ORDER NO. E16-91

STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

IN THE MATTER OF:

Proceeding by the Commissioner of Banking and Insurance, State of New Jersey, to fine, suspend and/or revoke Horizon Healthcare Services, Inc. and Horizon Healthcare of New Jersey, Inc.	)))))	CONSENT ORDER

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

This matter, having been opened by the Commissioner of Banking and Insurance ("Commissioner"), State of New Jersey, upon information that Horizon Healthcare Services, Inc. and Horizon Healthcare of New Jersey, Inc. (collectively "Horizon"), may have violated various provisions of the insurance laws of the State of New Jersey; and

WHEREAS, Horizon Healthcare Services, Inc. is a health service corporation authorized to transact business since February 4, 1986 pursuant to N.J.S.A. 17:48E-1 et seq.; and

WHEREAS, Horizon Healthcare of New Jersey, Inc. is a health maintenance organization authorized to transact business since May 1, 1986 pursuant to N.J.S.A. 26:2J-1 et seq.; and

WHEREAS, N.J.S.A. 17:48E-10.1d(1) provides that a health service corporation shall remit payment for every insured claim no later than the 30th day following receipt of the claim or no later than the time limit established for the payment of claims in the Medicare program

pursuant to 42 U.S.C. 1395u(c)(2)(B), whichever is earlier, if the claim is submitted by electronic means, and no later than the 40th day following receipt if the claim is submitted by other than electronic means, provided the health care provider is eligible on the date of service, the person who received the health care service was covered on the date of service, the claim is for a service or supply covered under the health benefits plan, the claim is submitted with all the information requested on the claim form or in other instructions that were distributed in advance to the health care provider or covered person pursuant to N.J.S.A. 17B:30-51, and the health service corporation has no reason to believe that the claim has been submitted fraudulently; and

WHEREAS, N.J.S.A. 26:2J-8.1d (1) provides that a health maintenance organization shall remit payment for every insured claim no later than the 30th day following receipt of the claim or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42 U.S.C. 1395u(c)(2)(B), whichever is earlier, if the claim is submitted by electronic means, and no later than the 40th day following receipt if the claim is submitted by other than electronic means, provided the health care provider is eligible on the date of service, the person who received the health care service was covered on the date of service, the claim is for a service or supply covered under the health benefits plan, the claim is submitted with all the information requested on the claim form or in other instructions that were distributed in advance to the health care provider or covered person pursuant to N.J.S.A. 17B:30-51, and the health service corporation has no reason to believe that the claim has been submitted fraudulently ; and

WHEREAS, N.J.S.A. 17:48E-10.1d (7) provides that an overdue payment of a claim by a health service corporation shall bear simple interest at the rate of 12% per annum; and

WHEREAS, N.J.S.A. 26:2J-8.1d (7) provides that an overdue payment of a claim by a health maintenance organization shall bear simple interest at the rate of 12% per annum; and

WHEREAS, N.J.S.A. 17:48E-10.1d(2) provides that if all or a portion of a claim is denied by a health service corporation as incomplete because the required substantiating documentation has not been submitted, the diagnosis coding, procedure coding or any other required information to be submitted with the claim is incorrect, the amount claimed is disputed or there is strong evidence of fraud by the provider and the health service corporation has initiated an investigation into the suspected fraud, the health service corporation shall advise within 30 days that the claim is incomplete with a statement as to what substantiating documentation is required for the adjudication of the claim, that the claim contains incorrect information with a statement as to what information must be corrected for the adjudication of the claim, of the amount disputed and the basis of the dispute, or that the health service corporation finds strong evidence of fraud and has initiated an investigation into the suspected fraud or referred the claim to the Office of the Insurance Fraud Prosecutor; and

WHEREAS, N.J.S.A. 26:2J-8.1d(2) provides that if all or a portion of a claim is denied by a health maintenance organization as incomplete because the required substantiating documentation has not been submitted, the diagnosis coding, procedure coding or any other required information to be submitted with the claim is incorrect, the amount claimed is disputed or there is strong evidence of fraud by the provider and the health maintenance organization has initiated an investigation into the suspected fraud, the health maintenance organization shall advise within 30 days that the claim is incomplete with a statement as to what substantiating documentation is required for the adjudication of the claim, that the claim contains incorrect information with a statement as to what information must be corrected for the adjudication of the claim, of the amount disputed and the basis of the dispute, or that the health maintenance

organization finds strong evidence of fraud and has initiated an investigation into the suspected fraud or referred the claim to the Office of the Insurance Fraud Prosecutor; and

WHEREAS, N.J.A.C. 11:22-1.6(a)1 requires that health service corporations and health maintenance organizations notify providers within 30 or 40 days of receipt of a claim of their decision to deny or dispute the claim, including the identification and explanation of all reasons why the claim was denied or disputed and further states that a health service corporation and a health maintenance organization shall not deny or dispute a claim for reasons other than those identified in the first review after the claim is entered, unless information or documentation is received after the first review and such documentation leads to additional reasons to deny or dispute which were not present at the time of that review ; and

WHEREAS, N.J.S.A. 26:2S-9.2 requires that health service corporations and health maintenance organizations reimburse participating providers in accordance with their contractual fee schedules; and

WHEREAS, N.J.S.A. 17B:30-13.1c defines an unfair claim settlement practice to include failing to adopt and implement reasonable standards for the prompt investigations of claims arising under insurance policies; and

WHEREAS, N.J.S.A. 17B:30-13.1d defines an unfair claim settlement practice to include refusing to pay claims without conducting a reasonable investigation based upon all available information; and

WHEREAS, N.J.S.A. 17B:30-13.1f defines an unfair claim settlement practice to include not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonable clear; and

WHEREAS, N.J.S.A. 17B:30-13.1n defines an unfair claim settlement practice to include failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; and

IT APPEARING that, Horizon entered into an agreement with CareCentrix, Inc., a certified organized delivery system, and CareCentrix of New Jersey, Inc., a licensed organized delivery system, for the provision of durable medical equipment, orthotics and prosthetics, home infusion services, home health services, medical foods and diabetic and medical supplies to Horizon commercial members effective July 1, 2015 (the "Agreement"); and

IT FURTHER APPEARING that, under the Agreement CareCentrix contracts with the providers of the above services, providers submit claims for these services to CareCentrix, CareCentrix applies mutually agreed upon systems edits to said claims and sends valid claims to Horizon, Horizon processes the claims and remits payment to CareCentrix, and CareCentrix then pays the providers consistent with Horizon's processing; and

IT FURTHER APPEARING that, the Department has received complaints from providers about CareCentrix's improper denial of claims, failure to promptly pay claims, inaccurate explanation of benefit and remittance advice forms and failure to pay interest on late claims with respect to services provided to Horizon commercial members on and after July 1, 2015; and

IT FURTHER APPEARING that, between July 1, 2015 and March 28, 2016, CareCentrix and Horizon had IT systems related issues that resulted in multiple errors in the processing of provider claims for services provided to Horizon commercial members under the Agreement, including failure to recognize modifiers used with certain HCPCS codes, failure to

recognize revenue codes used by home health care providers, failure to recognize more than one taxonomy code per claim, improper direction to home health care providers on how to submit private duty nursing home health claims and failure to pay more than one home infusion per day, which errors resulted in approximately 4,500 improper claim denials under insured commercial plans totaling $1.8 million, and also failed to pay appropriate interest on claims that were paid late; and

IT FURTHER APPEARING that the claim processing errors described above resulted in violations of N.J.S.A. 17:48E-10.1d(1), (2) and (7), N.J.S.A. 26:2J-8.1d(1), (2) and (7), N.J.S.A. 26:2S-9.2, N.J.S.A. 17B:30-13.1c, d, f and n and N.J.A.C. 11:22-1.6(a)1; and

IT FURTHER APPEARING that, the claim processing errors have been corrected and appropriate payment, including interest, remitted to affected providers; and

IT FURTHER APPEARING that, Horizon asserts that Horizon and Care Centrix continue to engage in a good faith effort to resolve any and all difficulties with provider claims that have arisen under the Agreement, and that they have continued to address and resolve all such issues with provider claims under the Agreement to date; and

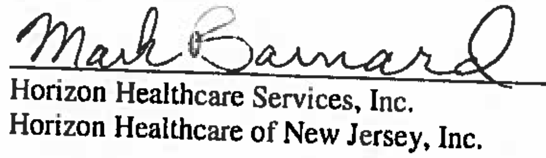
NOW, THEREFORE, IT IS on this 18th 21st day of September, 2016

ORDERED AND AGREED that, Horizon will pay a penalty of four hundred thousand dollars ($400,000), upon its execution of this Consent Order. The payment shall be made through a certified check, attorney trust account check, money order or electronic funds transfer made payable to "State of New Jersey – General Treasury" and shall be sent to Gale Simon, Assistant Commissioner, Department of Banking and Insurance, 20 West State Street, P. O. Box 329, Trenton, NJ 08625-0329; and

IT IS FURTHER ORDERED AND AGREED that the provisions of this Consent Order represent a final agency decision and constitute a full and final resolution of the matters addressed herein.

Peter L. Hartt
Director of Insurance

Consented to as to Form, Content and Entry:



Horizon Healthcare Services, Inc.
Horizon Healthcare of New Jersey, Inc.

9/15/2016
Date