



Edmund G. Brown Jr., Governor  
State of California  
Health and Human Services Agency

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April 29, 2013

via USPS Delivery and eFile

George Halvorson, Chairman of the Board and Chief Executive Officer  
**KAISER FOUNDATION HEALTH PLAN, INC.**  
One Kaiser Plaza  
Oakland, CA 94612

**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 the claims settlement practice and dispute resolution mechanism of Kaiser Foundation Health Plan, Inc. (the "Plan") for the three month period ending December 31, 2011. The examination was conducted by the Department of Managed Health Care (the "Department"), pursuant to Section 1382(a) of the Knox-Keene Health Care Service Plan Act of 1975.<sup>1</sup> The Department issued a Preliminary Report to the Plan on December 18, 2012. The Department accepted the Plan's electronically filed response on February 1, 2013, and the three monthly status update reports on March 1, 2013, April 1, 2013 and April 18, 2013 (collectively referred to as "Plan's Responses").

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 from the date of the Plan's receipt of this letter whether the Plan requests the Department to append its responses to the Final Report. If so, please indicate

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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, as codified in the 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 Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

which portions of the Plan's Responses shall be appended, and electronically file copies of those portions of the Plan's Responses excluding information held confidential pursuant to Section 1382(c). If the Plan requests the Department to append a brief statement summarizing the Plan's Responses to the report or wishes to modify any information provided to the Department in its responses, please provide the electronically 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 Corrective Action Plan system ("CAP system") within the Online Forms Section of the Department's eFiling web portal <https://wps0.dmhc.ca.gov/secure/login/>, as follows:

- From the main menu, select "eFiling".
- From the eFiling (Home) menu, select "Online Forms".
- From the Existing Online Forms menu click on the "Details" for the DFO Corrective Action Plan **L12-R-055**.
- Go to the "Messages" tab
  - Select "Addendum to Final Report" (**note this option will only be available for 10 days after the Final Report has been issued**)
  - Select the deficiency(ies) that are applicable
  - Create a message for the Department
  - Attach and Upload all documents with the name "Addendum to Final Report"
  - Click "Send Message"

As noted in the attached Final Report, the Plan's Responses did not fully respond to the deficiencies raised in the Preliminary Report issued by the Department on December 18, 2012. 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 CAP system within the Online Forms Section of the Department's eFiling web portal <https://wps0.dmhc.ca.gov/secure/login/>, as follows:

- From the main menu, select "eFiling".
- From the eFiling (Home) menu, select "Online Forms".
- From the Existing Online Forms menu click on the "Details" for the DFO Corrective Action Plan **L12-R-055**.
- Go to the "Data Requests" tab
  - Click on the "Details" for each data request that does not have a status of "Complete"
  - Follow the Instructions and/or use the form shown to add the requested data (depending on the type of data requested: New Filing, Document Request, Claims Data, or Financial Statement refile)

The Department will also send the Plan an e-mail(s) requesting those items that are still outstanding. The e-mail(s) will contain a link to the CAP system for the Plan to file the response electronically.

Questions or problems related to the electronic transmission of the above responses should be directed to Ted Zimmerman at (916) 255-2429 or email at [tzimmerman@dmhc.ca.gov](mailto:tzimmerman@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 through the eFiling system. The report will be located at the Department's web site at [View Department Issued Final Examination Reports](#).**

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

Sincerely,

**ORIGINAL SIGNED BY**

JOAN LARSEN  
Supervising Examiner  
Office of Financial Review  
Division of Financial Oversight

cc: Deborah Espinal, Executive Director of Policy, Kaiser Foundation Health Plan, Inc.  
Suzanne Goodwin-Stenberg, Chief, Division of Financial Oversight  
Sang Le, Senior Examiner (Supervisor), Division of Financial Oversight  
Elizabeth Spring, Senior Counsel, Office of Plan Licensing  
Nancy Wong, Assistant Chief Counsel, Division of Plan Surveys  
Ned Gennaoui, Senior Examiner, Division of Financial Oversight

**STATE OF CALIFORNIA  
DEPARTMENT OF MANAGED HEALTH CARE**

**DIVISION OF FINANCIAL OVERSIGHT**

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

**FILE NO. 933 0055**

**DATE OF FINAL REPORT: APRIL 29, 2013**

**SUPERVISING EXAMINER: JOAN LARSEN**

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

**FINANCIAL EXAMINERS:**

**FRANCISCO GARCIA**

**HUGO LOPEZ**

**SUSAN MILLER**

**SUHAG PATEL**

## **BACKGROUND INFORMATION FOR KAISER FOUNDATION HEALTH PLAN, INC.**

Date Plan Licensed:	November 4, 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:	6,938,003 as of December 31, 2011
Service Area:	Major counties within California
Date of last Final Routine Examination Report:	March 16, 2011
Date of last Final Non-Routine Examination Report:	April 30, 2010

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

This is the Final Report of the routine examination of the claims settlement practice and dispute resolution mechanism of Kaiser Foundation Health Plan, Inc. (the “Plan”) for the three month period ending December 31, 2011. The examination was conducted by the Department of Managed Health Care (the “Department”), pursuant to Section 1382(a) of the Knox-Keene Health Care Service Plan Act of 1975.<sup>1</sup> The Department issued a Preliminary Report to the Plan on December 18, 2012. The Department accepted the Plan’s electronically filed response on February 1, 2013, and the three monthly status update reports on March 1, 2013, April 1, 2013 and April 18, 2013 (collectively referred to as “Plan’s Responses”).

This Final Report includes a description of the compliance efforts included in the Plan’s Responses to the Preliminary Report, in accordance with Section 1382(c). The Plan’s Responses are noted in *italics*.

Our findings are presented in this report as follows:

Section I.	Compliance Issues
Section II.	Nonroutine Examination

***Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any requests for additional corrective action contained within 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, as codified in the 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 Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

**SECTION I. COMPLIANCE ISSUES**

**A. 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 table for the three month period October 1, 2011 to December 31, 2011:

Deficiency	Type of Referral Claims	Total Referral Claims in the Sample Population	Total Referral Claims in the Sample	Number of Deficiencies Found	% of Compliance
Failure to reimburse referral claims accurately, including paying interest and penalty.	Late	1,961	100	9	91%
Failure to provide written denial. <i>Repeat Deficiency</i>	Denied	109	64	12	81%

The following details the unfair payment practices and other claim settlement deficiencies found during our examination:

**1. PAYMENT ACCURACY OF CLAIMS**

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 Rules 1300.71 (i) and (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.

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.

### **The Permanente Medical Group - Referrals<sup>2</sup>**

The Department's examination found that nine (9) out of the 100 late paid referral claims reviewed had interest that was underpaid or not paid (a compliance rate of 91 percent). The incorrect payment of interest was the result of:

- a. 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 paid referral claims. This deficiency was noted in late paid referral claim sample numbers 54, 59 and 99. For sample number 59, the Plan used the date of receipt by the Northern California Region rather than the date of receipt by the Southern California Region when the claim was first received by the Plan.
- b. Processor errors resulted in referral claim underpayment for services and, as a result, the underpayment of interest. This deficiency was noted in late paid referral claim sample numbers 7, 63, 69, 86 and 88.
- c. Processor error of not correctly identifying an emergency claim. This deficiency was noted in late paid referral claim sample number 111.

### **This violation was referred to the Office of Enforcement for appropriate administrative action.**

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

- a. Training procedures to ensure that claim processors had been properly trained to prevent the recurrence of the claim underpayment issues noted during this examination, including the

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<sup>2</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.

selection of the date of receipt of a complete claim to ensure the accurate calculation of interest and penalty on late referral claim payments.

- b. Audit procedures implemented by the Plan to monitor correct payment of claims and interest and penalties on late and late adjusted referral claim payments.
- c. Identification of all late referral claims for which interest and penalties were not correctly paid from March 31, 2011 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 of receipt of new information
  - Date of receipt for complete claim
  - Total billed
  - Total paid
  - Paid date (mail date)
  - Amount of original interest paid
  - Date interest paid
  - Penalty amount originally paid
  - Number of late days used to calculate interest (with formula)
  - Total interest owed per claim (with formula)
  - Amount of additional interest paid in remediation (Total interest owed minus previous interest paid)
  - Penalty amount paid
  - Date additional interest and penalty paid, if applicable
  - Check number for additional interest and penalty paid amount
  - Provider name

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

- e. Revised policies and procedures implemented to ensure that the date of receipt of a complete referral claim was used to determine interest and penalty, if applicable, in compliance with the above Sections 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 the preliminary report, the Plan was required to submit a timeline that committed the Plan to completion of the CAP within 180 calendar days from the receipt of the preliminary report. If the Plan was not able to meet this timeframe, then 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. Training

*Claims processors were given training on using the correct receipt date on March 8, 2012, July 3, 2012 and October 17, 2012. This training occurred prior to a system enhancement to ensure that processors would manually delete/correct/remove the alternate receipt dates until the system itself was capable of assuring that the correct receipt date is captured.*

*On October 29, 2012, TPMG implemented an iFile system enhancement. As a result of this action, additional training is no longer required as iFile now retains the original receipt date of the claim when it is transferred internally to TPMG.*

b. Audit Procedures

*In the quarter ended March 31, 2012, TPMG identified that the alternative receipt date audit implemented on April 25, 2011 did not fully ensure that all claims initially received by California Claims Administration (“CCA”) and subsequently forwarded to TPMG Claims were paid correctly.*

*TPMG enhanced its alternative receipt date audit by modifying the exception report and changing the process from a review of a sample of misdirected claims to a review of 100% of all misdirected claims. The new exception report and audit will ensure that all claims received by CCA and forwarded to TPMG are processed and paid by TPMG claims using the initial CCA receipt date.*

*The new audit and exception report process implemented in the quarter ended June 30, 2012 ensures that an identified underpaid claim on which interest is due is corrected and the payment plus interest/penalty is sent to the impacted provider.*

*When TPMG implemented the new audit and exception report process in quarters ended June 30, 2012 and September 30, 2012, 4 claims were not compliant in quarter ended June 30, 2012 and 2 claims were not compliant in quarter ended September 30, 2012. Interest and penalty were paid to the impacted providers. In quarter ended December 31, 2012, only one claim was found to be not compliant (Note: this claim was processed prior to the October 29, 2012 iFile fix discussed under training above).*

c. Identification of Late Referral Claims

*The Plan identified 435 late referral claims from April 1, 2011 to October 29, 2012, the date of implementation of the corrective action plan, as reviewed for remediation.*

d. Evidence of Interest and Penalty Payment

*The Plan's monthly status update reported on March 1, 2013 that the Plan completed the remediation on late referral claim and remediated a total of 423 claims, resulting in interest and penalty payments of \$16,392.57 and \$4,230.00, respectively.*

e. Revised Policies and Procedures

*TPMG implemented an iFile system enhancement on October 29, 2012. iFile now retains the original receipt date of the claim when it is transferred internally to TPMG. This system change eliminated the need for specific policy and procedure revisions.*

*In addition, TPMG implemented an AOMS claims system enhancement on April 26, 2012 to automatically calculate late interest payments due for TPMG AOMS emergency claims, again obviating the need for a specific policy and procedure.*

f. Implementation Date: October 29, 2012

Management Oversight and Monitoring System

*As noted, TPMG implemented an iFile system enhancement on October 29, 2012, eliminating the need for specific policy and procedure revisions. The TPMG Claims Director and TPMG Claims Oversight Committee will be accountable for overseeing the CAP.*

**The Department finds that the Plan's compliance efforts are responsive to the deficiencies cited and corrective actions required. No further response required.**

## **2. WRITTEN DENIAL OF REFERRAL CLAIMS - REPEAT DEFICIENCY**

Section 1371 and Rule 1300.71 (h) require a health care service plan to contest or deny claims no later than 45 working days after the date of receipt of the claim by the plan.

Rule 1300.71(a)(8)(L) describes one unfair payment pattern as the failure to contest or deny a claim within the timeframes of Rule 1300.71(h) and Section 1371 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 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.

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

The Department's examination of denied referral claims disclosed that the Plan did not contest or deny claims within 45 working days of the date of receipt by failing to send a written denial letter to claimants informing them of the specific reasons for the denial. The Plan did not issue a denial letter on 12 out of the 64 denied referral claims reviewed (a compliance rate of 81 percent). Therefore, the Plan demonstrated an unfair payment pattern according to Rule 1300.71(a)(8)(L). This deficiency was noted in denied referral claim sample numbers 3, 13, 15, 16, 26, 44, 51, 54, 60, 63, 65 and 68.

The Plan's failure to provide written denials is a repeat deficiency, as this issue was previously noted in the Department's Final Report of Examination dated March 16, 2011, for the quarter ended September 30, 2009. This examination disclosed that the Plan's remediation efforts in response to this prior report have not achieved the necessary levels of compliance.

### **This repeat violation was referred to the Office of Enforcement for appropriate administrative action.**

The Plan was required to explain why the corrective actions implemented by the Plan to resolve the deficiency of not sending written denials of referral claims, found in the Department's prior examination, were not effective in ensuring ongoing compliance.

The Plan was required to submit a policy and procedures for ensuring that claimants are notified in writing of referral claim denials with specific reasons for the denials, pursuant to the above Sections and Rules. In addition, the Plan was required to indicate the date of implementation, the management position(s) responsible for compliance, and the controls implemented for monitoring continued compliance.

*The Plan responded as follows:*

#### *a. Corrective Action History*

*The 2010 corrective action plan partially resolved this deficiency. TPMG met the 95% threshold for denying claims correctly and using correct denial reason codes. However, we discovered that the process to monitor letter production was not successfully implemented and quarterly audit frequency did not adequately identify issues for prompt correction.*

*Because the process of denying a claim and sending a denial letter in the AOMS claims adjudication system requires significant manual processing, TPMG created new "Adverse Benefit Determination Denial Policy"; increased the frequency of denial audits (from quarterly to monthly); and initiated a daily "missing denial letters notification report".*

b. Policy and Procedure

*On May 4, 2012, a new “Adverse Benefit Determination Denial Policy” was created and implemented quarter ended June 30, 2012. A copy of this policy was attached to the Plan’s response.*

c. Implementation Date: Quarter ended June 30, 2012

Management Oversight and Monitoring

*On July 20, 2012, a new daily “missing denial letters notification” report was implemented. As a result of the new report, if a claims processor omits the creation of a denial letter after denying a claim, the claims processor and his/her supervisor/manager will receive an email the next day with a reminder to create/send the missing denial letter to the claimant.*

*Internal denial audits have been enhanced by increasing their frequency from quarterly to monthly and improving the feedback loop by providing the results directly to the managers and claims processors. The Plan attached to its response a copy of the Monitoring and Auditing of Denied Claims Workflow.*

*The management position responsible for compliance is the TPMG Claims Director.*

**The Department finds that the Plan’s compliance efforts are responsive to the deficiencies cited and corrective actions required. No further response required.**

**B. OTHER CLAIMS SETTLEMENT ISSUES**

The following are other claims settlement issues identified during the Department’s examination:

**1. REIMBURSEMENT OF CLAIMS**

Section 1371 requires a health care service plan to reimburse uncontested claims, by delivery to the claimants' address of record, 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 without requiring the claimant to submit a request for the interest amount.

Rule 1300.71(g) requires a health care service plan to reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than 45 working days after the date of receipt of the complete claim by the plan.

Section 1371 and Rules 1300.71 (i) and (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.

## A. Retro-Active Enrollment

### The Permanente Medical Group - Referrals

The Department's examination disclosed that the Plan failed to reprocess previously denied claims for dialysis treatment for members with retroactive reinstatement of enrollment. These claims were correctly denied due to member's ineligibility when they were originally submitted. However, the Plan should automatically sweep denied claims and reprocess them based on retroactive enrollment updates. Instead, the Plan waited for the provider to resubmit the claim before it reprocessed the claim based on the new eligibility information. Examples included denied referral claim sample numbers 2, 12, 20, 49 and 52.

The Plan was required to submit a CAP that includes the following:

1. Identification of all claims for dialysis treatment denied due to member ineligibility during the period of October 1, 2009 through the date corrective action had been implemented by the Plan for members with retroactively reinstated eligibility.
2. Evidence that these claims were reprocessed (paid or denied) and that interest was paid retroactively to the first calendar day after 45 working days from the date of receipt by the Plan of the member retroactive enrollment date. This evidence was 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 denied due to ineligibility
  - Enrollment date
  - Date of receipt of retroactive enrollment notice (Date of receipt of a complete claim)
  - Total billed
  - Total paid
  - Paid date (mail date)
  - Number of late days used to calculate interest (with formula)
  - Amount of interest paid
  - Date interest paid
  - Check number for claim payment and interest
  - Provider name

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

3. Implementing a policy and procedures to ensure the reprocessing of previously denied claims for dialysis treatment for members that were retroactively added to membership.

4. The date these policy 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 the preliminary report, the Plan was required to submit a timeline that committed the Plan to completion of the CAP within 180 calendar days from the receipt of the preliminary report. If the Plan was not able to meet this timeframe, then 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. *Identification of Claims for Dialysis Treatment Denied Due to Member Ineligibility*

*TPMG identified 125 dialysis claims denied due to member ineligibility during the period of October 1, 2009 through January 15, 2013 as reviewed for remediation.*

b. *Evidence of Claims Reprocessed and Interest Paid*

*The Plan's monthly status update reported on April 1, 2013 that it completed the remediation on referral claims relating to retroactive reinstatement of enrollment. The Plan remediated a total of 19 claims, resulting in additional payments, interest and penalty payments of \$21,332.10, \$3914.63 and \$30.00, respectively*

c. *Policy and Procedure*

*The "Adverse Benefit Determination (ABD) Denial Policy" was revised to explain that claims for service(s) authorized by the Plan must be processed for payment of the service(s) unless the provider was notified that the authorization was rescinded prior to the external provider rendering the services. Since these claims will be paid initially and not be denied for membership status on the date of service, reprocessing will not be needed.*

d. *Management Oversight and Monitoring System*

*The Plan implemented the revised "Adverse Benefit Determination (ABD) Denial Policy" on June 15, 2012, and distributed it to the claims processors. Retro-enrollment denials are included in the new denial audit process.*

*The TPMG Claims Director and Health Plan/TPMG Claims Oversight Committee will be accountable for overseeing the CAP.*

**The Department finds that the Plan's compliance efforts are responsive to the deficiencies cited and corrective actions required. No further response required.**

## B. Subscriber Claims

### Northern California Region

The Department's examination disclosed that the Plan did not pay interest on claim reimbursements to subscribers that were paid beyond 45 working days from the receipt date. This practice applied to the Northern California Region. Sections 1371 and 1371.35 requires interest to be paid on all late claim payments to the claimant, which includes subscribers as well as providers. This deficiency was noted with Northern California Region paid claim sample number 18.

The Plan was required to submit a CAP that included the following:

1. Policies and procedures implemented to ensure that payments of late claims to subscribers included interest and penalty, if applicable, in compliance with the above Sections and Rules.
2. Date the 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.

*The Plan responded as follows:*

#### *a. Policies and Procedures*

*Southern California (SCal) Claims Administration has historically applied interest on untimely claim reimbursements to subscribers paid beyond 45 working days from the date of receipt.*

*The Northern California (NCal) Claims Administration past inconsistent application of interest on untimely subscriber reimbursements resulted from the fact that their regional "Interest User Guide" was silent regarding this possibility. The Southern California "Interest User Guide" has now been adopted statewide to ensure consistent application of interest in all circumstances. A copy of the guide was filed with the Plan's response.*

*The daily interest control report was expanded to include subscriber payment claims paid beyond the 45 working days from date of receipt.*

#### *b. Implementation Date: January 2013*

##### *Management Oversight and Monitoring System*

*As noted above, this process is not new. However, California Claims Administration in Northern California changed its written "Interest Processing Statewide Guide" to reflect this process as of January 2013. The management positions responsible for compliance are the Statewide Claims Director and the Statewide Compliance Director.*

Description of monitoring process:

- *Audit results from the Daily Interest Control Report 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.*
- *A component of this audit is to validate that appropriate interest and penalty is applied and paid accurately on all affected claims.*
- *A daily interest control report has been in place since 2009 in SCAL. An earlier version of the current interest report was implemented in NCAL in 2009 and revised to align with the SCAL report in 2010.*

Training:

*All claims processors will attend refresher training on the application of interest for subscriber claims paid beyond 45 working days from the date of receipt. The target date for this training was February 15, 2013.*

**The Department finds that the Plan's compliance efforts are responsive to the deficiencies cited and corrective actions required. No further response required.**

## **2. 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 the provider remittance advice for seven (7) of the 100 late paid referral claims requested for review. These seven (7) provider remittance advices relate to one provider for referral claims paid during the month ended October 31, 2011. The missing provider remittance advices were noted in late paid referral claim sample numbers 6, 69, 97, 113, 126, 129 and 134.

The Plan was required to provide an explanation for the missing provider remittance advices. In addition, the Plan was requested to submit the policy and procedures implemented to ensure that a copy of provider remittance advices was maintained in compliance with Section 1385 and Rule 1300.85.1, the date of implementation of the policy and procedures, and the management position(s) responsible for ensuring continued compliance.

*The Plan responded as follows:*

a. Corrective Action History

*Nightly, the AOMS claims system sends an AP forward file to the OneLink (Accounts Payable system or AP) for claims payments. After OneLink makes the payments it sends an AP reverse file back to AOMS with the details of the payment. The AP reverse file data is posted into AOMS and triggers the creation of the provider remittance advices.*

*In quarter ended March 31, 2012, TPMG identified an OneLink AP system issue which apparently began in January 2011. The AP reverse files were not consistently received or were incomplete, which resulted in remittance advices not being consistently created and sent to providers.*

*On May 23, 2012, the Plan implemented an OneLink system fix to ensure that complete AP reverse files are received nightly and posted into the AOMS claims system. The AP production support team now closely monitors the AP reverse files and reprocesses the files the same night in the event a failure occurs.*

b. Policy and Procedures

*The TPMG “Business Records Retention Policy” addresses retention of provider remittance advices and was recently updated on January 9, 2013 and is pending final approval. A copy of the draft Business Records Retention Policy was filed with the Plan’s response.*

*The management position responsible for compliance is the TPMG Claims Director.*

**The Department acknowledges that the Plan’s compliance efforts are responsive to the deficiencies cited and the corrective actions required. However, the TPMG “Business Record Retention Policy” is not final. The Plan is required to submit this final Policy and Procedure to the Department in response to this report.**

### **3. Prematurely Closing Claims**

The Department’s examination noted that the Plan contested claims timely, and in writing, in compliance with Sections 1371 and 1371.35. However, when additional information was needed, the Plan’s contest letter stated, “...In order to make an informed decision regarding this claim we need additional information...If we [Plan] do not receive the necessary information within 45 working days from the date of this letter, we [Plan] will pay or deny the claim based solely on the information we already have...”.

#### **Southern and Northern California Regions**

The Department’s examination found that the Plan made a decision on the contested claims prior to the expiration of the grace period of 45 working days allowed in the contest letter for several of the claims reviewed in the Southern and Northern California Regions. Examples of this

deficiency were Southern California Region denial claim sample numbers 13 and 23 and Northern California Region denial claim sample numbers 30 and 38.

The Plan was required to submit a copy of the implemented policy and procedures to ensure compliance with the time extension as instructed in its contest letter prior to making a decision on contested claims. The Plan was also required to indicate the date of implementation, and the management position(s) responsible for continued compliance with the implemented policy and procedures.

*The Plan responded as follows:*

a. Policy and Procedures

*Statewide, the Plan will modify its practice to ensure that the 45 calendar days in its information request letter is respected and that a claim is not closed before the 46th calendar day after the request. If the provider does not respond, the Plan will adjudicate the claim based on the information the Plan has in its possession and finalize the claim after the 50th calendar day. The decision rationale may include the fact that the necessary information was not received.*

*California Claims Administration will implement this practice statewide by May 17, 2013. This date is necessitated by certain limitations in associated systems and processes.*

*The Plan's additional actions to address this specific recommendation include the following:*

- *Revised policy (Request for Information Letter Process Policy) for closing contested claims, where requested information is not received, was submitted in the Plan's April 18, 2013 response.*
- *Training/in-service for processors and for all auditors to be completed and documented by May 16, 2013.*
- *Revising inventory management reporting specific to suspended claims are on track to be completed by April 26, 2013 and implemented by May 1, 2013.*
- *Revised letter for Request for Information to be consistent in the Northern and Southern California regions was completed and submitted in the Plan's April 18, 2013 response.*

b. Implementation Date: *California Claims Administration will implement the modified practice statewide by May 17, 2013.*

Management Oversight and Monitoring System:

*The management positions responsible for compliance are the Statewide Claims Director and the Statewide Compliance Director.*

Description of monitoring process:

*This process change will be monitored through the monthly Quality Audits and monthly Compliance Performance Audits by validating that requested information was not received and determining whether the claim was closed prematurely in error. When a claim is*

*identified as closed prematurely, the auditor assigns an error. The auditors direct the claim to Operations to be re-adjudicated if the requested information was received.*

**The Department finds that the Plan's compliance efforts are responsive to the deficiencies cited and corrective actions required. No further response required.**

### **C. PROVIDER DISPUTE RESOLUTION ISSUE**

The following detailed the provider dispute resolution issue found during the Department's examination for the three-month period October 1, 2011 to December 31, 2011:

#### **MISDIRECTED PROVIDER DISPUTES – Repeat Issue**

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

The Department's examination found that the Plan failed to forward misdirected provider disputes regarding referral claims to TPMG, the appropriate entity responsible for reviewing, within ten (10) working days of receipt. The Plan was responsible for resolving these disputes timely. Provider disputes relating to referral claims should be processed in a timely manner by TPMG, without unnecessary delays by the Plan. The Plan did not forward 20 out of 50 provider disputes reviewed. Examples included referral provider dispute sample numbers 1, 13, 21, 33 and 48.

The Plan's failure to forward misdirected provider disputes relating to referral claims was a repeat deficiency, as this issue was previously noted in the Department's Final Report of Examination dated March 16, 2011, for the quarter ended September 30, 2009. This examination disclosed that the Plan's remediation efforts in response to this prior report had not achieved the necessary levels of compliance.

The Plan was required to explain why the corrective actions implemented by the Plan to resolve the deficiency of not timely forwarding misdirected provider disputes pertaining to referral claims, found in the Department's prior examination, were not effective in ensuring ongoing compliance.

The Plan was required to submit the policy and procedures implemented to monitor on, at least, a quarterly basis the timeliness of forwarding misdirected provider disputes regarding referral claims, and develop corrective actions where compliance falls below 95 percent of all misdirected provider disputes relating to referral claims. The Plan was also required to provide the date of implementation and the management position(s) responsible for timely forwarding of misdirected provider disputes regarding referral claims.

*The Plan responded as follows:*

*TPMG has been assured that California Claims Administration's (CCA) planned process improvements will ensure timely forwarding of misdirected provider disputes.*

a. Corrective Action History

*The Plan implemented a control process for this issue in January 2011 to address the Department's finding during the 2010 Claims survey. Although the process as developed appeared initially to adequately deal with this issue, subsequent review identified gaps in the reporting that allowed certain aspects of the process to be insufficiently monitored and, accordingly, failed to completely identify lapses in prompt forwarding.*

*As a result, the control process was revised in February 2012 to enhance its scope and accuracy. Since the revised control was not implemented until February 2012, the audit universe for the current survey did not reflect the work done to refine and improve this process.*

*TPMG will continue to explore additional monitoring options to ensure ongoing compliance.*

b. Policy and Procedures

*The Plan's April 1, 2013 response included a policy, desktop procedure, and implementation plan for the following enhanced monitoring process:*

- Monthly reports of all misdirected provider disputes will be reviewed validating the process and ensuring misdirected provider disputes are redirected within 10 working days from original date of receipt.*
- Log to record all misdirected provider disputes received and forwarded was implemented on January 18, 2013. This log includes: document ID, receipt date, forward date, and forwarded addressee.*
- Process will be documented and reviewed with all Provider Dispute staff.*

c. Implementation Date: April 1, 2013

*Management Oversight and Monitoring: The management positions responsible for compliance are the Statewide Claims Director, the Statewide Compliance Director, and the TPMG Director of Claims.*

**The Department finds that the Plan's compliance efforts are responsive to the deficiencies cited and corrective actions required. No further response required.**

**SECTION II. NONROUTINE EXAMINATION**

The Plan was 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 would be charged to the Plan in accordance with Section 1382 (b).

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