1999 TARGET CLAIMS AND PROCEDURES EXAMINATION

OF

UNITED HEALTHCARE OF FLORIDA, INC.

BY

THE FLORIDA DEPARTMENT OF INSURANCE

BUREAU OF MANAGED CARE

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I. OVERVIEW AND SUMMARY OF FINDINGS

General

United Healthcare of Florida, Inc., (Company), is a health maintenance organization domiciled in the State of Florida. The Company was licensed to conduct business in this State during the period (scope) of this examination.

The Florida Department of Insurance (Department) and the Agency for Healthcare Administration (AHCA) performed a target Claims and Procedures Examination of the Company pursuant to Section 641.27, Florida Statutes. Such examination took place at the Company's claims office in Maitland, Florida.

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

The scope period for the examination covered claims with dates of service from November 1998 through March 1999.

Findings

The examination uncovered multiple violations of statutes and regulations relating to claims processing. The violations included: failure to timely process claims; failure to accurately and timely pay interest; and, failure to properly notify providers when billings were reduced. The Company's conduct constitutes violations of Sections 641.3155, 641.3901, and 641.3903(5)(c) 1,3 and 4, Florida Statutes.

The examination also identified violations relating to the improper denial of Workers' Compensation and automobile accident health insurance (PIP) claims. These Workers' Compensation denials violate Florida's requirement that commercial contracts cover occupational claims not paid by Workers' Compensation coverage, Sections 641.3901 and 641.3903(5)(c) 1 and 4, Florida Statutes. These (PIP) automobile accident claim denials violate Sections 641.3901 and 641.3903(5)(c) 1 and 4, Florida Statutes.

The examination also found where the Company rescinded a contract for misrepresentation more than two years after its inception date, thereby violating Section 641.41(23), Florida Statutes. Further, the Company restricted reinstatement of small groups, violating Section 627.6699(5)(g), Florida Statutes.

Recommendations

Based on the findings detailed in this examination, the Department recommends that the Company be assessed certain administrative fines. These fines are memorialized in a Notice and Order to Show Cause dated March 30, 2000. In response to these findings, and in addition to the aforementioned administrative fines, the Company is directed to take the following corrective actions:

CLAIMS

- Process paid, denied and contested claims pursuant to Section 641.3155(1) and (3), Florida Statutes.
- Establish procedures that will facilitate compliance with Section 641.3903(5)(c), Florida Statutes.
- Calculate and process interest payments per Section 641.3155(2), Florida Statutes.
- Establish procedures that will record the date of receipt of a claim as the date received by the Company, regardless of which claims processing system ultimately processes the claim. The absence of these procedures substantially contributed to the non-compliance with Section 641.3155, Florida Statutes.
- Establish procedures that will track claim records from the time received, and establish denial records when claims are closed for reasons other than settlement. The absence of these procedures substantially contributed to the non-compliance with Section 641.3155, Florida Statutes.

PROCEDURE MANUALS

Amend the relevant manual(s):

- To ensure that automobile accident health insurance claims (PIP) are processed pursuant to Sections 641.3901, and 641.3903 (5)(c) 1 and 4, Florida Statutes.
- to assure that occupational claims not paid by Workers' Compensation insurance are covered by commercial contracts in compliance with Sections 641.3901 and 641.3903 (5)(c) 1 and 4, Florida Statutes.
- so that reinstatements of small group insurance contracts are properly effected as per Section 627.6699 (5)(g) 1, Florida Statutes.
- to ensure that individual contracts will not be terminated more than two (2) years after the issue date for any reason other than fraudulent misstatements, pursuant to Section 641.31(23), Florida Statutes.

II. CLAIMS REVIEW

Overview

The Company operates three claims systems:

Cosmos: This is the main claims processing system and handles the largest volume of transactions.

Pyramid: This system was obtained through an acquisition and currently processes claims for 4,000 to 5,500 subscribers.

Unet: This system handles multi-state contracts for 16,000 subscribers.

A total of two hundred ninety-two (292) claims were examined in the three claims systems being operated by the Company. Specific findings for each of the systems are as follows:

Operating Systems

A. COSMOS

Ninety-eight (98) claims processed by the COSMOS system were examined. The findings are (See Exhibit I):

1. Eight (8) claims were neither paid, denied nor contested within thirty-five (35) days of receipt. No documentation was provided to justify this delay.
2. The Company failed to pay interest on three (3) of these claims.

B. PYRAMID

Ninety-seven (97) claims processed by the PYRAMID system were examined. The findings are (See Exhibit II):

1. Forty-three (43) claims were neither paid, denied nor contested within thirty-five (35) days of receipt. No documentation was provided to justify this delay.
2. The Company failed to pay interest on these forty-three (43) claims.

C. UNET

Ninety-seven (97) claims processed by the UNET system were examined. The findings are (See Exhibit III):

1. One (1) claim was not paid, denied or contested within thirty-five (35) days of receipt. No documentation was provided to justify this delay.
2. The Company failed to pay interest on the claim.

Other Claims Areas Examined

D. NON-PAR EMERGENCY SERVICE CLAIMS

Sixty-three (63) commercial claim files, with a total of 168 claims, were reviewed by The Agency for Health Care Administration (AHCA) to determine compliance with the emergency services and care requirements of Section 641.513, Florida Statutes.

AHCA reviewed the claims and reported the Company to be in substantial compliance with commercial claims payment provisions of Section 641.513, Florida Statutes.

E. DOWNCODING

The Department has received numerous complaints from individual physicians and the Florida Medical Association regarding the Company's practice of changing certain billing codes which lowers the amount of remittance to the providers. In response to these complaints, the examination reviewed the Company's coding processes. The findings are:

The Company utilizes two methods of changing Physician's Current Procedural Terminology (CPT) codes that providers have submitted for claims payment.

The first method utilizes an Artificial Intelligence Audit in the COSMOS claim payment system. This audit looks for what it considers to be "unacceptable combinations" of International Classification of Diseases, 9th Edition (ICD-9) and CPT codes. For example, an "unacceptable combination" would be where a dermatologist submits a claim for open-heart surgery. If an "unacceptable combination" is identified, the system can automatically adjust the codes and pay a different amount without prior notification to the provider. This audit process was not reviewed during this examination.

The second method utilizes an audit system (Patterns Review) that is independent of the COSMOS system. The Patterns Review audit system currently focuses on physician office visit CPT codes 99214 and 99215. When an unacceptable code is identified, this system will automatically pay a reduced amount without prior notification to the provider. This audit process was reviewed.

Sixty (60) files were examined. The findings are:

1. Two (2) of the files were not paid or contested within thirty-five (35) days of receipt. No documentation was provided to justify this delay.
2. The Company failed to pay interest on these two (2) claims.

The May 1999 Patterns Review Summary Report (See Exhibit 1V) indicates that 7,834 physician office claims with CPT codes 99214 and 99215 were processed through the Patterns Review system. The Patterns Review Team, located in United's corporate office in Minnesota, and comprised of a medical doctor and registered nurses, reviewed 979 of these claims. Two hundred ninety-eight (298) claims were "downcoded", which the Company refers to as adjustment Code 702. There were 1,167 claims indicated as denials.

Six hundred fifty-one (651) of the 1,167 denials were due to frequency – (Code 700 - types of claims exceed average frequency during a specific time frame for a particular CPT code). The Company stated that as of June 1, 1999, this practice was phased out and those claims that are edited out because of the frequency (700) code will be submitted for manual review. There were 221 denials for Code 704 - (Exceeds allowable units).

The May 1999 Patterns Review Summary showed 7,834 claims were examined by the Patterns Review Team. The findings are:

1. 298 of the 7,834 claims were downcoded without the physicians being allowed to justify their codes. This is a violation of Section 641.3903(5)(c) 1 and 4, Florida Statutes.
2. 651 (code 700) and 221 (code 704) of the 7,834 claims were denied without the physicians being allowed to justify their codes. This is a violation of Section 641.3903(5)(c) 1 and 4, Florida Statutes.

F. GENERAL

The Company currently calculates interest up to the date the claims examiner approves payment, not the date the payment is received or electronically transferred or otherwise delivered. This is a violation of Section 641.3155 (2), Florida Statutes.

III. COMPLAINTS REVIEW

Overview

There were sixty-nine (69) consumer and provider complaint files reviewed from the Company and Department of Insurance's (DOI) records. There were also forty-one (41) complaint files reviewed from two (2) participating hospitals.

A. CONSUMER COMPLAINTS

Eighteen (18) consumer compliant files were reviewed (See Exhibit V).

The files included complaints regarding authorizations, coding errors, claims being sent to incorrect locations, and premium refunds. By the time our review was completed, and in response thereto, all files were closed. No violations were found in the examination.

B. PROVIDER COMPLAINTS

Fifty-one (51) provider complaint files were examined. The findings are (See Exhibit VI):

1. Four (4) claims were not paid within thirty-five (35) days.
2. The Company failed to pay interest on these four (4) claims.

C. HOSPITAL COMPLAINTS

1. WELLINGTON REGIONAL MEDICAL CENTER

Fifteen (15) claim files received from Wellington Regional Medical Center, West Palm Beach, Florida, were examined. The findings are (See Exhibit VII):

a. Nine (9) claims were not paid within thirty-five (35) days of receipt.
b. Interest payments for five (5) of these claims were made on July 13, 1999, as result of this audit.
c. One (1) claim had not been adjusted as the Company stated it was waiting for an invoice for a prosthetic implant. The Summary Report indicated that a copy of the invoice was sent to the Company on June 2, 1999. United Healthcare advised on July 15, 1999, that the invoice might have been received but that the system did not indicate such. According to records, approximately $8,508 was still pending on this claim. This claim was not paid within thirty-five (35) days of receipt. No interest was paid on this claim.

d. One (1) claim was still pending as of June 19, 1999. The claim was received with an incorrect member number and was, therefore, rejected from the system for payment. The correct member number was ultimately received and processed. Management advised that the claim would be released for payment on July 11, 1999. This claim was not paid within thirty-five days of receipt. This claim did not have interest paid.

2. MT. SINAI MEDICAL CENTER

Twenty-six (26) claim files received from Mt. Sinai Medical Center, Miami Beach, Florida, were examined. The findings are (See Exhibit VIII):

a. In response to the Department's questions, eighteen (18) claims were adjusted on or after July 12, 1999. As a result of the adjustments, an additional $86,231 was paid to one provider. Fifteen (15) of the these claims involved implants and high-cost drugs. An invoice is required for payment on these claims. No invoices had been provided by the Company as of the date of the examination. Two (2) of the adjustments were due to a change in Diagnostic Related Groups (DRG) guidelines. One (1) claim was adjusted to reflect a correction involving multi-vessel surgery.
b. None of the eighteen claims referenced above were paid within thirty-five (35) days of receipt. Five of the remaining eight claims were paid after the expiration of thirty-five (35) days.
c. The Company failed to pay interest on thirteen (13) of the eighteen claims mentioned in paragraph a. above. No interest was paid on the five claims mentioned in paragraph b.

IV. PROCEDURE MANUALS REVIEW

Policy and procedure manuals relating to the processing of claims, reinstatements of coverage, and rescissions were examined.

Coordination of Benefits

A review of the claims manual found that it is the policy of the Company to deny claims due to automobile accidents in which Personal Injury Protection (PIP) carriers have not settled prior to submission (See Exhibit IX). This is a violation of Sections 641.3901 and 641.3903(5)(c) 1 and 4, Florida Statutes.

The review also found it is the policy of the Company to deny all claims that are related to a Workers' Compensation claim (See Exhibit IX). The Explanation of Benefit (EOB) states "worker's compensation liability" and does not instruct the claimant to file with the workers' compensation carrier. United Healthcare of Florida does not determine if the claimant has workers' compensation coverage. This is a violation of Florida requirements for commercial contracts to cover occupational claims not **paid** by workers' compensation and Section 641.3903 (5)(c) 1,4, Florida Statutes.

Reinstatements

The Broker Newsletter indicates that only one reinstatement will be allowed for small groups, with no exceptions (See Exhibit X). This conflicts with the small group availability of coverage guarantee and is a violation of Section 627.6699 (5)(g) 1, Florida Statutes.

Rescissions

Five (5) rescinded individual contract files were examined (See Exhibit XI).

Section 641.31 (23), Florida Statutes, allows rescission of a policy after two years only if a fraudulent misstatement is reflected in the application. The Company rescinded one of the five policies for reasons other than fraudulent misrepresentation. This rescission violates the aforementioned Section.

V. FINDINGS/RECOMMENDATIONS

CLAIMS

COSMOS SYSTEM

Claims are closed out of the system for several reasons other than settlement, thereby terminating any tracking or record. Examples include claims intended for another processing system and claims requiring provider information. This practice impedes the ability to determine if claims are processed consistent with Section 641.3155 (1), Florida Statutes.

The "artificial intelligence" coding audit function of the system may reduce CPT codes and payments without prior notification to the provider as required in Section 641.3155 (1)(b), Florida Statutes.

Recommendation

The Company is directed to prepare an action plan within thirty (30) days from the date of receipt of this examination, that states the steps taken to allow for the tracking of the timely payment, denial, or contesting of claims, as required by Section 641.3155 (1), Florida Statutes. Further, the Company must include in its action plan a provision for the timely notification of providers when coding adjustments are made that reduce claims prior to the payment of such claims, as is required by Section 641.3155(1)(b), Florida Statutes. This plan will be submitted to the Department for review and approval prior to implementation.

PYRAMID SYSTEM

This is the least responsive of the claim systems and a large percentage of the claims are not processed as required by Section 641.3155(1)(2), Florida Statutes.

Recommendation

The Company is directed to prepare an action plan within thirty (30) days from the date of receipt of this examination that establishes the steps taken to bring this system into compliance with the timely resolution requirements of Section 641.3155(1)(2), Florida Statutes. This plan will be submitted to the Department for review and approval prior to implementation.

DOWNCODING

Downcoding CPT codes is effected outside of the COSMOS system. The Patterns Review system audits physician office visits, specifically codes 99214 and 99215. This audit can result in a reduction of the reported codes and reduced payments. The physicians must make a post claim appeal with full written documentation of the records in order to contest the payment. This system is not conducive to interaction with providers and may result in inequitable settlements. The practice of code adjustments without notification to the provider is not in compliance with Section 641.3155 (1)(b), Florida Statutes.

Recommendation

The Company is directed to prepare an action plan within thirty (30) days that states the steps to bring this system into compliance with Section 641.3155(1)(b), Florida Statutes. This plan will be submitted to the Department for review and approval prior to implementation.

COMPLAINTS

HOSPITALS

Special invoices are required to be submitted for reimbursement for certain implants and high-cost drugs. The Company has failed to communicate the required procedures to the hospitals.

Recommendation

The Company is directed to prepare an action plan within thirty (30) days from the date of receipt of this examination that establishes the steps taken to bring this procedure to the attention of participating hospitals. This plan will be submitted to the Department for review and approval prior to implementation.

PROCEDURE MANUALS

The Coordination of Benefits section of the Claims Manual requires that the PIP portion of any claim be settled before the Company settles the rest of the claim. This violates Sections 641.3901 and 641.3903(5)(c) 1 and 4, Florida Statutes, in that it specifically discourages any investigation of the merits of the claim. The same section requires an automatic denial of occupational claims without any prior review for workers' compensation insurance. There are no instructions as to how to proceed with the adjusting of a claim where workers' compensation insurance may be involved. This violates the Florida requirement for commercial contracts to cover occupational claims not **paid** by worker's compensation and these actions indicate a general business practice of violating Sections 641.3901 and 641.3903(5)(c) 1and 4, Florida Statutes.

The Company has an institutional practice of rescinding individual contracts for what it considers material misrepresentation, regardless of the length of time the contract has been in effect. This practice violates Section 641.31(23), Florida Statutes.

Recommendation

The Company is directed to revise its procedure manuals within thirty (30) days of receipt of this examination to correct these violations. This plan will be submitted to the Department for review and approval prior to implementation.

VI.

1999 TARGET CLAIMS AND PROCEDURES EXAMINATIONS OF UNITED HEALTHCARE OF FLORIDA, INC.

EXHIBITS

SUBJECT	EXHIBIT
Cosmos Claims Violations	I
Pyramid Claims Violations	II
Unet Claims Violations	III
Downcoding	IV
Consumer Complaints	V
Provider Complaints	VI
Wellington Medical Complaints	VII
Mount Sinai Medical Complaints	VIII
Coordination of Benefits	IX
Reinstatements	X
Rescissions	XI