THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION
MARKET INVESTIGATIONS

TARGET MARKET CONDUCT FINAL EXAMINATION REPORT

OF

HEALTH OPTIONS, INC. INSURANCE COMPANY

AS OF

February 28, 2013

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EXECUTIVE SUMMARY

A review of the Company's claim handling procedures; contracts with Behavioral Health and Substance Abuse Service providers; and contracts and audits of New Directions Behavioral Health was performed. In addition, random samples of 109 paid claims and 109 denied claims were reviewed. The following table represents general findings, however, specific details are found in each section of the report.

TABLE OF TOTAL VIOLATIONS

Statute/Rule	Description	Files Reviewed	Number of Violations
641.3155(6)	The Company failed to pay interest on overdue claims.	218	4

PURPOSE AND SCOPE OF EXAMINATION

The Office of Insurance Regulation (Office), Market Investigations conducted a target market conduct examination of Health Options, Inc. (Company), pursuant to Section 624.3161, Florida Statutes. The examination was performed by Examination Resources, LLC. The scope period of this examination was December 1, 2011, through May 31, 2012. The onsite examination began August 13, 2012, and ended October 30, 2012. The examination continued offsite and ended February 28, 2013.

The purpose of this examination was to review the Company's policies and procedures as they apply to the adjudication of in network Behavioral Health and Substance Abuse claims and to determine the Company's compliance with Florida Statutes and the Florida Administrative Code.

The examination included reviewing:

- The Company's claims handling procedures to ensure adoption and implementation of standards for proper investigation and settlement of claims;
- The Company's internal policies and procedures to determine the methodology for payment of Behavioral Health and Addiction Recovery claims; and
- Samples of paid and denied Behavioral Health and Addiction Recovery claims to determine timely acknowledgement, reasonable and proper investigation, resolution, timely payment and review for consistency with internal policies, procedures and Florida Statutes.

This Final Report is based upon information from the examiner's draft report, additional research conducted by the Office, and additional information provided by the Company. Procedures and conduct of the examination were in accordance with the *Market Regulation Handbook* produced by the National Association of Insurance Commissioners.

COMPANY OPERATIONS

Health Options, Inc. is a domestic Health Maintenance Organization licensed to conduct business in the State of Florida on September 25, 1984. The Company provides individual and group health coverage in the State of Florida.

Total Direct Health Premiums Written in Florida were as follows:

Year	Total Written Premiums In Florida (Per Schedule T of Annual Statement)
2009	399,515,908
2010	486,741,696
2011	419,394,145

Behavioral health claims are processed by the Company; however, the Company contracts with its affiliate, New Directions Behavioral Health (NDBH), for provider network management and development services as well as behavioral health management expertise.

CLAIMS PAYMENT REVIEW

I. COMPANY POLICIES AND PROCEDURES

The Company administers claims internally and has processes and policies in place for adjudicating claims. The Company's claims examiners undergo an eight-week training course before they are approved to process claims and utilize various aspects of the Company's system to assist them in correctly processing claims. Although claims examiners do not normally receive specialized training for adjudicating claims related to specific medical services, in instances where a claim requires special handling methods, on-line Desktop Procedures (DTP) or Cue Cards are created. For example, when Behavioral Health claims require special processing for Transition of Care (TOC), a DTP is created and claims examiners are provided with specialized training, when necessary.

The Company automatically acknowledges electronic claims within 24 hours and paper claims are acknowledged once they are entered into the Company's claim system. Medical providers are also able to access a website in order to verify that paper claims have been received.

The Company issues a new claim number each time a claim is reprocessed or if changes occur during the processing of a claim. For review purposes, the examiners treated all claim numbers submitted by the same provider for the same date of service as if they were related to the sample claim under review. As a result, all related claims were viewed as a single claim regardless of the Company's process of assigning different claim numbers to the same claim.

II. NEW DIRECTIONS BEHAVIORAL HEALTH (NDBH)

The Company contracted with NDBH in June 2011, to manage and develop its provider network; and provide behavioral health management expertise. The Company's goal was to support greater clinical efficiencies, improve outcomes, and enhance coordination of care for its respective members. The Company delegated its network management activities to NDBH which included contracting and credentialing of providers and the creation and transfer of provider contract data to the Company for claims adjudication. In August 2011, NDBH sent out 3,000 recruitment packages to previously terminated behavioral health medical providers asking them to join NDBH's network. In November 2011, NDBH provided the Company with contract data for approximately 1,700 providers that was auto-entered into the Company's claim adjudication system by December 1, 2011. The Company anticipated entering contract data for 1,300 additional providers at a rate of 100 per week; however, after the initial data was entered, errors were identified. Subsequent research efforts and necessary data correction caused fewer than 100 provider contracts to be entered on a weekly basis. The Company entered the contract data for the majority of the 1,300 additional providers by February 2012, but continued to experience errors in the data received from NDBH. The following outlines the steps the Company took to correct these issues and includes findings noted by the examiners:

- **HMO claims were denied for no authorization.** The system rule requiring authorization was removed on January 4, 2012.

  Finding: The Company continued to deny certain claims for no authorization after January 4, 2012.

- **Denied claims were reprocessed beginning January 1, 2012.** Denied claims were not reprocessed until the provider was correctly entered into the Company's claim adjudication system. Once a provider was entered, within one to three business days a search was conducted to identify improperly adjudicated claims. Identification of improperly adjudicated claims was to be completed within two to 15 business days.

  Finding: At the start of the examination, the Company indicated that most providers were entered into the claims adjudication system. However, the examiners identified claims that were not reprocessed for months after the providers were entered into the system.

  An additional finding was noted by the examiners:

  Finding: The examiners noted that neither the Company nor NDBH appeared to proactively inform providers of system issues affecting claim payments. Providers were apprised of issues only after they initiated contact with the Company or with NDBH to inquire about improperly denied claims. However, neither the Company nor NDBH later informed providers when their contracts were entered into the system. Providers were not provided with a timeline regarding how soon corrected claim payments could be expected or contacted when claims reprocessing was complete. However, the Company noted providers who inquired were provided with timeframe estimates as to when their claims would be reprocessed. The Company was requested to provide a list of

reprocessed claims so that examiners could verify that interest was paid if owed, however, the Company did not respond to this request.

III. CLAIMS REVIEW

The Company was requested to provide a list of all in network Behavioral Health and Substance Abuse claims paid or denied during the scope period. The Company identified a universe of 19,780 paid or denied claims. Random samples of 109 paid and 109 denied claim files were reviewed for compliance with Florida Statutes. The following exceptions were noted:

1) **In four (4) instances, the Company failed to pay interest on overdue claims, in violation of Section 641.3155(6) Florida Statutes**.

1a.) CORRECTIVE ACTION: The Company should review its existing procedures and implement necessary changes to ensure the proper payment of interest on overdue claims and pay any outstanding interest owed.

1b.) COMPANY RESPONSE: The Company agreed with all but one of the four errors stating that such claim did not require the payment of interest because the adjusted payment was made well within 20 days of the receipt of the denied claim.

The following findings were also noted during the examination:

1) **During the paid claims review, in five (5) instances, the Company improperly denied participating provider claims for no authorization.**

1a.) CORRECTIVE ACTION: The Company should review its existing procedures and implement necessary changes to ensure the proper investigation and payment of participating provider claims and pay any outstanding interest owed.

1b.) COMPANY RESPONSE: The Company agreed with this finding as it pertained to three (3) of the referenced claims and disagreed with the finding on the remaining two (2) claims.

2) **During the paid claims review, in one (1) instance, the Company improperly paid a non-participating provider at the participating provider rate.**

2a) CORRECTIVE ACTION: The Company should review its existing procedures and implement necessary changes to ensure the proper investigation and payment of non-participating provider claims.

2b) COMPANY RESPONSE: The Company agreed with this finding.

3) **During the paid claims review, in one (1) instance, the Company improperly denied a non-participating provider's claim for no-authorization after implementing a system rule that no longer required authorization to process payment of non-participating provider claims.**

3a) CORRECTIVE ACTION: The Company should review its existing procedures and implement necessary changes to ensure the proper investigation and payment of non-participating provider claims and pay any outstanding interest owed.

3b) COMPANY RESPONSE: The Company agreed with this finding.

4) During the paid claims review, in one (1) instance, the Company improperly paid two (2) different providers for the same claim.

4a.) CORRECTIVE ACTION: The Company should review its existing procedures and implement necessary changes to ensure the proper investigation and payment of claims.

4b.) COMPANY RESPONSE: The Company disagreed with the finding and stated the sampled claim was paid correctly and the claim paid in error was not contained in the sample.

5) During the paid claims review, in one (1) instance, the Company used an improper adjustment code to calculate the coordination of benefits provision for a participating provider's claim.

5a.) CORRECTIVE ACTION: The Company should review its existing procedures and implement necessary changes to ensure the proper investigation and payment of participating provider claims and pay any outstanding interest owed..

5b.) COMPANY RESPONSE: The Company agreed with this finding.

6) During the denied claims review, in 31 instances, the Company improperly denied participating provider claims for no authorization.

6a.) CORRECTIVE ACTION: The Company should review its existing procedures and implement necessary changes to ensure the proper investigation and payment of participating provider claims and pay any outstanding interest owed.

6b.) COMPANY RESPONSE: The Company agreed with this finding.

7) During the denied claims review, in 11 instances, the Company improperly denied non-participating provider claims for no-authorization after implementing a system rule that no longer required authorization to process payment of non-participating provider claims.

7a) CORRECTIVE ACTION: The Company should review its existing procedures and implement necessary changes to ensure the proper investigation and payment of non-participating provider claims and pay any outstanding interest owed.

7b) COMPANY RESPONSE: The Company disagreed with this finding because further research revealed that the underlying providers on each of the 11 claims never joined as participating providers and transition of care was not a factor. As such, the claims were correctly denied because an authorization was not obtained.

8) During the denied claims review, in one (1) instance, the Company improperly paid a participating provider at the out of network rate.

8a.) CORRECTIVE ACTION: The Company should review its existing procedures and implement necessary changes to ensure the proper investigation and payment of participating provider claims and pay any outstanding interest owed.

8b.) COMPANY RESPONSE: The Company agreed with this finding.

9) During the denied claims review, in two (2) instances, the Company improperly identified and denied claims as duplicates.

9a) CORRECTIVE ACTION: The Company should review its existing procedures and implement necessary changes to ensure the proper investigation and payment of claims and pay any outstanding interest owed.

9b.) COMPANY RESPONSE: The Company agreed with the finding as it pertained to one of the two referenced instances and disagreed with the second instance because the underlying sampled claim was processed correctly. The Company indicated that the actual incorrect denial occurred on a subsequent adjustment to the sample claim.

EXAMINATION FINAL REPORT SUBMISSION

The Office hereby issues this Final Report based upon information from the examiner's draft report, additional research conducted by the Office, and additional information provided by the Company.