



Edmund G. Brown Jr., Governor  
State of California  
Business, Transportation and Housing Agency

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In reply refer to file No. 933 0055  
Via Federal Express and eFile

March 16, 2011

George Halvorson, Chairman of the Board and Chief Executive Officer  
**Kaiser Foundation Health Plan, Inc.**  
One Kaiser Plaza  
Oakland, CA 94612

**RE: FINAL REPORT OF THE ROUTINE EXAMINATION OF KAISER  
FOUNDATION HEALTH PLAN, INC.**

Dear Mr. Halvorson:

Enclosed is the Final Report of the routine examination of Kaiser Foundation Health Plan, Inc.'s (the "Plan") claims settlement practices and provider dispute resolution mechanism for the three-month period ending September 30, 2009. The examination was conducted by the Department of Managed Health Care (the "Department") pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975 ("Act").<sup>1</sup> The Department issued a Preliminary Report to the Plan on November 22, 2010. The Department accepted the Plan's electronically filed responses on January 6, 2011, January 14, 2011, and February 4, 2011.

This Final Report includes a description of the compliance efforts included in the Plan's responses, 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."

Please indicate within ten (10) days whether the Plan requests the Department to append its January 6, 2011, January 14, 2011, and February 4, 2011 responses to the Final Report. If so, please indicate which portions of the Plan's response shall be appended, and electronically file copies of those portions of the Plan's response exclusive of information held confidential

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<sup>1</sup> 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.

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 responses to the Preliminary Report or wishes to modify any information provided to the Department in its responses, please provide the filed documentation no later than ten (10) days from the date of the Plan's receipt of this letter through the eFiling web portal.

Please file this addendum electronically via the Department's eFiling web portal <https://wpsso.dmhc.ca.gov/secure/login/>, as follows:

- From the main menu, select "eFiling".
- From the eFiling (Home) menu, select "File Documents".
- From the File Documents Menu for:
  - 1) File Type; select "Amendment to prior filing";
  - 2) Original Filing, select "Filing No. 20081998" assigned by the Department; and
  - 3) Click "create filing".
- From the Original Filing Details Menu, click "Upload Amendments"; select # of documents; select document type: "Plan addendum response to Final Report (FE5)"; then "Select File" and click "Upload".
- Upload all documents then upload a cover letter as Exhibit E-1 that references to your response.
- After upload, please select "Complete Amendment", complete "Execution" and then click "complete filing".

As noted in the attached Final Report, the Plan's responses of January 6, 2011, January 14, 2011, and February 4, 2011 were not fully responsive to the deficiencies raised in the Preliminary Report issued by the Department on November 22, 2010. Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any request for additional corrective action contained within the attached Final Report, within 30 days after receipt of the report. If the Plan fails to fully respond and/or resolve the deficiencies addressed in the Final Report, then a referral will be made to the Office of Enforcement for appropriate administrative action for any remaining, unresolved deficiencies.

Please file the Plan's response electronically via the Department's eFiling web portal <https://wpsso.dmhc.ca.gov/secure/login/>, as follows:

- From the main menu, select "eFiling".
- From the eFiling (Home) menu, select "File Documents".
- From the File Documents Menu for:
  - 1) File Type; select "Amendment to prior filing";
  - 2) Original Filing, select the "Filing No. 20081998" assigned by the Department; and
  - 3) Click "create filing".
- From the Original Filing Details Menu, click "Upload Amendments"; select # of documents; select document type: "Plan's Response to Final Report (FE10)"; then "Select File" and click "Upload".

- Upload all documents then upload a cover letter as Exhibit E-1 that references to your response.
- After upload, please select “Complete Amendment”, complete “Execution” and then click “complete filing”.

Questions or problems related to the electronic transmission of the above responses should be directed to Rita Ultreras at (916) 255-2443 or email at [rultreras@dmhc.ca.gov](mailto:rultreras@dmhc.ca.gov). You may also email inquiries to [wps@dmhc.ca.gov](mailto:wps@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. The report will be located at the Department’s web site at [www.dmhc.ca.gov](http://www.dmhc.ca.gov).**

If there are any questions regarding this report, please contact me.

Sincerely,

**Original Signed By**

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

ng:jn

cc: Maria Borje-Bonkowski, Director, Health Plan Licensing  
Dennis Balmer, Acting Chief, Division of Financial Oversight  
Marcy Gallagher, Chief, Division of Plan Surveys  
Elizabeth Spring, Counsel, Division of Licensing  
Sang Le, Senior Examiner, Division of Financial Oversight  
Ned Gennaoui, Senior Examiner, Division of Financial Oversight



**DIVISION OF FINANCIAL OVERSIGHT**

**FINAL REPORT OF  
THE ROUTINE EXAMINATION OF  
KAISER FOUNDATION HEALTH PLAN, INC.**

**FILE NO. 933 0055**

**DATE OF FINAL REPORT: MARCH 16, 2011**

**SUPERVISING EXAMINER: JANET NOZAKI**

**EXAMINER-IN-CHARGE: NED GENNAOUI**

**FINANCIAL EXAMINERS:**

**SUSAN MILLER  
CANDICE HAW  
ASHIKA VINOD  
TOM CHAN  
SUHAG PATEL**

## **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 the organizations that comprise the Kaiser Permanente Medical Care Program. The other organizations are Kaiser Foundation Hospitals, The Permanente Medical Group, and Southern California Permanente Medical Group.

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: 6,671,325 as of September 30, 2009

Service Area: Major counties within California.

Date of Last Routine Examination Final Report: November 26, 2007

Date of Last Non-Routine Examination Final Report: April 30, 2010

**FINAL REPORT OF THE ROUTINE EXAMINATION OF  
KAISER FOUNDATION HEALTH PLAN, INC.**

This is the Final Report of the routine examination of Kaiser Foundation Health Plan, Inc.'s ("the Plan") claims settlement practices and provider dispute resolution mechanism for the three-month period ending September 30, 2009. The examination was conducted by the Department of Managed Health Care (the "Department") pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975 ("Act").<sup>1</sup> The Department issued a Preliminary Report to the Plan on November 22, 2010. The Department accepted the Plan's electronically filed responses on January 6, 2011, January 14, 2011, and February 4, 2011.

This Final Report includes a description of the compliance efforts included in the Plan's January 6, 2011, January 14, 2011, and February 4, 2011 responses, in accordance with Section 1382 (c). The Plan's responses are noted in *italics*.

Our findings are presented in the accompanying attachment as follows:

Section I.	Compliance Issues
Section II.	Non-Routine Examination

***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***

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<sup>1</sup> 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. COMPLIANCE ISSUES**

**A. PROVIDER DISPUTE VIOLATIONS**

Rule 1300.71.38 (m)(2) states that the failure of a plan to comply with the requirements of a fast, fair and cost-effective dispute resolution mechanism shall be a basis for disciplinary action against the plan.

The Department’s examination found that the Plan failed to comply with the requirements of a fast, fair and cost-effective dispute resolution mechanism as summarized in the table below:

**SOUTHERN CALIFORNIA REGION**

<b>Deficiency</b>	<b>Total Claims in the Sample Population</b>	<b>Total Claims in the Sample</b>	<b>Number of Deficiencies Found</b>	<b>% of Compliance</b>
Failure to provide accurate or complete determination letter. <i>Repeat Deficiency</i>	7,240	50	4	92%
Incorrect date of receipt for interest and timeliness calculation.	“	“	3	94%

**NORTHERN CALIFORNIA REGION**

<b>Deficiency</b>	<b>Total Claims in the Sample Population</b>	<b>Total Claims in the Sample</b>	<b>Number of Deficiencies Found</b>	<b>% of Compliance</b>
Failure to reimburse claims accurately, including interest and \$10 penalty. <i>Repeat Deficiency</i>	4,161	50	3	94%

On November 19, 2010, the Plan filed signed acknowledgements with the Department that stated the following:

**SOUTHERN CALIFORNIA REGION**

*“The Plan acknowledges that a deficiency in its provider dispute resolution procedures, operations and related finalization processes has resulted in its failure to provide accurate or complete written determination letters of pertinent fact(s) in at least 95% of provider disputes. The Plan has agreed with the Department that there is no need to conduct further testing of additional SCAL provider disputes in light of the Plan’s acknowledgement of this deficiency.*

*The Plan further acknowledges its commitment to correcting this deficiency in accordance with requirements stated in all Department reports, including examination reports, issued in connection with this routine examination.*

*The Plan acknowledges that this deficiency has resulted in its violations of California Code of Regulations, Title 28, section 1300.71.38 (f). For purposes of assessing a penalty for this violation, the Plan agrees that the deficiency rate of 8 percent for failing to provide accurate or complete determination letters is representative of the percentage of deficiencies present in the entire universe of SCAL provider disputes adjudicated during the time frame defined by the Department's examination, specifically July 1, 2009 through September 30, 2009."*

### **NORTHERN CALIFORNIA REGION**

*"The Plan acknowledges that a deficiency in its provider dispute resolution procedures, operations and related finalization processes has resulted in the Plan paying fewer than 95% of NCAL provider disputes correctly. The Plan has agreed with the Department that there is no need to conduct further testing of NCAL provider disputes in light of the Plan's acknowledgement of this deficiency. The Plan further acknowledges its commitment to correcting this deficiency in accordance with requirements stated in all Department reports, including examination reports, issued in connection with this routine examination.*

*The Plan acknowledges that this deficiency has resulted in its violations of Health and Safety Code sections 1371 and 1371.35; and California Code of Regulations, Title 28, section 1300.71.38 (g). For purposes of assessing a penalty for this violation, the Plan agrees that the deficiency rate of 6 percent for incorrectly paying NCAL provider disputes is representative of the percentage of deficiencies present in the entire universe of NCAL provider disputes adjudicated during the time frame defined by the Department's examination, specifically July 1, 2009 through September 30, 2009."*

The following detailed the provider dispute resolution mechanism violations found during our examination:

#### **1. INTEREST ON LATE CLAIMS PAYMENTS RESULTING FROM PROVIDER DISPUTES – REPEAT DEFICIENCY**

Rule 1300.71.38 (g) states that if the provider dispute or amended provider dispute involves a claim and is determined in whole or in part in favor of the provider, the plan or the plan's capitated provider shall pay any outstanding monies determined to be due, and all interest and penalties required under Sections 1371 and 1371.35 and Rule 1300.71, within five (5) working days of the issuance of the written determination.

Section 1371 requires a health care service plan to reimburse uncontested claims no later than 45 working days after the date of receipt of the claim by the plan. 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.

Section 1371 and Rule 1300.71 (j) require 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 1371.35 and Rule 1300.71 (i), which refer to claims for emergency services, require that if an uncontested claim is not reimbursed within 45 working days after the date of receipt of the claim by the plan, the plan shall automatically include the greater of \$15 for each 12-month period or portion thereof on a non-prorated basis, or interest at the rate of 15% per annum for the period of time that the payment is late.

Rule 1300.71(a)(8)(K) describes one unfair payment pattern as the failure to reimburse at least 95% of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period.

### **Northern California Region**

The Department's examination found that interest was not paid correctly or was paid after the Department provided the sample selection to the Plan on adjusted claim payments that resulted from provider disputes in three (3) out of 50 of the provider disputes reviewed (a compliance rate of 94%). The failure to pay interest correctly was noted in provider dispute sample numbers PDR N-16, PDR N-23 and PDR N-48.

Northern California Region's failure to reimburse claims accurately was previously noted in the Final Report of the previous routine examination, dated November 26, 2007. At that time, the Plan was notified that this violation was referred to the Office of Enforcement for appropriate administrative action.

**The Plan's repeated failure to comply with the interest requirements of Sections 1371 and 1371.35; Rule 1300.71 and Rule 1300.71.38 (g) was referred to the Department's Office of Enforcement for appropriate administrative action. The enforcement action resulted in an \$750,000 fine being assessed against the Plan.<sup>2</sup>**

The Plan was required to explain why the corrective actions it implemented to resolve this deficiency in the prior routine examination were not effective in ensuring ongoing compliance.

In addition, the Plan was required to submit a detailed Corrective Action Plan ("CAP") to bring the Plan into compliance with the above Sections and Rules that was to include, but not be limited to, the following:

- a. Training procedures implemented to ensure that claim processors have been properly trained on interest and penalty requirements regarding additional payments resulting from provider disputes due to incorrect payment of the initial claim.

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<sup>2</sup> Letter of Agreement dated January 20, 2011 regarding Enforcement Matter Numbers 10-002, 07-329, 08-064, 09-197 and 09-368.

- b. Audit procedures implemented to ensure that the Plan was monitoring correct payment of interest and penalties on late adjusted claim payments resulting from provider disputes.
- c. Identification of all late claim payments resulting from provider disputes for which interest and penalties were not correctly paid from May 31, 2008 (the date of the last examination) through the date corrective action has been implemented by the Plan.
- d. Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in paragraph "c" above. This evidence was to include an electronic data file/schedule (Excel or Access) that identified the following:
  - Claim number
  - Date of service
  - Date original claim received
  - Date new information received (date claim was complete)
  - Total billed
  - Original total paid
  - Original paid date
  - Amount of adjustment paid (with check number)
  - Date adjustment paid
  - Amount of original interest paid
  - Original interest paid date
  - Number of days used to calculate interest
  - Amount of additional interest paid (with formula)
  - Date additional interest paid
  - Penalty paid
  - Date penalty paid
  - Check number for interest and/or penalty
  - Provider name
  - ER or Non-ER indicator

The data file was to provide the detail of all claims remediated; and, to include the total number of claims and the total additional interest and penalty paid, as a result of remediation.

- e. Revised policies and procedures implemented to ensure that interest on claims was calculated and paid in compliance with the above Section and Rules.
- f. Date the revised policies and procedures were implemented, the management position(s) responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

If the Plan was not able to complete the CAP or portions of the CAP within 45 calendar days of receipt of this report, the Plan was required to submit a timeline (that did not exceed 180 calendar days from the receipt of the Preliminary Report) with its response. If the Plan was not able to meet this timeframe, it was to justify the reason for the delay. The Plan was also required to submit monthly status reports until the CAP was completed.

*The Plan responded that during the 2007 Routine Financial Exam, NCCA received a deficiency for interest on late claim payment resulting from provider disputes. In the 2008 follow-up audit, NCCA was not cited for this issue. NCCA believes its prior 2007 corrective action plan adequately addressed correct payment of interest on provider disputes. The current audit finding for incorrect application of interest is limited to the inaccurate use of the infrequently used Good Cause letter.*

*The Plan stated that NCCA will implement a new timely filing letter by January 31, 2011. Upon review of a provider dispute related to an untimely filing denial for which we accept proof that the claim was filed timely, we will process the claim and apply appropriate interest rules. The Plan submitted sample "Contract Timely filing" letter and "Non contract Timely Filing" letter with its response.*

*Additional corrective actions to address this specific deficiency include the following:*

- a. All PDR claim examiners will attend a refresher training course regarding: 1) The requirement for payment of interest and penalty on late and adjusted claims. Adjusted claims include claims where a payment is issued because of a provider dispute. 2) Training on usage of the new "Timely Filing" letter versus the "Good Cause" letter; 3) In-service training sessions, which will be scheduled during the first quarter of 2011.*
- b. A daily audit will be implemented by January 3, 2011 to ensure interest and penalties are paid on late adjusted claim payments.*
- c. NCCA has identified the population of overturned claims resulting from an untimely filing provider dispute for which the "Good Cause" letter was issued beginning May 31, 2008 through the new letter implementation date of January 31, 2011. Each claim will be reviewed to determine if interest and penalty is owed.*
- d. All remediation activities will be completed by April 30, 2011. NCCA will submit a monthly status report, including an electronic data file with required data elements, to validate that interest and penalties were paid on affected claims.*
- e. The policy and procedure for the "Good Cause" criteria is being reviewed. It will be revised and implemented by January 31, 2011.*
- f. The policy and procedure will be implemented on January 31, 2011.*

*The Plan identified the Statewide Operations Manager, Provider Disputes and Rework Claims Processing; the NCCA Director; and the Statewide Director, Claims Compliance, as the management positions responsible for compliance.*

*The Plan stated that audit results of the daily interest control report are reviewed with the Operations Manager and Claims supervisors to ensure ongoing compliance. Errors identified are corrected and addressed with the claims processor to ensure understanding of the procedure. A component of this audit is to validate that appropriate interest and penalty is applied and paid accurately on affected claims.*

**The Department finds that the Northern California Claims Administration's ("NCCA") compliance efforts are not fully responsive to the deficiencies cited and the corrective actions required. The Plan is requested to submit a copy of the revised policy and procedure for the "Good Cause" criteria that were implemented January 31, 2011.**

**The Department acknowledges that the Plan's CAP will be completed by April 30, 2011. Therefore, monthly status reports are due within 15 days following the close of each month. The final status report (due by May 15, 2011) is required to include the detail of all claims remediated, the total number of claims, and the total payment, interest and penalty paid, as a result of the remediation.**

**A copy of the revised policy and procedure for the "Good Cause" criteria and the monthly status reports should be submitted through the Department's eFiling web portal.**

## **2. DETERMINATION LETTER – REPEAT DEFICIENCY**

Rule 1300.71.38 (f) states that the Plan shall issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days after the date of receipt of the provider dispute or amended provider dispute.

### **Southern California Region**

The Department's examination of provider disputes found that the Plan did not accurately disclose the pertinent facts and reasons for its determination to uphold the Plan's previous decision on the claim in four (4) out of 50 disputes reviewed (a non-compliance rate of 8 percent).

The following are the inaccurate facts and reasons found in provider dispute determination letters:

<b>DMHC PDR Sample No.</b>	<b>Determination Letter Date</b>	<b>Inaccurate Facts and Reasons on Determination Letter</b>	<b>Actual Facts and Reasons for Plan's Determination</b>
PDR S-8	09/14/09	Paid at contract rate	Provider is not contracted
PDR S-24	07/21/09	Plan upheld refund request	Plan paid on wrong member
PDR S-31	08/04/09	Identified member as the provider	Denied as non-referred service
PDR S-41	08/19/09	Paid at contract rate	Denied as non-referred service

Southern California Region's failure to accurately disclose the pertinent facts and reasons for its determinations was previously reported in the Final Report of the previous non-routine examination, dated September 29, 2009. At that time, the Plan was notified that this violation was referred to the Office of Enforcement for appropriate administrative action.

The Plan was required to explain why the corrective actions it implemented to resolve this deficiency in the prior non-routine examination were not effective in ensuring ongoing compliance.

In addition, the Plan was required to submit a detailed Corrective Action Plan ("CAP") to bring the Plan's into compliance with the above Sections and Rules that was to include, but not be limited to, the following:

- a. Training procedures implemented to ensure that processors were properly trained to accurately disclose the facts and reasons for provider disputes determination.
- b. Audit procedures implemented to ensure compliance and to identify the need for additional training.
- c. Date of implementation of the training and audit procedures.
- d. The management position responsible for compliance.

*The Plan stated that after the previous examination, SCCA worked on correcting the dispute disposition letters as part of a larger project that was completed in September 2009. The 2010 audit period selected was July 1, 2009 – September 30, 2009. The four findings in this examination fell within those months where the new letters process had not yet been fully implemented and staff had not been provided training of the new letters process.*

- a. SCCA provided detailed refresher training with the claims examiners on July 9, 2010 and addressed the findings related to Provider Dispute processing with respect to choosing the correct variable text language specific to the provider dispute determination.*
- b. Compliance will perform Internal Focus Performance Audits on a quarterly basis starting the first quarter of 2011 to ensure that the letter codes on dispute disposition notices are being chosen appropriately and accurately.*
- c. Implementation date of training was on July 9, 2010. Implementation date for performance audit and monitoring procedures is estimated to begin the first quarter of 2011.*
- d. The Plan identified the Statewide Operations Manager, Provider Disputes and Rework Claims Processing; the SCCA Director; and the Statewide Director, Claims Compliance, as the management positions responsible for compliance.*

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

**3. RECEIPT DATE OF CLAIMS**

Rule 1300.77.4 requires all plans to institute procedures whereby all claims received by the plan are maintained and accounted for in a manner which permits the determination of date of receipt of any claim, the status of any claim, the dollar amount of unpaid claims at any time and the rapid retrieval of any claim.

Rule 1300.71 (a)(6) defines the date of receipt as the working day when a claim is delivered to either the plan's specified claims payment site, post office box, or to its designated claims processor.

**Southern California Region**

The Department's examination found that the receipt date was not recorded correctly for three (3) out of 50 disputes reviewed (a non-compliance rate of 6 percent). They included provide dispute sample numbers PDR S-6, PDR S-32, and PDR S-45. These claims were generated as duplicates to other previously submitted claims to allow additional payments. In the duplication process, the duplication date was entered as the receipt date. The inaccurate receipt date can potentially impact the Plan's compliance with the timeliness and interest payment accuracy requirements.

The Plan was required to submit a description of its process to ensure that the actual date of receipt, and not the duplication date, was being captured in compliance with Rule 1300.71 (a)(6). The Plan was also required to provide the management position(s) responsible for compliance and a description of the monitoring system implemented to ensure continued compliance with this Rule.

*The Plan responded that Operations implemented a daily control report in the fourth quarter of 2009 to monitor and validate claims processing accuracy on adjusted claims including adjustments made pursuant to a provider dispute. The control report verifies that the correct receipt date has been applied. Any identified deficiencies on these daily control reports are escalated to upper level management for remediation and corrective action.*

*On June 23, 2010, refresher training was provided to the staff to address the finding where the incorrect receipt date was being applied on cases such as "duplicate claims" and other situation. The refresher training provided the staff with instructions on how to appropriately apply the receipt date in these types of situations.*

*The Plan identified the Statewide Operations Manager, Provider Disputes and Rework Claims Processing; SCCA Director; and the Statewide Director, Claims Compliance, as the management positions responsible for compliance.*

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

## **B. OTHER PROVIDER DISPUTE RESOLUTION DEFICIENCIES**

The following details other provider dispute resolution deficiencies found during the Department's examination:

### **1. MISDIRECTED PROVIDER DISPUTES**

#### **The Permanente Medical Group - Referrals**

The Department's examination found that the Plan failed to forward misdirected provider disputes regarding referral claims to the appropriate provider for processing within ten (10) working days of receipt. The Plan is responsible for resolving these disputes. They included referral provider dispute sample numbers PDR NR-15, PDR NR-27, PDR NR-28, PDR NR-33, PDR NR-37, PDR NR-38, PDR NR-40, PDR NR-41, PDR NR-43 and PDR NR-50.

The Plan was required to submit a policy and procedures to ensure that misdirected disputes were appropriately forwarded or returned to claimant timely. The Plan was also required to provide the date of implementation, the management position(s) responsible for compliance, and a description of the monitoring system implemented to ensure continued compliance with the above Rules.

*The Plan responded that TPMG implemented the Plan's updated NCAL Provider Dispute document on December 17, 2010 which describes the current process to route misdirected claims. A copy of the revised Provider Dispute Resolution Policy was filed with the Plan's response.*

*The Plan stated that the process is monitored on a daily basis to ensure review of all disputes occur within a 10-day (working days) turn around time. Once a dispute is identified as misdirected it is immediately routed to the proper entity responsible for review of the dispute.*

*There is a monthly audit process performed by the Quality Assurance Department within NCAL Claims Administration to ensure all disputes were handled as defined by the policy.*

*The Plan identified the Statewide Operations Manager, Provider Disputes and Rework, and the Statewide Director, Claims Compliance, as the management positions responsible for compliance.*

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

**C. CLAIM SETTLEMENT PRACTICES – “UNFAIR PAYMENT PATTERN”**

Section 1371.37 (a) prohibits a health care service plan from engaging in an unfair payment pattern. Subsection (c) includes the following claim settlement practices as “unfair payment patterns”:

- (1) Engaging in a demonstrable and unjust pattern, as defined by the department, of reviewing or processing complete and accurate claims that result in payment delays.
- (2) Engaging in a demonstrable and unjust pattern, as defined by the department, of reducing the amount of payment or denying complete and accurate claims.
- (3) Failing on a repeated basis to pay the uncontested portions of a claim within the timeframes specified in Section 1371, 1371.1, or 1371.35.
- (4) Failing on a repeated basis to automatically include the interest due on claims pursuant to Section 1371.

Rule 1300.71 (a)(8) defines a "demonstrable and unjust payment pattern" or "unfair payment pattern" as any practice, policy or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims.

The Department’s examination found that the Plan engaged in “unfair payment patterns” as summarized in the following tables:

**SOUTHERN CALIFORNIA REGION**

<b>Deficiency</b>	<b>Type of Claims in Sample</b>	<b>Total Claims in the Sample Population</b>	<b>Total Claims in the Sample</b>	<b>Number of Deficiencies Found</b>	<b>% of Compliance</b>
Failure to provide accurate or complete written denial. <i>Repeat Deficiency</i>	Denied	31,752	50	10	80%
Failure to forward misdirected claim in 10 working days.	“	“	“	5	90%
Failure to provide accurate explanation of payment.	Non-Contracted Emergency	46,538	50	10	80%
Failure to provide accurate explanation of payment.	Paid	134,516	50	4	92%

<b>Deficiency</b>	<b>Type of Claims in Sample</b>	<b>Total Claims in the Sample Population</b>	<b>Total Claims in the Sample</b>	<b>Number of Deficiencies Found</b>	<b>% of Compliance</b>
Failure to provide accurate explanation of payment.	Emergency	88,827	50	4	92%
Failure to reimburse claims accurately, including interest and \$10 penalty.	“	“	“	4	92%
Incorrect date of receipt for interest and timeliness calculation.	“	“	“	2	92%

**NORTHERN CALIFORNIA REGION**

<b>Deficiency</b>	<b>Type of Claim</b>	<b>Total Claims in the Sample Population</b>	<b>Total Claims in the Sample</b>	<b>Number of Deficiencies Found</b>	<b>% of Compliance</b>
Failure to provide accurate or complete written denial. <i>Repeat Deficiency</i>	Denied	17,669	50	11	78%
Failure to reimburse claims accurately, including interest and \$10 penalty. <i>Repeat Deficiency</i>	Late	3,279	25	3	88%
Failure to reimburse claims accurately, including interest and \$10 penalty.	Paid	59,621	50	5	90%
Failure to reimburse claims timely.	“	“	“	3	94%

**THE PERMANENTE MEDICAL GROUP – REFERRALS**

Deficiency	Type of Claim in Sample	Total Claims in the Sample Population	Total Claims in the Sample	Number of Deficiencies Found	% of Compliance
Failure to provide written denial.	Denied	1,857	50	6	88%
Failure to provide accurate or complete written denial.	“	“	“	4	92%
Failure to reimburse claims accurately. Denied incorrectly.	“	“	“	4	92%
Claim not provided.	“	“	“	3	94%
Failure to reimburse claims accurately, including interest and \$10 penalty.	Late	676	25	4	84%
Incorrect date of receipt for interest and timeliness calculation.	“	“	“	3	88%

On November 19, 2010, the Plan filed signed acknowledgements with the Department that stated the following:

**SOUTHERN CALIFORNIA REGION**

**Claim Payment Accuracy**

*“Kaiser Foundation Health Plan, Inc. (the “Plan”) acknowledges that certain deficiencies in its claims payment procedures, operations and related finalization processes have resulted in the Plan making correct payment on fewer than 95% of emergency SCAL claims and late SCAL claims. The Plan has acknowledged the findings of the on-site survey conducted by the Department of Managed Health Care (the Department) and agrees with the Department that there is no need to conduct further testing any additional claims in light of the Plan's acknowledgement of these deficiencies. The Plan further acknowledges its commitment to*

*correcting these deficiencies in accordance with requirements stated in all Department reports, including examination reports, issued in connection with this routine examination.*

*The Plan acknowledges that these deficiencies have resulted in its violations of Health and Safety Code sections 1371, 1371.35, 1371.37 and 1371.8; and California Code of Regulations, Title 28, sections 1300.71 (a)(8)(K), 1300.71 (i) and 1300.71 (j). For purposes of assessing a penalty for these violations, the Plan agrees that the deficiency rates of 8 percent found in the sample of 50 emergency SCAL claims and 8 percent found in the sample of 25 late SCAL claims are representative of the percentages of deficiencies present in the entire universe of emergency SCAL claims and late SCAL claims adjudicated during the time frame defined by the Department's examination, specifically July 1, 2009 to September 30, 2009."*

### **Misdirected Claims**

*"The Plan acknowledges that a deficiency in its claims payment procedures, operations and related finalization processes resulted in the timely forwarding of fewer than 95% of misdirected denied SCAL claims. The Plan has agreed with the Department that there is no need to conduct further review of additional denied SCAL claims in light of the Plan's acknowledgement of this deficiency. The Plan further acknowledges its commitment to correcting this deficiency in accordance with requirements stated in all Department reports, including examination reports, issued in connection with this routine examination.*

*The Plan acknowledges that this deficiency has resulted in its violation of California Code of Regulations, Title 28, sections 1300.71 (a)(8)(B). For purposes of assessing a penalty for this violation, the Plan agrees that the deficiency rate of 10 percent found in the sample of 50 denied SCAL claims is representative of the percentage of deficiencies present in the entire universe of denied SCAL claims adjudicated during the time frame defined by the Department's examination, specifically July 1, 2009 through September 30, 2009."*

### **Accurate Written Explanation and Explanation of Payment**

*"The Plan acknowledges that a deficiency in its claims payment procedures, operations and related finalization processes has resulted in failure to provide an accurate or complete written explanation of denial for at least 95% of denied SCAL claims, non-contracted emergency SCAL claims, emergency SCAL claims and paid SCAL claims. The Plan has agreed with the Department that there is no need to conduct further review of additional SCAL claims in light of the Plan's acknowledgement of this deficiency. The Plan further acknowledges its commitment to correcting this deficiency in accordance with requirements stated in all Department reports, including examination reports, issued in connection with this routine examination.*

*The Plan acknowledges that this deficiency has resulted in its violation of California Code of Regulations, Title 28, sections 1300.71 (a)(8)(F) and, in the case of denied SCAL claims, 1300.71 (d)(1). For purposes of assessing a penalty for this violation, the Plan agrees that the deficiency rate of 20 percent found in the sample of 50 denied SCAL claims, 20 percent in the sample of 50 non-contracted emergency SCAL claims, 8 percent in the sample of 50 emergency*

*SCAL claims, and 8 percent in the sample of 50 paid SCAL claims is representative of the percentage of deficiency present in the entire universe of SCAL claims adjudicated during the time frame defined by the Department's examination, specifically July 1, 2009 through September 30, 2009."*

### **Date of Receipt**

*"The Plan acknowledges that certain deficiencies in its claims and provider dispute resolution procedures and operations have resulted in the recording of correct dates of receipt on fewer than 95% of late SCAL claims and SCAL provider disputes. The Plan has agreed with the Department that there is no need to conduct further testing on additional late SCAL claims and SCAL provider disputes in light of the Plan's acknowledgement of these deficiencies. The Plan further acknowledges its commitment to correcting these deficiencies in accordance with requirements stated in all Department reports, including examination reports, issued in connection with this routine examination.*

*The Plan acknowledges that these deficiencies have resulted in its violation of California Code of Regulations, Title 28, section 1300.71 (a)(6). For purposes of assessing a penalty for this violation, the Plan agrees that the deficiency rates of 8 percent found in the sample of 25 late SCAL claims and 6 percent found in the sample of 50 SCAL provider disputes are representative of the percentages of deficiencies present in the entire universe of late SCAL claims adjudicated and SCAL provider disputes during the time frame defined by the Department's examination, specifically July 1, 2009 through September 30, 2009."*

## **NORTHERN CALIFORNIA REGION**

### **Claim Payment Accuracy**

*"Kaiser Foundation Health Plan, Inc. (the "Plan") acknowledges that certain deficiencies in its claims payment procedures, operations and related finalization processes have resulted in the Plan making correct payment on fewer than 95% of late NCAL claims and paid NCAL claims. The Plan has acknowledged the findings of the on-site survey conducted by the Department of Managed Health Care (the Department) in January of this year and agrees with the Department that there is no need to conduct further testing on any additional claims in light of the Plan's acknowledgement of these deficiencies. The Plan further acknowledges its commitment to correcting these deficiencies in accordance with requirements stated in all Department reports, including examination reports, issued in connection with this routine examination.*

*The Plan acknowledges that these deficiencies have resulted in its violations of Health and Safety Code sections 1371 and 1371.8; and California Code of Regulations, Title 28, sections 1300.71(a)(8)(K) and 1300.71(j). For purposes of assessing a penalty for these violations, the Plan agrees that the deficiency rates of 12 percent found in the sample of 25 late NCAL claims and 10 percent found in the sample of 50 paid NCAL claims are representative of the percentages of deficiencies present in the entire universe of late NCAL claims and paid NCAL claims adjudicated during the time frame defined by the Department's examination, specifically July 1, 2009 to September 30, 2009."*

### **Accurate Written Explanation**

*“The Plan acknowledges that a deficiency in its claims payment procedures, operations and related finalization processes has resulted in failure to provide an accurate or complete written explanation of denial for at least 95% of denied NCAL claims. The Plan has agreed with the Department that there is no need to conduct further review of additional NCAL claims denial notifications to providers in light of the Plan’s acknowledgement of this deficiency. The Plan further acknowledges its commitment to correcting this deficiency in accordance with requirements stated in all Department reports, including examination reports, issued in connection with this routine examination.*

*The Plan acknowledges that this deficiency has resulted in its violation of California Code of Regulations, Title 28, sections 1300.71(a)(8)(F). For purposes of assessing a penalty for this violation, the Plan agrees that the deficiency rate of 22 percent found in the sample of 50 denied NCAL claims is representative of the percentage of deficiencies present in the entire universe of denied NCAL claims adjudicated during the time frame defined by the Department’s examination, specifically July 1, 2009 through September 30, 2009.”*

### **Timely Payment**

*“The Plan acknowledges that a deficiency in its claims payment procedures, operations and related finalization processes has resulted in failure to make timely payments on at least 95% of paid NCAL claims. The Plan has agreed with the Department that there is no need to conduct further review of paid NCAL claims in light of the Plan’s acknowledgement of this deficiency. The Plan further acknowledges its commitment to correcting this deficiency in accordance with requirements stated in all Department reports, including examination reports, issued in connection with this routine examination.*

*The Plan acknowledges that this deficiency has resulted in its violations of Health and Safety Code sections 1371, 1371.35, 1371.37 and 1371.8; and California Code of Regulations, Title 28, section 1300.71(g). For purposes of assessing a penalty for this violation, the Plan agrees that the deficiency rates of 6 percent found in the sample of 50 paid NCAL claims is representative of the percentage of deficiencies present in the entire universe of paid NCAL claims adjudicated during the time frame defined by the Department’s examination, specifically July 1, 2009 through September 30, 2009.”*

## **THE PERMANENTE MEDICAL GROUP - REFERRALS**

### **Claim Payment Accuracy**

*“Kaiser Foundation Health Plan, Inc. (the “Plan”) acknowledges that certain deficiencies in its claims payment procedures, operations and related finalization processes have resulted in the Plan making correct payment on fewer than 95% of late NCAL referral claims. The Plan has acknowledged the findings of the on-site survey conducted by the Department of Managed Health Care (the Department) in January of this year and agrees with the Department that there is no need to conduct further testing on any additional claims in light of the Plan’s*

*acknowledgement of these deficiencies. The Plan further acknowledges its commitment to correcting these deficiencies in accordance with requirements stated in all Department reports, including examination reports, issued in connection with this routine examination.*

*The Plan acknowledges that these deficiencies have resulted in its violations of Health and Safety Code sections 1371, 1371.35, 1371.37 and 1371.8; and California Code of Regulations, Title 28, sections 1300.71 (a)(8)(K), 1300.71 (i) and 1300.71 (j). For purposes of assessing a penalty for these violations, the Plan agrees that the deficiency rates of 16 percent found in the sample of 25 late NCAL referral claims is representative of the percentage of deficiencies present in the entire universe of late NCAL referral claims adjudicated during the time frame defined by the Department's examination, specifically July 1, 2009 to September 30, 2009."*

### **Accurate Written Explanation**

*"The Plan acknowledges that a deficiency in its claims payment procedures, operations and related finalization processes resulted in failure to provide a written denial explanation, failure to provide an accurate or complete written denial explanation, and incorrect denials for at least 95% of denied NCAL referral claims. The Plan has agreed with the Department that there is no need to conduct further review of additional denied NCAL referral claims in light of the Plan's acknowledgement of this deficiency. The Plan further acknowledges its commitment to correcting this deficiency in accordance with requirements stated in all Department reports, including examination reports, issued in connection with this routine examination.*

*The Plan acknowledges that this deficiency has resulted in its violation of California Code of Regulations, Title 28, sections 1300.71 (a)(8)(F) and 1300.71 (d). For purposes of assessing a penalty for this violation, the Plan agrees that the deficiency rate of 12 percent found in the sample of 50 denied NCAL claims for failing to provide a written denial explanation, 8 percent for failure to provide an accurate or a complete written denial explanation and 8 percent for incorrect denials are representative of the percentage of deficiencies present in the entire universe of denied NCAL referral claims adjudicated during the time frame defined by the Department's examination, specifically July 1, 2009 through September 30, 2009."*

### **Access to Books and Records**

*"The Plan acknowledges that a deficiency in its claims payment procedures, operations and related finalization processes has resulted in failure to provide an unacceptable number of NCAL referral claims. The Plan has agreed with the Department that there is no need to conduct further additional review of additional NCAL referral claims in light of the Plan's acknowledgement of this deficiency. The Plan further acknowledges its commitment to correcting this deficiency in accordance with requirements stated in all Department reports, including examination reports, issued in connection with this routine examination.*

*The Plan acknowledges that this deficiency has resulted in its violation of Health and Safety Code section 1385; and California Code of Regulations, Title 28, section 1300.85.1. For purposes of assessing a penalty for this violation, the Plan agrees that the deficiency rate of 6 percent found in the sample of 50 denied NCAL referral claims is representative of the*

*percentage of deficiency present in the entire universe of denied NCAL referral claims adjudicated during the time frame defined by the Department's examination, specifically July 1, 2009 through September 30, 2009."*

**Date of Receipt**

*"The Plan acknowledges that a deficiency in its claims payment, procedures, and operations has resulted in the recording of correct dates of receipt on fewer than 95% of late NCAL referral claims. The Plan has agreed with the Department that there is no need to conduct further review of additional late NCAL referral claims in light of the Plan's acknowledgement of this deficiency. The Plan further acknowledges its commitment to correcting this deficiency in accordance with requirements stated in all Department reports, including examination reports, issued in connection with this routine examination.*

*The Plan acknowledges that this deficiency has resulted in its violation of California Code of Regulations, Title 28, section 1300.71(a)(6). For purposes of assessing a penalty for this violation, the Plan agrees that the deficiency rate of 12 percent found in the sample of 25 late NCAL referral claims is representative of the percentage of deficiency present in the entire universe of late NCAL referral claims adjudicated during the time frame defined by the Department's examination, specifically July 1, 2009 through September 30, 2009."*

The following detailed the unfair payment practices found during our examination:

**1. INCORRECT INTEREST ON LATE CLAIMS PAYMENT**

Section 1371 requires a health care service 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.

Section 1371 and Rule 1300.71 require 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 1371.35, which refers to claims resulting from emergency services, requires that if an uncontested claim is not reimbursed within 45 working days after receipt by a health care service plan, the plan shall pay the greater of \$15 per year or interest at the rate of 15 percent per annum, beginning with the first calendar day after the 45 working-day period.

Rule 1300.71 (a)(8)(K) describes one unfair payment pattern as the failure to reimburse at least 95% of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period.

### **Southern California Region**

**The Department removed the deficiency cited for the Southern California Region based on revised information submitted by the Plan.**

### **Northern California Region**

The Department selected a sample of 25 claims paid late during the three-month period ended September 30, 2009 to determine if interest and penalties were paid correctly in accordance with the Sections and Rules stated above.

The Department's examination found that the Plan did not pay or underpaid the amount of interest due in three (3) out of the 25 late claims reviewed (a compliance rate of 88 percent). The incorrect payment of interest was the result of the Plan not selecting the correct date of receipt of a complete claim to calculate the number of days used in determining the amount of interest payable on these late claims. They were late claim samples LP-12, LP-20 and LP-23.

The failure to pay interest and penalties in the Northern California Region was noted in the Final Reports of the two previous routine examinations, dated April 26, 2004 and November 26, 2007. In its responses to the Preliminary Reports of these examinations, the Plan proposed corrective actions in response to findings related to claims reimbursement interest payment and calculation deficiencies. These corrective actions were implemented by the Plan. While these corrective actions were reviewed and accepted by the Department at that time, this examination disclosed that the Plan's compliance efforts have not achieved the necessary levels of compliance with the Act and Regulations cited.

### **The Permanente Medical Group ("TPMG") - Referrals<sup>3</sup>**

The Department selected a sample of 25 referral claims that were paid late during the three-month period ended September 30, 2009 to determine if interest and penalties were paid correctly in accordance with the Sections and Rules stated above.

The Department's examination found that the Plan did not pay the interest due in four (4) out of the 25 late referral claims reviewed (a compliance rate of 84 percent). The failure to pay interest was the result of:

- Settlement agreement with provider consenting to the waiver of interest payment. They included late referral claim samples LP-12 and LP-21.

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<sup>3</sup> Referrals or referral claims are used interchangeably in this report. They are claims for authorized services processed by The Permanente Medical Group ("TPMG") for the Northern California Region, but the Plan is financially responsible for reimbursement. Therefore, the findings that involve TPMG are discussed separately in this report.

- Using the date of receipt by TPMG, rather than the Plan. TPMG is responsible for processing referral claims, but the Plan is financially responsible for reimbursement. They included late referral claim samples L-22 and L-24.

**The Plan's failure to comply with the interest requirements of Sections 1371 and 1371.35 and Rule 1300.71 was referred to the Department's Office of Enforcement for appropriate administrative action. The enforcement action resulted in an \$750,000 fine being assessed against the Plan.**

The Plan was required to explain why the corrective actions it implemented to resolve this deficiency in the prior routine examinations of the Northern California Region were not effective in ensuring ongoing compliance.

In addition, the Plan was required to submit a Corrective Action Plan ("CAP") to address the deficiency cited above. The CAP was to include the following:

- a. Training procedures to ensure that claim processors have been properly trained on interest and penalty requirements.
- b. Audit procedures to ensure that the Plan was monitoring correct payment of interest and penalties on late and late adjusted claims payments.
- c. Identification of all late claims for which interest and penalties were not correctly paid from May 31, 2008 through the date corrective action has been implemented by the Plan.
- d. Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in the paragraph immediately above. This evidence was to include an electronic data file (Excel or Access) or schedule that identified the following:
  - Claim number
  - Date of service
  - Date original claim received
  - Date new information received (date claim was complete)
  - Total billed
  - Original total paid
  - Original paid date
  - Amount of adjustment paid (with check number)
  - Date adjustment paid
  - Amount of original interest paid
  - Original interest paid date
  - Number of days used to calculate interest
  - Amount of additional interest paid (with formula)
  - Date additional interest paid
  - Penalty paid

- Date penalty paid
- Check number for interest and/or penalty
- Provider name
- ER or Non-ER indicator

The data file was to include the total number of claims and the total additional interest and penalty paid, as a result of remediation.

In addition, the Plan was required to state the management position(s) responsible for overseeing the CAP and a description of the monitoring system implemented to ensure continued compliance.

If the Plan was not able to complete the CAP or portions of the CAP within 45 calendar days of receipt of this report, the Plan was required to submit a timeline (that did not exceed 180 calendar days from the receipt of the Preliminary Report) with its response. If the Plan was not able to meet this timeframe, it was to justify the reason for the delay. The Plan was also required to submit monthly status reports until the CAP was completed.

### **Northern California Region**

*The Plan responded that during the 2007 Routine Financial Exam, NCCA received a deficiency for interest on late claim payments. In the 2008 follow-up audit, NCCA was not cited for this issue. NCCA believes its prior 2007 corrective action plan adequately addressed correct payment of interest. The current audit finding is based on specific claim examiner's errors.*

- a. All claims examiners will attend a refresher training course regarding the requirement for the correct payment of interest and penalty on late and adjusted claims. In-service training sessions will be scheduled during the first quarter of 2011.*
- b. A daily process audit is being implemented by January 3, 2011 to ensure interest and penalties are paid on late adjusted claim payments. The daily audits will be accompanied by two (2) process control charts.*
  - *Missed Interest – to identify adjusted claims where interest and penalty payments are not included.*
  - *Incorrect – to identify adjusted claims where the interest and/or penalty payments may be incorrect.*
- c. NCCA has identified the population of late claims for which interest and penalties were not correctly paid for the period of May 31, 2008 through the date the corrective action has been implemented by the Plan.*
- d. Evidence on remediation for all identified claims for which interest and penalties are due will be completed no later than May 22, 2011. NCCA will submit a monthly status*

*report, including an electronic data file with required data elements, to validate that interest and penalties were paid on affected claims until completed.*

*The Plan stated that audit results are reviewed with the Operations Manager and Claims supervisors. Errors identified are corrected and addressed with the claims processor to ensure understanding of the procedure.*

*The Plan identified the NCCA Claim Operations Manager, the NCCA Director, and the Statewide Director, Claims Compliance, as the management positions responsible for compliance.*

*The Plan stated that claim audits are reviewed by the Operations Manager and Claims supervisors to ensure continued compliance. Issues identified are addressed with the claims processor to ensure understanding of the policy.*

*The Plan added that it had revised the policy and procedure (“P&P”) governing the conduct of reconciliations in the Northern California Region. The revised P&P will be implemented effective January 1, 2011. The Reconciliation Scenarios Grid explicitly directs that an interest obligation, if any, shall not be waived through a settlement agreement. The content of the Reconciliations Scenario Grid will be used to inform the administration of interest payment rules. The Plan submitted with its response a copy of the Regional Medical Services Contracting (MSC) Reconciliations P&P and Reconciliation Scenarios Grid, both dated January 1, 2011.*

- a. MSC Contracting staff and claim processors will be trained on interest and penalty requirements no later than the end of the first quarter of 2011.*
- b. The January 1, 2011 Reconciliations Policy & Procedure requires claims processors to annotate data extracts used for invoice remediation with invoice/sequence level detail on i) the “received” date, ii) the additional, reconciled payment, iii) interest payment, if any, and iv) date paid per the applicable payment system. For the purpose of this corrective action, all additional data elements identified by the required corrective action will also be tracked at the invoice/sequence level, including additional penalty payments if the Plan failed to appropriately pay interest at the time of initial payment. Management will audit the data extracts to assure compliance.*
- c. Within 180 calendar days from the date of the Department’s Preliminary Report, the Plan will review all patient-specific invoices subject to any Northern California Region settlement agreement executed on or after May 31, 2008. Each resulting data extract will be subject to remediation in accordance with the January 1, 2011 Reconciliations Policy & Procedure and its attachment, Reconciliation Scenarios Grid.*

*The identified invoices will be remediated in accordance with the Corrective Action Plan requirements.*

- d. *The Plan identified the two MSC Contracting Directors, the MSC Leader for Regulatory Compliance, and the AOMS Operations Leader, Referrals, as the management positions responsible for compliance.*

*The Plan stated that management will audit the resulting data extracts from (b), above, to assure compliance with the immediate corrective action, and audit annotated extracts required by the January 1, 2011 P&P to assure continued compliance.*

**The Permanente Medical Group (“TPMG”)**

*Regarding the incorrect interest finding on late claims payment resulting from using the date of receipt by TPMG rather than the Plan, the Plan respectfully submits that the Department's interpretation of the regulatory standard stated in 28 CCR 1300.71 regarding the receipt date of misdirected claims is not consistent with the plain wording of the regulation. The regulation states, "Date of receipt means the working day when a claim, by physical or electronic means, is first delivered to either the plan's specified claims payment office, post office box, or designated claims processor or to the plan's capitated provider for that claim. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code section 641. In the situation where a claim is sent to the incorrect party, the "date of receipt" shall be the working day when the claim, by physical or electronic means, is first delivered to the correct party responsible for adjudicating the claim." (emphasis added). This language clearly supports the TPMG practice of starting the initial claim adjudication "clock" from the time that it receives a claim that was initially misdirected. This is, of course, separate from any applicable time frame within which a misdirected claim must be forwarded to the correct entity, in this case TPMG. However, any delay in that forwarding process is not the responsibility of TPMG and their statutory adjudication time frame should not be compromised as a result of any such delay.*

**The Department acknowledges that the NCCA's CAP will be completed by May 22, 2011. Therefore, monthly status reports are due within 15 days following the close of each month. The final status report (due by June 15, 2011) is required to include the detail of all claims remediated, the total number of claims, and the total payment, interest and penalty paid, as a result of the remediation. The monthly status reports should be submitted through the Department's eFiling web portal.**

**The Department finds that the Plan's compliance efforts regarding referral claims processed by TPMG are not fully responsive to the deficiencies cited and the corrective actions required for the reason stated below.**

**The Department disagrees with the Plan's interpretation of the date of receipt for referral claims. Rule 1300.71 (a)(6) states, "Date of receipt means the working day when a claim, by physical or electronic means, is first delivered to either the plan's specified claims payment office, post office box, or designated claims processor or to the plan's capitated provider for that claim."**

**The Department interprets the “designated claims processor” pursuant to Rule 1300.71 (a)(6) to mean the entity financially responsible to pay the referral claims, rather than the entity providing the administrative services of processing referral claims. The Northern California Region is “the plan’s specified claims payment office,” responsible for reimbursing referral claims. Referral claims are processed by TPMG since it operates the referral claim processing system, Authorized Outside Medical Services system (“AOMS”). In addition, TPMG is not the capitated provider responsible for reimbursing these referral claims. Therefore, the Plan is required to use the date of receipt by the NCCA to determine timeliness of referral claims, if they were received by the NCCA prior to TPMG.**

**Consequently, the Plan is required to submit a Corrective Action Plan (“CAP”) as previously required to resolve the deficiency for referral claims processed by TPMG. The CAP shall include the following:**

- a. Training procedures to ensure that claim processors have been properly trained on choosing the earlier of the NCCA or TPMG date of receipt to determining whether interest and penalty are due.**
- b. Audit procedures to ensure that the Plan was monitoring correct payment of interest and penalties on late and late adjusted claims payments using the correct date of receipt.**
- c. Identification of all late referral claims for which interest and penalties were not correctly paid, by using TPMG’s date of receipt rather than the NCCA’s date of receipt, from May 31, 2008 through the date corrective action has been implemented by the Plan.**
- d. Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in the paragraph immediately above. This evidence is to include an electronic data file (Excel or Access) or schedule that identifies the following:**
  - Claim number**
  - Date of service**
  - Date original claim received**
  - Date new information received (date claim was complete)**
  - Total billed**
  - Original total paid**
  - Original paid date**
  - Amount of adjustment paid (with check number)**
  - Date adjustment paid**
  - Amount of original interest paid**
  - Original interest paid date**
  - Number of days used to calculate interest**
  - Amount of additional interest paid (with formula)**

- **Date additional interest paid**
- **Penalty paid**
- **Date penalty paid**
- **Check number for interest and/or penalty**
- **Provider name**
- **ER or Non-ER indicator**

**The data file is to include the total number of referral claims and the total additional interest and penalty paid, as a result of remediation.**

**In addition, the Plan is required to state the management position(s) responsible for overseeing the CAP and a description of the monitoring system implemented to ensure continued compliance.**

**If the Plan is not able to complete the CAP or portions of the CAP within 180 calendar days from the date it received the Preliminary Report, it must justify the reason for the delay. The Plan is also required to submit monthly status reports until the CAP was completed.**

## **2. TIME LIMITS FOR REIMBURSEMENT, CONTEST, OR DENIAL OF CLAIMS**

Sections 1371 and 1371.35 states each plan shall reimburse claims or any portion of any claim, whether in state or out of state, as soon as practical, but no later than 45 working days after receipt of the claim, unless the claim or portion thereof is contested by the plan in which case the claimant shall be notified, in writing, that the claim is contested or denied within 45 working days after receipt of the claim. Section 1371.35 refers to claims resulting from emergency services.

Section 1371.37 (a) states each plan is prohibited from engaging in an unfair payment pattern. Section 1371.37 (c)(3) defines an "unfair payment pattern," as failing on a repeated basis to pay the uncontested portions of a claim within the timeframes specified in Sections 1371 and 1371.35.

### **Northern California Region**

The Department selected a sample of 50 claims paid during the three-month period ended September 30, 2009 to determine timely reimbursement of claims in compliance with the Sections and Rules stated above.

The Department's examination found that the Plan failed to reimburse three (3) out of the 50 paid claims in a timely manner (a non-compliance rate of 6 percent). These claims were paid claim sample numbers PD-22, PD-29 and PD-49.

**The Plan's failure to comply with the requirements of processing claims timely pursuant to Sections 1371 and 1371.35 demonstrates an unfair payment pattern, and was referred to the Department's Office of Enforcement for appropriate administrative**

**action. The enforcement action resulted in an \$750,000 fine being assessed against the Plan.**

The Plan was required to demonstrate to the Department that it had retained sufficient staffing to ensure that claims were processed timely. In addition, the Plan was required to submit monthly status report until it had sustained six consecutive months of compliance. The monthly status report should include a description of any new problem(s) found by the Plan that caused claims to be processed untimely, a description of the root cause of the problem(s), and the action(s) taken by the Plan to correct the problem.

Furthermore, the Plan was required to identify the management position(s) responsible for ensuring compliance and the controls implemented for monitoring continued compliance.

*The Plan responded that the concern regarding sufficient staffing is addressed in Section E of this report. The Plan added that Claims Timeliness is managed on a claim by claim basis. Supervisors and leads monitor aged claims through ad hoc reports focusing on claims 21 days and older. Timeliness performance review meetings are held weekly to determine opportunities for improvement.*

*NCCA submitted a report demonstrating compliance with timeliness metrics for each month for the period of July 2009 through November 2010.*

*The Plan identified the NCCA Claims Operation Manager, the NCCA Director, and the Statewide Director, Claims Compliance, as the management positions responsible for compliance.*

*The Plan stated that Claims supervisors will use a daily report of aged claims to manage claim inventory and to ensure continued compliance.*

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

### **3. INCORRECT CLAIMS DENIAL EXPLANATIONS**

Rule 1300.71 (a)(8)(F) describes an "unfair payment pattern" as the Plan's failure to provide a provider with an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim consistent with section (d)(1) at least 95% of the time for the affected claims over the course of any three-month period;

Rule 1300.71 (d) (1) states that a plan shall provide an accurate and clear written explanation of the specific reasons for the action taken within the timeframes specified in sections (g) and (h).

The Department selected a sample of 50 denied claims in each region and 50 denied referral claims in the Northern California Region for the three-month period ended September 30, 2009 to determine compliance with Rule 1300.71 (d)(1).

The Department's examination found that the Plan did not consistently provide accurate denial reasons on denial letters to providers. An inaccurate denial reason on the denial letter does not allow a provider to submit the correct information to result in a complete claim.

### **Southern California Region**

The examination noted that ten (10) of the 50 denied reviewed claims did not include accurate denial explanations (a compliance rate of 80 percent). They included denied claim sample numbers D-2, D-12, D-20, D-22, D-27, D-29, D-30, D-38, D-43 and D-50.

### **Northern California Region**

The examination noted that eleven (11) of the 50 denied claims reviewed did not include accurate denial explanations (a compliance rate of 78 percent). They included denied claim sample numbers D-12, D-17, D-18, D-21, D-30, D-31, D-32, D-37, D-42, D-48 and D-52.

### **The Permanente Medical Group - Referrals**

The examination noted that four (4) of the 50 denied referral claims reviewed did not include accurate denial explanations (a compliance rate of 92 percent). They included denied referral claim sample numbers D-1, D-4, D-33 and D-39.

In addition, the Plan failed to provide written explanations in six (6) of the 50 denied referral claims (a compliance rate of 88 percent). They included denied referral claim sample numbers D-6, D-13, D-20, D-29, D-41 and D-48.

The failure by the Southern and Northern California Regions to provide correct denial explanations was noted in the Final Reports of the previous routine and non-routine examinations, dated November 26, 2007 and September 29, 2009, respectively. In response to the Preliminary Report for those examinations, the Plan described various corrective action plans. This examination disclosed that the Plan's compliance efforts had not achieved the necessary levels of compliance with the Act and Regulations cited.

### **The Plan's failure to provide accurate denial reasons pursuant to Rule 1300.71 (d)(1) was referred to the Department's Office of Enforcement for appropriate administrative action. The enforcement action resulted in an \$750,000 fine being assessed against the Plan.**

The Plan was required to state the reasons why its compliance efforts had not achieved the necessary levels of compliance with the Act and Regulations cited.

The Plan was required by Region to submit a Corrective Action Plan ("CAP") that included the following:

- a. Training procedures implemented to ensure that claim processors were continually trained to provide correct claims denial reasons.

- b. Audit procedures implemented to ensure that the Plan was monitoring processors for using correct claims denial reasons.
- c. Date of implementation of the training and audit procedures.
- d. The management position responsible for compliance.

**Southern California Region**

*The Plan responded that although SCCA has been cited in this category in the past, the current findings concern language that has not been found objectionable in the past.*

*The Plan will implement the following CAP:*

- a. *Revised letter content will be utilized to provide additional specificity regarding denial explanations as part of a letter revision project. Revised letters will be implemented no later than May 22, 2011. Staff will be trained on the changes in letter content to ensure correct choice of denial letter. The Plan submitted copies of revised denial letters for eligibility, authorized services and Modifier 26 with its response.*
- b. *SCCA will review letter content annually to ensure letters are in compliance with any legislative, regulatory, and benefit changes in addition to ensuring consistency with SCCA processes.*
- c. *The review of letter content will be performed in the first quarter of 2011. Staff will be trained by May 22, 2011 in conjunction with the letter revision project.*
- d. *The Plan identified the SCCA Claims Operations Manager, the SCCA Director, and the Statewide Director, Claims Compliance, as the management positions responsible for compliance.*

**Northern California Region**

*The Plan added that although NCCA has been cited in this category in the past, the current findings concern language that has not been found objectionable in the past.*

*The Plan stated that the pre-eligibility letter was revised on April 10, 2010 to address the deficiency cited. Additional actions include the following:*

- a. *Staff communication of revised pre-eligibility letter was made on April 20, 2010.*
- b. *NCCA will review letter content annually to ensure letters are in compliance with any legislative, regulatory, and benefit changes in addition to ensuring consistency with NCCA processes.*

- c. *The pre-eligibility denial letter was revised on April 10, 2010. A copy of a sample denial letter was submitted with the Plan's response.*
- d. *The Plan identified the NCCA Claims Operations Manager, the NCCA Director, and the Statewide Director, Claims Compliance, as the management positions responsible for compliance.*

### **The Permanente Medical Group - Referrals**

*The Plan responded that the process to deny a referral claim in the current claims adjudication system requires significant manual intervention by the claims processor. A claims processor must thoroughly evaluate the claim and all supporting documents submitted with the claim, determine why the claim must be denied, identify the correct reason code for the denial and input the denial code in the system. TPMG Referral Operations has identified that claims processors were inconsistent in following policies and procedures and, as a result, the expected level of compliance was not achieved.*

*TPMG Referral Operations will develop a reference guide that will include all denial codes and explanations, the corresponding text that is printed on denial letters when the denial code is used and specific instructions to indicate when a code should be used. The reference guide will be completed by January 15, 2011.*

- a. *All referral coordinators will be in-serviced on the appropriate use of the reference guide by January 30, 2011. Subsequent review of the denial reference guide will be conducted every other month at the All Referral Coordinators meeting.*
- b. *Beginning in 2011, the audit team will perform a quarterly audit of a representative sample of denied claims. The audit will be performed during the month following the end of each quarter. The Operations Leader will review the audit results with the claims processors at the All Facility Referral Coordinators meeting scheduled every other month.*
- c. *Subsequent review of the denial reference guide will be conducted every other month at the All Referral Coordinators meeting.*
- d. *The Plan identified the TPMG Referrals Operations Leader as the management position responsible for compliance.*

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

#### **4. CLEAR EXPLANATION OF PAYMENT**

Rule 1300.71 (d)(1) requires that the Plan shall not improperly deny, adjust, or contest a claim. For each claim that is denied, adjusted or contested, the Plan shall provide an accurate and clear written explanation of the specific reasons for the action taken.

### **Southern California Region**

The Department's examination disclosed that the explanation of claim payment on provider remittance advices ("RAs") was not provided for claim adjustments, or incorrect explanation was provided. This deficiency was noted on:

- Four (4) out of 50 paid claims reviewed (a noncompliance rate of 8 percent). They included claim samples 25, 34, 38 and 49.
- Ten (10) out of 50 paid non-contracted provider emergency claims reviewed (a noncompliance rate of 20 percent). They included claim samples 1, 2, 23, 31, 33, 38, 40, 43, 44 and 45.
- Four (4) out of 50 paid emergency claims reviewed (a noncompliance rate of 8 percent). They included claim samples 7, 14, 30 and 43.

**The above violation was referred to the Office of Enforcement for appropriate administrative action. The enforcement action resulted in an \$750,000 fine being assessed against the Plan.**

The Plan was required to submit a Corrective Action Plan ("CAP") to address the deficiency cited above. The CAP was to include the following:

- Procedures implemented to ensure that adjustment and payment reasons were correctly described on RAs.
- Training conducted to inform staff of the new procedures implemented.
- Audit procedures established to ensure that the Plan was monitoring the implementation of the new procedures.

In addition, the Plan was required to state the management position(s) responsible for overseeing the CAP and a description of the monitoring system implemented to ensure continued compliance.

*The Plan responded as follows:*

- a. System enhancements were implemented to address auto-population of incorrect explanation codes. The system logic was updated in the first quarter of 2010 to reflect the correct auto-populated explanation code. The enhancement will be reviewed annually to ensure the correct code is being used.*
- b. For errors identified outside of the system enhancements auto-population issue, claims adjusters will receive focus training on explanation code selection in the first quarter of 2011.*

- c. *SCCA will perform monthly audits beginning the first quarter of 2011 to ensure claims adjusters are selecting the correct explanation code.*
- d. *The Plan identified the SCCA Claims Operations Manager; the Statewide Operations Manager, Provider Disputes and Rework Claims Processing; the SCCA Director; and the Statewide Director, Claims Compliance, as the management positions responsible for compliance.*

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

## **5. CLAIM DENIAL**

Rule 1300.71 (a)(8)(K) describes one unfair payment pattern as the failure to reimburse at least 95% of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period.

Rule 1300.71 (d) states that a plan or a plan's capitated provider shall not improperly deny, adjust, or contest a claim.

### **The Permanente Medical Group - Referrals**

The examination found that the Plan incorrectly denied referral claims that should have been paid on four (4) out of 50 denied referral claims reviewed (a compliance rate of 92 percent). They included denied referral claim sample numbers D-1, D-13, D-17 and D-20.

**This violation was referred to the Office of Enforcement for appropriate administrative action. The enforcement action resulted in an \$750,000 fine being assessed against the Plan.**

The Plan was required to submit a detailed Corrective Action Plan ("CAP") to bring the Plan into compliance with the above Section and Rule that was to include, but not be limited to, the following:

- a. Identification of all referral claims processed from May 31, 2008 to the present that were incorrectly denied.
- b. Evidence that interest and penalties, as appropriate, were paid retroactively for the referral claims identified in paragraph "a" above. This evidence was to include an electronic data file/schedule (Excel or Access) that identified the following:
  - Referral claim number
  - Date of service
  - Date of receipt
  - Total billed

- Total paid
- Date of payment
- Number of days used to calculate interest
- Amount of interest paid
- Amount of penalty paid
- Interest and penalty paid date
- Check number for payment, interest and penalty
- Provider name

The data file was to provide the detail of all claims remediated; and, to include the total number of referral claims and the total additional amount, interest and penalty paid, as a result of remediation

- c. Policies and procedures implemented to ensure that referral claims were paid in compliance with the above Section and Rules.
- d. Date the policies and procedures were implemented, the management position responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

If the Plan was not able to complete the CAP or portions of the CAP within 45 calendar days of receipt of this report, the Plan was required to submit a timeline (that did not exceed 180 calendar days from the receipt of the Preliminary Report) with its response. If the Plan was not able to meet this timeframe, it was to justify the reason for the delay. The Plan was also required to submit monthly status reports until the CAP was completed.

*The Plan responded as follows:*

- a. *TPMG Referral Operations will identify all final denied referral claims processed from May 31, 2008 to November 30, 2010. A file containing the impacted claims was submitted to the Department. Each claim will be reviewed to determine the accuracy of the denial. Claims identified to have been denied inappropriately will be reprocessed and paid, with applicable interest.*
- b. *All remediation activities will be completed by May 22, 2011. TPMG Referral Operations will submit a monthly status report, including an electronic data file with required data elements to demonstrate evidence that incorrectly denied claims were reprocessed and paid with applicable interest.*
- c. *Policies and procedures are in place to ensure that claims are denied or pended appropriately. Although the dates listed in the policy, attached to the response, and procedure documents are not recent, the processes have not changed and continue to represent current practice. As mentioned in C3 above, the current process requires significant manual intervention by the claims processor. The findings that were identified in the audit resulted from errors made by claims processors.*

- d. *Beginning in 2011, the audit team will perform a quarterly audit of a representative sample of denied claims. The audit will be performed during the month following the end of each quarter. The Operations Leader will review the audit results with the claims processors at the All Facility Referral Coordinators meeting scheduled every other month.*

*The Plan identified TPMG Referral Operations Leader, NCAL Continuum Claims Director and NCAL Continuum Claims Manager as the management positions responsible for compliance.*

**The Department finds that the Plan's compliance efforts are not fully responsive to the corrective actions required because TPMG's remediation efforts are ongoing.**

**The Department acknowledges that the Plan's CAP will be completed by May 22, 2011. Therefore, monthly status reports are due within 15 days following the close of each month. The final status report (due by June 15, 2011) is required to include the detail of all claims remediated, the total number of claims, and the total payment, interest and penalty paid, as a result of the remediation. The monthly status reports should be submitted through the Department's eFiling web portal.**

## **6. CLAIM PAYMENT ACCURACY**

Section 1371 requires a health care service 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.

Section 1371 and Rule 1300.71 require 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 1371.35, which refers to claims resulting from emergency services, requires that if an uncontested claim is not reimbursed within 45 working days after receipt by a health care service plan, the plan shall pay the greater of \$15 per year or interest at the rate of 15 percent per annum, beginning with the first calendar day after the 45 working-day period.

Rule 1300.71 (a)(8)(K) describes one unfair payment pattern as the failure to reimburse at least 95% of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period.

### **Northern California Region**

The examination found that five (5) out of 50 paid claims were not paid correctly (a compliance rate of 90 percent). They included paid claim sample numbers PD-7, PD-18, PD- 29, PD-43 and PD-49.

**This violation was referred to the Office of Enforcement for appropriate administrative action. The enforcement action resulted in an \$750,000 fine being assessed against the Plan.**

The Plan was required to submit a Corrective Action Plan (“CAP”) to address the deficiency cited above. The CAP was to include the following:

- a. Training procedures to ensure that claim processors had been properly trained on interest and penalty requirements.
- b. Audit procedures to ensure that the Plan was monitoring correct payment of interest and penalties on late and late adjusted claims payments.
- c. Identification of all paid claims for which interest and penalties were not correctly paid from May 31, 2008 through the date corrective action had been implemented by the Plan.
- d. Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in the paragraph immediately above. This evidence was to include an electronic data file (Excel or Access) or schedule that identified the following:
  - Claim number
  - Date of service
  - Date original claim received
  - Date new information received (date claim was complete)
  - Total billed
  - Original total paid
  - Original paid date
  - Amount of adjustment paid (w/ check number)
  - Date adjustment paid
  - Amount of original interest paid
  - Original interest paid date
  - Number of days used to calculate interest
  - Amount of additional interest paid (with formula)
  - Date additional interest paid
  - Penalty paid
  - Date penalty paid
  - Check number for interest and/or penalty
  - Provider name
  - ER or Non-ER indicator

The data file was to include the total number of claims and the total additional payment, interest and penalty paid, as a result of remediation.

In addition, the Plan was required to state the management position(s) responsible for overseeing the CAP and a description of the monitoring system implemented to ensure continued compliance.

If the Plan was not able to complete the CAP or portions of the CAP within 45 calendar days of receipt of this report, the Plan was required to submit a timeline (that did not exceed 180 calendar days from the receipt of the Preliminary Report) with its response. If the Plan was not able to meet this timeframe, it was to justify the reason for the delay. The Plan was also required to submit monthly status reports until the CAP was completed.

*The Plan responded that the incorrectly paid claims identified in the examination related to two specific instances of claim adjustors errors. The claim adjustors failed to follow the correct procedures related to processing member liability for the DHMO product, and failed to apply a system override for certain code payment within an emergency claim.*

*Additional corrective actions to address the specific claims deficiency cited above include the following:*

- a. All claims processors will attend a refresher training course to include; 1) Proper application of DMHO co-insurance and deductibles; 2) processing of ER claims with Follow-up of Care (FC) code. Training to be completed by January 31, 2011.*
- b. Focused audits will be performed beginning the first quarter of 2011 on the following deficiencies until three consecutive quarters of satisfactory levels of compliance are achieved:*
  - Auditing report identifying claims adjusted inappropriately due to misapplied DHMO co-insurance and deductible allowance.*
  - Auditing report identifying claims in which there was a failure to override an ER system code of FC on line items causing the ER claims to be paid incorrectly on first pass.*
- c. Improper application of DHMO co-insurance and failure to override ER system code FC will be identified for the period May 31, 2008 through the implementation of refresher training, to be completed by January 31, 2011.*
- d. Evidence on remediation for all identified claims for which interest and penalties are due, will be completed no later than May 22, 2011. NCCA will submit a monthly status report, including an electronic data file with required data elements, to validate that interest and penalties were paid on affected claims until completed.*

*The Plan submitted a data file which identified the population of claims with improperly applied DHMO coinsurance application and failure to override ER system code FC for the period May 31, 2008 through January 31, 2011.*

*The Plan identified the NCCA Claims Operations Manager, the NCCA Director, and the Statewide Director, Claims Compliance, as the management positions responsible for compliance.*

*The Plan stated that focus audits will be performed beginning the first quarter of 2011 until three quarters of satisfactory levels of compliance are achieved to ensure continue compliance.*

**The Department finds that the Plan's compliance efforts are not fully responsive to the corrective actions required because NCCA's remediation efforts are ongoing.**

**The Department acknowledges that the Plan's CAP will be completed by May 22, 2011. Therefore, monthly status reports are due within 15 days following the close of each month. The final status report (due by June 15, 2011) is required to include the detail of all claims remediated, the total number of claims, and the total payment, interest and penalty paid, as a result of the remediation. The monthly status reports should be submitted through the Department's eFiling web portal.**

## **7. MISDIRECTED CLAIMS**

Rule 1300.71 (a)(8)(B) describes an "unfair payment pattern" as the failure to forward at least 95% of misdirected claims consistent with sections (b)(2)(A) and (B) over the course of any three-month period.

Rule 1300.71 (b)(2)(A) & (B) states that when a claim is sent to a health care service plan that has contracted with a capitated provider that is responsible for adjudicating the claim, the plan shall do the following:

- If the claim involves emergency services, the plan must forward the claim to the appropriate capitated provider within ten (10) working days of receipt of the claim that was incorrectly sent to the plan.

For those claims that do not involve emergency service or care:

- If the provider that filed the claim is contracted with the plan's capitated provider, the plan within ten (10) working days of the receipt of the claim must either send the claimant a notice of denial including instructions to bill the capitated provider or send the claim to the appropriate capitated provider.
- For all other claims, the plan within ten (10) working days of the receipt of the claim incorrectly sent to the plan must forward the claim to the appropriate capitated provider.

### **Southern California Region**

The Department's examination found that the Plan failed to timely forward misdirected claims within ten (10) working days of receipt to the appropriate capitated provider, Northern California Region, or send the claims back to the claimant with instructions to bill the correct provider on five (5) out of 50 denied claims reviewed (a compliance rate of 90 percent). They included denied claim sample numbers D-1, D-6, D-16, D-25 and D-35.

**This violation was referred to the Office of Enforcement for appropriate administrative action. The enforcement action resulted in an \$750,000 fine being assessed against the Plan.**

The Plan was required to submit a policy and procedures to ensure that misdirected claims are appropriately forwarded or returned to a claimant timely. The Plan was also required to provide the date of implementation, the management position(s) responsible for compliance, and a description of the monitoring system implemented to ensure continued compliance with the above Rules.

*The Plan responded that no formal Policy and Procedure for this process exists. However, the Plan attached Training Update that would be formalized as a policy and Procedure by January 31, 2011.*

*The logic of the Misdirected Report is under review and will be refined by January 31, 2011 to tighten existing controls. The current logic is too broad and includes claims that are not misdirected. Operations will continue to monitor the report daily to ensure the timely forwarding of misdirected claims.*

*SCCA will perform an audit to ensure that misdirected claims are being forwarded to the appropriate party within ten (10) working days.*

*The Plan identified the SCCA Claims Operations Manager, the SCCA Director, and the Statewide Director, Claims Compliance as the management positions responsible for compliance.*

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

### **8. INCORRECT DATE OF RECEIPT**

Rule 1300.71 (a)(6) defines the date of receipt of a claim as the working day when a claim, by physical or electronic means, is first delivered to either the plan's claims payment facility, post office box, or designated claims processor or to the plan's capitated provider.

### **Southern California Region**

The examination found that the Plan failed to record the correct receipt date for two (2) out of 25 late claims (a non-compliance rate of 8 percent). They included late claim sample numbers LP-3 and LP-9.

### **The Permanente Medical Group - Referrals**

The examination disclosed that the Plan failed to record the correct receipt date for three (3) out of 25 late referral claims (a non-compliance rate of 12 percent). The date of receipt by The Permanente Medical Group (“TPMG”) was input in the claim payment processing system, rather than the date of receipt by the Plan responsible for reimbursement. They included late referral claim sample numbers LP-22 and LP-24. The third referral claim with an incorrect date of receipt was caused by a human error and involved late referral claim sample number LP-19.

**The above violation was referred to the Office of Enforcement for appropriate administrative action. The enforcement action resulted in an \$750,000 fine being assessed against the Plan.**

The Plan was required to submit, by region, a description of its process to ensure that the correct referral claim receipt date is being captured in compliance with Rule 1300.71 (a)(6). The Plan was also required to provide the management position(s) responsible for compliance and a description of the monitoring system implemented to ensure continued compliance with this Rule.

### **Southern California Region**

*The Plan responded that SCCA Operations implemented a daily control report in the fourth quarter of 2009 to monitor and validate claims processing accuracy on adjusted claims including adjustments made pursuant to a provider dispute. The control report verifies that the correct receipt date has been applied. Any identified deficiencies on these daily control reports are escalated to upper level management for remediation and corrective action.*

*On June 23, 2010, refresher training was provided to the staff to address the finding where the incorrect receipt date was being applied on cases such as “duplicate claims” and other situations. The refresher training provided the staff with instructions on how to appropriately apply the receipt date in these types of situations. The Plan submitted evidence of the training with its response..*

*The Plan identified the Statewide Operations Manager, Provider Dispute and Rework Claims Processing, and the SCCA Director Statewide Director, Claims Compliance as the management positions responsible for compliance.*

### **The Permanente Medical Group (“TPMG”) - Referrals**

*The Plan responded that it respectfully submitted that the Department's interpretation of the regulatory standard stated in 28 CCR 1300.71 regarding the receipt date of misdirected claims was not consistent with the plain wording of the regulation. The regulation states, "Date of receipt means the working day when a claim, by physical or electronic means, is first delivered to either the plan's specified claims payment office, post office box, or designated claims processor or to the plan's capitated provider for that claim. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code section 641. In the situation where a claim is sent to the incorrect party, the "date of receipt" shall be the working day when the claim, by physical or electronic means, is first delivered to the correct party responsible for adjudicating the claim." [emphasis added]. This language clearly supports the TPMG practice of starting the initial claim adjudication "clock" from the time that it receives a claim that was initially misdirected. This is, of course, separate from any applicable time frame within which a misdirected claim must be forwarded to the correct entity, in this case TPMG. However, any delay in that forwarding process is not the responsibility of TPMG and their statutory adjudication time frame should not be compromised as a result of any such delay.*

**The Department finds that the Plan's compliance efforts are not fully responsive to the deficiency cite and the required action regarding referral claims processed by TPMG. As explained in Section C.1. of this Report, the Department interprets the "designated claims processor" pursuant to Rule 1300.71 (a)(6) to mean the entity obligated to pay for the referral claims, rather than the entity providing the administrative services of processing the referral claims. Therefore, the Plan is required to use the date of receipt by the NCCA to determine timeliness of referral claims, if they were received by the NCCA prior to TPMG. The Plan is requested to describe TPMG's process to ensure that the correct referral claim receipt date is being captured in compliance with Rule 1300.71 (a)(6). The Plan is also required to provide the management position(s) responsible for compliance and a description of the monitoring system implemented to ensure continued compliance with this Rule.**

## **9. ACCESS TO BOOKS AND RECORDS**

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

### **The Permanente Medical Group - Referrals**

The Plan failed to provide the Department with three (3) of the 50 denied referral claims requested for review, a noncompliance rate of six percent. The referral claims were processed at the Plan's regional facilities for skilled nursing and durable medical equipments. The missing denied referral claim sample numbers were D-5, D-13, and D-48.

**The above violation was referred to the Office of Enforcement for appropriate administrative action. The enforcement action resulted in an \$750,000 fine being assessed against the Plan.**

The Plan was required to submit a detailed Corrective Action Plan ("CAP") that demonstrated that TPMG had the administrative capacity to ensure that books and records could be timely provided to the Department upon request.

*The Plan responded that the Continuum Claims processing department did not have a consistent process for maintaining files containing vendor denial letters generated outside of claim adjudication system (AOMS).*

*The Continuum Claims processing department now has individual files for each vendor which facilitates retrieval of documents when requested.*

*The Plan stated that "individual files" are now being maintained by the Continuum Claims processing department contain all documentation relating to a specific claim: any invoice(s) from the provider and any letter(s) from the Plan.*

*The AOMS Policy & Procedure for manually created vendor denial letters was reviewed in March 2010. The Plan submitted a copy of TPMG Policy "Paper Invoice Returned to Vendor" with its response.*

*Claims processor training was completed March 2010 regarding the policy for manually created letters. This element will be part of the routine internal monitoring process.*

*The Plan identified the NCAL Continuum Claims Director as the management position that is responsible for ensuring compliance.*

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

#### **D. OTHER CLAIMS SETTLEMENT DEFICIENCIES**

The following are other claims settlement deficiencies identified during the Department's examination:

## 1. OVERSIGHT OF CLAIMS REPRICING SERVICES

Rule 1300.71 (d)(1) states that a plan or a plan's capitated provider shall not improperly deny, adjust, or contest a claim. For each claim that is denied, adjusted or contested, the plan or the plan's capitated provider shall provide an accurate and clear written explanation of the specific reasons for the action taken.

### **Southern California Region**

The examination found that the Plan failed to monitor the accuracy of claims payments determined by Viant, a repricing vendor. This issue was noted in three (3) out of 50 paid non-contracted provider emergency claims (an error rate of 6 percent). The claim sample numbers were 4, 13 and 46.

The examination disclosed that after these claims were paid, the Plan would make an additional payment after receiving a provider complaint concerning the lower payment amount.

The Plan was required to submit its policies and procedures for monitoring and ensuring the accuracy of payments made by its repricing vendors. The Plan was requested to state the date the policies and procedures were implemented, the management position(s) 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 by March 31, 2011, the rental networks will report monthly performance metrics. A notification process is being implemented on March 31, 2011 in which the rental networks will report self-identified errors in pricing and pricing agreements loaded past the effective date, along with identifying the affected claims. The P&P on the oversight process is under development and will be submitted by March 31 2011.*

*The Plan stated that an oversight audit plan will be developed by March 31, 2011 which will include:*

- *Frequency of audit*
- *Number of claims to be audited*
- *Threshold (pay amount) audited*

*By March 31, 2011, SCCA will perform regular oversight audits in accordance with the audit plan and review a monthly control report that recaps the previously identified pricing errors to validate that all impacted claims were remediated correctly as needed.*

*The Plan identified the SCCA Senior Operations Manager, Provider Contracting, the SCCA Director, and the Statewide Director, Claims Compliance, as the management positions responsible for ensuring ongoing compliance.*

**The Department finds that the SCCA's compliance efforts are not fully responsive to the corrective actions required. The Department acknowledges that the policy and procedure on the oversight process and the oversight audit plan are under development and will be submitted by March 31, 2011. The Plan is reminded to file the implemented policy and procedure and oversight audit plan through the Department's eFiling web portal.**

## **2. PROVIDER CONTRACTS WITH AUTOMATIC FEE RATE INCREASES**

Section 1371 requires a health care service 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.

### **The Permanente Medical Group - Referrals**

The Department's examination disclosed that referral claim (sample number PD-24) was paid at a previous contract rate. The provider contract had automatic increases in the fee schedule. The Plan had a policy of waiting 45 working days once a missed increase in rate was discovered to allow for the processing of all referral claims on hand. At the end of the 45-working day period, the Plan sends a report to the provider listing all referral claims that were underpaid. The Plan paid the referral claims without interest once it received a confirmation from the provider regarding the completeness of the report.

A similar deficiency in the Southern California Region was noted in the Final Report of the previous routine examination, dated November 26, 2007, regarding retro-active provider contracts.

The Plan was required to submit a policy and procedures to pay interest on all referral claims paid beyond 45 working days from the effective date of the automatic rate increases in provider contracts. The Plan should state the date the policy and procedures were implemented, the management position(s) 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 has revised the policy and procedure (P&P) governing the conduct of reconciliations in the Northern California Region. The revised P&P was implemented effective January 1, 2011. Regional Medical Services Contracting (MSC) Reconciliations Policy and Procedure and its attachment, Reconciliation Scenarios Grid, both dated January 1, 2011 were submitted with the Plan's response.*

*The Plan stated that regular internal monitoring will be conducted. Monitoring for compliance with the corrective action will be performed through new reporting protocol utilizing established Future Action (FA) Codes maintained in the NCR contract system (OMCS). Such reporting will evaluate the scheduled effective date of future rate changes established in the contract document and calendared by use of FA Codes, against the date*

*the rate change activity was completed in OMCS. Management will actively monitor the timeliness and progress of these contract administration activities.*

*The Plan identified the two Contracting Directors, MSC; the Leader, Regulatory Compliance, MSC; and the AOMS Operations Leader, Referrals, as the management positions responsible for overseeing this corrective action.*

**The Department finds that the Plan's compliance efforts are not fully responsive to the corrective actions required for the reason stated below.**

**As stated in Section C.1. of this Report, the MSC Reconciliation Scenarios Grid ("Grid") requires the accrual of interest starting on the 46<sup>th</sup> business day of contract execution, original claim receipt date or mutual agreement on amount owed. However, Sections 1371 and 1371.35 require the accrual of interest to begin on the first calendar day after the 45 working day period. Therefore, the Plan is required to revise the Grid stating that interest accrual starts on the first calendar day after the 45 working day period. The Plan also needs to submit a copy of the revised Grid, through the Department's eFiling web portal.**

#### **E. ADMINISTRATIVE CAPACITY**

Section 1367 (g) and Rule 1300.67.3 require that health care service plans maintain "the organizational and administrative capacity to provide services to subscribers and enrollees" and that a plan's organization, administrative services, and policies must "result in the effective conduct of the plan's business" and "provide effective controls."

The Plan had not demonstrated "effective controls" over its claims processing functions and provider dispute resolution mechanism.

The repeated deficiencies found during the Department's current and past examinations demonstrated that the Plan's organization, administrative services and policies were insufficient to provide effective controls over the accurate processing of claims and provide disputes.

The Plan was required to submit a detailed Corrective Action Plan ("CAP") that demonstrated that it has the administrative capacity to ensure sustained compliance with the Knox-Keene Act and Title 28 Regulations at all times.

*The Plan responded that administrative capacity is fundamental to ensuring that health care service plans run efficiently and effectively to promote the delivery and the quality of health and medical care to our members. The Plan further respectfully submits that any deficiency related to the processing of claims identified in this or any prior Examinations has not resulted from inadequate organizational and administrative capacity or staffing that impaired the plan's ability to provide services to its members.*

*The Plan added that it is confident that it has sufficient administrative capacity and staffing to timely and accurately process claims and provider disputes and is committed to continuing to*

*maintaining that capacity. Regular employed staff includes those with decision-making authority and the ability to provide immediate resolution to potential problem areas. The Plan acknowledges and agrees that there are certain documented deficiencies in its processing of claims and related issues. Nonetheless, these are human and system errors not resulting from lack of capacity; rather, they are issues that need to be addressed with existing staff and systems through improved education and more stringent monitoring.*

*The claims inventory management process includes daily morning meetings attended by operation managers and supervisors from each area to set the work plan for each day. The department organization includes embedded compliance, training and IT staff to ensure that all manner of issues are addressed timely and effectively to allow uninterrupted claims processing. This is performed in both regions.*

*With regard to the Plan's post-service claims settlement practices and provider dispute resolution mechanism, the Plan has, subsequent to every Examination, undertaken substantial and responsive corrective actions to eliminate any identified deficiency. In addition, the Plan's own compliance efforts include performing, on a regular basis, its own internal auditing to self-identify any emerging issues. The self-identified issues are corrected and remediated as needed. The compliance efforts focus on people, process improvements and technology enhancements. While perhaps not yet perfect, these processes have to date produced positive results. The Plan intends to continue improving these processes with the goal of continued overall performance improvement.*

*In 2009, the Plan began a project to replace all California claims processing platforms. The current age of its claims systems generally limits the ability to improve auto adjudication, to most efficiently process newer products such as deductible HMO and POS plans, and to keep pace with regulatory changes such as 5010 and ICD-10.*

*The California Claims and Encounter Strategy (CCES) project is implementing a Dell Xcelys claims platform for the California regions. The implementation will replace the existing end-of-cycle Legacy claims systems and bring contemporary technology to the Plan's claims and encounter processing, products, pricing and customer service. The project cost is \$230 million. Planning and preparation stages are well under way and implementation is scheduled to begin by 2013. TPMG claim processing will also use the Xcelys platform.*

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

## **SECTION II. NON-ROUTINE EXAMINATION**

The Plan is advised that the Department may conduct a non-routine examination, in accordance with Rule 1300.82.1, 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 for this Section.**