Arnold Schwarzenegger, Governor
State of California
Business, Transportation and Housing Agency

**Department of Managed Health Care**
320 West Fourth Street, Suite 880
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Via: UPS

October 14, 2005

Ms. Maria Borje-Bonkowski, Director, HP Licensing/Submissions
**KAISER FOUNDATION HEALTH PLAN, INC.**
1800 Harrison Street, 8th Floor
Oakland, CA 94612

RE: FINAL REPORT FOR THE REVIEW OF THE PROVIDER DISPUTE RESOLUTION MECHANISM OF KAISER FOUNDATION HEALTH PLAN, INC.

Dear Ms. Borje-Bonkowski:

Enclosed is the Final Report for the review of the Provider Dispute Resolution Mechanism of Kaiser Foundation Health Plan, Inc. (the "Plan") for the period January 1, 2004 to December 31, 2004. The Department of Managed Health Care (the "Department") conducted the review pursuant to Rule 1300.71.38 (m) (1) and Section 1382 (a) of the Knox-Keene Health Care Service Plan Act of 1975 ("Act").[1] The Department issued a Preliminary Report to the Plan on July 18, 2005. The Department accepted the Plan's response and addendums electronically on September 8, 2005, September 19, 2005, October 5, 2005 and October 6, 2005, respectively.

This Final Report includes a description of the compliance efforts included in the Plan's response and addendums, in accordance with Section 1382 (c).

Section 1382 (d) states "If requested in writing by the plan, the director shall append the plan's response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and provide modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public."

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Division 1 of Chapter 1, Title 28, and California Code of Regulations, beginning with Section 1300.43.

Please indicate within ten (10) days whether the Plan requests the Department to append its response to the Final Report. If so, please indicate which portions of the Plan's response shall be appended and provide electronically those portions of the Plan's response exclusive of information held confidential pursuant to Section 1382 (c), no later than ten (10) days from the date of the Plan's receipt of this letter.

If the Plan requests the Department to append a brief statement summarizing the Plan's response to the report or wishes to modify any information provided to the Department in its response, please provide the documentation electronically no later than ten (10) days from the date of the Plan's receipt of this letter.

As noted in the attached Final Report, the Plan's response did not fully resolve some of the deficiencies raised in the Preliminary Report issued by the Department on July 18, 2005. Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for the corrective actions requested in the Final Report, within thirty (30) days, after receipt of the report.

Please file the Plan's response electronically via the Department's eFiling web portal <https://wpso.dmhc.ca.gov/secure/login/>. Please note this process is separate from the electronic financial reporting and is for the response to this final report only. From the drop-down menu, select "Report/Other: Response to Final Routine Financial Examination Report-Public (RX004)", and then upload your response. Questions or problems related to the electronic transmission of the response should be directed to Siniva Pedro at (916) 322-5393 or email to spedro@dmhc.ca.gov. You may also email inquiries to wpso@dmhc.ca.gov.

**The Department will make the attached Final Report available to the public in ten (10) days from the Plan's receipt of this letter**

If you have any questions regarding this report, please contact me.

Sincerely,

JANET NOZAKI
Supervising Examiner
Office of Health Plan Oversight
Division of Financial Oversight

km/jn

cc: Mark Wright, Chief, Division of Financial Oversight
Marcy Gallagher, Chief, Division of Plan Surveys
Melissa H. Moon, Counsel, Division of Licensing
Kim Malme, Senior Examiner, Division of Financial Oversight

# CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE

# DIVISION OF FINANCIAL OVERSIGHT

**FINAL REPORT FOR THE REVIEW OF**
**THE PROVIDER DISPUTE RESOLUTION MECHANISM OF**

## KAISER FOUNDATION HEALTH PLAN, INC.

## FILE NO. 933 0055

## DATE OF FINAL REPORT: OCTOBER 14, 2005

**SUPERVISING EXAMINER: JANET NOZAKI**

**EXAMINER-IN-CHARGE: KIM MALME**

**FINANCIAL EXAMINERS:**

**GALAL GADO**
**DERRICK TSANG**

BACKGROUND INFORMATION FOR KAISER FOUNDATION HEALTH PLAN, INC.

| | |
|---|---|
| Date Plan Licensed: | October 27, 1977 |
| Organizational Structure: | Kaiser Foundation Health Plan, Inc. ("Plan") is a nonprofit, public benefit corporation, licensed as a Knox-Keene plan and as a federally qualified HMO. The Plan is one of three organizations that comprise the Kaiser Permanente Program. The other two organizations are Kaiser Foundation Hospitals, a nonprofit public benefit corporation; and, The Permanente Medical Groups, a for-profit professional organizations. |
| Type of Plan: | A health care service plan providing the full range of health benefits, including hospital, medical and pharmacy, to commercial, Medicare and Medi-Cal members. |
| Provider Network: | Integrated care model offering health care services through a network of hospitals and physician practices operating under the Kaiser Permanente name. Compensation arrangements include capitation, discounted fee for service, per diem and case rate basis. |
| Plan Enrollment: | As of June 30, 2005, the Plan reported 6,531,629 members. The Plan has over 8.3 million members nationwide, which includes its licensed health plan subsidiaries outside of California. |
| Service Area: | Major counties within California: Capital, Central California, East Bay, Golden Gate, North Bay, South Bay, Coachella Valley, Inland Empire, Metropolitan Los Angeles/West Los Angeles, Orange County, San Diego County, the Valleys (Woodland Hills, Kern County and Panorama City), Tri-Central (Baldwin Park, Harbor City, Bellflower), and Ventura County. |
| Date of Last Public Routine Financial Examination Report: | April 21, 2004 |

**FINAL REPORT FOR THE REVIEW OF THE PROVIDER DISPUTE RESOLUTION MECHANISM OF KAISER FOUNDATION HEALTH PLAN, INC.**

This is the Final Report for the review of the Provider Dispute Resolution Mechanism of Kaiser Foundation Health Plan, Inc. The Department of Managed Health Care (the "Department") conducted the review pursuant to Rule 1300.71.38 (m) (1) and Section 1382 (a) of the Knox-Keene Health Care Service Plan Act of 1975 ("Act").[1] The Department issued a Preliminary Report to the Plan on July 18, 2005. The Department accepted the Plan's response and addendums electronically on September 8, 2005, September 19, 2005, October 5, 2005 and October 6, 2005, respectively.

This Final Report includes a description of the compliance efforts included in the Plan's response and addendums to the Preliminary Report, in accordance with Section 1382 (c).

We performed a limited review of the Plan's Provider Dispute Resolution Mechanism for the period January 1, 2004 to December 31, 2004. Our findings are presented in the accompanying attachment as follows:

| | |
|---|---|
| Section I. | Internal Controls |
| Section II. | Compliance Issues |

***Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for the corrective actions requested in this report, within 30 days after receipt of this report.***

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Division 1 of Chapter 1, Title 28, and California Code of Regulations, beginning with Section 1300.43.

## SECTION I. INTERNAL CONTROL ISSUES

Statement on Auditing Standards (SAS) No. 78 states "Internal control is a process---effected by an entity's board of directors, management, and other personnel---designed to provide reasonable assurance regarding the achievement of objectives in the following categories: (a) reliability of financial reporting, (b) effectiveness and efficiency of operations, and (c) compliance with applicable laws and regulations."

SAS 60 requires an auditor to communicate reportable conditions noted during the examination to appropriate personnel. Reportable conditions involve matters coming to the auditor's attention relating to significant deficiencies in the design or operation of the internal control structure, which could adversely affect the organization's ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial statements.

Our review found discrepancies in the Plan's database for its provider disputes. The Plan believes that these discrepancies are due to the incompatibility between the two different systems that are used to process provider disputes. Payments arising from a provider dispute or an enrollee grievance are processed through the Plan's claim processing system called "Authorized Outside Medical Services" ("AOMS"), while provider disputes are recorded in the Plan's PDR input system called "Provider Dispute Tools" ("PDT").

Our review found provider disputes were recorded as denied in the PDT system, while subsequently (or during the same time period) the same claims involved in these provider disputes were paid through the AOMS system. As a result, the provider dispute database provided for our review showed some paid disputes with paid amounts of $0 or less. Likewise, denied disputes showed paid amount greater than $0.

The following table for the period January 1, 2004 to December 31, 2004 illustrates these discrepancies:

| Kaiser region name | Number of Paid PDRs with Paid Amount $0 or Less | Number of Denied PDRs with Paid Amount > $0 |
|---|---|---|
| Northern Region and TPMG | 520 | 667 |
| Southern Region and SCPMG | 821 | 1,331 |
| Total | 1,341 | 1,998 |

In the Annual Claims Payment and Dispute Resolution Report for the period October 1, 2003 to September 30, 2004, the Plan reported 23 provider disputes for The Permanente Medical Group ("TPMG"). However, the PDR database provided for our review disclosed a total of 74 provider disputes for TPMG during the 2nd and 3rd quarters of 2004 which is a much larger number than the 23 reported to the Department in the Plan's Annual Report.

In addition, a review of the PDR database indicated a significant difference in the number of provider disputes filed for the Northern Region and The Permanente Medical Group ("TPMG") compared to the number filed for the Southern Region and the Southern California Permanente Medical Group ("SCPMG"), especially in relationship with the number of claims received and processed by the respective regions.

The following table illustrates this difference:

| Kaiser Region Name | Total PDR Per Database |
|---|---|
| Northern Region and TPMG | 13,968 |
| Southern Region and SCPMG | 19,737 |
| Difference | 5,769 |

Due to these discrepancies in the Plan's PDR database, we are not able to verify that provider disputes are accurately compiled for the annual claims payment and dispute resolution reports filed by the Plan to the Department.

The Plan was required to submit a Corrective Action Plan ("CAP") that outlines in detail how the Plan will correct these discrepancies. The CAP was to include the policies and procedures implemented to ensure its database for provider disputes is accurate. The CAP was also to state the date the policies and procedures were implemented, the management position responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.

*The Plan responded that the spreadsheet provided by the Department and completed by the Plan provided all of the claim information including any payments that occurred. This can occur if the member is balanced billed after a provider dispute is closed and the member's payment is handled as a member grievance.*

*The corrected numbers for the annual reporting were re-run to determine that MediCare disputes are not included, that the numbers are correct for TPMG, and that all of the member grievances forwarded to the provider dispute unit are included.*

*The corrected numbers for the 2004 annual report, fourth quarter of 2004, first and second quarter of 2005 were submitted in the Plan's addendum electronically accepted by the Department on September 19, 2005.*

*The Plan identified the Director of Regulatory Compliance - California Claims Administration as the individual response for overseeing the corrective actions.*

**The Department finds that the Plan's response was not fully responsive to the deficiencies cited. The addendum submitted by the Plan did not indicate whether the numbers of provider disputes reported by TPMG were revised or not. The Plan is requested to submit a response that addresses this remaining issue.**

## SECTION II. COMPLIANCE ISSUES

### A. BOOKS AND RECORDS

Section 1385 requires that each plan keep and maintain current books of account and other records that the Director may require. Rule 1300.85.1 requires that every plan preserve for a period of not less than five years, the books and account and other records, the last two years of which shall be in an easily accessible place at the office of the plan. After such books and records have been preserved for two years, they may be warehoused, stored or microfilmed, subject to their availability to the Director within not more than 5 days after the request.

The following records requested during our review were not provided in a timely manner or were not provided:

| Requested Document | Date Requested | Date Provided |
|---|---|---|
| Beech Street Network Rental Agreement | 4/11/2005 | 5/12/2005 |
| Provider Contract with University of California - Davis | 4/20/2005 | Not Provided |
| Provider Contract with Yosemite Pathology Medical Group | 4/20/2005 | Not Provided |
| Provider Contract with Children's Hospital Medical Center | 4/20/2005 | Not Provided |

In addition, our review found the following provider disputes were not adequately documented:

**Southern Region and SCPMG – Statistically Valid Random Sample (50 out of a total population of 19,737 provider disputes)**

The Southern Region was not able to provide written provider disputes for 4 out of the 50 disputes reviewed in this sample, or 8%, as follows:

| Sample No. | Receipt Date | Determination Letter Date |
|---|---|---|
| 7 | 9/3/2004 | 10/6/2004 |
| 8 | 3/1/2004 | 3/24/2004 |
| 25 | 3/24/2004 | 4/10/2004 |
| 44 | 10/25/2004 | 11/9/2004 |

The Southern Region was not able to provide copies of written determination letters to providers for 10 out of the 50 provider disputes reviewed in this sample, or 20%. The following are some examples:

| Sample No. | Receipt Date | Date Paid/Denied |
|---|---|---|
| 2 | 3/23/2004 | Paid on 4/8/2004 |
| 5 | 7/1/2004 | Denied date unknown |
| 16 | 5/28/2004 | Paid on 6/22/2004 |
| 18 | 6/14/2004 | Paid on 8/17/2004 |

The Plan was required to submit the revised policies and procedures implemented to ensure that provider disputes are adequately documented. The Plan was also to provide the date the policies and procedures were implemented, the management position responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.

*The Plan responded that it identified inconsistencies in entering documents into the iFile system that were sent for screening as well as an issue that not all of the documents in the case file were sent for scanning upon closure of the case. Since this was a potential issue in the northern region also, both regions were given in-service training on the correct scanning procedures in March 2005 and April 2005.*

*The Plan implemented a new procedure for the preparation of files for audits as of April 6, 2005 to assure that all documents are within claim file folders during an internal or external audit.*

*The Plan stated that the California Claims Administration will perform quarterly audits of provider dispute files to verify that all the required documents are present and can be retrieved in hard copy. The audit will begin with provider disputes received during the 2nd quarter of 2005. The audit will be completed by September 30, 2005. The results of the quarterly audits will be reported to the PACE (Claims Executives) Committee and the Claims Compliance Committee.*

*The Plan identified the following individuals are responsible for overseeing the corrective action:*

*Director of Regulatory Compliance - California Claims Administration*
*Manager of Provider Disputes - SCAL California Claims Administration*
*Manager of Quality Assurance - NCAL California Claims Administration.*

**The Department finds that the Plan's compliance efforts are responsive to the corrective actions required. However, the Plan is requested to provide written assurance that its provider contracts will be provided to the Department in a timely manner upon request.**

## B. DATE OF RECEIPT

Rule 1300.71.38 (a) (3) defines the "Date of receipt" to mean the working day when the provider dispute or amended provider dispute, by physical or electronic means, is first delivered to the plan's or the plan's capitated provider's designated dispute resolution office or post office box.

Our review found receipt dates recorded in the Plan's PDT system were different from receipt dates stamped on provider disputes. In addition, our review found several provider disputes that were not date stamped or the date stamped on the scanned image of the dispute was illegible.

**Northern Region – Statistically Valid Random Sample (50 out of a total population of 13,804 provider disputes)**

The Northern Region had incorrect receipt dates recorded for 8 out of 50 provider disputes reviewed in this sample, or 16%. The following are some examples:

| Sample No. | Receipt Stamp/Scan Date | System Receipt Date |
|---|---|---|
| 2 | 9/27/2004 | 9/30/2004 |
| 19 | 4/13/2004 | 3/13/2004 |
| 34 | 5/14/2004 | 5/17/2004 |
| 35 | 8/6/2004 | 8/16/2004 |

**Northern Region – Audit Sample (30 out of a total population of 2,068 late disputes identified in the 2nd quarter of 2004**

The Northern Region had incorrect receipt dates recorded for 5 out of 30 provider disputes reviewed in this sample, or 17%. The following are some examples:

| Sample No. | Receipt Stamp/Scan Date | System Receipt Date |
|---|---|---|
| 9 | 9/5/2004 | 9/14/2004 |
| 14 | 7/28/2004 | 8/10/2004 |
| 16 | 6/8/2004 | 7/1/2004 |
| 24 | 11/10/2004 | 11/15/2004 |

**TPMG – Random Sample (68 out of a total population of 164 provider disputes)**

TPMG had incorrect receipt dates recorded for 7 out of 68 provider disputes reviewed in this sample, or 10%. The following are some examples:

| Sample No. | Receipt Stamp/Scan Date | System Receipt Date |
|---|---|---|
| 22 | 7/19/2004 | 7/26/2004 |
| 23 | 7/19/2004 | 8/4/2004 |
| 44 | 9/28/2004 | 9/29/2004 |
| 53 | 11/5/2004 | 11/9/2004 |

**Southern Region and SCPMG – Statistically Valid Random Sample (50 out of a total population of 19,737 provider disputes)**

The Plan stated that red ink was initially used to date stamp the provider disputes but black ink is now used. Therefore, the receipt dates were illegible on 33 out of the 50 provider disputes reviewed in this sample, or 66%. The following are some examples:

| Sample No. | Receipt Stamp/Scan Date | System Receipt Date |
|---|---|---|
| 1 | Cannot determine | 3/9/2004 |
| 3 | Cannot determine | 2/27/2004 |
| 6 | Cannot determine | 2/27/2004 |
| 7 | Cannot determine | 9/3/2004 |

**Northern Region – Statistically Valid Random Sample (50 out of a total population of 13,804 provider disputes)**

The Northern Region did not date stamp the provider disputes for 9 out of the 50 disputes reviewed in this sample, or 18%. The following are some examples:

| Sample No. | Receipt Stamp/Scan Date | System Receipt Date |
|---|---|---|
| 1 | Cannot determine | 2/18/2004 |
| 12 | Cannot determine | 9/29/2004 |
| 17 | Cannot determine | 4/7/2004 |
| 26 | Cannot determine | 4/5/2004 |

**Northern Region – Audit Sample (30 out of population of 2,068 late disputes identified in the 2nd quarter of 2004**

The Northern Region did not date stamp the provider disputes for 16 out of the 30 disputes reviewed in this sample, or 53%. The following are some examples:

| Sample No. | Receipt Stamp/Scan Date | System Receipt Date |
|---|---|---|
| 11 | Cannot determine | 9/27/2004 |
| 12 | Cannot determine | 9/27/2004 |
| 13 | Cannot determine | 9/27/2004 |
| 20 | Cannot determine | 9/27/2004 |

**TPMG – Statistically Valid Random Sample (68 out of total population of 164)**

TPMG did not date stamp provider disputes for 13 out of 68 disputes reviewed in this sample, or 19%. The following are some examples:

| Sample No. | Receipt Stamp/Scan Date | System Receipt Date |
|---|---|---|
| 10 | Cannot determine | 6/24/2004 |
| 13 | Cannot determine | 7/9/2004 |
| 24 | Cannot determine | 8/9/2004 |
| 25 | Cannot determine | 8/10/2004 |

The Plan was required to submit the revised policies and procedures implemented to ensure that the receipt dates for provider disputes are accurately documented in its PDR database. The Plan was also to provide the date the policies and procedures were implemented, the management position responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.

*Northern California Region*

*The Plan responded that errors in entering receipt dates were due to the failure to date stamp the provider dispute and using the date on the letter rather than a date stamp for entry into the provider dispute tracking system. The Plan found that a temporary employee was entering the letter date, rather than the date the dispute was actually received in the department. The entire mailroom department was given an in-service training regarding the proper procedures for date stamping in April 2005. To address the data entry issue, in-service training was given to the temporary employee in April 2005 regarding which date must be entered into the provider dispute tracking system.*

*Southern California Region*
*The Plan responded that the issue of the red date stamp not photocopying was identified during an audit in early March 2005 prior to the DMHC's provider dispute audit. To correct this issue, a black ink date stamp was purchased. The requirement to use black ink was implemented in March 2005. The corrective action and the ability to see the date stamp was demonstrated to DMHC during the on-site review.*

*The Plan stated that the Northern and Southern Region California Claims Administration will perform quarterly audits of provider dispute files to verify that all the required documents are present with legible date stamps and the dates are accurately noted in the PRD program. The audit will begin with provider disputes received during the 2nd quarter of 2005. The audit will be completed by September 30, 2005. Results of the quarterly audits will be reported to the PACE (Claims Executives) Committee and the Claims Compliance Committee*

*The Plan identified the following individuals are responsible for overseeing the corrective actions:*

- *Director of Regulatory Compliance, California Claims Administration*
- *Front End Claims Supervisor. SCAL California Claims Administration*
- *Claims and Provider Relations Supervisor, SCAL California Claims Administration*
- *Senior Claim Operations Leader, NCAL California Claims Administration*
- *Manager of Quality Assurance, NCAL California Claims Administration*

*The Permanente Medical Group ("TPMG")*
*The Plan responded that the contracted and non-contracted provider dispute units within TPMG have synchronized their procedure to insure the correct received date stamp is on the hard copy of the provider dispute and entered into the provider dispute tracking program.. Training was conducted with the units to review the policy and procedure and reinforce the need for accuracy in September 2005.*

*The Plan identified AOMS Operations Manager and Director of UM and Provider Relations as the individuals responsible for overseeing the corrective actions.*

*The Plan stated that it will include the audit of the provider disputes in their current oversight of TPMG.*

**The Department finds that the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required.**

## C. TIME PERIOD FOR ACKNOWLEDGMENT

Rule 1300.71.38 (e) (2) requires a plan to acknowledge a provider dispute within fifteen (15) working days (or 21 calendar days) from the date of receipt of the written provider dispute by the office designated to receive provider disputes.

An analysis was performed on the PDR database provided by the Plan for the period January 1, 2004 through December 31, 2004. Based on the analysis, we determined that the Plan was not in compliance with Rule 1300.71.38 (e) (2) for approximately 13.8% of the total provider disputes received during 2004 for dates of service January 1, 2004 and after. The analysis indicated that the Plan's non-compliance peaked to 38.2% during the 1st quarter of 2004.

**Northern Region – Statistically Valid Random Sample (50 out of a total population of 13,804 provider disputes)**

Acknowledgement letters for provider disputes processed by the Northern Region were not mailed within the required timeframe for 31% of the disputes reviewed in this sample. The following are some examples:

| Sample No. | PDR Receipt Date | Acknowledgement Letter Date | Days Over 15 Working Days |
|---|---|---|---|
| 1 | 2/18/2004 | 4/28/2004 | 49 |
| 5 | 3/5/2004 | 3/29/2004 | 3 |
| 7 | 7/9/2004 | 12/30/2004 | 153 |
| 8 | 4/5/2004 | 10/21/2004 | 178 |

**Northern Region – Audit Sample (30 out of population of 2,068 late disputes identified in the 2nd quarter of 2004**

Due to the large amount of late disputes noted in the PDR database for the Northern Region, we reviewed an additional 30 late provider disputes filed during the 2nd quarter of 2004. The review indicated that the Northern Region's non-compliance rate was 73% for timely mailing of acknowledgement letters.

The Plan was required to submit the revised policies and procedures implemented to ensure that acknowledgement of provider disputes are mailed in compliance with the requirements. The Plan was also to provide the date the policies and procedures were implemented, the management position responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.

*At the opening of the provider dispute mechanism audit, the Plan acknowledged to the Department that the northern region was significantly impacted with an increase in volume of provider disputes and member balance billing issues during the 2nd and 3rd quarter of 2004. The Plan stated this unexpected volume and the northern region's inability to respond contributed to the delay in sending the acknowledgement letters. The northern region, recognizing the problem, responded to this by bringing on three temporary staff to process the front-end review of all provider disputes and to send acknowledgement letters beginning on June 7, 2004. The backlog was resolved in the 4th quarter 2004. To ensure that the inventory is being managed effectively, as of April 18, 2005 a production report for timeliness of acknowledgement letters is generated on a daily basis. The Manager of Quality Assurance is responsible for the review of the report and managing the inventory to ensure acknowledgement letters are sent within the required time frame. Since the changes in the management of this process, the provider dispute tracking system has reported the timeliness of the acknowledgement letters as follows:*

- *Q1 2005 Timeliness – 88.5%*
- *Q2 2005 Timeliness – 94.8%*

*The Plan responded that the California Claims Administration will perform quarterly audits of provider dispute files to verify that acknowledgement letters are present and sent within the required time frame. The audit will begin with provider disputes received during the 2nd quarter of 2005. The audit will be completed by September 30, 2005. The results of the quarterly audits will be reported to the PAC (Claims Executives) Committee and Claim Compliance Committee.*

*The Plan identified the Director of Regulatory Compliance - California Claims Administration and the Manager of Quality Assurance - NCAL California Claims Administration as the individuals responsible for overseeing the corrective actions.*

**The Department finds that the Plan's compliance efforts are responsive to the deficiency cited and the corrective action required.**

## D. MISDIRECTED PROVIDER DISPUTES

The Department's position is that ten (10) working days is a reasonable time to forward a misdirected provider dispute and is consistent with the requirement for forwarding misdirected claims.

Disputes sent by providers to the wrong address were not being forwarded to the provider dispute unit timely. The Plan's position is that the Rule 1300.71.38 does not specify a timeframe to forward a misdirected dispute. In addition, the Plan believes that 10 working days is an unreasonable timeframe to forward the dispute to the responsible party for handling the dispute.

The following are some examples of misdirected provider disputes that were not forwarded within 10 working days by TPMG:

| Sample No. | Dispute Received/Scanned Date | System Input Date | Number of Days to Forward Disputes |
|---|---|---|---|
| 22 | Letter date 6/17/2004 | 7/26/2004 | 39 |
| 23 | Letter date 6/17/2004 | 8/3/2004 | 46 |
| 29 | 8/5/2004 | 8/20/2004 | 20 |
| 66 | 8/3/2004 | 1/6/2005 | 156 |

The Plan was required to revise its policy and procedures for misdirected provider disputes that incorporates a reasonable timeframe and explain why TPMG is unable to comply with the 10 working days timeframe for redirecting a dispute. The Plan was to provide the date the policies and procedures were implemented, the management position responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.

*The Plan responded that it respectively notes that Rule 1300.71.38 specifically speaks to misdirected claims not provider disputes. In 1300.71(a)(6) the "date of receipt" means when the claim is first delivered to either the plan's specified claim payment area or the plan's capitated provider payment*

*area for that claim. In accordance to 1300.71(a)(8)(B) on a quarterly and annual basis the Plan submits the compliance rate for forwarding misdirected claims for itself and its delegated providers.*

*In accordance to Rule 1300.71.38 (a)(3) a provider dispute is considered received when it is first delivered to the plan's or the plan's capitated provider's designated dispute resolution office or post office box. As required in the regulations, the Plan's capitated provider, TPMG, has informed both contracted and non-contracted providers in their claim system, through their annual AB 1455 notification letter of the designated dispute resolution office and mailing address. In addition to the annual AB 1455 notification letter, the remittance advice for each claim contains the provider dispute information which includes the appropriate entity and mailing address for submitting a provider dispute. (Rule 1300.71.38(c)(3))*

**The Department finds that the Plan was not responsive to the corrective action required. Consequently, this issue will be referred to the Office of Enforcement.**

## E. TIME PERIOD FOR RESOLUTION AND WRITTEN DETERMINATION

Rule 1300.71.38 (f) requires a plan to issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days (or 64 calendar days) after the date of receipt of the provider dispute.

An analysis was performed on the PDR database provided by the Plan for provider disputes received from January 1, 2004 through December 31, 2004. Based on the analysis, we determined that the Plan was not in compliance with Rule 1300.71.38 (f) for approximately 34.6% of the total provider disputes received during 2004 for dates of service January 1, 2004, and after. The analysis indicated that the Plan's non-compliance peaked to 68.5% during the 2nd quarter of 2004.

**Northern Region – Statistically Valid Random Sample (50 out of a total population of 13,804 provider disputes)**

Our review noted that resolutions were not made and written determination letters were not issued timely on 32 of the 50 random provider dispute samples, or 65% of the total samples reviewed. The following are some examples:

| Sample No. | PDR Receipt Date | Determination Letter Date | Days Over 45 Working Days |
|---|---|---|---|
| 1 | 2/18/2004 | 4/29/2004 | 7 |
| 4 | 3/25/2004 | 6/4/2004 | 7 |
| 7 | 5/13/2004 | 7/29/2004 | 13 |
| 8 | 7/9/2004 | 12/30/2004 | 110 |

The Plan was required to submit the revised policies and procedures implemented to ensure that determination letters to providers are mailed in compliance with Rule 1300.71.38 (f). The Plan was also to provide the date the policies and procedures were implemented, the management position responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.

*As stated previously, the Plan acknowledged to the Department that the northern region was significantly impacted with an increase in volume of provider disputes and member balance billing issues during the 2nd and 3rd quarter of 2004. This unexpected volume and the northern region's inability to respond contributed to the delay in sending the resolution letters. The northern region responded to this problem by bringing on two temporary staff to process the resolution of all provider disputes and to send resolution letters on June 7, 2004. The backlog was resolved in the 4th quarter 2004. To ensure that the inventory is being managed effectively, a production report for timeliness of resolution letters is generated on a daily basis as of April 18, 2005. The Manager of Quality Assurance is responsible for the review of the report and managing the inventory to ensure resolution letters are sent within the required time frame. Since the changes in the management of this process, the provider dispute tracking system has generated the following reports on the timeliness of the resolution letters.*

- *Q1 2005 Timeliness – 93.6%*
- *Q2 2005 Timeliness – 99.2%*

*The Plan responded that California Claims Administration will perform quarterly audits of provider dispute files to verify that resolution letters are present and were sent within the required time frame. The audit will begin with provider disputes received during the 2nd quarter of 2005. The audit will be completed by September 30, 2005. The results of the quarterly audits will be reported to the PACE (Claims Executives) Committee and the Claims Compliance Committee.*

*The Plan identified the Director of Regulatory Compliance - California Claims Administration and the Manager of Quality Assurance - NCAL California Claims Administration as the individuals responsible for overseeing the corrective actions.*

**The Department finds that the Plan's compliance efforts are responsive to the deficiency cited and the corrective actions required.**

## F. PAST DUE PAYMENTS

Rule 1300.71.38 (g) requires a plan to pay any outstanding monies and all interest and penalties required under Sections 1371 and 1371.35, that results from a provider dispute involving a claim, to be paid within five (5) working days (or 7 calendar days) of the issuance of the written determination.

**Northern Region – Statistically Valid Random Sample (50 out of a total population of 13,804 provider disputes)**

Our review noted that 5 out of the 50 provider disputes in this sample, or 10%, were paid more than 5 working days of the issuance of the written determination. The following are some examples:

| Sample No. | Determination Letter Date | Paid Date | Day (s) Over 5 Working Days |
|---|---|---|---|
| 2 | 11/24/2004 | 2/10/2005 | 71 |
| 5 | 5/10/2004 | 5/18/2005 | 1 |
| 7 | 7/29/2004 | 2/24/2005 | 203 |
| 51 | 8/10/2004 | 8/19/2004 | 2 |

**Northern Region – Audit Sample (30 out of population of 2,068 late disputes identified in the 2nd quarter of 2004**

Due to the large amount of late disputes noted in the PDR database for the Northern Region, we reviewed an additional 30 late provider disputes identified in the 2nd quarter of 2004. The review indicated that the Northern Region's non-compliance rate was 33% for paying disputes over 5 working days of the written determination.

**TPMG – Statistically Valid Random Sample (68 out of total population of 164)**

Our review noted that 14 of the 68 provider disputes reviewed in this sample, or 21%, were paid over 5 working days of the written determination. The following are some examples:

| Sample No. | Determination Letter Date | Paid Date | Days Over 5 Working Days |
|---|---|---|---|
| 6 | 8/18/2004 | 10/8/2004 | 44 |
| 7 | 8/18/2004 | 10/19/2004 | 55 |
| 8 | 8/18/2004 | 10/19/2004 | 55 |
| 9 | 8/16/2004 | 9/1/2004 | 9 |

The Plan was required to submit the revised policies and procedures implemented to ensure that payments for disputes are mailed in compliance with Rule 1300.71.38 (g). The Plan was also to provide the date the policies and procedures were implemented, the management position responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.

*The Plan responded that the provider dispute resolution unit was established to investigate and resolve provider payment disputes. The function for generating payments to the providers remains*

*with the claim adjusters. The determinations from the disputes that required payments are sent to an adjuster for processing. This process appears to have resulted in delays in the payment..*

*To correct this issue, two claim processors in the Research Resolution area have been assigned the responsibility of generating payments on finalized provider dispute cases. Another change was made in early April 2005, to have the routing report generated daily instead of weekly to prevent delays in payment. The Quality Assurance Manager is responsible for monitoring the routing report daily to verify all payments for disputes are completed.*

*The Plan stated that the northern and southern region California Claims Administration will perform quarterly audits of provider dispute files to verify that payment is made within 5 working days of the written determination. The audit will begin with provider disputes received during the 3rd quarter of 2005. The results of the quarterly audits will be reported to the PACE (Claims Executives) Committee and the Claims Compliance Committee*

*The Plan identified the Director of Regulatory Compliance - California Claims Administration and the Manager of Quality Assurance - NCAL California Claims Administration as the individuals responsible for overseeing the corrective actions.*

*The Facility Referral Coordinator (FRC) policy and procedure Provider Dispute Resolution Process for TPMG was revised on August 29, 2005 to include more detailed instructions regarding the application of interest. Training has been conducted for all of the FRCs regarding the revisions.*

*TPMG Provider Dispute Unit will audit all cases that take longer than 5 working days to pay after the issuance of the written determination to pay. These results will be discussed with the manager and as appropriate corrective actions taken. The Plan identified the AOMS Operation Manager and the Director of UM and Provider Relations as the individuals responsible for overseeing the corrective actions.*

**The Department finds that the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required.**

## G. LATE CLAIM PAYMENTS

Section 1371 requires a plan to reimburse uncontested claims no later than 45 working days after receipt of the claim. This Section also requires that if an uncontested claim is not reimbursed within 45 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 45 working day period. This Section requires that all interest that has accrued shall be automatically included in the claim payment. The penalty for failure to comply with this requirement shall be a fee of ten ($10) dollars paid to the claimant. Section 1371 also requires that if the claim is contested or denied by the plan, the claimant shall be notified, in writing, that the claim is contested or denied within 45 working days after receipt of the claim by the health plan. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.

Section 1371.35, which refers to claims resulting from emergency services, requires that if an uncontested claim is not reimbursed within 45 working days after receipt, the plan shall pay the greater of $15 for each year or interest at the rate of 15 percent per annum, beginning with the first calendar day after the 45 working-day period.

Our review disclosed that interest on adjusted claim payments were not paid in accordance with the above requirements as follows:

**Southern Region and SCPMG – Statistically Valid Random Sample (50 out of a total population of 19,737 provider disputes)**

Interest was underpaid on additional payments for 3 out of 50 provider disputes reviewed in this sample, or 6%. Examples of underpayment included the following:

| Sample No. | Dispute Payment Date | Plan Calculated Interest Paid | DMHC Calculated Interest | $10 Fee | Under Paid Difference |
|---|---|---|---|---|---|
| 18 | 8/17/2004 | $69.59 | $138.96 | $0 | $69.37 |
| 32 | 9/17/2004 | $2.48 | $4.10 | $0 | $1.62 |
| 34 | 6/15/2004 | $0.21 | $15.00 | $10.00 | $24.79 |

**Northern Region – Statistically Valid Random Sample (50 out of a total population of 13,804 provider disputes)**

Interest was underpaid on additional claim payments for 13 out of 50 provider disputes reviewed in this sample, or 27%. Examples of underpayment included the following:

| Sample No. | Dispute Payment Date | Plan Calculated Interest Paid | DMHC Calculated Interest | $10 Fee | Under Paid Difference |
|---|---|---|---|---|---|
| 5 | 5/18/2004 | $0.00 | $0.44 | $10.00 | $10.00 |
| 10 | 6/30/2004 | $0.00 | $1.18 | $10.00 | $11.18 |
| 17 | 6/8/2004 | $0.00 | $15.00 | $10.00 | $25.00 |

**Northern Region – Audit Sample (30 out of population of 2,068 late disputes identified in the 2nd quarter of 2004**

Interest was underpaid on additional claim payments for 11out of 30 provider disputes reviewed in this sample, or 37%. Examples of underpayment included the following:

| Sample No. | Dispute Payment Date | Plan Calculated Interest Paid | DMHC Calculated Interest | $10 Fee | Under Paid Amount |
|---|---|---|---|---|---|
| 2 | 9/24/2004 | $0.00 | $1.00 | $10.00 | $11.00 |
| 3 | 9/7/2004 | $0.00 | $4.83 | $10.00 | $14.83 |
| 5 | 9/24/2005 | $0.00 | $2.66 | $10.00 | $12.66 |
| 6 | 1/14/2005 | $0.00 | $79.84 | $10.00 | $89.84 |

**TPMG – Statistically Valid Random Sample (68 out of total population of 164)**

Interest was underpaid on additional claim payments for 4 out of 68 provider disputes reviewed in this sample, or 6%. Examples of underpayment included the following:

| Sample No. | Dispute Payment Date | Plan Calculated Interest Paid | DMHC Calculated Interest | $10 Fee | Under Paid Amount |
|---|---|---|---|---|---|
| 3 | 8/6/2004 | $0.00 | $70.03 | $10.00 | $83.03 |
| 9 | 9/1/2004 | $0.00 | $151.48 | $10.00 | $161.48 |
| 65 | 3/21/2005 | $0.00 | $7.89 | $10.00 | $17.89 |
| 66 | 2/14/2005 | $0.00 | $3.18 | $10.00 | $13.18 |

The Plan was required to submit a CAP that identifies all provider disputes with date of service after January 1, 2004 that required additional payments. In addition, the Plan was required to submit evidence in its response that the correct amount of interest and $10 fee, if applicable, were paid on the additional payments identified. Evidence was to be in electronic form that includes at a minimum: claim number, date of service, receipts dates, paid amounts, paid dates, provider name, number of days late, amount of interest paid, penalty paid, and check number for each additional payment identified.

The CAP was to include the policies and procedures implemented to ensure that the correct amount of interest and applicable penalties are paid on additional payments involving provider disputes. The CAP was also to state the date the policies and procedures were implemented, the management position responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.

*The Plan responded that the provider disputes with dates of service after January 1, 2004 that meet one of the following criteria were isolated within the PDR tool for both the NCAL and SCAL region:*

- *Disputes paid in excess of 45 days after receipt*
- *Disputes paid in response to reasonable and customary reimbursement (for reason other than member balance billing) regardless of payment time-frame*

*The total number of disputes requiring remediation within each region:*

- *NCAL – 2,597 provider disputes*
- *SCAL – 1,121 provider disputes*

*Time-Line for Remediation Process:*

- *NCAL Remediation Plan*
    - *Five dedicated resources already identified.*
    - *By September 12, 2005: 600 cases will be completed.*
    - *By September 19, 2005: an additional 1000 cases will be completed.*
    - *By September 26, 2005: remaining cases will be completed.*
    - *On September 26, 2005: a report will be generated to confirm all cases have been remediated and that the appropriate amount of interest was paid.*
    - *The report of the interest remediation with the requested data fields will be sent to the Department on September 27, 2005.*

- *SCAL Remediation Plan:*
    - *Four dedicated resources already identified.*
    - *By September 12, 2005: 600 cases will be completed.*
    - *By September 19, 2005: all remaining cases will have been remediated.*
    - *On September 19, report will be generated to confirm all cases have been remediated and that the appropriate amount of interest was paid.*
    - *The report of the interest remediation with the requested data fields will be sent to the Department on September 20, 2005.*

*The Plan responded that the northern and southern region California Claims Administration will perform quarterly audits of provider dispute files to verify interest is paid correctly. The audit will begin with provider disputes received during the 3rd quarter of 2005. The audit will be completed by the 4th quarter 2005. The results of the quarterly audits will be reported to the PACE (Claims Executives) Committee and the Claims Compliance Committee.*

*The Plan identified the Director of Regulatory Compliance, the Claims and Provider Relations Supervisor – SCAL and the Manager of Quality Assurance – NCAL as the individuals responsible for overseeing the corrective actions.*

*The reports for remediation of claims by TPMG were electronically accepted by the Department on October 5, 2005. TPMG also updated their Provider Dispute Resolution Process policy and procedures were updated to clearly describe how to process adjustment on claims to apply interest as required by H&S Code Section 1371.35. Training regarding the application of interest was conducted with Facility Referral Coordinator's that process provider disputes payments to insure understanding of the changes.*

*The Plan responded that TPMG will conduct audit cases paid from a provider dispute determination to insure correct process are followed to allow for correct interest payments with their routine quality audits. The Plan identified the AOMS Operation Manager and the Director of UM and Provider Relations for TPMG as the individuals responsible for overseeing the corrective action.*

*The reports for remediation of claims by the southern, northern region and the Southern Permanente Medical Group were electronically accepted by the Department on October 6, 2005.*

## H. MONITORING DISPUTE RESOLUTION MECHANISM FOR CAPITATED PROVIDERS

Rule 1300.67.8 (c) requires a health plan to monitor the financial capacity of providers when they are compensated on a capitated basis. Section 1375.1 (a) (3) and (b) requires a health plan to demonstrate a procedure for prompt payment or denial of provider claims and the financial soundness of the Plan's arrangements for health care services. Health plans that capitate provider groups and delegate claims payment functions to these provider groups must have procedures in place to ensure that these groups comply with Sections 1371, 1371.35 and 1375.1 (a) (3) and (b). In addition, Rule 1300.71.38 (h) requires a health plan's designated officer to review the delegated provider's compliance with these requirements.

Our review noted that the Plan's internal auditors have not performed an annual review of the provider disputes mechanism for the following delegated providers:

- American Specialty Health Plans, Inc.
- Desert Medical Group
- Oasis Independent Practice Association Medical Group

The Plan was required to submit a summary of the results for its annual 2004 review, including a copy of all reports issued where a corrective action plan was required by the Plan from the delegated provider.

*The Plan responded that it conducted audits in 2004 of the claims processing for the delegated providers. However, actual provider dispute files were not included in the audit. The Plan also submitted audit work papers of the claims processing for their delegated providers.*

**The Department finds that the Plan's response was not fully responsive to the deficiency cited and the corrective actions required. The Plan is requested to provide written assurances that the audit of provider disputes will be included in the Plan's current oversight of the above named delegated providers.**

## I. METHODOLOGY FOR REIMBURSING NON-CONTRACTING PROVIDERS

Our review disclosed that the Plan was reimbursing non-contracting institutional providers at a discounted rate of the provider's billed charges. Schedules of the discounted rates were shown to the examiners during the review.

An amendment filing to this Department to verify compliance of the implementation of the Claims Settlement Practice and Dispute Resolution Mechanism regulation did not include schedules detailing the discounted rates applied to non-contracting institutional providers. In addition, the Plan did not provide any actuarial support to show that these discount rates resulted in a reasonable and customary value for the services rendered pursuant to Rule 1300.71(a) (3) (B).

The Plan was required to submit with its response to this report, these schedules along with the actuarial support to show that these discounted rates meet the requirements of Rule 1300.71 (a) (3) (B).

*The Plan responded that it has acted fully in accordance with Sections 1352(a) and (b) and Rules 1300.52 and 1300.5.1. The Plan has never been required to formally file their specific fee schedule. The Plan included in its response an attachment, which provides information regarding the Plan's validation of the statistical credibility on which its payment methodology is based, in compliance with Rule 1300.71(a)(3).*

**The Department finds that the Plan was not responsive to the corrective action required. Consequently, this issue will be referred to the Office of Enforcement.**

## J. PROVIDER DISPUTE AND ENROLLEE GRIEVANCE

Rule 1300.71.38 (c) (4) requires the plan to resolve any provider dispute submitted on behalf of an enrollee or a group of enrollees treated by the provider in the plan's consumer grievance process and not in the plan's or the plan's capitated provider's dispute resolution mechanism.

Rule 1300.71.38 (a) (2) defines a "Non-Contracted Provider Dispute" to mean a written notice to the plan or the plan's capitated provider challenging, appealing or requesting reconsideration of a claim.

Rule 1300.68 (a) (1) and (2) defines a grievance or a complaint to mean a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

Rule 1300.68 (d) (3) requires the plan's written response to an enrollee grievance to be sent to the complainant within thirty (30) calendar days of receipt of the grievance.

Our review disclosed that balance billings submitted to the Plan from non-contracting providers and/or enrollees are being processed by the Plan as an enrollee grievance and as a provider dispute.

However, we were unable to verify whether these submissions to the Plan were being properly reported to the Department as provider disputes.

The Plan was required to confirm that these balance billings submitted to the Plan from non-contracting providers and/or enrollees are being reported as provider disputes to the Department.

*The Plan responded that the corrected numbers for the annual reporting were re-run to determine that the universe does not include Medicare cases, that the numbers are correct for TPMG, and that all of the member grievances forwarded to the provider dispute unit are included. The validation of these numbers is currently in process. The Plan will provide the Department the corrected numbers on September 14, 2005 and will correct any identified incorrect reporting for the 1st and 2nd quarter 2005.*

**The Department finds that the Plan's compliance efforts were not fully responsive to the deficiency cited and the corrective action required. The Plan is required to confirm in writing that balance billings submitted to the Plan from non-contracting providers and/or enrollees are being reported as provider disputes to the Department.**

## K. REPRICING AGREEMENTS WITH BEECH STREET CORPORATION

The Department is currently reviewing the network rental agreement between the Plan and Beech Street Corporation. A letter to address any concerns about this arrangement will be issued separately from this report.

**No response was required to this Section.**

## M. NON-ROUTINE EXAMINATION

The Plan is advised that the Department may conduct a non-routine examination to verify representations made to the Department by the Plan in response to this report. The cost of such examination will be charged to the Plan in accordance with Section 1382 (b).

**No response was required to this Section.**