FLORIDA DEPARTMENT OF INSURANCE

TARGET MARKET CONDUCT REPORT

OF

HUMANA MEDICAL PLAN, INC.

AS OF

MARCH 7, 2000

DIVISION OF INSURER SERVICES
BUREAU OF MARKET CONDUCT

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INSURANCE ANALYST II

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I. OVERVIEW AND SUMMARY OF FINDINGS

General

Humana Medical Plan, Inc., (Company), is a health maintenance organization domiciled in the State of Florida, and licensed to conduct business in this State during the period (scope) of this examination.

The Florida Department of Insurance (Department) performed a target Claims and Procedures Examination of the Company pursuant to Section 641.27, Florida Statutes, at the Company's office in Miramar, Florida, from March 7, 2000, to April 15, 2000. The Company challenged the original draft report and an additional audit was performed at the Company's office from April 4, 2002, to April 11, 2002.

The purpose of the examination was to determine if the Company's practices and procedures relating to claims processing, and related procedure manuals, comport with Florida Statutes and the Florida Administrative Code.

The scope period for the examination covered claims with dates of service from June 1, 1999, to March 7, 2000.

On July 13 through July 15, 1999, the Agency for Health Care Administration (AHCA) and the Department of Insurance (Department) conducted a joint examination of emergency room claims from noncontract providers. The scope period for that examination was April through June 1998. The scope period predates Section 641.3155, Florida Statutes, Ed. 99, which went into effect October 1, 1998, so no findings from that examination are included in this report.

Findings

The examination identified violations of statutes relating to claims processing. The violations included: failure to timely process claims; failure to accurately and timely pay interest; failure to adopt and implement standards for the proper investigation of claims; and failure to conduct reasonable investigations before denying claims. In certain instances, the Company failed to comply with Sections 627.4235, 641.3155, 641.3901 and 641.3903(5)(c) 1 and 4, Florida Statutes, Ed. 99.

Moreover, the examination found violations relating to the improper denial of private passenger automobile accident health insurance (PIP) claims. These denials violate Sections 627.4235, 641.31(7), 641.3155(1), 641.3901, and 641.3903(5)(c) 1 and 4, Florida Statutes, Ed. 99.

The examination found violations related to the improper denial of Workers' Compensation claims. These denials violate Sections 641.3155(1), 641.3901, and 641.3903(5)(c) 1 and 4, Florida Statutes, Ed. 99.

The examination found violations related to the improper denial of Other Health Insurance claims. These denials violate Sections 627.4235, 641.31(7), 641.3155(1), 641.3901, and 641.3903(5)(c) 1 and 4, Florida Statutes, Ed. 99.

Recommendations

Based on the findings detailed in this examination, the Department will issue a Consent Order in which certain corrective measures will be established. The Consent Order will require that the Company establish other corrective measures. A penalty in the amount of eighty five thousand five hundred dollars ($85,500), plus appropriate Administrative Legal costs, will also be levied in response to the violations of law determined during this examination. Note: violations, fines and corrective actions of Section 641.3155(2) and (4), Florida Statutes for failure to timely pay claims are addressed in the 2002 investigation of the prompt payment of claims that followed this examination. In response to these findings, and in addition to the aforementioned administrative fines, the Company should take the following corrective actions:

CLAIMS

- Process paid, denied and contested claims pursuant to Section 641.3155(2), Florida Statutes, Ed. 01.
- Calculate and process interest payments pursuant to Section 641.3155(3), Florida Statutes, Ed. 01.
- Process paid and denied claims pursuant to Section 641.3155(4), Florida Statutes, Ed. 01.
- Establish procedures that will facilitate compliance with Sections 641.3901 and 641.3903(5)(c), Florida Statutes.

COMPLAINTS

- Process paid, denied and contested claims pursuant to Section 641.3155(2), Florida Statutes, Ed. 01.
- Process paid and denied claims pursuant to Section 641.3155(4), Florida Statutes, Ed. 01.

PROCEDURE MANUALS

Amend the relevant manual(s):

- To ensure that automobile accident health insurance claims (PIP) are processed pursuant to Sections 627.4235, 641.3155(2), 641.3901, and 641.3903(5)(c) 1 and 4, Florida Statutes, Ed. 01
- To ensure that Workers' Compensation claims are processed pursuant to Sections 641.3155(2), 641.3901, and 641.3903(5)(c) 1 and 4, Florida Statutes, Ed. 01.
- To ensure that Other Health Insurance claims are processed pursuant to Sections 627.4235, 641.3155(2), 641.3901, and 641.3903(5)(c) 1 and 4, Florida Statutes, Ed. 01.
- To ensure that the interest formula is calculated pursuant to 641.3155(3), Florida Statutes, Ed. 01.

II. CLAIMS REVIEW

Overview

PCA Family Health Plan, Inc., and PCA Health Plans were merged into Humana Medical Plan, Inc., effective September 30, 1998.

The Company processes claims directly using both the Humana and PCA claim systems. The Company also utilizes Management Service Organizations (MSOs):

Magellan Behavioral Health (Magellan): processes behavioral health claims for Humana.

Aztec Medical Systems (AMS): reviews physician claims for the proper use of Current Procedural Terminology (CPT) codes for Humana.

Operating Systems

A. Humana Medical Plan, Inc.

Seventy eight (78) claims processed by the Company's system were examined. See Exhibit I for details. The findings are summarized below:

1. Four (4) claims were not paid, denied or contested within thirty-five (35) days of receipt. No documentation was provided to justify these delays.

2. The Company failed to pay interest on all four (4) of these claims.

B. PCA

Thirty four (34) claims processed by the PCA system were examined. See Exhibit II for details. The findings are summarized below:

1. Four (4) claims were not paid, denied or contested within thirty five (35) days of receipt. No documentation was provided to justify these delays.

2. The Company failed to pay interest on two (2) of these claims.

C. Magellan Behavioral Health

Twenty three (23) claims processed by this system were examined. No violations were found.

D. Aztec Medical Systems

Correspondence on all claims submitted to this coding review system requires that providers submit the requested additional information within fourteen days of the date of the request. The governing statute, Section 641.3155, Florida Statutes, Ed. 99, allows providers to submit additional information within 35 days of receipt of a request for such information.

When the provider fails to submit all of the information to support a claim, Humana pays only the uncontested portion. The balance of these claims are not paid or denied within the one hundred twenty (120) days established by Section 641.3155(3), F.S., Ed. 99. See Exhibit III for details.

III. COMPLAINTS REVIEW

Overview

Twenty seven (27) consumer complaints were examined. All of the files were closed during the examination. No violations were found.

Ten (10) provider complaints were examined. One (1) file was closed because a lawsuit was filed against the Company. Eight (8) files were closed during the examination. One (1) file was closed following the examination.

The file that was closed following the examination contained claims that were not paid, denied or contested within thirty-five (35) days of receipt, or were not paid within one hundred twenty (120) days. The company, Capitated Health Care Services, Inc., (CHCS), complained that contracts with Humana and an Independent Provider Organization, North American Medical Management, (NAMM), were not being properly administered. Fee for service claims were not honored by Humana due to contract misinterpretation. The complaint was resolved with approximately 3,000 claims totaling $697,790.00 being paid. See Exhibit IV for details.

Sixty four (64) open grievances were included in the investigation. All of the grievances were opened within the last thirty (30) days of the examination. No violations were found.

IV. PROCEDURE MANUALS REVIEW

Policy and procedure manuals relating to the processing of claims were examined. The findings are:

1. Coordination of Benefits (COB)

   It is the practice of the Company to deny Personal Injury Protection (PIP) claims that are submitted without the attendant PIP worksheet typically prepared by the PIP carrier. The denial of these claims violates Sections 627.4235, 641.3155(1), 641.3901, and 641.3903(5)(c) 1 and 4, Florida Statutes, Ed. 99. See Exhibit V for details.

   It is the practice of the Company to deny Workers' Compensation claims without further investigation. This is a violation of Sections 641.3155(1), 641.3901 and 641.3903(5)(c) 1 and 4, Florida Statutes, Ed. 99. See Exhibit V for details.

   It is the practice of the Company to deny claims if Other Health Insurance information is not received. The denial of these claims violates Sections 627.4235, 641.3155(1), 641.3901, and 641.3903(5)(c) 1 and 4, Florida Statutes, Ed. 99. See Exhibit V for details.

2. Interest Calculation

   The Company's current procedure is to calculate interest up to the date the claim is processed, not the date the payment is received or otherwise delivered. This procedure violates Section 641.3155(2), Florida Statutes, Ed. 99. See Exhibit VI for details.

V. FINDINGS/CORRECTIVE ACTIONS

CLAIMS

The Humana and PCA claim systems had claims that were not being processed as required by Sections 641.3155 (1), (2) and (3), Florida Statutes, Ed. 99.

Corrective Action

The Company should prepare an action plan within thirty (30) days from the date of the Consent Order that outlines the steps taken to bring its inhouse and contracted claim systems into compliance with the requirements of Section 641.3155(3), Florida Statutes, Ed. 01. This plan should be submitted to the Department for review and approval prior to implementation.

COMPLAINTS

A review of open complaints found one (1) complaint with multiple claims that were not processed as required by Sections 641.3155(1) and (3), Florida Statutes, Ed. 99.

PROCEDURE MANUALS

A review of the claim procedures found that it is the policy of the Company to deny Personal Injury Protection (PIP) claims received without the automobile carrier's PIP worksheets. This practice violates Sections 627.4235, 641.3155(1), 641.3901, and 641.3903(5)(c) 1 and 4, Florida Statutes, Ed. 99.

A review of the claim procedures found that it is the policy of the Company to deny Workers' Compensation claims. This practice violates Sections 641.3901 641.3155(1) and 641.3903(5)(c) 1 and 4, Florida Statutes, Ed. 99.

A review of the claim procedures found that it is the policy of the Company to deny Other Health Insurance claims when the COB information is not updated. This practice violates Sections 627.4235, 641.3155(1), 641.3901, and 641.3903(5)(c) 1 and 4, Florida Statutes, Ed. 99.

The current Company procedure is to calculate interest up to the date the claim is processed and not the date the payment is received or otherwise delivered. This practice violates 641.3155 (2), Florida Statutes, Ed. 99.

Corrective Action

The Company should revise its procedure manuals within thirty (30) days of the date of the Consent Order to insure future compliance with the requirements of Sections 627.4235, 641.3155, 641.3901, and 641.3903(5)(c) 1 and 4, Florida

Statutes, Ed. 01. Revisions to the procedure manuals should be submitted to the Department for review and approval prior to implementation.

VI. ADDENDUM

Overview

The Company challenged the original draft report and an additional audit was performed at the Company's office from April 4, 2002, to April 11, 2002.

The purpose of the examination was to determine if the Company's practices and procedures relating to coordination of benefits, comport with the Florida Statutes and the Florida Administrative Code.

Coordination of Benefits (COB)

A. Personal Injury Protection (PIP)

Eighty-three (83) PIP claims processed by the Company were examined. See Exhibit VII for details. The findings are summarized below:

Forty-one (41) claims were denied without any further investigation.

B. Workers' Compensation (WC)

Twenty-eight (28) WC claims processed by the Company were examined. See Exhibit VII for details. The findings are summarized below:

Twenty-eight claims were denied without any further investigation.

C. Other Health Insurance (OHI)

One hundred three (103) OHI claims processed by the Company were examined. See Exhibit VII for details. The findings are summarized below:

Twenty-two (22) claims were determined to be Medicare claims.

Seventy-five (75) claims were denied without any further investigation.

FINDINGS/CORRECTIVE ACTIONS

PROCEDURE MANUALS

A review of the claim procedures found that is it the policy of the Company to deny PIP claims that are received without the automobile carrier's PIP worksheets. Claims are also denied as auto related, even though the claim forms do not have any indication that the claim is auto related. This practice violates

Sections 627.4235, 641.3155(1), 641.3901, and 641.3903(5)(c) 1 and 4, Florida Statutes, Ed. 99.

A review of the claim procedures found that is it the policy of the Company to deny Workers' Compensation claims. The Company does not do any investigation to ensure that a claim is in fact work related, or that the member is actually covered by WC. Several claims were initially denied even though the claim form was clearly documented as not being work related. This practice violates Sections 641.3155(1), 641.3901, and 641.3903(5)(c) 1 and 4, Florida Statutes, Ed. 99

A review of the claim procedures found that it is the policy of the Company to ultimately deny Other Health Insurance claims received without the other carrier's explanation of benefits. Also, the claims manager from the COB unit stated that determinations regarding other insurance are processed annually; however, only upon receipt of a claim. Once the determination is made that this information has not been updated within the 12 months preceding the receipt of a claim, the company states that (2) phone calls are made to the member as well as a follow up letter. The company allows (28) days for receipt of the requested information, and on the twenty- eighth day if no response is received the claim is denied. An EOB is forwarded to the provider at the time of the denial notifying them that claim has been denied code "8E - other carrier information requested/not received." No further attempts are made to contact the member via telephone or mail, and all subsequent claims for the entire family are denied using the same code and reason. The provider is notified via an EOB that the claims have been denied; however, no further opportunity to provide the documentation is given. Subsequent claims received after the initial denial for a failure to respond by the member are automatically denied without an opportunity to provide the information on the subsequent claims. This practice violates Sections 627.4235, 641.3155(1), 641.3901, and 641.3903(5)(c) 1 and 4, Florida Statutes, Ed. 99.

Corrective Action

The Company should revise its procedure manuals within thirty (30) days of the date of the Consent Order to insure future compliance with the requirements of Sections 627.4235, 641.3155(2), 641.3901, and 641.3903(5)(c) 1 and 4, Florida Statutes, Ed. 01. Revisions to the procedure manuals should be submitted to the Department for review and approval prior to implementation.

2000 TARGET CLAIMS AND PROCEDURES EXAMINATION

OF

HUMANA MEDICAL PLAN, INC.

EXHIBITS