ORDER NO. E12-101

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 American Specialty Health ODS of New Jersey, Inc., NAIC No. 11866	)))))	CONSENT ORDER

TO: American Specialty Health ODS of New Jersey, Inc.
10221 Wateridge Circle
San Diego, CA 92121

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, 2010 to April 26, 2012 examination of chiropractic claims processed by American Specialty Health ODS of New Jersey, Inc. ("the Company") under the CIGNA Open Access Plus plans, 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 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 4TH day of SEPTEMBER, 2012

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 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 monitor the Company's compliance with the recommendations contained in the attached Report to determine if a reexamination of the company within two years of the date of this Consent Order is warranted; and

IT IS FURTHER ORDERED AND AGREED that in the event it is determined through reexamination 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: 8/26/2013

MARKET CONDUCT EXAMINATION

of

AMERICAN SPECIALTY HEALTH ORGANIZED DELIVERY SYSTEM OF NEW JERSEY, INC

located in

WEST TRENTON, NEW JERSEY

as of

April 26, 2012

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:

SEPTEMBER 5, 2012

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I. INTRODUCTION

This is a report of the Market Conduct activities of American Specialty Health Organized Delivery Service of New Jersey, Inc. (hereinafter referred to as ASH or the company). This review was limited to chiropractic services that ASH performed as an ODS on behalf of CIGNA HealthCare of New Jersey, Inc. 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**. Further authority for this examination is found under the provisions of **N.J.A.C. 11:22-4.7**, made applicable to the operations of an ODS by **N.J.S.A. 17:48H-33**. Lastly, **N.J.A.C. 11:22-4.7** requires an ODS 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 the 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 and Robert Greenfield.

In this report, examiners of the New Jersey Department of Banking and Insurance (NJDOBI) present their findings, conclusions and recommendations as a result of their examination.

A. SCOPE OF EXAMINATION

The scope of the examination included chiropractic claims that ASH processed under the CIGNA Open Access Plus plans issued in New Jersey. The purpose of this examination was to determine compliance with fair settlement practices, including ASH's overall claim determination methodology. Additional focus included compliance with prompt pay requirements outlined in **N.J.A.C. 11:22-1.5(a)1** and **N.J.A.C. 11:22-1.5(a)2**, 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, 2010 through the present. The examiners conducted this review as a desk audit in Trenton N.J. between November 14, 2011 and April 26, 2012.

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 NJDOBI 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. Whenever the examiners find that the errors cited constitute an improper general business practice, they have stated this in the report.

The examiners sometimes find improper general business practices or errors of an insurer 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 count each of these files as an error in 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 ASH the opportunity to respond to the examiners' findings and to provide exceptions to the statutory and/or regulatory errors or mishandling of files reported. In response to these inquiries, ASH 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

American Specialty Health ODS of New Jersey, Inc. ("ASH ODS-NJ") assumes risk for complementary health care benefit programs in New Jersey by contracting directly with health maintenance organizations (HMOs) and insurance companies. Currently, ASH ODS-NJ administers chiropractic and physical and occupational therapy benefits on behalf of licensed insurers and HMOs in New Jersey on a delegated, at-risk basis. ASH ODS-NJ contracts with providers to support network access for its HMO and insurance company clients in New Jersey. ASH ODS-NJ also performs clinical services evaluation (utilization

management) in New Jersey for such clients. Through its affiliate, American Specialty Health Networks, Inc., ASH ODS-NJ also supports third party administrator functions, such as claim processing, for its clients in New Jersey.

ASH ODS-NJ is a subsidiary of American Specialty Health Incorporated (ASH). Founded in 1987, ASH provides specialty network management, total population health, and fitness programs to nearly 26 million customers nationwide. More than 18 million of those customers are covered under its specialty network management programs alone.

II. CLAIMS ADJUDICATION

A. INTRODUCTION

Based on electronic records that ASH provided to the examiners, the Company processed a total of 77,933 claim events between April 1, 2010 and August 29, 2011. The examiners define a claim event as one discreet date of service for a particular type or level of treatment associated with a unique Current Procedural Technology (CPT) code.

The examiners randomly selected and manually reviewed a total of 108 claim events from the total population of 77,933 claim events that were processed during the review period. Of these, providers submitted 34 claims electronically and 74 by regular mail. In reviewing these claims, 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)** and **N.J.S.A. 17B:27-44.2(d)1** and **N.J.A.C. 11:22** et seq. (Prompt Payment of Clean Claims), **N.J.S.A. 17B:30-13.1** and **N.J.A.C. 11:2-17.1** et seq. (Unfair Claim Settlement Practices Act), **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. The examiners also conducted a population-wide or census time study on all 77,933 claim events to determine ASH's compliance with prompt pay rules stated in **N.J.A.C. 11:22-1.5** and **N.J.A.C. 11:22-1.6**.

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.

Error Ratio Chart

Type of Claim	Files Reviewed	Files in Error	Error Ratio
Random File Sample			
Electronic Claims	34	19	56%
Mailed Claims	74	41	55%
Random File Totals	108	60	56%
Targeted CTF Sample*	20	1	05%
Census Population	77,933	21,141	27%

*A random sample from a subpopulation of claims denied under denial code 14 - Failure to Submit Clinical Treatment Form (CTF).

C. EXAMINERS' FINDINGS

1. Failure to Adjudicate Claims in Accordance with Provider Contract and Fee Schedule

According to the ASH provider contract and fee schedule, benefits are evaluated in descending order, from primary services (evaluation and management and chiropractic manipulative therapy such as spinal adjustments) to adjunctive services (therapeutic modalities such as exercise, electrical stimulation, traction). As an example, where a provider bills chiropractic manipulative therapy (CMT), the associated CPT code is evaluated as a primary service that is subject to payment at 100% of the fee schedule, minus applicable copayments, coinsurance or deductibles. The Fee Schedule stipulates, however, that no more than one CMT or primary service per date of treatment is payable at a rate of 100%. Where two or more such treatments occur on the same date, the service of equal or lesser complexity is evaluated either as adjunctive with a lower rate of payment in the case of specific CPT codes, or denied as mutually exclusive. Where multiple adjunctive, non-CMT services are billed for the same treatment date, only the higher-rated service is paid at 100%. A secondary adjunctive service is paid at a reduced rate, and a tertiary adjunctive service is paid at a further reduced rate.

While conducting an electronic analysis of ASH's claim populations, the examiners discovered a recurring pattern of claim denials on specific Evaluation and Management CPT Codes, Chiropractic Manipulative Treatment CPT Codes and Adjunctive Therapy CPT Codes. Within this pattern, the examiners found claim subsets in which ASH inconsistently paid and denied primary (i.e., CPT 98941) and adjunctive (i.e., CPT 97530, 97110 and 97140) CPT codes. The examiners attempted to apply the above-referenced primary and adjunctive Fee Schedule methodology to actual file records (provider billing notices, provider Remittance Advices, member Explanation of Benefits claim handler note) from the random claim sample. This resulted in several inquiries that yielded the following findings relative to the provider contract and Fee Schedule settlement methodology.

a. Failure to Adjudicate CMT 98941 as a Primary Service (110 Population Wide Files in Error: $9,673.37 in Improperly Denied Benefits; $1,627.21 in Interest)

Pursuant to the ASH provider contract and Fee Schedule, Chiropractic Manipulative Therapy CPT Code 98941 is designated as a primary service while Neuromuscular Reeducation CPT Code 97112 is designated as an adjunctive service. On claim number 25402330, the provider was eligible for payment of both services; however, the claim representative mistakenly designated CPT 98941 as adjunctive and CPT 97112 as primary. Since only one primary service is eligible under the contract and Fee Schedule, the ASH-CIGNA claim system

paid primary and higher priced CPT 98941 at a reduced rate, while paying the full value of a lower priced CPT 97112.

In response to this finding, the examiners requested ASH to conduct a self-audit of all affected claims. In response, ASH identified a total of 110 errors out of 25,536 claims in which this error could have occurred. Overall, this error resulted in underpayments that totaled $9,673.37 in actual benefits and $1,627.21 in interest penalties.

Pursuant to **N.J.S.A. 26:2S-9.2b**, ASH is obligated to reimburse providers "... in accordance with the fee schedule provided to the health care provider pursuant to the contract." Contrary to this requirement, the above-referenced primary/adjunctive inversion error resulted in partial and at times, full denial of the services referenced above. Lastly, ASH failed to comply with **N.J.S.A. 26:2J-8.1d(1)**, **N.J.S.A. 17B:27-44.2d(1)** and **N.J.A.C. 11:22-1.5(a)1** and **2**, which permitted 30 days to investigate clean electronic claims and 40 days to investigate clean claims submitted by mail. Based on the datasets provided to the examiners in response to this error, ASH was unable to conclude (pay or deny) these claims in no fewer than 240 days from date of notice. The examiners note that ASH remediated all principal and interest on April 18, 2012.

b. Failure to Adjudicate CPT 97140-59 as Primary Adjunctive Service (1 Random Sample File in Error; $12.06 in Underpaid Benefits)

Pursuant to the ASH provider contract and Fee Schedule, CPT 97140-59 (Active, Manual therapy) is deemed a primary service only when not provided on the same treatment date as Chiropractic Manipulative Treatment (CPT Codes 98940, 98941, 98942 and 98943). On claim number 27929246, the provider did in fact administer 98941 on the same date as 97140-59. When this occurs, the Fee Schedule stipulates that 97140-59 be reordered as an adjunctive service at a reduced whole dollar rate. However, when 97140-59 as an adjunctive service is accompanied by other adjunctive services on the same date, the Fee Schedule states that 97140-59 is paid at 100% of the reduced adjunctive rate and that the remaining adjunctive services are to be reduced to 66% and 33% of the applicable whole dollar Fee Schedule rate.

Contrary to **N.J.S.A. 26:2S-9.2b**, the claim representative inverted the primacy of adjunctive services, such that CPT 97140-59 was paid at only 33% when the provider contract and fee schedule required payment at 100% of its adjunctive value. This resulted in an underpayment of $12.06, which ASH remitted to the provider along with interest, on February 29, 2012. Lastly, ASH failed to settle this electronically submitted claim within 30 days as required by **N.J.S.A. 17B:27-44.2d(1)**, **N.J.S.A. 26:2J-8.1d(1)** and **N.J.A.C. 11:22-1.5(a)1**. The examiners report a settlement delay of 212 days measured from the claim receipt date of July 2, 2011 to the final settlement date of February 29, 2012.

c. **Unfair Denials due to Failure to Comply with Treatment Form Waiver Program (One CTF Sample File in Error, One Random Sample File in Error; $102 in Denied Benefits)**

ASH's Provider Services Agreement (Attachment K, Tier 3 of Form NJ-CPSA 1-2011 dated 1/1/2011) outlines a Treatment Form Waiver Program that allows providers to submit specific CPT codes for the first five dates of service that "... are not subject to the submission of a Clinical Treatment Form (CTF) for verification of medical necessity." Thereafter, the provider is required to submit a CTF for purposes of demonstrating the medical necessity of a specified treatment plan.

On Targeted CTF Sample claim numbers 24255238 and random sample claim number 24687101, the examiners noted from electronic and hard copy claim records certain denied CPT codes that appeared to be eligible for payment without a CTF under the Treatment Form Waiver Program. In response to the examiners' inquiries, ASH advised that these codes were denied in error and did in fact qualify under the Waiver Program. Accordingly, the examiners cited these denials as inconsistent with **N.J.S.A. 26:2S-9.2b**, which requires payment in accordance with the provider contract and fee schedule. The examiners also cited ASH for delayed settlements, contrary to **N.J.S.A. 26:2J-8.1d(1)**, **N.J.S.A. 17B:27-44.2d(1)** and **N.J.A.C. 11:22-1.5(a)2**, which require a company to process clean mailed claims within 40 days from receipt. As indicated below, settlement delays ranged from 607 to 617 days beyond 40 days.

Claim Number	Fee Schedule Amount	No CPT Codes	Date of Receipt	Date of Remediation	Days > 40
24244238	$98	3	5/21/10	2/27/12	607
24687101	$44	2	5/15/10	3/02/12	617

2. **Systemic Claim Settlement Delays – 21,141 Population Review Records in Error; 60 Random Sample Files in Error (Improper General Business Practice)**

N.J.S.A. 26:2J-8.1d(1), **N.J.S.A. 17B:27-44.2d(1)**, **N.J.A.C. 11:22-1.5(a)2**, **N.J.A.C. 11:22-1.5(a)1** and **N.J.A.C. 11:22-1.6(a)** require a company to process (e.g., pay or deny) 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 19 electronic and 41 mailed paid claim events from the random sample that ASH settled beyond the 30 and 40 day periods referenced above, for an overall random sample error ratio of 56%.

On electronic claims, delays ranged from a low of 3 days to a high of 446 days beyond 30. The average settlement delay on all 19 electronic claims cited as delayed was 192 days, or 162 days beyond the maximum 30 day period. The

average settlement period calculated on all 34 electronic claims including those settled timely, was 99 days from notice of claim, or 69 days beyond the maximum 30 day period. On mailed claims, delays ranged from a low of 2 days to a high of 495 days beyond 40. The average settlement delay on all 41 mailed claims cited as delayed was 189 days, or 149 days beyond the maximum 40 day period. The average settlement period calculated on all 74 mailed claims including those settled timely, was 97 days from notice of claim, or 57 days beyond the maximum 40 day period. The combined electronic and mailed settlement period on all 108 claims was 97 days.

In response to the examiners' inquiries, ASH attributed these delays to three primary events: 1) a systemic error in CIGNA's claim processing platform that erroneously adjudicated in-network providers as out-of-network; 2) incompatibility between the ASH and CIGNA claims system edit logic in which specific CPT codes were erroneously denied or underpaid; and 3) use of time and resources necessary to retroactively reprocess certain other CPT codes that were erroneously denied due to assumed treatment overlap. ASH advised the examiners that each error type was fully remediated with interest.

In order to quantify the effect of these errors on the Company's success in settling claim events timely and accurately, the examiners analyzed ASH's claim population by itemizing total CPT codes billed and adjudicated, as well as total CPT codes reprocessed as unresolved from a prior adjudication. Overall, the examiners found that ASH and CIGNA required five attempts to settle the entirety of the 77,933 claims that providers submitted during the review period. The following chart itemizes success and failure rates for all five settlement attempts.

Itemized Claim Settlement Iterations

Claim Iteration	Number Claims	Number Successes[1]	Number Failures[2]	Elapsed Time[3]	Error Ratio	Success Ratio
Original	77,933	68,515	9,418	28	12%	88%
First	9,418	5,249	4,169	63	44%	56%
Second	4,169	3,370	799	123	19%	81%
Third	799	547	252	60	32%	68%
Fourth	252	247	5	53	2%	98%
Fifth	5	5	0	59	0%	100%

[1]. Refers to successful closure of a claim event without ASH identifying a need to reopen later in order to correct a prior handling error.

[2]. Refers to unsuccessful closure of a claim due to the need to reopen and correct a prior handling error.

3. Refers to average number of days taken to complete all claims within the claim iteration subset, e.g., Original, First, Second and so on. For example, the average time taken to reprocess all 9,418 in the first reprocessing iteration was 63 days.

As the above chart indicates, ASH was unable to properly finalize settlement on 9,418 claim events, or 12% of all claims processed upon first submission. Due to the three processing error types referenced above, ASH reopened those 9,418 claims (the first reprocessing iteration identified above) to correct the error(s), and was able to conclude 5,249. However, the remaining 4,169 claims, or 44%, were reopened as the second reprocessing iteration due either to a continuation of the prior error or newly discovered errors upon readjudication. Notably, these claims and subsequent iterations were pending since the providers' original claim submission. Subsequently, ASH was required to reopen and reprocess 799 of the 4,169 claims as the third reprocessing iteration. ASH was still unable to conclude 252 of the 799 previously pending claim events. These 252 were reprocessed as the fourth iteration due to error continuation or emergence of additional errors. Finally, the last 5 claim events were finalized upon the fifth reprocessing iteration.

Pursuant to the above, the examiner found on mailed and electronically submitted paid and denied claims that ASH failed to comply with **N.J.S.A. 26:2J-8.1d(1), N.J.S.A. 17B:27-44.2d(1), N.J.A.C. 11:22-1.5(a)1** and **2, N.J.S.A. 17B:30-13.1e** and **N.J.A.C. 11:22-1.6(a)** on a systemic basis and as an improper general business practice. ASH also failed to comply with **N.J.S.A. 17B:30-13.1c**, which requires the Company to adopt and implement reasonable standards for the prompt investigation of claims. Based on the foregoing, ASH was unable to comply with these statutes and regulations. In response to the examiners' inquiries, the Company acknowledged the above settlement delays and advised that corrective measures have been implemented.

Please See Appendix A-1 for Claims in Error

3. Failure to Maintain Auditable Claim Records (Improper General Business Practice)

N.J.A.C. 11:22-1.5(d) and **N.J.A.C. 11:2-17.12** require a company 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. ASH failed to comply with these requirements as outlined below.

a. Examiners' Inability to Reconstruct Claim Settlement due to Aggregation of Data Fields that Impede Auditability

The examiners found that ASH's electronic claim system is designed to record and maintain aggregated claim settlement information (e.g., amount allowed, amount not allowed, coinsurance, amount paid etc.) based on date of service. Where a provider bills five specific CPT codes with different service fees for the same treatment date, ASH totals, among other fields, the amount allowed, amount not allowed and amount paid for each CPT Code. ASH refers to this methodology as claim level data where all CPT's are grouped and aggregated by date of

service. The following summary chart on claim number 25001799 illustrates this methodology.

CPT Code	Amount Billed	**Amount Allowed**	**Not Allowed**	**Amount Paid**	Service Date
97530-52	$50.00	**$82.00**	**$25.46**	**$59.37**	6/16/10
97110-52	$50.00	**$82.00**	**$25.46**	**$59.37**	6/16/10
98943	$35.00	**$82.00**	**$25.46**	**$59.37**	6/16/10
97112	$75.00	**$82.00**	**$25.46**	**$59.37**	6/16/10
98941	$60.00	**$82.00**	**$25.46**	**$59.37**	6/16/10

In the above example, the Amount Billed column represents the actual value billed by the provider for each CPT code for a June 16, 2010 date of service. The Amount Allowed value of $82.00, however, is the aggregate amount allowed for all five CPT codes. According to ASH, this claim system cannot itemize or apportion the $82 value among the five CPT codes. Similarly, the Not Allowed value of $25.46 is the aggregate amount not allowed among the five CPT codes. The Amount paid column is also the total amount paid at the claim level; ASH's systems cannot itemize or apportion the paid value of $59.37 among the five CPT codes.[1]

In response to the examiners' inquiries requesting clarity, ASH advised that line level data was available only through CIGNA. As such, the examiners were unable to conduct an independent review of ASH's settlement determination on a per-CPT code basis. ASH's claim system is therefore not auditable and inconsistent with **N.J.A.C. 11:22-1.5(d)** and **N.J.A.C. 11:2-17.12** because the examiners could not independently reconstruct ASH's claim settlement activities.

b. Company Inability to Reconstruct Claim Settlement due to Aggregation of Data Fields that Impede Auditability

Notwithstanding ASH's assertion that line level claim data is available through CIGNA, the examiners nevertheless note that ASH was unable to derive actual principal and interest payments on a specific population of claim errors that the company remediated due to improper denial. In response to an inquiry regarding key elements of the remediation process, the company advised that the claim "... system does not have the ability to report paid amounts, member cost share and interest payment by line level." ASH could only estimate these values. Since the Company cannot accurately reconstruct its own settlements, the examiners cited ASH's claim methodology as an improper general business

[1] The amount allowed and paid values are affected and/or reduced by several factors, such as medical necessity, overlap with other services, variable fee schedule tier factors, coinsurance, copayments, deductibles, discounts for submitting claims electronically. The purpose of this chart is to illustrate the affect on aggregated values on the examination process.

practice pursuant to **N.J.A.C. 11:22-1.5(d)** and **N.J.A.C. 11:2-17.12** as addressed above, as well as **N.J.S.A. 17B:30-13.1c**, which requires a regulated entity to adopt and implement reasonable standards for the prompt investigation of claims. Notably, claim number 25001799 referenced above was originally received on August 27, 2010 and concluded 322 days later on July 15, 2011 after four adjudication cycles. This type of delay is highlighted in the subsection that follows.

4. Improper Copayment Assessment Resulting in Claim Underpayment (1 Random File in Error; 24 Overall Files in Error)

According to the Open Access Plus plan that ASH administers on behalf of CIGNA, members may be subject to a defined co-payment such as $5, $10, $15 and so on, depending on coverage level selected. While manually adjudicating random sample claim number 24687101 from the master population claim dataset, the examiners noted coinsurance and copayment values that were inconsistent with the amounts billed for specific CPT Codes. Because of aggregated values, the examiners were unable to determine the correct cost-sharing amount applicable to each CPT code from the electronic record. Consequently, the examiners requested hard copy to conduct a full review.

While assembling the requested material, ASH reported to the examiners that it assessed CPT code 98941 at twice the contracted co-payment rate at $10 versus the correct rate of $5 over a total of two dates of service (5/15/10 and 7/19/10). ASH attributed this underpayment to an error in CIGNA's claim system. This error required an adjustment to the member's deductible, which in turn increased the amount payable on the claim. As a result, ASH paid an additional $76.59 to the provider, including interest from the period 6/15/10 to the final payment date of 4/4/12. The examiners cited this claim as an error pursuant to **N.J.A.C. 11:2-17.8(1)** since ASH did not issue the full payment due upon the first adjudication. ASH also failed to comply with **N.J.S.A. 26:2S-9.2b** since it failed to apply the copayment in accordance with the provider contract. Lastly, ASH failed to comply with **N.J.S.A. 26:2J-8.1d(1)**, **N.J.S.A. 17B:27-44.2d(1)**, **N.J.A.C. 11:22-1.5(a)1** and **N.J.S.A. 17B:30-13.1(d)** since it did not settle this claim in a reasonable or prompt manner.

ASH conducted a self-audit and identified 23 additional claims where copayments were over assessed. This yielded an additional principal payment of $86.76 and interest of $125.31. The examiners did not include these 23 claims in the error ratio.

5. Failure to Provide Reasonable Explanation of Benefits and Utilization of Misleading Statements on Provider Remittance Advices (Improper General Business Practice)

Pursuant to **N.J.S.A. 17B:30-13.1(n)**, ASH is required to provide a reasonable, factual explanation of the basis for denying a claim. **N.J.A.C. 11:2-17.8(a)** supplements **N.J.S.A. 17B:30-13.1(n)** by requiring the Company to provide a specific reference to the language of a policy provision and a statement of the facts which make that language operative when denying a claim due to a policy provision. Contrary to these statutes and regulation, the examiners found all 108 claims in error from the random sample in which ASH failed to provide a reasonable explanation for claim denial and benefit determination, and further failed to state policy or contract provisions applicable to denial or compromise. Additionally, and contrary to **N.J.S.A. 17B:30-13.1a,** ASH included misleading statements in its Remittance Advice denials and compromises to the provider and the Explanation of Benefit (EOB) to the member (collectively, claim determination documents). Each error type is illustrated below.

a. Failure to Provide Adequate Explanation of Reason for Claim Denial - 11,320 Denial Code 11 Errors affecting $140,980 in Claimed Benefits (Improper General Business Practice)

On random sample claim number 24687101, ASH issued a Remittance Advice that denied CPT Code 97110 for date of service May 15, 2010. The reason for denial, coded in the claims system and the Remittance Advice as Denial Code 11, stated "This service is considered mutually exclusive with another service billed on the same date." The examiners note that the provider also billed CPT Codes 97032 and 98941 for service date May 15, 2010. Contrary to the specificity requirements outlined in **N.J.A.C. 11:2-17.8(a)**, ASH failed to identify which of the remaining two CPT Codes was mutually exclusive with CPT Code 97110. ASH also failed to comply with **N.J.S.A. 17B:30-12.1(n)**, which requires a company to provide a reasonable, factual explanation for the basis of denial. Reason code 11 is unreasonable to the extent that it requires the provider to determine which CPT Code was mutually exclusive with CPT Code 97110.

In order to determine the extent of this error, the examiners analyzed ASH's master claim dataset and found that ASH denied a total of 11,320 claim events under Denial Code 11. The examiners identified a total of 77 different CPT Codes that comprised the 11,320 denied claim events. The examiners then applied the fee schedule rate to each CPT Code by frequency and developed a total value of $140,980 in benefits that ASH denied without proper notice to the provider. [2]

b. Improper Use of Conjunctive Statement in Claim Determination Document that Results in Ambiguous Explanations of Claim Denial – 2,766 Denial Code 14 Errors affecting $35,953 in Claimed Benefits (Improper General Business Practice)

[2] Ibid. Flat fee was $212,000 and adjusted downward to $140,980, or 66% of claimed benefits. Population wide average adjustment unknown due to aggregation. This calculation also does not include copayments, coinsurance and deductibles.

On random sample claim number 24687101, ASH issued a Remittance Advice that denied CPT Code 97032. The reason for denial, coded in the claims system as Denial Code 14, stated "The Clinical Treatment Form (CTF) required per your provider contract for medical necessity review has not been received **or** was not approved (emphasis added)." This language includes a conjunctive reference to "or" along with two possible reasons for denial. These include: 1) the provider's failure to submit a CTF; or 2) the company's rejection of a CTF that the provider did in fact submit. However, only one of these two conditions can be true. In short, the referenced language requires the provider to determine which of the two "or" arguments is applicable. Denial Code 14 is therefore inconsistent with **N.J.A.C. 11:2-17.8(a)**, which requires a specific reason for denial. ASH also failed to comply with **N.J.S.A. 17B:30-12.1(n)**, which requires a company to provide a reasonable, factual explanation for the basis of denial; a denial reason that is ambiguous is neither reasonable nor factual in content.

In order to determine the extent of this error, the examiners analyzed ASH's master claim dataset and found that ASH denied a total of 2,766 claim events under Denial Code 14. The examiners identified a total of 28 different CPT Codes that comprised the 2,766 denied claim events. The examiners then applied the fee schedule rate to each CPT Code by frequency and developed a value of $35,953 in claimed fee schedule benefits that ASH denied without proper notice to the provider.[3]

c. Improper Representation of Provider Compensation as Provider Amount Billed for Medical Services Incurred (Improper General Business Practice)

Pursuant to ASH's contract with CIGNA and the Open Access Plus benefit plan, members receive an Explanation of Benefit for each benefit claimed under the contract. On claim number 24502337, the Company issued an Explanation of Benefit (EOB) for services provided to the member on June 10, 2010. However, contrary to **N.J.A.C. 11:2-17.12(b)** and **(c)**, the Company failed to include the issuance date on the EOB. As such, the examiners were not able to confirm the actual date the Company sent the EOB to the member.

On page 1 of the first of three member EOB's relative to treatment date June 10, 2010, the examiners note a heading designated as Amount Billed. The value $50.92 is associated with that heading, and is further described as "... the amount

[3] The flat fee schedule rate for these services totaled $54,065; however, these benefits are subject to primary, secondary and tertiary ordering with applicable factor reductions as outlined in the fee schedule. These factor reductions are posted at 66% and 33% of the maximum reimbursement rate. As such, the examiners applied an average factor of 66.5 to the $54,065 flat fee schedule rate which yielded a net value of $35,953. The 66.5 relativity represents the mid point between the maximum 100% reimbursement rate and the lowest 33% reimbursement rate. This calculation does not include copayments, coinsurance and deductibles.

that was billed for your visit on 6/10/2010." The examiners note, however, that this value represents ASH's administrative compensation for processing these claims. This value is inconsistent with **N.J.S.A. 17B:30-13.1a**, which prohibits misrepresentation of pertinent facts or insurance policy provisions. Notably, a review of the provider Remittance Advice and CMS 1500 claim form reveals that the provider billed a total of $160 for date of service June 10, 2012. Reference to $50.92 is therefore untrue within the context of **N.J.S.A. 17B:30-13.1a**. This same value appears under the heading Amount not Covered, which is described as that "...portion of your bill that's not covered..." The correct value under this heading is $160.00.

On page 3 of the first member EOB, the company referenced denial of two non-specific treatments that occurred on June 6, 2010. These treatments, designated merely as Spinal Care and without any reference to a CPT Code or other narrative description, appear under a column designated as Type of Service. The amount billed for each service is exactly 50% of the $50.92 administrative fee referenced above, i.e., $25.46. As such, the value portrayed as the amount billed is once again the provider's administrative compensation and not the actual fee for the treatment provided.

Moreover, the company assigned note code A to each of the two denials. That code stated: "This procedure code represents service integral to the more complex primary procedure submitted on this claim." On this document, the value is explained to the member as if it represented the fee for the medical service, rather than ASH's administrative fee; this inconsistency exists in the definition and use of the term "fee". The stated value is either an administrative fee or a fee for the actual medical service and can be only one or the other since, by definition, they represent different values.

Given this fee ambiguity and inconsistency, as well as the same two non-specific and ambiguous service descriptions, the member is unable to determine which of the two services is in fact included in the other "more complex primary procedure." This is particularly problematic considering that the provider Remittance Advice and CMS-1500 included four separate CPT codes. Accordingly, page 3 of this EOB is inconsistent with **N.J.S.A. 17B:30-13.1a** and **N.J.A.C. 11:22-1.6(a)** to the extent that: 1) the Type of Service column refers to different procedures collectively as "spinal care" and not the exact procedure performed; 2) the Amount Billed column for each of the two listed services merely states 50% of the ASH's compensation and not the amount billed for the medical services provided [or vice versa]; and 3) the Notes column implies that the billed service is included in a primary procedure that is not identified by type or other distinguishing narrative.

The examiners further note a significant discrepancy on page three of the EOB. As previously stated, the company lists ASH's compensation under the Amount Billed column rather than the actual amount the provider charged for

rendering treatment. However, the company's explanation for denial of that amount is based on medical treatment protocols (reference to components of a complex primary procedure). In totality, the CMS-1500 form and the RA state that the provider billed a total of $160. The RA to the provider states an amount paid value of $0.00, whereas page 1 of the EOB to the member incorrectly states that the provider billed $50.92 for the services provided to the member. At the same time, page 3 of the EOB denied that same administrative fee of $50.92, while explaining that denial in terms of the propriety of the medical treatment rendered to the member. Accordingly, the EOB is untrue and misrepresents pertinent facts, contrary to **N.J.S.A. 17B:30-13.1a**. The member is clearly unable to discern how this claim was adjudicated.

The examiners also reviewed the last of three EOBs necessary to resolve this claim. Page one (again, not dated) indicates an Amount Billed as $50.92 and an Amount not covered as $50.92. The latter includes a disclaimer stating that the member may or may not be responsible for this amount, and directs the member to "See the Notes section on the following pages." The Notes section refers to code C, which states that "These expenses are duplicates and have been previously processed." Read literally, and in conjunction with the company's statement that this value represents compensation to ASH, the member EOB actually advises the member that s/he may be responsible for paying ASH's compensation.

Page 1 of the third EOB to the member states an Amount Billed value of $50.94. The EOB further states that the plan paid $50.92 out of the billed amount of $50.94. Located below those values on page 1 is an Amount Not Covered of $0.02; that value represents the difference between the billed amount and the paid amount. At the bottom of page 1, the EOB states "You saved 99%." The company derived that value by converting $50.92 to a percentage of the $52.94 value ($50.92/$50.94 = 99%). In reality, the member saved nothing, let alone 99% of what in reality is a 2 cent reduction in ASH's administrative fee. This language is a misrepresentation within the context of **N.J.S.A. 17B:30-13.1a**.

Lastly, page 3 of the third EOB was amended to include four iterations of spinal care provided on June 10, 2010 (previously only two iterations were stated). For reasons indiscernible on the EOB, the company appears to have assigned one penny to each of the two additional spinal care iterations. The EOB further states that these iterations (devoid of a CPT code of other descriptive language that distinguishes one from the other) represent "Zero dollars billed; no payment due." In reality, the provider billed four separate CPT codes with specific dollar amounts.

Overall, page three of the EOB appears to serve no purpose or utility for the member; the content appears to be specific to ASH's administrative fees. Based on the foregoing, and as an improper general business practice, the EOB is contrary to **N.J.S.A. 17B:30-13.1a**, **N.J.S.A. 17B:30-13.1n** which requires a reasonable explanation of claim denial. To the extent that an EOB is designed by

regulation to explain benefit adjudication, the content of this form is factually incorrect and misleading. This EOB misrepresents pertinent facts insofar as the member was advised of significant savings when in fact two paid CPT codes incurred unnecessary interest penalties while two CPT codes remained denied. Moreover, the EOB does not identify paid and denied CPT codes or at least narrative descriptions of those codes for identification purposes, billed amounts, allowed amounts, and other pertinent information necessary for the member to appeal adverse determinations or coordinate benefits with other carriers.

III. PROVIDER APPEAL MECHANISM

A. INTRODUCTION

The examiners reviewed ASH's internal appeal process and appeal mechanism for compliance with **N.J.A.C. 11:22-1.8(a)** and **(b)** and **N.J.A.C. 24B-3.9.**

Based on its contractual relationship with CIGNA, ASH is responsible for handling the entirety of administrative and prompt pay appeals submitted by members and/or providers. ASH does not review or make determinations on clinical or medical necessity appeals. CIGNA retains that function, but ASH serves as a support mechanism for CIGNA's medical necessity appeals by providing claim-related records.

The examiners reviewed ASH's formal appeal mechanism for compliance with the above regulations and found no errors. The examiners did not, however, review actual appeals to compare actual appeal handing with the appeal mechanism.

IV. RECOMMENDATIONS

ASH 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 ASH to provide its personnel with a document they can use for future reference, the examiners have listed all recommendations below.

A. GENERAL INSTRUCTIONS

All items requested for the Commissioner and copies of all written instructions, procedures, recommended forms, etc., should be sent to the Commissioner, c/o Clifton J. Day, Manager of Market Conduct Examinations and Anti-Fraud Compliance, 20 West State Street, PO Box 329, Trenton, NJ 08625, within thirty (30) days of the date of the adopted report.

On claims 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 denials and recommended a further review to determine if additional benefits and interest are payable. Our review indicated that we (improperly denied CPT Codes/underpaid CPT Codes) 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. CLAIM ADJUDICATION

1. ASH should issue written instructions to all appropriate claim handling personnel stating that Chiropractic Manipulative Treatment (CMT) codes (e.g. 98941) should be processed as a primary service in accordance with the provider contract and fee schedule pursuant to **N.J.S.A. 26:2S-9.2b** and **N.J.S.A. 17B:30-13.1(d)**. These instructions should also clarify the proper ordering of adjunctive CPT Code 97112 in relation to CMT codes.

2. The Company should issue a reminder to all appropriate claim handling personnel advising that, when and where applicable, CPT 97140-59 is billed with other adjunctive services, the fee schedule specifies that this code is payable at 100% of the reduced adjunctive rate.

3. ASH should remind all appropriate claims processing staff of the eligibility requirements governing the Treatment Form Waiver Program to assure that eligible services are paid as required by the provider contract and fee schedule as required by **N.J.S.A. 26:2S-9.2b** and **N.J.S.A. 17B:30-13.1(d)**.

4. ASH should issue written instructions to all personnel who process claims stating that **N.J.S.A. 17B:27-44.2d(1)**, **N.J.S.A. 26:2J-8.1d(1)** and **N.J.A.C. 11:22-1.5(a)1** require a company to pay 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)**, ASH is obligated to utilize this time period in order to develop a final claim determination within 30 days. ASH should further include reference to **N.J.A.C. 11:22-1.6**, which makes the foregoing applicable to denied claims.

5. The Company should issue written instructions to all claims personnel stating that **N.J.S.A. 17B:27-44.2d(1)**, **N.J.S.A. 26:2J-8.1d(1)** and **N.J.A.C. 11:22-1.5(a)2** require a company to pay 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)**, ASH is obligated to utilize this time period in order to obtain a treatment plan. ASH should further include reference to **N.J.A.C. 11:22-1.6**, which makes the foregoing applicable to denied claims.

6. The Company must remind all applicable staff that, pursuant to **N.J.A.C. 11:22-1.5(d)** and **N.J.A.C. 11:2-17.12**, ASH 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. In order to comply with this requirement, ASH should avoid its practice of aggregating multiple claims and CPT Codes by date of service as outlined in this report.

7. ASH should issue written instructions to all appropriate claim staff stating that, pursuant to **N.J.S.A. 26:2S-9.2b** and **N.J.S.A. 17B:30-13.1(d)**, the Company is required to assess the correct copayment, coinsurance and deductible as defined in the provider contract, the fee schedule and the member contract. ASH should provide the Commissioner with a summary listing of all 24 claims events that it remediated relative to Section II.C.4 of this report.

8. In order to comply with **N.J.S.A. 17B:30-13.1(n)**, **N.J.A.C. 11:2-17.8(a)** and **N.J.S.A. 17B:30-13.1a**, ASH must cease its practice of utilizing misleading, contradictory and/or factually deficient statements in its Explanation of Benefits to the member. Specifically, ASH:

a) must avoid representing ASH's administrative fees as the fee for medical treatment;
b) must avoid conjunctive statements that utilize "OR" conditions as the reason for denial;
c) must identify which services are considered to be mutually exclusive;

ASH should provide a revised Explanation of Benefit form to the Commissioner for review.

APPENDIX A – CLAIM ERRORS

1. **Failure to Settle Electronic Claims within 30 Days and Failure to Settle Mailed Claims Within 40 Days from Receipt (60 Random Sample Claims in Error.**

Claim Number	Electronic or Mail	Paid or Denied	Date of Receipt	Date Claim Last Processed	Days Delayed
24528458	Mail	Paid	06/21/10	12/08/11	495
23811363	Electronic	Paid	04/07/10	07/27/11	446
23811363	Electronic	Paid	04/07/10	07/27/11	446
28818398	Mail	Paid	06/21/10	10/17/11	443
23925132	Electronic	Paid	04/20/10	07/27/11	433
28320923	Electronic	Paid	06/09/10	08/22/11	409
24197930	Mail	Paid	05/17/10	07/27/11	396
27959608	Electronic	Paid	06/18/10	07/15/11	362
24460480	Mail	Paid	06/16/10	07/08/11	347
24460480	Mail	Paid	06/16/10	07/08/11	347
24664273	Mail	Paid	07/06/10	07/08/11	327
24664284	Mail	Paid	07/06/10	07/08/11	327
24059339	Mail	Paid	04/29/10	04/29/11	325
24792511	Mail	Paid	07/19/10	07/19/11	325
24841383	Mail	Paid	07/23/10	07/22/11	324
25014058	Mail	Paid	08/16/10	07/29/11	307
26215689	Mail	Paid	07/06/10	06/17/11	306
24502337	Mail	Paid	06/23/10	06/03/11	305
25007199	Electronic	Paid	08/27/10	07/15/11	292
26627250	Electronic	Paid	04/16/10	03/04/11	292
26854473	Mail	Paid	09/24/10	08/12/11	282
25014182	Mail	Paid	08/16/10	06/03/11	251
25681927	Mail	Paid	10/25/10	08/05/11	244
26641610	Mail	Paid	06/01/10	03/04/11	236
25232078	Mail	Paid	09/13/10	06/03/11	223
24586252	Mail	Paid	06/25/10	03/11/11	219
25966119	Electronic	Paid	12/10/10	07/29/11	201
24706698	Mail	Paid	07/06/10	01/14/11	152
24685152	Mail	Paid	07/08/10	01/14/11	150
24643555	Mail	Paid	06/01/10	12/08/10	150
24724058	Mail	Paid	07/12/10	01/14/11	146
24758143	Mail	Paid	07/12/10	01/14/11	146
24723812	Electronic	Paid	07/27/10	01/14/11	141
24850062	Mail	Denied	07/26/10	01/14/11	132
24850062	Mail	Paid	07/26/10	01/14/11	132
24885511	Mail	Paid	07/29/10	01/14/11	129
24900480	Mail	Paid	08/02/10	01/14/11	125

24960039	Electronic	Paid	08/23/10	01/14/11	114
25835841	Mail	Paid	07/13/10	12/08/10	108
25836196	Mail	Paid	07/22/10	12/08/10	99
28543178	Electronic	Paid	05/16/11	09/06/11	83
23777351	Electronic	Denied	04/01/10	06/04/10	64
23777351	Electronic	Denied	04/01/10	06/04/10	64
26045574	Mail	Paid	11/29/10	02/25/11	48
26652905	Mail	Paid	02/11/11	05/06/11	44
24147572	Mail	Paid	05/10/10	07/30/10	41
23925132	Electronic	Paid	04/20/10	06/25/10	36
23931365	Electronic	Paid	04/20/10	06/25/10	36
28281670	Electronic	Denied	08/04/11	10/06/11	33
26095180	Mail	Paid	12/10/10	02/18/11	30
28072472	Electronic	Paid	06/23/11	08/22/11	30
24045638	Electronic	Paid	04/30/10	06/25/10	26
27849859	Mail	Paid	06/09/11	08/12/11	24
25209592	Mail	Denied	08/16/10	10/12/10	17
27823767	Mail	Paid	06/23/11	08/12/11	10
24268974	Mail	Paid	05/21/10	07/09/10	9
24158913	Mail	Paid	05/10/10	06/25/10	6
25226710	Electronic	Denied	09/22/10	10/25/10	3
24195119	Mail	Paid	05/14/10	06/25/10	2
25247609	Mail	Paid	09/13/10	10/25/10	2

V. VERIFICATION PAGE

I, Clifton J. Day, am the Examiner-in-Charge of the Market Conduct Examination of American Specialty Health Organized Delivery System 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 American Specialty Health Organized Delivery System of New Jersey, Inc. as of April 26, 2012.

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.

June 1, 2012
Date

Clifton J. Day
Clifton J. Day, MPA, CPM, CSM
Manager and Examiner-In-Charge
New Jersey Department of
Banking and Insurance