic means. Pursuant to **N.J.S.A. 26:2J-8.1d(9)** and **N.J.S.A. 17B:27-44.2d(9)**, a HMO and an insurance company are required to pay interest when the payment exceeds either the 30 day (claims submitted electronically) or 40 day (claims submitted by mail) maximum payment periods.

Contrary to above statutes, the examiners found a total of eight random claims and thirteen select claims where AmeriHealth failed to settle claims timely and further failed to pay interest as required. On six random delayed claims and eight claims from the select review, AmeriHealth failed to pay interest in the amount of $270.18. Moreover, the company underpaid interest on two delayed claims from the random review and five claims from the select review, by a total of $40.49 among both reviews. The average interest due on all claims was $14.79.

AmeriHealth disagreed with the examiners' findings that interest was due on five of the 21 claims cited for delayed settlement. On these five claims, the providers resubmitted the bills as new claims. Upon receipt, and based on procedure, the Company coded each claim as a new claim with a receipt date that corresponded to the second submission. However, use of that date and not the original claim submission date reduced the total number of days that the claim pended from initial submission to subsequent resubmission, thus resulting in interest underpayments due to understating total days delayed. The Company further stated that it would have paid interest on the initially delayed claim had the provider contacted AmeriHealth to request an adjustment/re-adjudication. The examiners note that a carrier's statutory obligation is to pay claims promptly and with interest where delayed, and not to rely on providers to request an adjustment when a carrier fails to properly pay claims.

Please See Appendix B-9a for Random Files in Error
Please See Appendix B-9b for Select Files in Error

10. Failure to Issue EOB with Specific Denial Reason - 19 Files in Error (2 Random AH and 17 Select AH Claims)

N.J.S.A. 17B:30-13.1n requires a carrier to provide a reasonable explanation of the contractual and legal basis for denying a claim. Also, **N.J.A.C. 11:24-8.4(e)** applicable to an HMO, and **N.J.A.C. 11:24A-3.5(h)** applicable to a health insurance company, state in part that an initial adverse benefit determination state specify the reason for the adverse benefit determination, as well as provide a description of any standards that the carrier utilized in its decision to deny benefits. Lastly, **Bulletin No. 13-09** reminds carriers of their obligation to issue explanation of benefits (EOBs) or remittance advice forms or other types of written statements that accurately or for outpatient services provided by a non-participating provider completely state the reasons for claim denial.

On AH claim 3010141303930, AH denied benefits for lack of a referral. However, the EOB states that, "This service must be performed by your primary physician's designated provider or site." Contrary to the above statute and regulations, the EOB fails to mention the member's need for a referral.

On AH claim 3212111309403, AH denied benefits because precertification was not obtained for outpatient services provided by a non-participating provider. The EOB corresponding to the claim states, "This service must be performed by your primary physician's designated provider or site." Contrary to the above statue and regulations, the EOB does not state that the member must obtain precertification for outpatient services provided by a non-participating provider.

During a select review of claims with CPT code 90744 (Hepatitis B Immunizations), the examiners found 17 additional AH claims that AH denied because the member did not have a primary care physician selected on the policy. However, the reason on the Explanation of Benefits stated: "Referral Required - Not Found." Inconsistent with the above statute, this language fails to state the underlying concern regarding members' apparent failure to select a participating provider. The Company agreed with these errors.

Please See Appendix B-10a for Random Files in Error
Please See Appendix B-10b for Select Files in Error

11. Improper Handling of Claims Resulting in Underpayments – 4 Files in Error (1 Random AH and 3 Random AHIC Claims)

N.J.S.A. 17B:30-13.1f prohibits insurance companies and HMOs from not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. In addition,

N.J.A.C. 11:4-28.7, applicable to an HMO and insurance company when paying as a secondary payer under Coordination of Benefits (COB), specifies that a carrier may reduce benefits to the extent that the total benefit paid among all plans does not exceed the total allowable expense. The examiners found that AmeriHealth failed to comply with these provisions as outlined below.

On AH claim 3204161309405, the claims analyst manually priced the procedure code incorrectly at 50% of the allowed amount, resulting in a corresponding underpayment of the claim. On AHIC claim 7212051314401, the Company applied an incorrect deductible that caused an underpayment. On AHIC claim 7712071409411, the company applied an incorrect coinsurance value. The examiners cited all three claims as inconsistent with **N.J.S.A. 17B:30-13.1f**. On AHIC claim number 7205231351501, the Company failed to comply with **N.J.A.C. 11:4-28.7** by applying an excessive benefit reduction when calculating its responsibility as the secondary payer.

Upon receipt of a provider or member inquiry, the Company issued the appropriate settlement with interest, on all four claims, totaling $526.50. The examiners also cited these claims as delayed settlements, pursuant to **N.J.S.A. 26:2J-8.1d(1)**, as applicable to an HMO, and **N.J.S.A. 17B:27-44.2d(1)**, as applicable to an insurance company. The Companies agreed with these errors.

Please See Appendix B-11 for Random Files in Error

12. Failure to Request Missing Information within Seven Days - 1 Random AH File in Error

N.J.S.A. 26:2J-8.1d(3) states that, if any portion of an electronically submitted claim cannot be adjudicated because of missing diagnosis codes, procedure codes or any other necessary information, a carrier is required to electronically notify the provider within seven days of that determination and request any missing information necessary to complete adjudication of the claim. AH received AH claim number 3206141319201 on March 18, 2013. However, the provider submitted this claim with an incorrect address. Contrary to the above statute, the Company did not request the correct address from the provider until April 24, 2013, or 29 days after receipt of this claim.

Please See Appendix B-12 for file in Error

13. Miscellaneous Claim Denial Errors – 7 Random Files in Error (3 Random AH and 4 Random AHIC Claims)

Pursuant to **N.J.S.A. 17B:30-13.1d**, an unfair claim settlement practice includes refusing to pay claims without conducting a reasonable investigation

based upon all available information. The Company failed to comply with this statute on the following claims.

a. Denials Resulting from Erroneous Hold Codes.

1. AHIC denied mental health claim 7705091311107 with hold code 6I (in network provider/precert required). However, precertification is not required for the mental health services provided.

2. AHIC denied claim 7202061409411 with hold code 8S (incorrect place of service billed) because the member was treated out of the New Jersey service area. AmeriHealth improperly denied the claim since the member's policy allows for out of area health care services.

3. AHIC denied claim 7212201343503 with a ZM (the rental purchase price has exceeded for durable medical equipment) hold code. This hold code was invalid for the claim since the purchase price of the equipment did not exceed the allowable amount based on materials that the examiners reviewed.

The Company neither agreed nor disagreed with these findings.

Please See Appendix B-13a for Files in Error

b. Denial Resulting from Erroneous Termination Processing

1. AH denied claim 3202281429745 as the group/broker for the member requested an enrollment termination. However, AH did not use the correct member termination date and erroneously denied the claim. The Company agreed with this finding.

Please See Appendix B-13b for file in Error

c. Denial Resulting from Referral Error

AH claim 3008081301721 was improperly denied on August 20, 2013 for not having a referral on file. Company records indicate the provider submitted a referral on July 12, 2013. However, the referral named the facility where the radiology service was provided and not the individual provider who performed the professional component of the service, i.e., reading the test materials. In response to the denial, the provider contacted the Company to advise that a referral was not necessary in this scenario. This claim is also cited in section III. D. 9 of this report. The Company agreed with this finding.

Please See Appendix B-13c for File in Error

d. Denial Resulting from Authorization Error.

AH claim 3209251319201 was incorrectly denied due to a claim analyst's error. The Company stated that although the authorization was correctly updated, the analyst still denied the claim in error. The Company agreed with this finding.

Please See Appendix B-13d for File in Error

e. Denial Resulting from Payment to Wrong Provider

AHIC claim 7212271309401 was originally paid to the wrong provider due to the incorrect manual assignment of the National Provider Identifier (NPI) to a non-participating provider. The Company agreed with this error.

Please See Appendix B-13e for File in Error

AmeriHealth paid each of the above claims after the member or provider requested a re-adjudication. The examiners note that all seven errors above were single errors that occurred only once during the claim review period.

IV. ADVERTISING and MARKETING

The examiners reviewed AmeriHealth's Internet site and 104 pieces of advertising materials, which consisted of posters, brochures, radio advertisements, billboards and social media announcements for compliance with all regulatory and statutory requirements relating to advertising. The examiners placed particular emphasis on **N.J.S.A. 26:2J-15a(1) and (2)** and **N.J.S.A. 17B:30-4**, (which prohibit untrue or misleading advertising materials); **N.J.S.A. 17B:30-3** (prohibits misrepresentations and false advertising of policies) and **N.J.A.C. 11:2-11.1 et seq.** (rules governing health insurance advertising).

The examiners found neither the printed material nor the content of the Internet site to be contrary to the aforementioned regulations or statutes.

V. RECOMMENDATIONS

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

Throughout this report, the examiners cite all errors found. If the report cites a single error, the examiners often include a "reminder" recommendation because a single error may indicate that 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 AmeriHealth 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. Provider Appeals and Appeal Mechanism

1. The Company should issue written instructions to applicable personnel stating that, according to **N.J.A.C. 11:24-8.7(k)** and **N.J.A.C. 11:24A-3.6(j)2** the IURO's determination shall be binding on the carrier and the member. The carrier shall provide benefits (including payment of the claim) without delay.

2. AmeriHealth should issue written reminders to all applicable personnel stating that:

   a. **N.J.A.C. 11:24-8.5** requires an HMO to conclude all non-urgent Stage 1 appeals within 10 calendar days from the date of receipt;

   b. **N.J.A.C. 11:24A-3.5(j)1.ii** requires an insurance company to conclude non-urgent Stage 1 appeals as soon as possible in accordance with the medical exigencies of the case, but in no event shall exceed ten calendar days for a resolution.

   c. **N.J.A.C. 11:24-3.7(a)4** and **N.J.A.C. 11:24A-4.6(a)4** require a carrier to respond to a complaint within 30 days from receipt.

3. AmeriHealth should issue a written reminder to all personnel that **N.J.A.C. 11:24-8.7(k)** and **N.J.A.C. 11:24A-3.7** requires a carrier to submit a written report to the covered person, the Department of Banking and Insurance and the IURO describing how the carrier will implement the IURO's decisions within 10 business days of the date the carrier receives the decision of the IURO.

C. Claims Adjudication and Re-Adjudication/Adjustment

4. AmeriHealth should issue a reminder to all appropriate claims personnel stating that **N.J.S.A. 26:2J-8.1d(1),** as applicable to an HMO, and **N.J.S.A. 17B:27-44.2d(1)**, as applicable to an insurance company, require an insurer to pay or deny a claim no later than the 30th calendar day for a claim submitted by electronic means and the 40th day for a claim submitted by other than electronic means. This reminder should also state that, pursuant to **N.J.S.A. 26:2J-8.1d(9)** with respect to HMOs and **N.J.S.A. 17B:27-44.2d(9)** with respect to insurance companies, interest at 12% is required is required when the settlement exceeds either the 30 day (claims submitted electronically) or 40 day (claims submitted by mail) maximum settlement periods.

   The Companies should also remind all appropriate staff that, where a claim is denied upon initial adjudication and then appealed or otherwise re-adjudicated and paid due to a provider or member inquiry or complaint, interest accrues from the original claim receipt date.

5. The Company should issue written instructions to claims handling personnel stating that:

   a. according to **N.J.S.A. 17B:30-53**, no payer shall deny reimbursement to a hospital or physician on the basis of medical necessity if the payer approved authorization for the health care services delivered prior to rendering the service;

   b. **N.J.S.A. 17B:30-13.1d** states no person shall refuse to pay claims without conducting a reasonable investigation based upon all available information;

   c. Pursuant to **N.J.S.A. 17B:27-46.1h** and **N.J.S.A. 26:2J-4.6a**, an insurance company and a HMO are required to provide coverage for wellness physicals on an annual basis.

6. To assure compliance with **N.J.S.A. 17B:30-53(1)** and **N.J.S.A. 17B:30-13.1d**, AmeriHealth must submit to the Commissioner a plan of correction that addresses the PEGA programing error that did not link authorizations and referrals to submitted claims. The Company should also provide the total number of claims that were affected by this error, including original claim number, CPT code, amount denied, amount subsequently paid, date paid, receipt date and interest paid. This review should not be limited to those claims in which the member or provider questioned the denial. See general instructions for language to be included in the cover letter sent with each payment.

7. To assure compliance with **N.J.S.A. 17B:30-13.1d** the Company must revise its claim processing system to ensure all diagnosis and service classes are properly updated for psychiatric office visits billed with depression diagnosis codes. AmeriHealth should provide an updated list of all affected claims, including original claim number, CPT code, amount denied, amount subsequently paid, date paid, receipt date and interest paid.

8. AmeriHealth must submit to the Commissioner, a report that describes why its claim system did not re-adjudicate the 11 claims cited in section III. D. 3 of this report. The Company should adjust the 11 claims and provide documentation that shows original claim number, date of adjustment, CPT code, original claim receipt date, date of payment, amount of payment, dates used to calculate interest and the amount of interest paid. See general instructions for language to be included in the cover letter sent with each payment.

9. In order to comply with N.J.S.A. 17B:30-13.1d and to avoid inappropriate claim denial, AmeriHealth should implement a plan of correction that assures that CPT code 90658 is properly programmed into the Company's computer system.

10. In order to comply with N.J.S.A. 17B:27-46.1x, N.J.S.A. 17B:30-13.1fB and N.J.S.A. 26:2J-4.23:

    a. The Company should provide training on the proper usage of hold codes as they relate to NJ mandated infertility benefits.

    b. Perform system updates to retract benefit exclusion codes when they pertain to NJ mandated benefits.

11. AmeriHealth should provide the following instruction to all appropriate personnel regarding Hepatitis B Immunizations:

    a. Pursuant to N.J.S.A. 17B:27-46.1l, N.J.S.A. 17B:27A-7e(2) and N.J.S.A. 17B:27A-19k(2), as applicable to an insurance company, and N.J.S.A. 26:2J-4.1, as applicable to an HMO, carriers are required to provide benefits for specified childhood immunizations, including the Hepatitis B vaccine;

    b. On the proper application and usage of hold codes BE and 67 to ensure mandated benefit claims for the Hepatitis B Immunizations are not improperly denied.

12. Pursuant to N.J.S.A. 17B:30-13.1d and N.J.S.A. 26:2S-9.2b, AmeriHealth should monitor its claim systems and programming to assure that the correct deductibles are applied to the corresponding benefits packages. The Company should re-open and review the 13,621 claims affected by the assignment of the improper deductible for benefit package 5BMZ. The proper payment amounts should be calculated and issued with the correct interest. A list including original claim numbers, original claim submission dates, principal paid, amount of interest paid, interest rate and dates utilized to calculate the actual delayed period, should be provided to the Commissioner to verify compliance with this recommendation. See general instructions for language to be included in the cover letter sent with each interest payment.

13. The Company should implement a procedure or amend the claim system's "hard logic" to recognize initial versus duplicate claims and/or services submitted on the same day. These procedures should recognize the first claim submission (by time or other means) as being subject to the adjudication process, while also recognizing subsequent submission

of claims and/or services submitted on the same date as duplicates should not be subject to automatic denial.

14. The Company must re-open and review all claims listed in Appendix B-9 of this report. AmeriHealth should calculate and pay the correct interest due for the period as required by **N.J.S.A. 26:2J-8.1d(9)** and **N.J.S.A. 17B:27-44.2d(9)**. A list including original claim numbers, amount of interest paid, interest rate, principal and dates utilized to calculate the actual delay period, should be provided to the Commissioner to verify compliance with this recommendation. See general instructions for language to be included in the cover letter sent with each payment.

15. AmeriHealth should inform all appropriate claims personnel in writing that **N.J.S.A. 17B:30-13.1n**, **N.J.A.C. 11:24-8.4(a) and N.J.A.C. 11:24A-3.5(h)** require a carrier to state the contractual, legal and factual basis for denying a claim. The Company should also reference **Bulletin No. 13-09,** which reminds carriers of the obligation to issue explanation of benefits (EOBs) or remittance advice forms or other types of written statements that accurately or completely state the reason for denial of claims.

16. AmeriHealth should instruct all appropriate personnel that:

    a. Deductibles must be calculated in accordance with the terms of the member's contract;

    b. Coinsurance should be properly assigned to all claims where applicable;

    c. When a claim is manually priced, it should be done in accordance with the member and provider contract, if the provider is participating.

    In addition, AmeriHealth should remind all appropriate staff that, pursuant to **N.J.A.C. 11:4-28.7**, a carrier acting as a secondary payer, may reduce benefits only to the extent that the total benefit paid among all plans does not exceed the total allowable expense.

17. AmeriHealth should remind all appropriate claims personnel in writing that, according to **N.J.S.A. 26:2J-8.1d(3)** applicable to HMO claims and **N.J.S.A. 17B:27-44.2d(3)** applicable to health insurance claims, if all or a portion of an electronically submitted claim cannot be adjudicated because the diagnosis coding, procedure coding or any other required data for the claim is missing, the payer shall electronically notify the health care provider or its agent within seven

days of that determination and request any information required to complete adjudication of the claim.

18. Pursuant to **N.J.S.A. 17B:30-13.1d**, AmeriHealth should remind all appropriate personnel that:

    a. Hold code 6I should not be used in the event precertification is not required from an in network provider. Also, hold code 8S should not be used when an out-of-area health service is allowed. The correct codes should be utilized when processing claims to avoid improperly denying claims with the incorrect code.

    b. When benefits are paid for the rental of durable medical equipment, benefits from the inception of the rental up to the termination of the rental should be properly calculated in order to determine if the rental paid meets or exceeds the purchase price of the equipment.

    c. When a member enrollment termination is received, the termination date should be verified in order to avoid improper denial of benefits prior to the actual date of termination.

    d. Instructions should be issued to appropriate personnel stating that claims should not be denied when a referral is made out to a participating facility with multiple providers.

    e. AmeriHealth should remind the appropriate personnel that it must assign the proper National Provider Identifier (NPI) to all providers.

APPENDIX A – PROVIDER APPEALS AND APPEAL MECHANISM

1. **Failure to Pay Internal and External Appeal Awards Promptly upon Notice of Decision – 7 Files in Error (4 AH and 3 AHIC Appeal Files)**

a. External Utilization Management Appeals

Appeal #	Plan	Claim #	Date IURO Decision Received	Date Co. Paid Claim	Total Days to Finalize
192449	AH	3210141353001	8/5/13	11/5/13	92
203273	AHIC	7212151110701	10/30/13	11/21/13	22
211181	AH	3002081302054	10/24/13	11/12/13	19
211239	AHIC	7612171200404	7/24/13	10/1/13	69

b. Internal Administrative Appeals

Appeal #	Plan	Claim #	Date Resolved by Co.	Date Co. Paid Claim	Days Over 30
210513	AHIC	7009061200825	2/4/2013	3/12/2013	6
217184	AH	3210311309407	9/26/2013	11/1/2013	6
218309	AH	3211141353007	11/5/2013	9/16/2014	285

2. **Failure to Conclude Stage One UM Appeals within Required Time Frame – 2 Files in Error (1 AH and 1 AHIC Appeal File)**

Appeal #	Plan	Date Appeal received	Date Co. sent resolution letter	Days Over 10
209645	AH	1/15/13	1/29/13	4
213629	AHIC	5/17/13	5/29/13	2

3. **Unfair Denial of Benefits and Misrepresentation of Policy Provisions – 2 Insurance Claim Files in Error**

Appeal #	Claim #	Date Received	Date Paid	Days Over 30	Amount Owed	Unpaid Interest
219603	7510281302397	10/28/13	1/14/14	48	$145.05	$2.28
219442	7506111301392	6/11/13	1/8/14	181	$84.00	$5.00

4. **Failure to Submit Written Report Timely – 1 AHIC Appeal File in Error**

Appeal #	Claim #	Date Co. Received IURO's Decision	Date Co. Issued Report	Working Days Over 10
203273	7212151110701	10/30/13	11/19/13	4

APPENDIX B – CLAIMS ADJUDICATION and RE-ADJUDICATION/ADJUSTMENTS

1. **Failure to Settle Claims Timely – 2 Files in Error (1 Random AHIC and 1 Random AH)**

Claim	Plan	Date Received	Date Paid/Denied	Days Over 30/40
7509201303533	AHIC	8/23/13	9/27/13 (P)	5
3002071327013	AH	02/07/13	04/15/13 (D)	27

2. **Systemic Failure to Link Authorizations and Referrals to Corresponding Claims (9 Files in Error - 8 Random AH and 1 Random AHIC Claim - Improper General Business Practice)**

Claim Number	Plan	Date Auth/Referral Approved/Received	Date Bill Received	Date Original Claim Denied
3203081404106	AH	12/5/13	12/23/13	1/2/14
3212261305207	AH	5/28/13	7/3/13	7/16/13
3207101305201	AH	4/26/13	5/2/13	5/15/13
3205201311004	AH	2/7/13	2/22/13	3/6/13
3202221304009	AH	1/2/13	1/10/13	2/22/13
3202111311002	AH	1/7/13	1/14/13	1/29/13
3202181405601	AH	9/20/13	10/14/13	11/12/13
3212121340501	AH	6/19/13	7/22/13	7/30/13
7212271309401	AHIC	11/4/13	11/25/13	12/24/13

3. **Improper Denial and Delayed Resolution of Psychiatric Services Due to Claim System Errors – 15 Files in Error (4 Random AHIC and 11 Select AHIC Claims - Improper General Business Practice)**

a. Random Files in Error

Original Claim	Plan
7504031301173	AHIC
3003181327018	AHIC
7501301302063	AHIC
7507051302693	AHIC

b. Select Files in Error

Original Claim	Plan
7511041301532*	AHIC
7501301401473*	AHIC
7502061401623*	AHIC
7710171322845*	AHIC
7710171322856*	AHIC
7502271402117*	AHIC
7510161302252*	AHIC

7510231300552*	AHIC
7511011301596*	AHIC
7511191301266*	AHIC
7512271301323*	AHIC

*-Claim still denying for "ineligible provider of service". Company still investigating at time of report writing

4. **Improper Systemic Denial of Influenza Vaccination CPT Code 90658 – 42 Files in Error (1 Random AH, 26 Select AH and 15 Select AHIC Claims - Improper General Business Practice)**

a. 1 Random Files in Error

Claim Number	Plan
3206271338406#	AH

#-claim denied with JX Code and no interest paid when claim was corrected

b. 41 Select Files in Error

Claim Number	Plan	Claim Number	Plan
3002071300291*	AH	3207161409424*	AH
7002071300238*	AHIC	7207161409401*	AHIC
7502061300802*	AHIC	7207161409403*	AHIC
3207161409401*	AH	7207161409404*	AHIC
3207161409402*	AH	7207161409418*	AHIC
3207161409403*	AH	3001081302522#	AH
3207161409404*	AH	3012111203119#	AH
3207161409405*	AH	7501021303247#	AHIC
3207161409406*	AH	7501181302902#	AHIC
3207161409407*	AH	3001141303005**	AH
3207161409408*	AH	3001231304471**	AH
3207161409409*	AH	3001311303015**	AH
3207161409410*	AH	3012111203187**	AH
3207161409411*	AH	7002051301410**	AHIC
3207161409412*	AH	7012111201604**	AHIC
3207161409413*	AH	7012111201628**	AHIC
3207161409414*	AH	7012311201604**	AHIC
3207161409416*	AH	7501221304902**	AHIC
3207161409417*	AH	7501231303632**	AHIC
3207161409422*	AH	7512111202743**	AHIC
3207161409423*	AH		

*-claims denied with CU Code
**-claims denied with JX Code
#-claim denied with JX Code and no interest paid when claim was corrected

5. **Unfair Denial of Mandated Infertility Benefits – 22 Files in Error (1 Random AHIC, 3 Select AH and 18 Select AHIC Errors - Improper General Business Practice)**

a. 1 Random File in Error

Claim Number	Plan	CPT Code	Reason for the Denial
7501311302844	AHIC	58970	Claims Analyst's Failure to follow BZ hold code correctly. Company's failure to initiate adjustment on a Mandated Benefit claim - no payment to date.

b. 21 Select Denied Files in Error

Claim Number	Plan	CPT Code	Reason for the Denial
3004051301847	AH	58970	Examiner's Error
1004041300502	AH	58970	Member's Group did not reflect the NJ Mandated Benefit – 213086 *
3004011303704	AH	58970	Claims Analyst's Failure to follow BZ hold code correctly
7502071302405	AHIC	58970	Member's Group did not reflect the NJ Mandated Benefit - 515649
7512021302926	AHIC	58970	Member's Group did not reflect the NJ Mandated Benefit - 461966
7511181301434	AHIC	58970	Member's Group did not reflect the NJ Mandated Benefit - 515649
7502081300634	AHIC	58970	Member's Group did not reflect the NJ Mandated Benefit - 483867
7507031301615	AHIC	58970	Claims Analyst's Failure to follow BZ hold code correctly
7505311301216	AHIC	58970	Claims Analyst's Failure to follow BZ hold code correctly, (Benefit Exclusion-Not Covered)
7508021302373	AHIC	89250 & 89272	Claims Analyst's Failure to follow BZ hold code correctly, (Benefit Exclusion-Not Covered)
7703011303101	AHIC	89272	Claims Analyst's Failure to follow BZ hold code correctly, (Benefit Exclusion-Not Covered)
7011111301361*	AHIC	89268	Member's Group did not reflect the NJ Mandated Benefit -485284
7004261300814	AHIC	89272	Claims Analyst's Failure to follow BZ hold code correctly, (Benefit Exclusion-Not Covered)
7504011301061	AHIC	89272	Member's Group did not reflect the NJ Mandated Benefit - 483867
7502111301436	AHIC	89280	Claims Analyst's Failure to follow BZ hold code correctly, (Benefit Exclusion-Not Covered)
7504161301006	AHIC	89280	Claims Analyst's Failure to follow BZ hold code correctly, (Benefit Exclusion-Not Covered)
7502051301017	AHIC	89280	Claims Analyst's Failure to follow BZ hold code

			correctly, (Benefit Exclusion-Not Covered)
7510111300250	AHIC	89280	Claims Analyst's Failure to follow BZ hold code correctly, (Benefit Exclusion-Not Covered)
7508191300352	AHIC	89280	Claims Analyst's Failure to follow BZ hold code correctly, (Benefit Exclusion-Not Covered)
3011221302711	AHIC	89280	IBC Error , denial for authorization when one is not required for Mandated Benefit
3010031301352	AHIC	89272	IBC Error , denial for authorization when one is not required for Mandated Benefit

* Claim remains as an improper Denied Claim – not paid

6. **Unfair Denial of Mandated Childhood Hepatitis B Immunization Benefits due to Claim System Errors - 15 Files in Error (1 Random AH, 10 Select AH and 4 Select AHIC - Improper General Business Practice)**

a. 1 Random File in Error

Claim Number	Plan
3211201326246	AH

b. 14 Select Files in Error

Claim Number	Plan
3004151303149	AH
3005131302911	AH
3001151301655	AH
3002191302524	AH
3005061302827	AH
7006171301251	AHIC
3010241301457	AH
3010101301022	AH
7510031300971	AHIC
7010091301016	AHIC
3010011302713	AH
3010031300331	AH
3010151302032	AH
7010141301326	AHIC

7. **Improper Application of Deductible due to Incorrect System Coding – 8 Files in Error (1 Random AHIC and 7 Select AHIC Claim - Improper General Business Practice)**

a. 1 Random AHIC File in Error

Claim Number
7505091300926

b. 7 Select AHIC Files in Error

Claim Number
7502211302102
7612261300132
7507151302903
7612191300314
7602121300246
7610291300314
7608151300310

8. Improper Denials of Duplicate Claims - 2 Random AHIC Files in Error (Improper General Business Practice)

Claim	Original Received Date	Date of Payment	Days Over 30/40
7712061310103	8/2/13	12/16/13	96
7703191407602	11/18/13	3/19/14	91

9. Failure to Settle Claims Timely and Pay Required Interest on Re-adjudicated Claims – 21 Files in Error (6 Random AH, 2 Random AHIC, 3 Select AH and 10 Select AHIC Claims)

a. 8 Random Files in Error

Claim Number	Plan	Date Received	Date Paid	Days over 30 or 40	Allowed Amount	Interest Paid	Interest in Error
3008081301721*	AH	4/23/13	9/24/13	124	$16.17	$0.00	-$0.66
3205061309411	AH	3/26/13	5/15/13	20	$46.82	$0.00	-$0.31
3206271338406	AH	1/7/13	3/26/13	48	$96.71	$0.00	-$1.53
3208131314407	AH	6/11/13	8/20/13	40	$209.43	$0.00	-$2.75
3208011314403	AH	4/9/13	8/6/13	89	$284.00	$0.00	-$8.31
3207101305201	AH	5/2/13	7/10/13	39	$684.99	$8.11**	-$0.67
7702201309401^	AHIC	1/4/13	2/25/13	12	$234.50	$0.00	-$0.77
7705091311107	AHIC	2/22/13	5/15/13	52	$60.00	$0.50**	-$0.35

^-Mailed Claim
*from denied review
**Interest was not calculated using the original receipt date

b. 13 Select Files in Error

Claim Number	Plan	Date Received	Date Paid	Days over 30 or 40	Allowed Amount	Interest Paid	Interest in Error
3001081302522*	AH	1/7/13	3/26/13	48	$17.69	$0.00	-$0.28
3012111203119^*	AH	12/6/12	4/3/13	78	$17.69	$0.00	-$0.45
3004051301847*	AH	4/5/13	7/11/13	67	$1200.00	$0.00	-$26.43
7501021303247^*	AHIC	12/26/13	2/12/13	8	$17.69	$0.00	-$0.04
7501181302902^*	AHIC	1/16/13	3/26/13	29	$17.69	$0.00	-$0.14

76102913003l4*	AHIC	10/21/13	4/7/14	138	$63.00	$2.73	-$0.12
7608151300310*	AHIC	8/6/13	4/7/14	214	$1263.19	$85.97**	-$2.90
7006171301251*	AHIC	6/17/13	1/29/14	196	$28.37	$0.00	-$1.52
7507031301615*	AHIC	7/3/13	10/15/13	74	$1225.00	$6.42**	-$18.41
7511181301434*	AHIC	2/7/13	1/17/14	314	$340.98	$0.00	-$32.14
7502081300634*	AHIC	2/8/13	5/13/14	429	$375.00	$40.08	-$4.00
7011111301361*	AHIC	11/11/13	6/25/14	196	$306.60	$2.43	-$14.03
7004261300814*	AHIC	4/26/13	10/16/14	508	$1400.00	$0.00	-$194.85

^-Mailed Claim
*from denied review
**Interest was not calculated using the original receipt date

10. Failure to Issue EOB with Specific Denial Reason - 19 Files in Error (2 Random AH and 17 Select AH Claims)

a. 2 Random AH Files in Error

Claim Number	Claim Number
3010141303930	3212111309403

b. 17 Select AH Files in Error

Claim Number	Claim Number	Claim Number
3012131302110	3012261301593	3006031302068
3001151301655	3001101302729	3005131302911
3004151303149	3003041300611	3003071302543
3002191302524	3005061302827	3003271301873
3007161302118	3007051301947	3005211301824
3012171302004	3004041302064	

11. Improper Handling of Claims Resulting in Underpayments – 4 Files in Error (1 Random AH and 3 Random AHIC Claims

Claim Number	Plan	Issue	Amount Paid	Amount Underpaid	Days over 30
7205231351501	AHIC	Coordination of Benefit	30.97	-$250.00	112
7212051314401	AHIC	Deductible	$0.00	-$78.72	18
7702071409411	AHIC	Coinsurance	$0.00	-$110.00	107
3204161309405	AH	Incorrect Pricing	$87.78	-$87.78	46

12. Failure to Request Missing Information within Seven Days - 1 Random AH File in Error

Claim	Plan	Date of Receipt	Date of Information Request
3206141319201	AH	3/18/13	4/24/13

13. **Miscellaneous Claim Denial Errors – 7 Random Files in Error (3 Random AH and 4 Random AHIC Claims)**

a.

Claim	Plan	Error Description
7202061409411	AHIC	Incorrect hold code
7705091311107	AHIC	Incorrect hold code
7212201343503	AHIC	Durable Medical Equipment rental calculation error

b.

Claim	Plan	Error Description
3202281429745	AH	Incorrect termination date applied

c.

Claim	Plan	Error Description
3008081301721	AH	Incorrect referral requirement

d.

Claim	Plan	Error Description
3209251319201	AH	Claim analyst error

e.

Claim	Plan	Error Description
7212271309401	AHIC	Incorrect provider paid

VI. VERIFICATION PAGE

I, Monica Koch, am the Examiner-in-Charge of the Market Conduct Examination of AmeriHealth Insurance Company of New Jersey, Inc. and AmeriHealth HMO, 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 AmeriHealth Insurance Company of New Jersey, Inc. and AmeriHealth HMO., as of December 17, 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.

3/16/15
Date

Monica Koch
Examiner in Charge
New Jersey Department of Banking
and Insurance