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April 26, 2004

IN REPLY REFER TO:
FILE NO: 933 0055
USPS Priority Mail

FINAL REPORT

George Charles Halvorson, Chairman and CEO
KAISER FOUNDATION HEALTH PLAN, INC.
One Kaiser Plaza
Oakland, CA 94612

RE: ROUTINE EXAMINATION OF KAISER FOUNDATION HEALTH PLAN, INC.

Dear Mr. Halvorson:

Enclosed is the Final Report of a limited scope routine examination of the fiscal and administrative affairs of Kaiser Foundation Health Plan, Inc. (the "Plan") for the period ending March 31, 2003, conducted on behalf of the Department of Managed Health Care (the "Department") by Macias, Gini & Company, LLP and Macias Consulting Group, Inc. ("Macias") pursuant to Section 1382¹ of the Knox-Keene Health Care Service Plan Act of 1975 ("Act") and in accordance with generally accepted auditing standards. Macias conducted its examination in two parts: Kaiser Foundation Health Plan, Southern California and Kaiser Foundation Health Plan, Northern California. Two separate reports were prepared by Macias and included in the Department's Preliminary Report issued to the Plan on January 21, 2004. The Department received the Plan's response on March 17, 2004. Please also be aware that the Department conducted a separate limited scope examination of the health plan and its' affiliate, Kaiser Foundation Hospitals. Issues related to that examination are presented in a separate report.

This Final Report includes a description of the compliance efforts included in the Plan's March 17, 2004 response, in accordance with Section 1382(c).

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

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

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

If the Plan requests the Department to append a brief statement summarizing the Plan's response to the report or wishes to modify any information provided to the Department in its March 17, 2004 response, please provide the documentation no later than ten (10) days from the date of the Plan's receipt of this letter.

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

As noted in the attached Final Report, the Plan's March 17, 2004 response did not fully respond to the deficiencies raised in the Preliminary Report issued by the Department on January 21, 2004. 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 presented 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 send a hardcopy of your response directly to the undersigned. In addition, please file the Plan's response electronically, just as you do for regular licensing filings via the Department's web portal <<http://wp.dmhc.ca.gov/efile>> under Report/Other, subfolder RUXAM and barcode RX004. Do not file an Execution Page or Exhibit E-1 (Summary of Filing). Please note this process is separate from the electronic financial reporting and is for the response to this report only. Questions or problems related to the electronic transmission of the response should be directed to Angie Rodriguez at (916) 324-9048 or email at arodriguez@dmhc.ca.gov or Ed Cheever at (916) 324-8738 or email at echeever@dmhc.ca.gov. You may also email inquiries to helpfile@dmhc.ca.gov.

The Executive Summary to the Department's most recent Medical Survey Report is located at the Department's web site at www.dmhc.ca.gov.

If there are any questions regarding this report, please call.

Sincerely,

Mark Wright
Chief
Division of Financial Oversight
(916) 324-9026

Cc: Martha Sikkens, Director Regulatory Compliance, Kaiser Foundation Health Plan, Inc
Maria Borje-Bonkowski, Director Health Plan Licensing, Kaiser Foundation Health Plan, Inc.

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Patricia Mazzeo, Examiner, DMHC Division of Financial Oversight
Melissa Moon, Counsel, DMHC Division of Licensing



Macias Consulting Group, Inc.
Management Consultants

CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE

REPORT OF ROUTINE EXAMINATION
-ACCRUED CLAIMS LIABILITY
-TIME FOR REIMBURSEMENT OF CLAIMS
-CLAIMS ACCURACY
-EMERGENCY SERVICES AND CARE

KAISER FOUNDATION HEALTH PLAN, SOUTHERN CALIFORNIA

Period Work Performed: July 1 through November 14, 2003

FILE NO: 933-0055

DATE OF FINAL REPORT: April 26, 2004

PERFORMED BY:

MACIAS, GINI & COMPANY, LLP
MACIAS CONSULTING GROUP, INC.

KAISER FOUNDATION HEALTH PLAN, SOUTHERN CALIFORNIA

Routine Examination Report

April 2004

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BACKGROUND INFORMATION ON KAISER FOUNDATION HEALTH PLAN

- Year Plan Licensed:** October 27, 1977
- Organizational Structure:** A nonprofit and charitable California corporation, the Kaiser Foundation Health Plan is a Knox-Keene licensed full-service health plan HCSP ID 94-1230523. In Southern California, the Kaiser Foundation Health Plan enrolls members and contracts with the Southern California Permanente Medical Group (SCPMG) to provide medical and health care services to Health Plan members. SCPMG takes direct responsibility for organizing and providing care to the Plan's members.
- Type of Plan:** Kaiser Foundation Health Plan is a full-service health care plan.
- Provider Network:** Services are provided through a network of associated hospitals, medical offices, pharmacies, and laboratories. When necessary, they also contract with non-Kaiser Permanente providers for certain services.
- Plan Enrollment:** A total of 6,581,124 enrollees were reported as of 3/31/03 for the entire Plan.
- Claims Processing Location:** Kaiser Foundation Health Plan
393 East Walnut Street
Pasadena, CA 91188
- Process for Other Entities:** No

SECTION I: SCOPE OF EXAMINATION

A. ROUTINE EXAMINATION OBJECTIVES

The California Department of Managed Health contracted with Macias Consulting Group to conduct a routine examination of the fiscal and administrative affairs of Kaiser Foundation Health Plan, Southern California.

The scope of the review was limited to the fiscal and administrative affairs of Kaiser Foundation Health Plan, as related to Southern California operations, which incorporates claims from the following categories:

- Out of Plan Emergency Claims – Processed by the California Claims Administration (CCA) in the Outside Claims Processing System (OCPS);
- Ambulance Claims – Processed by a third party administrator (TPA) covered by an Administrative Service Agreement (ASA) as of Nov. 2002; and
- Durable Medical Equipment (DME) – Processed by the Kaiser accounts payable system and OCPS.

Our specific objectives were to determine:

- A. Adequacy of estimating liability for claim reimbursement under Rule 1300.77.1 and 1300.77.2 of Title 28 of the California Code of Regulations;
- B. Adequacy of claims reimbursement under Sections 1371 and 1371.35 of the Knox-Keene Health Act; and
- C. Adequacy of access to emergency services and care under Section 1371.4 of the Knox-Keene Health Act.

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.

SECTION II: REGULATORY CALCULATIONS

A. ADEQUACY OF ESTIMATING LIABILITY FOR CLAIMS REIMBURSEMENTS

We determined that the Plan is in compliance with requirements of Rule 1300.77.1 and 1300.77.2 when all claims categories are considered in their entirety for the health plan.

Summary of Issue

The Plan uses an adequate method for calculating incurred but not reported (IBNR) reserve amounts. We determined that the plan uses a hybrid approach for determining IBNR, incorporating both a development method (paid claims lag patterns) and projection method (per member per month averages). IBNR calculations for the Southern California region classify

claims into the following categories. Lag studies are then developed for each of the individual categories.

- Commercial Inpatient, In Area
- Commercial, Inpatient, Out of Area
- Commercial, Outpatient, In Area
- Commercial, Outpatient, Out of Area
- Cost, Inpatient
- Cost, Outpatient
- Risk, Inpatient, In Area
- Risk, Inpatient, Out of Area
- Risk, Outpatient, In Area
- Risk, Outpatient, Out of Area
- South Bulk Claims
- South DME Claims
- Ambulance, TPA (Third Party Administrator) Non-Scheduled
- Ambulance, TPA Scheduled
- South Ambulance OCPS Referral
- South Ambulance, other

To verify the Plan's liability reserves as of 03/31/03 were adequate, we calculated the claims to be paid for those incurred prior to 03/31/03 based upon completion factors on 07/31/03 and compared the total claims to be paid to the actual paid claims run out through 07/31/03. This was done for all claim categories. The paid amounts were subsequently compared to the organization's general ledger amounts.

Our calculations show that for 12 health plan claim categories, the plan overestimated the total liabilities for claims by approximately 26 percent. However, for four ambulance categories – Ambulance TPA Scheduled, Ambulance TPA Non-Scheduled, South Ambulance OCPS Referral, and South Ambulance – we could not verify Kaiser South reserve estimates because Kaiser could not provide information that showed the specific reserve amounts for each of these types of claims. As a result, we could not fully verify the reserve amounts reported on the 3/31/03 Orange Blank report submitted by Kaiser to the DMHC.

Nevertheless, we examined historic paid ambulance expenses for all ambulance claim categories and find that the planned reserve is based upon a per member per month (PMPM) rate of approximately \$3.41 for 2003. We estimate this to be reasonable based upon the historic PMPM of between \$2.38 and \$3.52.

Table 1.0 shows the calculated IBNR amounts for the claims categories compared to the amounts booked to the 3/31/03 Orange Blank report.

Table 1.0. Southern California Kaiser Health Plan IBNR by Claims Category

Health Plan Claims Category	Estimated Claims to be Paid as of 7/31/03 for Claims Incurred Before 3/31/03	Claims Paid from 4/1/2003 to 7/31/2003, for Claims Incurred before 3/31/03	Total IBNR Estimate at 7/31/03 for Claims Incurred before 3/31/03	Over or Under Estimate on 3/31/03 Orange Blank	Amount Booked by Kaiser on 3/31/03 Orange Blank, Column 3	Amount Booked by Kaiser on 3/31/03 Orange Blank, Column 2
Commercial, InPatient, In Area	\$ 15,448,347	\$ 30,831,024	\$ 46,279,372	Over	\$ 55,378,615	\$ 50,200,984
Commercial, InPatient, Out of Area	\$ 3,009,428	\$ 5,788,336	\$ 8,797,764	Over	\$ 11,708,493	\$ 10,613,806
Commercial, OutPatient, In Area	\$ 6,679,223	\$ 16,475,298	\$ 23,154,520	Over	\$ 28,465,840	\$ 25,804,423
Commercial, OutPatient, Out of Area	\$ 1,273,170	\$ 2,727,521	\$ 4,000,691	Over	\$ 6,143,640	\$ 5,569,240
Cost, InPatient	\$ 138,407	\$ 273,791	\$ 412,198	Over	\$ 438,042	\$ 397,087
Cost, OutPatient	\$ 80,435	\$ 188,116	\$ 268,551	Over	\$ 428,265	\$ 388,224
Risk, InPatient, In Area	\$ 3,499,183	\$ 7,030,661	\$ 10,529,844	Over	\$ 14,369,264	\$ 13,025,808
Risk, InPatient, Out of Area	\$ 671,338	\$ 1,858,891	\$ 2,530,229	Over	\$ 4,430,388	\$ 4,016,168
Risk, OutPatient, In Area	\$ 1,022,573	\$ 2,792,696	\$ 3,815,269	Over	\$ 4,843,638	\$ 4,390,781
Risk, OutPatient, Out of Area	\$ 138,608	\$ 253,659	\$ 392,267	Over	\$ 826,553	\$ 749,274
South Bulk	\$ 127	\$ 254,805	\$ 254,932	Over	\$ 291,042	\$ 263,831
South DME	\$ 331,304	\$ 1,603,233	\$ 1,934,537	Under	\$ 1,712,145	\$ 1,552,068
Ambulance TPA Non-Scheduled*					\$ 24,163,787	\$ 21,904,591
Ambulance TPA Scheduled	\$ 554,780	\$ 1,733,062	\$ 2,287,841	Over	\$ 3,323,235	\$ 3,012,529
South Ambulance	\$ 2,412,264	\$ 2,420,408	\$ 4,832,671		Amount Unavailable	Amount Unavailable
South Ambulance OCPS Referral	\$ 229,925	\$ 781,498	\$ 1,011,423		Amount Unavailable	Amount Unavailable

* Developmental lag not possible due to immaturity of historic paid claims information

SECTION III: COMPLIANCE ISSUES

B. ADEQUACY OF CLAIMS REIMBURSEMENT

Payment of Interest and Late Fees

Sections 1371 and 1371.35 state that if an uncontested claim is not reimbursed within the forty-five (45) working day period, the Plan shall pay the greater of fifteen dollars (\$15) per year (non-prorated) or interest at the rate of 15 percent per annum beginning with the first calendar day after the appropriate working day period. A health care service plan shall automatically include the fifteen dollars (\$15) per year or interest due in the payment made to the claimant, without requiring a request.

In order to determine if the Plan was compliant with interest or late fee requirements, we tested samples of claims from the population of emergency room (ER) claims, DME, and ambulance claims. The sample was drawn for the population of claims processed and paid during the period 4/1/01 to 3/31/03 that had TATs over 65 calendar days (approximately 45 working days).

Ambulance claims for the Plan's southern region, prior to November 2002, were processed by the Plan's California Claims Administration (CCA) office within their Outside Claims Processing System (OCPS). After Nov 2002, the TPA processes all 911 and ground ambulance claims. The CCA office still processes air ambulance, wheelchair van, and gurney van transports. As such, we selected samples from both the TPA and from the OCPS system.

Our review found the following issues:

- (1) 9.7 percent of sampled paid ER claims with TATs over 65 calendar days did not owe or pay late fees or interest.**
- (2) 82.1 percent of sampled paid ER claims with TATs over 65 calendar days that did owe interest or late fees were not paid correctly.**

Summary of Issue

From the population of 9,905 paid commercial ER claims with turn-around times (TATs) over 65 calendar days, a random sample of 31 claims was chosen. TATs were determined by taking the difference between the recorded date of receipt of the claim and the recorded payment date of the claim. The sample was tested for the appropriate and correct payment of interest and late fees associated with the untimely payment of claims.

Of the 31 claims tested, three claims were not owed interest because they were claims that contained a pended status by the Plan (with timely notification of members and providers), and five claims showed that interest was paid correctly.

The remaining 23 claims in the sample either did not pay interest or late fees, or did pay interest, but in an amount that was less than the minimum \$15 per annum (non-prorated) as specified in Section 1371.35.

Table 2.0 lists those claims found to have been paid outside the appropriate timeframe wherein the correct interest amount or late fee was not applied.

Table 2.0: Sampled Claims with Interest or Late Fee Errors

Claim Number	Interest / Late Fee Paid	Interest / Late Fee Owed	Comment
002311874	\$0.00	\$33.93	Claim needed interest payment of \$33.93.
002342971	\$6.29	\$15.00	Should pay minimum late fee of \$15.
002991934	\$0.00	\$15.00	Should pay minimum late fee of \$15.
003323287	\$7.51	\$15.00	Should pay minimum late fee of \$15.
010396582	\$0.00	\$15.00	Should pay minimum late fee of \$15.
010453481	\$0.00	\$15.00	Should pay minimum late fee of \$15.
010881230	\$4.55	\$15.00	Should pay minimum late fee of \$15.
010912124	\$2.14	\$15.00	Should pay minimum late fee of \$15.
010929969	\$5.83	\$15.00	Should pay minimum late fee of \$15.
020111264	\$11.38	\$15.00	Should pay minimum late fee of \$15.
020114912	\$0.00	\$51.88	Claim needed interest payment of \$51.88.
600001389	\$0.00	\$15.00	Should pay minimum late fee of \$15.
X01430317	\$6.03	\$15.00	Should pay minimum late fee of \$15.
X01612155	\$2.60	\$15.00	Should pay minimum late fee of \$15.
X02907653	\$0.00	\$15.00	Should pay minimum late fee of \$15.
X03169080	\$5.20	\$15.00	Should pay minimum late fee of \$15.
X06046065	\$0.31	\$15.00	Should pay minimum late fee of \$15.
010601328	\$0.00	\$15.00	Should pay minimum late fee of \$15.
X01561553	\$0.00	\$15.00	Should pay minimum late fee of \$15.
020002983	\$0.00	\$15.00	Should pay minimum late fee of \$15.
X01588958	\$6.52	\$15.00	Should pay minimum late fee of \$15.
002222862	\$13.18	\$15.00	Should pay minimum late fee of \$15.
X03285451	\$0.18	\$15.00	Should pay minimum late fee of \$15.

(3) Two of ten sampled DME claims with TATs over 65 calendar days were processed incorrectly.

Summary of Issue

From a population of 147 commercial DME claims with a TAT over 65 calendar days, a sample of 10 claims was selected for review to determine if the correct interest fees were applied.

Eight of the 10 claims were processed appropriately with the correct interest amounts, or timely notification of pend or deny status was sent to the provider and member.

One claim was reported as being pended and then denied on a timely basis, but the Plan could not provide copies of the pend and denial letters to substantiate the claims system information. The final claim was pended incorrectly and caused the extended TAT. The claim was eventually paid, but interest was not applied to the payment. Table 3.0 lists those claims found to be in error.

Table 3.0: Sample DME Claims With TATs Over 65 Calendar Days Found to Have Been Processed Incorrectly.

Claim Number	Interest / Late Fee Paid	Interest / Late Fee Owed	Comment
6651	\$0.00	Accruing if not appropriately pended.	Copy of pend and denial letters unavailable and interest may be owed.
3752	\$0.00	\$12.00	Claim was incorrectly pended. The Plan should have paid interest, but no interest payment was issued.

- (4) 100 percent of sampled CCA ambulance claims with TATs over 65 calendar days, which were determined to have owed interest or late fees, contained processing errors.**
- (5) One of two ambulance claims sampled from the TPA with TATs over 65 calendar days was not processed correctly.**

Summary of Issue

From a population of 2,052 CCA ambulance claims that had TATs over 65 calendar days, we randomly selected 8 claims to test for either payment of interest or late fee, or the timely notification of pend or deny status to the provider and member.

Of the eight claims tested, the Plan processed one claim correctly for a refund from the provider that did not owe interest or a late fee. The remaining seven other claims had errors in processing or payment of interest or late fees. For three of the seven claims, the Plan paid interest in the amount of 15 percent per annum, but this amount was less than the \$15 per year (non-prorated) prescribed in Section 1371.35. Thus, the payment amount was found to be in error. For another two claims, the Plan should have paid interest expenses or a late fee and did not. The remaining two claims were denied, but the denial letters were either not sent to

providers and members in a timely manner, or could not be provided by the Plan. Table 4.0 lists those CCA ambulance claims with TATs over 65 calendar days

Table 4.0: Sampled CCA Ambulance Claims with TATs Over 65 Calendar Days Found to Have Had Processing Errors

Claim Number	Interest / Late Fee Paid	Interest / Late Fee Owed	Comment
250169	\$0.00	\$15.00	Claim should have paid \$15 late fee.
40168	\$0.00	\$15.00	Claim should have paid \$15 late fee.
12835	\$1.19	\$15.00	Claim should have paid late fee of \$15 instead of interest payment of \$1.19.
157259	\$3.62	\$15.00	Claim should have paid late fee of \$15 instead of interest payment of \$3.62.
298635	\$0.00	\$0.00	Claim denied as a duplicate. Denial letter is dated 121 days after receipt.
90785	\$0.00	\$15.00	Portion of the claim denied, but copy of the denial letter is not available. If not appropriately denied, interest is owed.
3752	\$12.96	\$15.00	Claim should have paid late fee of \$15 instead of interest payment of \$12.96.

From a population of 255 TPA ambulance claims with TATs over 65 calendar days, two claims were randomly selected for review. One claim was found to have actually been paid on a timely basis, but had been pended between the received and final paid dates so the claim appeared in our population and sample. The other claim did pay interest in the amount of \$9.45, but the Plan should have paid a late fee of the minimum \$15. Table 5.0 lists the sample claim found to have had an error in processing.

During our review of the TPA claims database, we noted that many claims with TATs over 65 calendar days were paid, but appeared in the claims database with a paid amount of zero.

Table 5.0: Sample TPA Ambulance Claim with Processing Error

Claim Number	Interest / Late Fee Paid	Interest / Late Fee Owed	Comment
0.04	\$9.45	\$15.00	Claim should have paid late fee of \$15 instead of interest payment of \$9.45.

The Preliminary Report required that the Plan respond as follows:

1. The Plan should examine their claim system edits to properly identify claims falling outside of the appropriate TAT. Issues were noted with the pending of claims that may have caused errors in identifying proper TATs.

2. The Plan should institute a company-wide policy on the payment of interest or late fees associated with the late payment of a claim. Emergency claims that were examined, in most cases, paid at the 15% per annum rate, instead of the greater of 15% per annum or \$15 per year non-prorated.

The Plan's response to the Preliminary Report was as follows:

Issue Number 1

The Plan's response included an acknowledgement that the claims processing system, The Outside Claims Payment System (OCPS), does not have a field for the alternative receipt date. The Plan stated that it is in the process of adding a new field to record the receipt date of requested information. This field would be a required entry if the claim is pended and used for reports to determine actual TAT. The Plan stated that this system modification will be completed, tested, and implemented by August 2004.

The Plan stated that in December 2003 it began monitoring turn around times using weekly production reports on claims paid beyond the regulatory time frames. Claims identified in the report are audited and, if interest is due, it is paid along with applicable penalties. When the audit indicates interest is not due because the claim was pended with a request for information, the receipt date filed is properly edited to reflect the date the additional information was received and notations made in the claim notepad of this entry. The Plan stated that this will be monitored in the monthly audits performed by the Plan and the annual audits performed by Health Plan Regulatory Services. The Plan stated that the responsible party is the SCCA Claims Operational Leader.

The Plan stated that ambulance claims are adjudicated through the EMI system and the confirmation of the interest due was impaired due to the inability to retrieve the pended letters, thus verifying the system entries. The Plan stated that this issue has been resolved with the new process of archiving all member and provider correspondence on a secure internet site in PDF images since January 2004. The Plan stated that letter retrieval will be monitored by the Plan in an annual oversight audit and the responsible party is the CCA Director of Compliance and Governance.

Issue Number 2

The Plan stated that it reviewed the system logic for interest and took the following corrective action: The OCPS interest calculation logic was revised to calculate the greater of \$15 or 15% on emergency services claims. The revised interest policy will be approved in the 2nd quarter 2004. A weekly production report was implemented in December 2003 that identifies any paid commercial/Medi-Cal claim with lags times greater than 63 calendar days which does not indicate that interest was paid. Claims on the report are audited to determine if interest should have been paid. The Plan stated that the monitoring of this report is the responsibility of the claims supervisor and if the audit indicates that interest is due, it is the responsibility of the assigned supervisor to process the claim applying the appropriate interest and penalty payment. The Plan stated that this procedure will be monitored in the monthly audits

performed by the Plan and the annual audits performed by Health Plan Regulatory Services and the responsible party is the SCCA Claims Leader.

The Plan has programmed the automatic interest payment based upon the greater of \$15 per claim or 15% annum. In the event that interest is paid after the initial payment, a specific code flag is applied and the interest is manually applied to include the penalty. The Plan stated that the application of interest will be monitored in an annual oversight audit and the responsible party is the CCA Director of Compliance and Governance.

The Plan’s compliance efforts, as described above, are responsive to the corrective action required.

Timely Notification of the Denial or Pending of a Claim

Section 1371.35 states that a plan may contest or deny a claim, or portion thereof, by notifying the claimant, in writing, that the claim is contested or denied, within forty-five (45) working days after receipt of the claim by the health care service plan. The notice that a claim, or portion thereof, is contested shall identify the portion of the claim that is contested, by revenue code, and the specific information needed from the provider to reconsider the claim. The notice that a claim, or portion thereof, is denied shall identify the portion of the claim that is denied, by revenue code, and the specific reasons for the denial.

In order to determine compliance, we tested samples of ER, DME and ambulance claims that were either denied or pended. Copies of denial or pend letters were requested and checked to ensure timely notification was given.

Our review found the following issues:

- (1) The Plan could not provide documentation of timely denial notification on 6 of the 31 sampled denied ER claims.**

Summary of Issue

From a population of 321,036 denied commercial ER claims dated from 4/1/01 to 3/31/03, a random sample of 31 claims was selected and tested for the timely notification of providers and members on the denial status of their claims. We determined that for 25 claims sampled, the Plan provided timely notification to the providers and members. For the remaining six claims, the Plan could not provide denial letters. These six claims are listed in Table 6.0.

Table 6.0: Sampled Denied Claims Found to be in Error

Claim Number	Error
010424444	Copy of denial letter unavailable.
X01293128	Copy of denial letter unavailable.
X01601685	Copy of initial denial letter unavailable.

X02207256	Copy of denial letter unavailable.
X02468918	Copy of denial letter unavailable.
010890313	Copy of denial letter unavailable.

(2) Four of nine sampled denied ER claims with TATs over 65 calendar days did not provided timely notification to providers and members.

Summary of Issue

From a population of 9,126 denied commercial ER claims with TATs over 65 days, we selected a random sample of 9 claims to test for the timely notification of denial to the providers and members. For five claims, the Plan provided timely notification, but the claims appeared in the database as having extended TATs due to the claim initially being pended (with proper provider and member notification) before eventually being denied. For the remaining four claims, the Plan did not provide timely notification of denial. Table 7.0 lists those four claims.

Table 7.0: Denied ER Claims with TATs over 65 Days That Did Not Provide Timely Notification to Providers and Members

Claim Number	Error
020152414	Denial letter late going out to provider/member.
X06296421	Denial letter late going out to provider/member.
600014846	Denial letter late going out to provider/member.
010550400	Denial letter late going out to provider/member.

(3) The Plan could not provide documentation of timely pend notification on two of ten sampled pended ER claims.

Summary of Issue

From a population of 6,629 pended ER commercial claims, we randomly selected 10 claims to test for timely notification of providers and members of the pend status of the claim and the request for additional information.

For eight of the 10 claims reviewed, the Plan provided timely notification to the providers and members. For the remaining two claims, the Plan could not provide copies of substantiating pend letters.

Table 8.0 lists those sampled pended claims wherein copies of the pend letters to providers and members could not be provided.

Table 8.0: Sample Pended ER Claims Found to be in Error

Claim Number	Error
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X06615847	Copy of pend letter not available.
600037919	Copy of pend letter not available.

(4) 100 percent of sampled denied DME claims were processed correctly.

Summary of Issue

From a population of 2,600 denied commercial DME claims, a sample of five claims was randomly selected for review of timely notification to the provider and member.

For all five claims reviewed, the Plan provided timely notification to the provider and member of the claim denial.

(5) Documentation of time denial notification could not be provided for one of eight sampled CCA denied ambulance claims.

Summary of Issue

From a population of 34,248 commercial zero paid claims, eight claims were randomly selected for review of timely notification of providers/members of the denial of the claim. For six of the eight claims tested, the Plan provided timely notification letters to providers/members. Another claim involved the processing of a refund that did not require the issuance of a denial letter. Another claim was denied and is reported in the database as being denied timely, but a copy of the denial letter supporting the database information was not available. Table 9.0 lists the CCA ambulance claim wherein a copy of the denial letter could not be provided by the Plan.

Table 9.0: Sample CCA Ambulance Claim with Processing Error

Claim Number	Error
162059	Claim reported as being denied timely, but a copy of the denial letter was unavailable.

In addition, from a population of 3701 zero-paid TPA ambulance claims, two claims were selected for review. No errors were found in processing or notification to providers.

The Preliminary Report for Issue 3 required that the Plan examine their internal process of denial and pend letter generation in order to ensure that all denial and pend letters are sent to providers and members in a timely manner. The maintenance and storage of these documents should also be a priority as without the hard-copy documentation, there is not a proper substantiation of notification.

The Plan responded to Issue 3 by stating that the Plan’s SCCA’s current process of generating and archiving pended letters resides in the actual claims system, OCPS. The Plan stated that these letters are archived onto CDs making retrieval difficult. The Plan also stated that all other letters have been generated and archived through Aurora DS since 2001 and to ensure

the pending letters can be retrieved in hardcopy upon request, the Plan will implement the generation and archiving of pending letters through Aurora DS beginning June 2004. The Plan stated that this will be monitored in the monthly audits performed by SCCA and the annual audits performed by Health Plan Regulatory Services. The Plan stated that the responsible party is the SCCA Claims Operational Leader.

The Plan’s compliance effort, as described above, is responsive to the corrective action required.

Accuracy of Claim Reimbursement

(1) The Plan’s paid ER claims database tested with 99.1 percent financial accuracy, 90.9 percent payment accuracy, and 95.9 percent non-payment accuracy.

Summary of Issue

From a population of paid emergency claims from 4/1/01 to 3/31/03, numbering 669,440, we selected a stratified random sample of claims to test for financial, payment and non-payment accuracy. When all the claims in the sample were examined and re-priced, we identified nine claims containing errors in the payment amount. As a result, we estimate a 99.1 percent financial accuracy rate and a 90.9 percent payment accuracy rate for the Plan’s payment of emergency claims. Table 10.0 shows the amount of financial accuracy per payment level strata.

Table 10.0: Financial Accuracy by Payment Level Strata

Claim Strata	Sample Absolute Error	Sample Size	Average Error	Total Number of Claims	Paid Population	Financial Accuracy Projection
\$0.01 - \$99.99	\$49.42	33	\$1.50	202,441	\$8,398,949	96.4%
\$100 - \$349.99	\$130.00	33	\$3.94	230,511	\$47,746,178	98.1%
\$350 +	\$413.75	33	\$12.54	236,488	\$386,290,121	99.2%
TOTAL		99		669,440	\$442,435,249	99.1%

Table 11.0 shows the payment accuracy by payment level strata. While the Plan exhibits a very high financial accuracy, the payment accuracy is lower due to the relatively large number of errors, but at a low dollar amount.

Table 11.0: Payment Accuracy by Payment Level Strata

Claim Strata	Sample Size	Payment Errors	Sample Payment Accuracy	Number of Claims	Weighted Payment Accuracy	Weighted Payment Accuracy (percent)
\$0.01 - \$99.99	33	3	90.9%	202,441	184,037	
\$100 - \$349.99	33	3	90.9%	230,511	209,555	

\$350 +	33	3	90.9%	236,488	214,989	
TOTAL	99	9		669,440	608,582	90.9%

Table 12.0 lists those claims found to have had errors in the payment amounts. Of the nine claims found to have had payment errors, three claims were found to have non-application of interest or late fees. Another three claims were found to have errors in the application of the correct provider contract. Two other claims were the result of incorrect deductions or copays and the remaining claims contained an incorrect denial of a procedure.

Table 12.0: Sample Claims Found to Have Had Financial and Payment Errors

Claims Number	Error Amount	Error Type	Comment
020158919	\$15.00	Underpayment	Paid four days late, owed \$15 late fee, none paid
X01666801	\$28.17	Underpayment	Incorrect contracted pricing.
X03263512	\$6.25	Underpayment	One procedure denied in error.
X01056822	\$15.00	Underpayment	Adjustment to previous claim, late fee owed, none paid.
X02224750	\$100.00	Underpayment	Incorrect contract pricing.
X02847916	\$15.00	Underpayment	Adjustment to previous claim, late fee owed, none paid.
X01757703	\$293.75	Overpayment	Incorrect contract pricing.
X02372806	\$70.00	Underpayment	Incorrect deduction amount.
X06421260	\$50.00	Underpayment	Incorrect copay applied.

Our testing of claims identified four claims with non-payment errors, as shown in Table 13.0. For two of the claims, the errors were associated with the incorrect recording of the received date of the claim. Another claim was incorrectly processed as a commercial claim when it should have been processed as a Medi-Care Cost claim. A fourth claim did not send out timely notification to the member and provider of the claim being pended. As a result, we estimate the Plan's claims database of emergency claims has a non-payment accurate of 95.9 percent, as shown in Table 14.0. Non-payment errors are those items contained on a claim that do not affect the payment amount of a claim. These errors include the recorded date of receipt, dates of service, paid date, and amount claimed.

Table 13.0: Sample Claims Found to Have Had Non-Payment Errors

Claims Number	Error Amount	Error Type	Comment
X02153322	Na	Non-Payment	Pend letter sent out to provider and member late.
X01056822	Na	Non-Payment	Incorrect received date recorded in system
X02969072	Na	Non-Payment	Should have been processed as Medi-Care Cost, instead of Commercial
X06189564	Na	Non-Payment	Incorrect received date recorded in system

Table 14.0: Non-Payment Accuracy by Payment Level Strata

Claim Strata	Sample	Non-Sample	Number of	Weighted	Weighted
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	Size	Payment Errors	Non-Payment Accuracy	Claims	Non-Payment Accuracy	Non-Payment Accuracy (percent)
\$0.01 - \$99.99	33	1	97.0%	202,441	196,306	
\$100 - \$349.99	33	1	97.0%	230,511	223,526	
\$350 +	33	2	93.9%	236,488	222,155	
TOTAL	99	4		669,440	641,988	95.9%

It is the Plan's policy to review all claims and compare the billed amounts for procedures to a published customary and reasonable (C&R) amount. The C&R amounts are derived from published Ingenix schedules based upon the procedure and the location the procedure is performed. It is the Plan's practice to pay the C&R rate if the C&R rate is less than the billed amount; otherwise the billed amount is reimbursed.

The C&R rate is paid at 80 percent of the published amounts for standard procedure codes. For some CPT code modifiers, such as 54, a further reduction of 20% is taken. Kaiser could not produce an official policy letter stating this.

(2) Sampled paid DME claims from the Plan's OCPS system tested with 92 percent financial, 70 percent payment, and 100 percent non-payment accuracy.

(3) DME claims processed in the Plan's accounts payable system could not be tested due to the lack of recorded information.

Summary of Issue

DME claims for the south region are processed in the OCPS system (same system as emergency claims) for prosthetics and orthotics. All other DME claims in the south region are processed within the local accounts payable system. The OCPS system contained 12,727 claims for the period of our review, while the accounts payable system contained 38,232 claims. The only fields that the Plan's accounts payable system could provide in a database were: vendor name, vendor number, invoice number, invoice amount, check number and paid date. The Plan could not provide, and did not have available, a listing of the items associated with the claim, the date the claim was received, the billed amount, the claim category (commercial, Medi-Care, risk, etc), dates of service, member information, or deduction information. Without this data, a thorough review for accuracy of the claims within the database could not be performed for the DME claims within the accounts payable system. As a result, our review was restricted to DME claims that were processed within the OCPS system (prosthetics and orthotics).

From the population of 12,727 commercial DME paid claims within the OCPS system, a sample of 10 claims was randomly selected for review of financial, payment, and non-payment accuracy.

Three claims were found to have had payment errors in the amounts noted in Table 15.0. Table 16.0 shows the amount of financial and payment accuracy of the sampled DME claims.

Table 15.0: Sample paid DME Claims Found to Have Had Payment Errors.

Claim Number	Error Amount	Error Type	Comment
13847	\$210.52	Underpayment	Incorrect application of contract pricing.
6985	\$0.82	Underpayment	Incorrect application of contract pricing.
10970	\$46.62	Overpayment	Incorrect application of contract pricing.

Table 16.0: Sample DME Claims Financial and Payment Accuracy

Sample Size	Number of Payment Errors	Sample Absolute Error	Sample Paid Population	Financial Accuracy	Payment Accuracy
10	3	\$257.96	\$3,137.82	92%	70%

No non-payment errors were found in the sample.

(4) Sample of paid ambulance claims tested with 88 percent financial, 88 percent payment and 100 percent non-payment accuracy.

Summary of Issue

From a population of 145,676 CCA commercial ambulance claims (total paid amount by Kaiser South of \$74,179,866.81), eight claims were randomly selected to review for financial and non-payment accuracy.

Of the eight claims tested, seven were processed correctly by the Plan. For the remaining one claim, an error was identified because the incorrect contracted amount was applied. Table 17.0 shows the amount of financial and payment accuracy of the sample and Table 18.0 lists the claim found to have had an error in processing.

Table 17.0: Sample CCA Ambulance Claims Financial and Payment Accuracy

Sample Size	Number of Payment Errors	Sample Absolute Error	Sample Paid Population	Financial Accuracy	Payment Accuracy
8	1	\$488.58	\$3,966.20	88%	88%

Table 18.0: Sample CCA Ambulance Claim Found to be in Error.

Claim Number	Error Amount	Error Type	Comment
161056	\$488.58	Underpayment	Incorrect contract pricing applied

In addition, we also tested two claims from a population of 23,545 paid commercial ambulance claims that were processed by the TPA. Both claims were tested and no financial, payment, or non-payment errors were noted.

The Preliminary Report required that the Plan respond as follows:

4. The Plan's system edits and processing should be examined to identify methods of applying member co-pays and registration fees to a single episode of care (or as defined by the member's contract).
5. The Plan should take efforts to ensure that all provider contracts are input into the claims processing system, minimizing the need for claim administrators to manually retrieve contract information and apply it to a claim.
6. The Plan should examine their method of processing and recording DME claims within their AP system (all DME claims except prosthetics and orthotics). Recorded information should be sufficient to conduct proper auditing and evaluation for compliance to appropriate laws and regulations.

The Plan's response to the Preliminary Report was as follows:

Issue Number 4

The Plan stated that in the Southern California Claims system, OCPS, the application of co-payments is automated. OCPS is linked to the Foundation System used for membership accounting. The Plan stated that co-payments are assessed at a service level when appropriate and not necessarily only at an episode of care level. The Plan stated that it is appropriate that multiple co-payments may be assessed and that the finding of 2 claims out of 99 with inaccurate application demonstrates a 97.92% accuracy rate which demonstrates that OCPS has a high level of accuracy when assessing co-payments and registration fees.

The Plan stated that the accuracy of co-payments will be reviewed in the monthly audits performed by SCCA and the annual audits performed by Health Plan Regulatory Services. The Plan stated that the responsible party is the SCCA Claims Leader.

Issue Number 5

The Plan stated that in SCCA, the provider contract terms are coded to OCPS and more than 70% of professional contract terms are fully automated. The Plan stated that many of the facility contract terms are also automated and where the system is not able to fully automate contract terms, the Adjuster can access summaries of the contract terms through an on-line system known as COOL (Contracts On-Line). The Plan stated that it is only in circumstances where contract terms are not fully automated that the adjuster must manually calculate contract pricing.

The Plan stated that in November 2002 SCCA began a reorganization to manage complex contract interpretation more effectively through contract specialization. The Plan stated that this involved reorganizing the routing of claims and linking them to contract managers and included monthly meetings with the contract managers to discuss contract application. The Plan stated that these meetings are now held on a quarterly basis and the reorganization was completed in May 2003.

The Plan stated that the accuracy of the application of contract terms will be reviewed in the monthly audits performed by SCCA and the annual audits performed by Health Plan Regulatory Services. The Plan stated that the responsible party is the SCCA Claims Leader.

Issue Number 6

The Plan stated that since January 2003, Health Plan Regulatory Services began working with both the Durable Medical Equipment (DME) Department and the Home Health Services to automate their claims processing. The Plan stated that after review and analysis of possible systems it was determined that SCCA would handle the processing of these claims. The Plan stated that system interfaces were established and processes defined between DME, HHS and SCCA and that DME and Home Health began processing their claims through OCPS on 1/04/04. The Plan stated that the monitoring of this process will be through the annual audits performed by Health Plan Regulatory Services and the responsible party is the Director of Survey Readiness.

The Plan's compliance efforts, as described above, are responsive to the corrective action required.

Payment Timeliness

Sections 1371 and 1371.35 require a full service health care plan to reimburse claims within forty-five (45) working days after receipt of the claim, unless the claim is contested or denied by the Plan. The sections also require that if the claim is contested by the Plan, the claimant shall be notified, in writing, that the claim is contested, within forty-five (45) working days after receipt of the claim by the Plan. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.

Our review identified the following conditions related to Sections 1371 and 1371.35

(1) Kaiser South's claim system does not effectively identify claims eligible for interest payments.

Summary of Issue

During our testing of claims to verify payment timeliness, we determined that the Plan's method for processing and recording claims into their database does not ensure that all claims eligible for interest or late fee payments are identified. An examination of the claims history for the period of 4/01/2001 to 3/31/2003 was conducted to determine the Plan's timeliness of

claims processing. It was determined that due to the Plan's method of processing and recording of claims data, an accurate determination of payment timeliness could not be made through an examination of the recorded received and paid dates associated with a claim. The Plan records a received date that the claim was first received. In Southern California, this date is usually imprinted onto a scanned copy of the claim form in Julian format. There is an "alternate received" date field that is also available for the recording of the date additional information regarding the claim is received. This field is not consistently used. The claims system also records a paid date, recording when the claim was finally processed and paid. In an uncontested or "clean" claim, the received date and paid dates are enough to determine a turn-around time (TAT). However, the Plan's processing of pended claims causes problems with TAT determination because the claims system does not have a field to record the date a letter is sent to the provider and member informing them that a claim is pended for additional information. The result is an artificially high TAT if examining just the system recorded date of receipt and paid date.

Also, we determined the system does not have data fields to record the date additional information may be received allowing final adjudication of the claim. Instead, the Plan staff use the "notepad" feature to annotate information about the pend status of the claim. A claim that had been pended may therefore appear in the system as having a TAT of over 45 working days, but in reality, may have been pended for a period of time between initial receipt and payment and ultimately processed in a timely manner. The Plan would have to individually examine all claims to ensure timely processing of claims.

The Preliminary Report for Issue 7 required that the Plan should consider re-evaluating their method of processing pended claims. The system currently cannot account for the time between notification of the provider and member that a claim has been pended, and the subsequent receipt of information that will allow for the adjudication of the claim.

The Plan responded to Issue 7 by stating that SCCA has reviewed the findings regarding the 16 pended letters that were not retrieved for the audit. The Plan stated that upon further investigation SCCA was able to retrieve 10 of the letters (included in the Plan's response) and the other 6 letters are pended letters produced by OCPS and archived on CDs which created the difficulty to retrieve.

The Plan stated that SCCA's current process of generating and archiving pended letters resides in the actual claims system, OCPS. These letters are archived onto CDs that make it difficult to retrieve. The Plan stated that all other letters have been generated and archived through Aurora DS since 2001 and to ensure the pended letters can be retrieved in hardcopy upon request, the Plan will implement the generation and archiving of pended letters through Aurora DS beginning June 2004. The Plan stated that this will be monitored in the monthly audits performed by SCCA and the annual audits performed by Health Plan Regulatory Services. The Plan stated that the responsible party is the SCCA Claims Operations Leader.

The Plan stated that SCCA acknowledges that OCPS does not have a field for the alternate receipt date and SCCA is in the process of determining the feasibility of adding a new field in the HX and MX screen to record the receipt date of requested information. The Plan stated that this

field would be a required entry of the claim, and used as the receipt date for, for reports to determine actual TAT. The Plan stated that it is expected that this system modification will be completed, tested, and implemented by August 2004.

The Plan stated that along with the system fix, SCCA implemented a manual process for managing this issue and in December 2003 SCCA began monitoring appropriate payment of interest using a daily production report on claims paid beyond the regulatory timeframes (Paid Claims with Lags > 63 With No Interest). The Plan stated that claims identified in the report are audited and, if interest is due, it will be paid along with applicable penalties. When the audit indicates interest is not due because the claim was pended with a request for information, the receipt date filed will be properly edited to reflect the date the additional information was received and notations made in the claim notepad of this entry. The Plan stated that this process will be monitored in the monthly audits performed by SCCA and the annual audits performed by Health Plan Regulatory Services. The Plan stated that the responsible party is the SCCA Claims Operational Leader.

The Plan's compliance effort, as described above, is responsive to the corrective action required.

C. EMERGENCY SERVICES AND CARE

At the time of our review, no exceptions were identified with the Plan's compliance with Section 1371.4.

(1) The Plan has adequate processes in place for members to obtain emergency services and authorizations.

Summary of Issue

The Plan currently does not require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition or active labor. This policy will change on 01/01/04. At the time of our review, 24-hour access for enrollees and providers to obtain timely authorization for medically necessary care is provided. This authorization is accessed through a telephone access number printed on the enrollee's membership card. A physician and surgeon are available for consultation and to resolve disputed requests for authorization.

The Plan reimburses providers for emergency services and care provided to its enrollees until the care results in the stabilization of the enrollee. A provider is not required to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.

If there is a disagreement between the Plan and the provider regarding the need for necessary medical care following stabilization of the enrollee, the Plan assumes responsibility for the care of the enrollee either by having medical personnel contracting with the Plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by

having another general acute care hospital under contract with the Plan agree to accept the transfer.

SECTION IV: SUMMARY OF RECOMMENDATIONS

1. The Plan should examine their claim system edits to properly identify claims falling outside of the appropriate TAT. Issues were noted with the pending of claims that may have caused errors in identifying proper TATs.
2. The Plan should institute a company-wide policy on the payment of interest or late fees associated with the late payment of a claim. Emergency claims that were examined, in most cases, paid at the 15% per annum rate, instead of the greater of 15% per annum or \$15 per year non-prorated.
3. The Plan should examine their internal process of denial and pend letter generation in order to ensure that all denial and pend letters are sent to providers and members in a timely manner. The maintenance and storage of these documents should also be a priority as without the hard-copy documentation, there is not a proper substantiation of notification.
4. The Plan's system edits and processing should be examined to identify methods of applying member co-pays and registration fees to a single episode of care (or as defined by the member's contract).
5. The Plan should take efforts to ensure that all provider contracts are input into the claims processing system, minimizing the need for claim administrators to manually retrieve contract information and apply it to a claim.
6. The Plan should examine their method of processing and recording DME claims within their AP system (all DME claims except prosthetics and orthotics). Recorded information should be sufficient to conduct proper auditing and evaluation for compliance to appropriate laws and regulations.
7. The Plan should consider re-evaluating their method of processing pended claims. The system currently cannot account for the time between notification of the provider and member that a claim has been pended, and the subsequent receipt of information that will allow for the adjudication of the claim.

APPENDIX

Methodology

MCG's examination of the Plan's fiscal and administrative affairs included several phases. First, MCG staff assessed the Plan's claims processing environment by conducting a walkthrough of the Plan's claim processing facilities, and reviewing policies and procedures related to claims processing, referral and financial accounting. This was mainly focused upon the Plan's processing of emergency claims and those other claims associated with the Plan's commercial health plan (DME and Ambulance). Secondly, MCG requested claims database information from the Plan for the period of 4/1/01 to 3/31/03 and performed a series of statistical analysis on the database. The Plan's claim database for the period was tested to evaluate a turn-around time (TAT) calculation. TAT is usually determined by calculating the number of days between the receipt date and the paid date for an entire claim. The Plan's claim database was also analyzed to determine claims accuracy by testing a sample of claims processed and paid. Claims accuracy testing is based upon a point in time; therefore the tested sample accuracy is based upon whether the claim was paid correctly on the date the sampled claim was processed. For this reason, any claim that is subsequently reprocessed and corrected at a later date is still considered to be in error.

Using the stratified random sampling technique for emergency claims, the paid claims were selected randomly within each of the three strata listed below. A sample size of 33 for each stratum was selected to provide total claims sample of 99.

The claims were stratified based upon paid amount per claim. Stratification levels were selected to provide an even distribution of claims between strata.

\$0.01 - \$99.99

\$100.00 - \$349.99

\$350.00 +

A limited review of claims was also conducted for the DME and ambulance claims categories, but a standard random selection method was used.

Terms

Financial Accuracy – Calculated by dividing the net of the total tested dollars minus the gross dollars in error by the total tested dollars.

Payment Accuracy – Calculated by dividing the net of the number of tested claims paid correctly by the number of tested claims audited.

Non-Payment Error – Errors that do not affect the payment amount of a claim. These errors include the recorded date of receipt, date of service, paid date, amount claimed.

Non-Payment Accuracy – Calculated by dividing the number of tested claims without non-payment errors by the number tested claims audited.

Turn-around Time (TAT) – TAT is the number of days needed to process a claim. The calculation covers the period from the day the claim is received to the day the claim payment is made, suspended or denied.



Macias Consulting Group, Inc.
Management Consultants

CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE

REPORT OF ROUTINE EXAMINATION
-ACCRUED CLAIMS LIABILITY
-TIME FOR REIMBURSEMENT OF CLAIMS
-CLAIMS ACCURACY
-EMERGENCY SERVICES AND CARE
-CLAIMS PROCESSING ENVIRONMENT

KAISER FOUNDATION HEALTH PLAN, NORTHERN CALIFORNIA

Period Work Performed: July 1 through November 14, 2003

FILE NO: 933-0055

DATE OF FINAL REPORT: April 26, 2004

PERFORMED BY:

MACIAS, GINI & COMPANY, LLP
MACIAS CONSULTING GROUP, INC.

KAISER FOUNDATION HEALTH PLAN, NORTHERN CALIFORNIA

Routine Examination Report

April 2004

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BACKGROUND INFORMATION ON KAISER FOUNDATION HEALTH PLAN

Year Plan Licensed: October 27, 1977

Organizational Structure: A nonprofit and charitable California corporation, the Kaiser Foundation Health Plan is a Knox-Keene licensed full-service health plan HCSP ID 94-1230523. In Northern California, the Kaiser Foundation Health Plan contracts with the Permanente Medical Group (TPMG) to provide care. TPMG takes direct responsibility for organizing and providing care to the Plan's members.

Type of Plan: Kaiser Foundation Health Plan is a full-service health care plan.

Provider Network: Services are provided through a network of associated hospitals, medical offices, pharmacies, and laboratories. When necessary, they also contract with non-Kaiser Permanente providers for certain services.

Plan Enrollment: A total of 6,581,124 enrollees were reported as of 3/31/03 for the entire Plan.

Claims Processing Location: Kaiser Foundation Health Plan
1800 Harrison, 12th floor
Oakland, CA

Process for Other Entities: No

SECTION I: SCOPE OF EXAMINATION

A. ROUTINE EXAMINATION OBJECTIVES

The California Department of Managed Health contracted with Macias Consulting Group to conduct a routine examination of the fiscal and administrative affairs of Kaiser Foundation Health Plan, Northern California which incorporates claims from the following categories:

- Out of Plan Emergency Claims – Processed by the California Claims Administration (CCA);
- Ambulance Claims – Processed by third party administrator (TPA) covered by an Administrative Service Agreement (ASA);
- Durable Medical Equipment (DME) – Processed by the Kaiser accounts payable system;
- Skilled Nursing Facility Claims (SNF) – Processed in the Authorized Outside Medical Services system (AOMS); and
- End-Stage Renal Disease (ESRD) Claims – Processed by AOMS.

Our specific objectives were to determine:

- A. Adequacy of estimating liability for claim reimbursement under Rule 1300.77.1 and 1300.77.2 of Title 28 of the California Code of Regulations;
- B. Adequacy of claims reimbursement under Section 1371 and 1371.35 of the Knox-Keene Health Act; and
- C. Adequacy of access to emergency services and care under Section 1371.4 of the Knox-Keene Health Act.

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.

SECTION II: REGULATORY CALCULATIONS

A. ADEQUACY OF ESTIMATING LIABILITY FOR CLAIMS REIMBURSEMENTS

We determined that the Plan is in compliance with requirements of Rule 1300.77.1 and 1300.77.2 when all claims categories are considered in their entirety.

Summary of Issue

The Plan uses an adequate method for calculating incurred but not reported (IBNR) reserve amounts for most all categories. We determined that the plan uses a hybrid approach for determining IBNR, incorporating both a development method (paid claims lag patterns) and projection method (per member per month averages). INBR calculations for the Northern

California region classify claims into the following categories. Lag studies are then developed for each of the individual categories.

- Commercial Inpatient, In Area
- Commercial, Inpatient, Out of Area
- Commercial, Outpatient, In Area
- Commercial, Outpatient, Out of Area
- Cost, Inpatient, In Area
- Cost, Inpatient, Out of Area
- Cost, Outpatient, In Area
- Cost, Outpatient, Out of Area
- Risk, Inpatient, In Area
- Risk, Inpatient, Out of Area
- Risk, Outpatient, In Area
- Risk, Outpatient, Out of Area
- Ambulance, TPA (Third Party Administrator) Non-Scheduled
- Ambulance, TPA Scheduled
- Northern CA Ambulance, other
- ESRD (End-Stage Renal Disease)
- SNF (Skilled Nursing Facilities)

To verify that the Plan's liability reserves as of 03/31/03 were adequate, we calculated the claims to be paid for those incurred prior to 03/31/03 based upon completion factors on 07/31/03 and compared to total claims to be paid to the actual paid claims run out through 07/31/03. This was done for all claim categories except ESRD and SNF. Paid claims run-out information for ESRD and SNF claims was only available through 05/31/03 at the time of our review, so the IBNR calculations for these two categories was only estimated through 05/31/03. We subsequently compared the paid amounts for the different types of claims to the general ledger entries. DME claims are processed in the accounts payable and material management system for Northern California, but do not appear as a category in reserved amounts. DME claims are accounted for in the reserve calculations for Southern California.

Overall, our calculations show that the Plan overestimates the total liability for claims in their Health Plan categories by approximately 18 percent. When examining individual categories of Claims, the Plan underestimated liability amounts by six percent for Northern California Ambulance, ESRD and SNF claims. The liability amounts for all other categories of claims were overestimated. In total, however, the Plan has accrued sufficient liability to cover expected Health Plan claim expense. Table 1.0 shows the IBNR amounts as calculated, incorporating paid claims information through 7/31/03 (5/31/03 for ESRD and SNF), and compares the amounts to those recorded in the 03/31/03 Orange Blank.

The Preliminary Report required that the Plan respond as follows:

1. The Plan should either re-evaluate their methodology for calculation of SNF and ESRD IBNR liability, or add a conservancy factor to the amount booked. The adjusted methodology should be re-evaluated periodically to ensure sufficiency.

2. The Plan should evaluate their DME expenses for northern California and if material, establish an appropriate reserve.

The Plan's response to the Preliminary Report was as follows:

Issue Number 1

The Plan stated that in December 2003 the process for calculating IBNR reserves for SNF and ESRD in the Northern California region of Kaiser Foundation Health Plan was changed in order to address this weakness. As modified, the process is now consistent with the process used to calculate all other categories of claims reserve estimation (Northern and Southern California emergency claims and Southern California referrals). The Plan stated that under the new process, a claim payment triangle for SNF and ESRD is produced on a monthly basis detailing the claims paid to date by month of service. This data is then used as part of an Actuarial model to calculate an IBNR balance. The Plan stated that checking claim run-outs and making revisions as payments emerge is an integral part of this process and that the general ledger reserves are reconciled to the actuarial estimates on a monthly basis. The Plan's certifying actuary is responsible for the monthly production and review of the reserves currently and going forward and monitoring is performed through review of the reserves at a monthly meeting with the Northern California Financial staff, including the Northern California Controller, prior to the financial close. As part of the response, the Plan also included a summary of the results generated under the revised approach and the reconciliation of general ledger reserves to the actuarial estimates for January 2004.

Issue Number 2

The Plan stated that their certifying actuary and the Northern California manager of Financial Reporting will review the DME expense payments in the Northern California region by the end of the first quarter 2004. If the review indicates a material reserve is needed, an estimated amount will be booked for March reporting and a process similar to the one for the other IBNR categories will be developed for subsequent calculations.

The Plan's compliance efforts, as described above, are responsive to the corrective action required.

Table 1.0. Northern California Kaiser Health Plan IBNR by Claims Category

Health Plan Claims Category	Estimated Claims to be Paid as of 7/31/03 for Claims Incurred Before 3/31/03	Claims Paid from 4/1/2003 to 7/31/2003, for Claims Incurred before 3/31/03	Total IBNR Estimate at 7/31/03 for Claims Incurred before 3/31/03	Over or Under Estimate on 3/31/03 Orange Blank	Amount Booked by Kaiser North on 3/31/03 Orange Blank, Column 3	Amount Booked on 3/31/03 Orange Blank, Column 2
Commercial, InPatient, In Area	\$ 4,282,076	\$ 34,947,908	\$ 39,229,984	Over	\$ 54,238,556	\$ 50,989,505
Commercial, InPatient, Out of Area	\$ 1,311,039	\$ 5,519,214	\$ 6,830,253	Over	\$ 10,552,966	\$ 9,920,812
Commercial, OutPatient, In Area	\$ 2,636,751	\$ 11,642,993	\$ 14,279,744	Over	\$ 16,172,718	\$15,203,924
Commercial, OutPatient, Out of Area	\$ 1,372,193	\$ 4,393,566	\$ 5,765,759	Over	\$ 6,976,932	\$ 6,558,993
Cost, InPatient, In Area	\$ 6,854	\$ 18,308	\$ 25,162	Over	\$ 88,872	\$ 83,548
Cost, InPatient, Out of Area	\$ 11,974	\$ 33,958	\$ 45,933	Over	\$ 103,377	\$ 97,184
Cost, OutPatient, In Area	\$ 20,176	\$ 36,424	\$ 56,600	Over	\$ 67,046	\$ 63,030
Cost, OutPatient, Out of Area	\$ 25,197	\$ 23,925	\$ 49,122	Over	\$ 57,727	\$ 54,269
Risk, InPatient, In Area	\$ 598,216	\$ 4,351,419	\$ 4,949,635	Over	\$ 5,350,352	\$ 5,029,850
Risk, InPatient, Out of Area	\$ 383,883	\$ 1,427,826	\$ 1,811,709	Over	\$ 3,393,017	\$ 3,189,765
Risk, OutPatient, In Area	\$ 230,226	\$ 934,084	\$ 1,164,310	Over	\$ 1,188,788	\$ 1,117,576
Risk, OutPatient, Out of Area	\$ 198,492	\$ 447,170	\$ 645,662	Over	\$ 921,801	\$ 866,582
Amb. TPA Non-Scheduled	\$ 2,300,736	\$ 16,211,927	\$ 18,512,663	Over	\$ 18,522,180	\$ 17,412,646
Amb. TPA Scheduled	\$ 710,606	\$ 2,995,395	\$ 3,706,001	Over	\$ 4,089,957	\$ 3,844,956
North Ambulance	\$ 199,310	\$ 696,451	\$ 895,761	Under	\$ 621,446	\$ 621,446
End-Stage Renal Disease*	\$ 2,045,131*	\$ 10,012,809*	\$ 12,057,940*	Under	\$ 11,616,125	\$ 10,920,284
Skilled Nursing Facilities*	\$ 4,328,529*	\$ 12,047,116*	\$ 16,375,644*	Under	\$ 15,346,553	\$ 14,427,249

*Calculated with actual paid claims information through 5/31/03 instead of 7/31/03

SECTION III: COMPLIANCE ISSUES

B. ADEQUACY OF CLAIMS REIMBURSEMENT

Payment of Interest and Late Fees

Sections 1371 and 1371.35 state that if an uncontested claim is not reimbursed within the forty-five (45) working day period, the Plan shall pay the greater of fifteen dollars (\$15) per year (non-prorated) or interest at the rate of 15 percent per annum beginning with the first calendar day after the appropriate working day period. A health care service plan shall automatically include the fifteen dollars (\$15) per year or interest due in the payment made to the claimant, without requiring a request.

In order to determine if the Plan was compliant with interest or late fee requirements, we tested samples of claims from the population of emergency room (ER) claims, ESRD claims, SNF claims, DME claims, and ambulance claims. The sample was drawn for the population of claims processed and paid during the period 4/1/01 to 3/31/03 that had turn-around times (TATs) over 65 calendar days (approximately 45 working days).

Our review found the following issues:

- (1) 71 percent of sampled paid ER claims with TATs over 65 calendar days did not owe or pay late fees or interest.**
- (2) 88.9 percent of sampled paid ER claims with TATs over 65 calendar days that did owe interest or late fees were not paid correctly.**

Summary of Issue

A random sample of 31 claims was selected for review from a population of 59,928 paid commercial emergency claims with TATs over 65 calendar days. TATs were determined by taking the difference between the recorded date of receipt of the claim and the recorded payment date of the claim. The sample was tested for the appropriate and correct payment of interest and late fees associated with the untimely payment of claims.

Twenty-two of the sampled claims did not owe and did not pay late fees or interest. These claims appeared in the sample selected because the claim was placed in a pend status at some point during processing. The claims were eventually either paid within the prescribed time limits, or denied, but the total time between initial receipt and final determination was greater than 65 calendar days. This aspect of the Plan's claims processing makes it difficult to accurately determine the number of claims that were actually paid outside of a 45 working day window.

For the remaining nine claims with TATs over 65 calendar days, the Plan paid them outside the appropriate time window. Of these nine claims, the Plan paid the correct interest / late fee amount for only one of them. For another two claims, the Plan paid interest at a rate of 15%

per annum, but since the 15% per annum amount is less than the \$15 per year (non-prorated) required in Section 1371.35, the claim payment amount is determined to be in error.

The six other claims were found to have owed the late fee, but the Plan did not pay. These claims were not identified as needing to be paid by the claims system due to the Plan internally pending the claim for review or the misprocessing of the claim.

Table 2.0 lists those claims found to have been paid outside the appropriate timeframe wherein the correct interest amount or late fee was not applied.

Table 2.0: Sampled ER Claims with Interest or Late Fee Errors

Claim Number	Interest / Late Fee Paid	Interest / Late Fee Owed	Comment
130304	\$0.00	\$ 30.00	Paid after 483 calendar days.
187805	\$0.00	\$ 15.00	Paid after 86 calendar days.
195487	\$4.33	\$ 15.00	Should pay minimum late fee of \$15.
202003	\$0.00	\$ 15.00	Paid after 221 calendar days.
209940	\$0.00	\$ 15.00	Paid after 270 calendar days.
127260	\$0.40	\$ 15.00	Should pay minimum late fee of \$15.
327597	\$0.00	\$ 15.00	Paid after 87 calendar days.
10797	\$0.00	\$ 15.00	Paid after 370 calendar days.

(3) Four of ten sampled ESRD claims with TATs over 65 calendar days contained processing errors.

Summary of Issue

A random sample of 10 claims was selected for review from a population of 290 Paid Commercial ESRD claims with TATs over 65 calendar days. These claims were reviewed to determine reasons for extended turn-around times and to see if the correct interest had been applied.

For six of the claims, interest was determined to have either been paid appropriately, or was not needed.

For another two claims, the Plan did not pay the interest expense that was due. The remaining two claims were reported by the Plan as not eligible for interest due to the claim being pended, but supporting documentation in the form of copies of the pend letters was not provided.

Table 3.0 lists those four sampled ESRD claims with TATs over 65 calendar days that were found to be in error.

Table 3.0: Sample ESRD Claims with TATs Over 65 Calendar Days Found to be in Error

Claim Number	Interest / Late Fee Paid	Interest / Late Fee Owed	Comment
54073	\$0.00	\$ 108.53	Adjustment to original claim paid outside the TAT window. Needs to have paid interest.
99030	\$0.00	\$ 26.12	Adjustment to original claim paid outside the TAT window. Needs to have paid interest.
167048	\$0.00	\$ 15.02	No copy of pend letter available. If not pended, needs to have paid interest.
31428	\$0.00	\$ 18.45	No copy of pend letter available. If not pended, needs to have paid interest.

(4) Two of ten of sampled SNF claims with TATs over 65 days contained processing errors.

Summary of Issue

A random sample of 10 claims was selected for review from a population of 1601 commercial SNF claims with TATs over 65 calendar days. These claims were tested for the correct payment of interest.

Eight of the sampled claims were processed correctly. For another claim, the Plan did not pay interest on the eligible claim, which the Plan reported as a rounding error. For the remaining claim, the Plan paid interest on the claim, but the amount was incorrect. We determined that the error was caused by the recording of an incorrect received date. As a result, the correct TAT was not calculated and the interest amount was shorted by \$0.38.

Table 4.0 lists those two sample SNF claims found to have had errors in processing.

Table 4.0: Sampled SNF Claims with TATs Over 65 Calendar Days Found to be in Error

Claim Number	Interest / Late Fee Paid	Interest / Late Fee Owed	Comment
47890	\$0.00	\$ 0.54	Paid late by 8 days, owed interest of \$0.54. Plan paid no interest.
188658	\$0.57	\$ 0.95	Incorrect recorded received date. Plan paid for 12 days of interest, should have paid for 16 days. Additional \$0.38 owed.

(5) One of ten sampled DME claims with TATs over 65 calendar days contained processing errors.

Summary of Issue

Ten claims were randomly selected for review to test for the proper payment of interest from a population of 790 DME commercial claims that had TATs over 65 calendar days. All 10 claims were found to have owed interest. Nine of the claims paid interest appropriately in accordance with Section 1371. For the remaining claim, the Plan did not pay interest that was due and copies of the letters notifying the provider and member of the pend status of the claim could not be provided by the Plan.

Table 5.0 lists the sample claim found to be in error.

Table 5.0: Sample DME Claim with TAT Over 65 Calendar Days Found to be in Error

Claim Number	Interest / Late Fee Paid	Interest / Late Fee Owed	Comment
242551	\$0.00	\$ 22.25	Claim paid after 110 calendar days. No interest paid.

(6) Six of ten sampled ambulance claims with TATs over 65 calendar days contained processing errors.

Summary of Issue

Ten claims were randomly selected for review from a population of 5200 commercial ambulance claims with recorded TATs over 65 days. These claims were reviewed for the payment of interest. Four of the claims were not owed interest. The Plan processed these four claims correctly. The four claims were identified in our sample because they were either reprocessed internally for data purposes or involved reprocessing due to a provider refund.

Three claims involved an appeal by the provider or member and were eventually paid by the Plan, but did not include interest or late fees that were owed. Copies of the pend or denial letters were also not available for these three claims. Two other claims were also reported as being denied in-part or in-whole, but the Plan could not provide copies of the denial letters on these two claims either. One additional claim was reported as being processed in error and did not include an interest or late fee.

Table 6.0 lists the sampled claims found to have contained errors.

Table 6.0: Sampled Ambulance Claims with TATs Over 65 Calendar Days Found to be in Error

Claim Number	Error
35135	No copy of pend or deny letters available to substantiate extended TAT.

	Interest owed if not denied or pended.
183950	Copy of denial letter for single line item not available. Interest owed of not denied.
64776	Copy of denial letter not available. Later appealed and paid. No interest paid with claim.
64527	Copy of denial letter not available. Later appealed and paid. No interest paid with claim.
317497	Processing error, claim paid 250 days after receipt. No interest paid with claim.
68627	Copy of denial letter for single line item not available. Interest owed if not denied or pended.

The Preliminary Report required that the Plan respond as follows:

3. The Plan should examine their claim system edits to properly identify claims falling outside of the appropriate TAT. Issues were noted with the pending of claims that may have caused errors in identifying proper TATs.
4. The Plan should institute a company-wide policy on the payment of interest or late fees associated with the late payment of a claim. Emergency claims that were examined, in most cases, paid at the 15% per annum rate, instead of the greater of 15% per annum or \$15 per year non-prorated.

The Plan's response to the Preliminary Report was as follows:

Issue Number 3

The Plan stated that the Northern California Claims Administration (NCCA) adjudication system, Claim Adjudication and Tracking System (CATS) does provide a field for the entry of the alternate receipt date. CATS is programmed to apply interest to claims using the original or alternate receipt date field if an entry has been made. The Plan stated that the adjudicators have been re-trained on the use of the alternate date field (New Info field) during orientation and the revised Request for Information "RFI" policy (included as part of the Plan's response) delineates how to manage this field. The Plan stated that the revised RFI policy will be approved in the 2nd quarter 2004 and the current audits tools for NCCA will be revised to include an indicator that monitors the entry to this field.

The Plan stated that NCCA will also monitor this entry from weekly production reports on claims paid beyond the regulatory timeframes (Paid Claims with Lags > 63 With No Interest) The Plan stated that claims identified in the report will be audited and, if interest is due, it will be paid along with applicable penalties. When the audit indicates interest is not due because the claim was pended with a request for information, the New Info date field will be properly edited to reflect the date the additional information was received and notations made in the claim notepad of this entry. The Plan stated that this report and the audits will begin March 2004. The Plan stated that this process will be monitored in the monthly audits performed by

NCCA and the annual audits performed by Health Plan Regulatory Services. The Plan also stated that the responsible party is the NCCA Claims Operational Leader.

The Plan stated that ESRD and DME claims are adjudicated through the Authorized Outside Medical Service (AOMS) system. The confirmation as to whether interest was due was related to the fact that the Plan could not retrieve the pended letters, thus verifying the system entries. The Plan stated that this issue has been resolved with the installation of the Aurora DS as of 1/04/04. The Plan also stated that in the DMHC Preliminary Report, Deficiency II F, Books and Records, further information is provided in the response. The Plan stated that the retrieval of letters will be monitored in the annual oversight audits performed by Health Plan Regulatory Services and the responsible party is the Director of Survey Readiness.

The Plans stated that ambulance claims are adjudicated through the EMI system. The confirmation of the interest due was impaired due to the inability to retrieve the pended letters, thus verifying the system entries. The Plan stated that this issue has been resolved with the new process of archiving all member and provider correspondence on a secure internet site in PDF images since January 2004. The Plan stated that the letter retrieval will be monitored by the Plan in an annual oversight audit and the responsible party is the Director of Survey Readiness.

Issue Number 4

The Plan stated that NCCA has reviewed its interest logic in accordance with the current statute and the logic was revised to pay the greater of \$15 or 15% for emergency services claims when the payment is sent beyond the regulatory requirement of 45 working days. The Plan stated that the revised interest policy (included as part of the Plan's response) will be approved in the 2nd quarter 2004 and, as of 2/13/04, to ensure the late fee is also paid on claims meeting this regulatory requirement, it has instituted a daily report as of March 2004 that contains the listing of claims that had payments made after the 45 working days, but no interest was paid. The claim supervisors will be accountable to manage the remediation process for these claims. Comparison of the reports will be made from one day to the next to ensure proper management. The reports will be kept for a period of 6 months for reference. The Plan stated that the application of interest will be monitored in the monthly audits performed by NCCA and the annual audits performed by Health Plan Regulatory Services. The Plan stated that the responsibility party is the NCCA Operational Leader.

The Plan stated that EMI programmed the automatic interest payment based upon the greater of \$15 per claim or 15% annum whichever is greater. In the event that interest is paid after the initial payment, a specific code flag is applied and the interest is manually applied to include the penalty. This was completed in January 2004. The Plan stated that the application of interest will be monitored by the Plan in an annual oversight audit and the responsible party is the Director of Survey Readiness.

The Plan's compliance efforts, as described above, are responsive to the corrective action required.

Timely Notification of the Denial or Pending of a Claim

Section 1371.35 states that a plan may contest or deny a claim, or portion thereof, by notifying the claimant, in writing, that the claim is contested or denied, within forty-five (45) working days after receipt of the claim by the health care service plan. The notice that a claim, or portion thereof, is contested shall identify the portion of the claim that is contested, by revenue code, and the specific information needed from the provider to reconsider the claim. The notice that a claim, or portion thereof, is denied shall identify the portion of the claim that is denied, by revenue code, and the specific reasons for the denial.

In order to determine compliance, we tested samples of ER, ESRD, SNF, DME and ambulance claims that were either denied or pending. Copies of denial or pending letters were requested and checked to ensure timely notification was given.

Our review found the following issues:

(1) The Plan could not provide documentation of timely denial notification on 9.7 percent of sampled denied ER claims.

Summary of Issue

A random sample of 31 claims was selected and tested for the timely notification of providers and members on the denial status of their claims from a population of 270,883 denied commercial ER claims dated from 4/01/01 to 3/31/03. Twenty-eight claims reviewed were determined to have provided timely notification to the providers and members.

For the remaining three claims, denial letters were not available. Two of the claims were denied previously, but the second submission of the claims was not acknowledged with another denial letter. The Plan reported that this practice was changed in 2002 and all denied claims are now acknowledged, whether they were previously denied or not. One of the claims was reported as being denied timely, but no denial letter could be produced as supporting documentation.

The three outstanding claims are noted in Table 7.0.

Table 7.0: Sampled Denied ER Claims Found to be in Error

Claim Number	Error
133360	No copy of denial letter available. Claim had been denied as non-emergent
47796	Claim previously denied. No denial letter sent for this 2nd submission of the claim
12461	Claim previously denied. No denial letter sent for this 2nd submission of the claim

(2) All eight sampled denied ER claims with TATs over 65 calendar days provided timely notification to providers and members.

Summary of Issue

A sample of 11 claims was randomly selected to test for the proper notification of providers and members and the reasons for the extended TATs from a population of 49,741 commercial denied ER claims with TATs over 65 calendar days. In all cases, no exceptions were noted. The extended TATs were from claims pending within the appropriate timeframe. Proper notification letters to the providers and members were provided and found to be timely.

(3) All 12 sampled pending ER claims provided timely notification to providers and members.

Summary of Issue

A sample of 12 claims was selected to test for the timely notification to providers of the pending status of the claims from a population of 4734 pending commercial ER claims. These claims were properly processed.

(4) Two of 12 sampled pending ER claims with TATs over 65 calendar days did not send out timely notification to providers and members.

Summary of Issue

A sample of 12 claims was randomly selected to test for the timely notification of members and providers of the pending status from a population of 148 pending commercial ER claims that showed a TAT over 65 calendar days. For two of the 12 claims, the Plan did not send out the appropriate notification to the providers due to misprocessing of the claim.

We also determined that on two claims reviewed, the claims were still in a current pending status even though they were received in January and February 2002 (over 400 days in pending status). Initial notification was sent to the providers and members in a timely manner, but no subsequent information was received and the status of the claims was not changed to denied. The claims administration office explained that they were overlooked in not setting the claims to a denied status.

Table 8.0 lists those sampled pending claims with TATs over 65 calendar days wherein timely notification was not provided to the members and providers.

Table 8.0: Sampled Pending ER Claims with TATs Over 65 Calendar Days Found to be in Error

Claim Number	Error
1368	Incorrectly placed in system as a document instead of a claim. Notice to Provider/Member sent out 169 calendar days after receipt.

1304	Claim sent to Q/A, but not processed. Notice to Provider/Member sent out 114 calendar days after receipt.
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(5) Copies of denial letters could not be produced for seven of ten sampled denied ESRD claims.

Summary of Issue

A sample of 10 claims was chosen to test for the timely notification to providers of the denial of the claim from a population of 171 denied commercial ESRD claims.

We could not determine if timely notification was given to providers and members on seven of the claims, as the Plan could not provide copies of the denial letters. Table 9.0 lists those sample claims wherein copies of the denial letters could not be provided.

Table 9.0: Sampled Denied ESRD Claims Found to be in Error

Claim Number	Error
17431	Copy of denial letter not available.
31264	Copy of denial letter not available.
31421	Copy of denial letter not available.
9733	Copy of denial letter not available.
93639	Copy of denial letter not available.
16857	Copy of denial letter not available.
37265	Copy of denial letter not available.

(6) Five of ten sampled denied SNF claims contained processing errors.

Summary of Issue

A sample of 10 claims was randomly selected for reviewing the Plan’s timely notification to the providers and members of claims denial from a population of 169 denied commercial SNF claims. For five of the claims reviewed, the Plan provided timely notification, or notification was not necessary.

The Plan could not provide copies of denial letters on four of the claims reviewed, so we could not determine if denial letters were sent out timely.

One claim notified the provider 650 calendar days after receipt of the claim.

Table 10.0 lists those sample claims found to have had errors.

Table 10.0: Sampled Denied SNF Claims Found to be in Error

Claim	Error
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Number	
63929	No denial letter available.
150995	No denial letter available.
165626	No denial letter available.
34978	No denial letter available.
16937	Denial letter dated 650 days after receipt of claim.

(7) All eight sampled denied DME claims were processed incorrectly.

Summary of Issue

From a population of 13 denied DME claims, a sample of eight claims was selected to test for the proper notification of providers and members of the denied status of the claim.

Seven of the sampled claims were denied as duplicates of previously paid invoices and the one remaining claim was denied as a duplicate of an AOMS referral claims.

No denial letters were sent to providers for these eight claims.

Table 11.0 lists those sampled denied DME claims wherein denial letters were not sent to providers and members.

Table 11.0: Sampled Denied DME Claims Found to be in Error

Claim Number	Error
234228	No denial letter sent to provider and member.
234850	No denial letter sent to provider and member.
237949	No denial letter sent to provider and member.
238817	No denial letter sent to provider and member.
255507	No denial letter sent to provider and member.
256153	No denial letter sent to provider and member.
279142	No denial letter sent to provider and member.
257477	No denial letter sent to provider and member.

(8) All ten sampled denied ambulance claims contained processing errors.

Summary of Issue

Ten randomly selected claims were reviewed for timely notification of providers and members of the denial of the claim from a population of 45,375 commercial ambulance claims that were denied. The Plan could not provide supporting documentation as to the timely notification of providers and members for the 10 claims, shown in Table 12.0.

Table 12.0: Sampled Denied Ambulance Claims Containing Processing Errors

Claim Number	Error
331698	No copy of denial letter available.
150456	No copy of denial letter available.
14492	No copy of denial letter available.
300948	No copy of denial letter available.
64440	No copy of denial letter available.
199491	No copy of denial letter available.
257064	No copy of denial letter available.
130544	No copy of denial letter available.
155618	No copy of denial letter available.
242181	No copy of denial letter available.

The Preliminary Report for Issue 5 required that the Plan should examine their internal process of denial and pend letter generation in order to ensure that all denial and pend letters are sent to providers and members in a timely manner. The maintenance and storage of these documents should also be a priority because without the hard-copy documentation, there is not a proper substantiation of notification.

The Plan’s response to Issue 5 stated that the NCCA notes that the audits performed included claims from 4/01/01 to 3/31/03 and the claims noted in the audit findings where timely notification to the member and provider was not verified due to the fact that letters could not be retrieved were all claims dated prior to 9/01.

The Plan stated that in June of 2001 the Department noted this same finding during an audit. NCCA corrected this through the implementation of a new system, Aurora DS, on 9/13/01. Aurora DS interfaces with Claims Adjudication and Tracking System (CATS) to generate and maintain archive files of all letters sent to members and providers. The Plan stated that this was verified in a follow-up review in 2002 and deemed corrected. The Plan stated that this is monitored in the monthly audits performed by NCCA and in the annual oversight audits performed by Health Plan Regulatory Services. The Plan stated that the responsible party is the NCCA Claims Leader.

The Plan stated that SNF and DME claims are adjudicated through the AOMS system and the confirmation as to whether there was timely notification to the member and provider was related to the fact that the Plan could not retrieve the pended letters, thus verifying the system entries. The Plan stated that this issue has been resolved with the installation of the Aurora DS as of 1/04/04 and in the DMHC Preliminary Report, Deficiency II F, Books and Reports, further information is provided in the response. The Plan stated that this retrieval of pended letters will be monitored in the annual oversight audits performed by Health Plan Regulatory Services and the responsible party is the Director of Survey Readiness.

The Plan stated that the ambulance claims are adjudicated through the EMI system and the confirmation of the as to whether there was timely notification to the member and provider was impaired due to the inability to retrieve the pended letters, thus verifying the system entries. The Plan stated that this issue has been resolved with the new process of archiving all member and provider correspondence on a secure internet site in PDF images since January 2004. The Plan stated that the letter retrieval will be monitored by the Plan in an annual oversight audit and the responsible party is the Director of Survey Readiness.

The Plan’s compliance effort, as described above, is responsive to the corrective action required.

Accuracy of Claim Reimbursement

(1) The Plan’s paid ER claims database tested with 99.8 percent financial accuracy, 90.8 percent payment accuracy, and 96.8 percent non-payment accuracy.

Summary of Issue

From a population of paid commercial emergency claims from 4/1/01 to 3/31/03, numbering 443,375, we selected a stratified random sample of 99 claims to test for financial, payment and non-payment accuracy. When all the claims in the sample were examined and re-priced, we identified nine claims containing errors in the payment amount. As a result, we estimate a 99.8 percent financial accuracy rate and a 90.8 percent payment accuracy rate for the Plan’s payment of commercial emergency claims. Table 13.0 shows the amount of financial accuracy per payment level strata.

Table 13.0: Financial Accuracy by Payment Level Strata

Claim Strata	Sample Absolute Error	Sample Size	Average Error	Total Number of Claims	Paid Population	Financial Accuracy Projection
\$0.01 - \$99.99	\$92.40	33	\$2.80	139,241	\$6,245,939	93.8%
\$100 - \$299.99	\$57.40	33	\$1.74	143,046	\$26,785,844	99.1%
\$300 +	\$180.02	33	\$5.46	161,088	\$581,658,771	99.8%
TOTAL		99		443,375	\$614,690,554	99.8%

Table 14.0 shows the payment accuracy by payment level strata. While the Plan exhibits a very high financial accuracy, the payment accuracy is lower due to the relatively large number of errors, but at a low dollar amount.

Table 14.0: Payment Accuracy by Payment Level Strata

Claim Strata	Sample Size	Payment Errors	Sample Payment Accuracy	Number of Claims	Weighted Payment Accuracy	Weighted Payment Accuracy (percent)
\$0.01 - \$99.99	33	2	93.9%	139,241	130,802	

\$100 - \$299.99	33	3	90.9%	143,046	130,042	
\$300 +	33	4	87.9%	161,088	141,562	
TOTAL	99	9		443,375	402,406	90.8%

Table 15.0 lists those claims found to have had errors in the payment amounts. Of the nine claims found to have had payment errors, three were due to the non-application of interest or late fees, three were due to errors in the application of copays or registration fees, and three were errors in pricing of the procedures.

Table 15.0: Sample Claims Found to Have Had Financial and Payment Errors

Claims Number	Error Amount	Error Type	Comment
314409	\$15.00	Underpayment	Originally denied in error. Eventually paid, but needed late fee.
331898	\$77.40	Underpayment	Originally paid at Medi-Cal rate incorrectly.
116082	\$10.00	Underpayment	Member charged \$20 registration fee. Should be \$10.
353630	\$15.00	Underpayment	Member charged \$15 registration fee in error.
431567	\$32.40	Overpayment	Paid at billed amount, instead of Multiplan rate.
33939	\$51.23	Underpayment	Should have paid at billed amount.
34884	\$68.79	Underpayment	Claim needs to have paid interest/late fee
253421	\$45.00	Underpayment	Copay of \$45 deducted in error
520023	\$15.00	Underpayment	Reimbursement originally sent to incorrect address. Needs to have paid late fee.

Our testing of claims identified three claims with non-payment errors, as shown in Table 16.0. For two of the claims, the errors are attributed to the incorrect recording of the dates of service and received date. Confirmation on the contracted pricing could not be provided on the third claim. As a result, we estimate that the Plan's claims database of emergency claims has a 96.8 percent non-payment accuracy rate, as shown in Table 17.0. Non-payment errors are those items contained on a claim that do not affect the payment amount of a claim. These errors include the recorded date of receipt, dates of service, paid date, and amount claimed.

Table 16.0: Sample Claims Found to Have Had Non-Payment Errors

Claims Number	Error Amount	Error Type	Comment
30964	na	Non-Payment	Confirmation on contracted pricing not available.
34884	na	Non-Payment	Incorrect dates of service recorded in system
127875	na	Non-Payment	Incorrect received date recorded in system

Table 17.0: Non-Payment Accuracy by Payment Level Strata

Claim Strata	Sample Size	Non-Payment Errors	Sample Non-Payment	Number of Claims	Weighted Non-Payment Accuracy	Weighted Non-Payment
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			Accuracy			Accuracy (percent)
\$0.01 - \$99.99	33	0	100.0%	139,241	139,241	
\$100 - \$299.99	33	1	97.0%	143,046	138,711	
\$300 +	33	2	93.9%	161,088	151,325	
TOTAL	99	3		443,375	429,277	96.8%

Also of note: Of the 99 claims tested, 10 involved adjusted reimbursements to providers for the difference between the initial reimbursed amounts at customary and reasonable (C&R) rates, and the billed amounts. These claims dealt with situations wherein the providers attempted to bill the Plan members for the difference, or the provider submitted an appeal to the amount originally reimbursed. In these cases, the claim was submitted for medical review and a decision made to either pay the difference or deny the appeal. In the cases noted in our sample, the Plan tended to pay the difference. It was reported by the Plan that in an effort to "protect the members", the Plan will pay the difference if the provider tries to bill the members for the difference.

It is the Plan's policy to review all claims and compare the billed amounts for procedures to a published C&R amount. The C&R amounts are derived from published Ingenix schedules based upon the procedure and the location the procedure is performed. It is the Plan's practice to pay the C&R rate if the C&R rate is less than the billed amount by \$15; otherwise the billed amount is reimbursed.

The C&R rate is paid at 80% of the published amounts for standard procedure codes. For some CPT code modifiers, such as 54, 80% of the 80% is paid. The Plan could not produce an official policy letter stating this.

In addition to the testing and evaluation done on the paid ER claims database, we also conducted a limited review of paid ESRD, SNF, DME and ambulance claims.

(2) Sampled paid ESRD claims tested with 100 percent financial, payment and non-payment accuracy.

Summary of Issue

From a population of 19,387 paid commercial ESRD claims, a sample of 10 claims was chosen for review of payment, financial, and non-payment accuracy.

No errors were found. The sample tested with 100% financial, payment, and non-payment accuracy.

(3) Sampled paid SNF claims tested with near 100 percent financial accuracy, 90 percent payment accuracy, and 100 percent non-payment accuracy.

Summary of Issue

A sample of 10 claims was selected for review to test for payment, non-payment and financial accuracy from a population of 18,760 paid commercial SNF claims.

One claim was found to be in error for late payment without adding the 15% per annum interest fee. When considering this one error in our financial accuracy calculations, the error was so small (\$0.25) when compared to the total paid amount of the sample that it had little impact upon overall financial accuracy.

No non-payment errors were noted in the sample

Table 18.0 lists the claim found to have had a payment error.

Table 18.0: Sampled Paid SNF Claim Found to be in Error.

Claim Number	Error
30164	Paid claim eight days late. Owed \$0.25 in interest. None paid.

(4) Sampled paid DME claims tested with 100 percent financial, payment and non-payment accuracy.

Summary of Issue

A sample of 10 claims was randomly selected for review of financial and non-payment accuracy from a population of 30,781 commercial paid DME claims. The Plan processed these claims with 100 percent financial, payment and non-payment accuracy.

(5) Sampled paid ambulance claims tested with 100 percent financial, payment and non-payment accuracy.

Summary of Issue

A sample of 10 claims was randomly selected and tested for financial, payment, and non-payment accuracy from a population of 118,471 paid commercial ambulance claims. The Plan processed these claims with 100 percent financial, payment and non-payment accuracy.

The Preliminary Report for Issue 6 required the Plan’s system edits and processing be examined to identify methods of applying member co-pays and registration fees to a single episode of care (or as defined by the member’s contract).

The Plan’s response to Issue 6 stated that the NCCA notes the claims audited are from 4/01/01 to 3/31/03 and that during this time, in late 2002, the NCCA evaluated its management of co-pays and registration fees. The Plan stated that the result was to implement a fully automated system for this application in December 2002. The current claim processing system, CATS, sorts the

claims by episode of care thus linking the claims. The management of this process is provided in an orientation (policy included as part of the Plan's response). The Plan stated that the monitoring of the co-pay and registration fee occurs in the monthly audits performed by NCCA and the annual audits performed by Health Plan Regulatory Services. The Plan stated that the responsible party is the NCCA Claims Operations Leader

The Plan's compliance effort, as described above, is responsive to the corrective action required.

Payment Timeliness

Sections 1371 and 1371.35 require a full service health care plan to reimburse claims within forty-five (45) working days after receipt of the claim, unless the claim is contested or denied by the Plan. The sections also requires that if the claim is contested by the Plan, the claimant shall be notified, in writing, that the claim is contested, within forty-five (45) working days after receipt of the claim by the Plan. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.

Our review identified the following conditions related to Sections 1371 and 1371.35

(1) Kaiser North's claim system does not effectively identify claims eligible for interest payments.

Summary of Issue

During our testing of claims to verify payment timeliness, we determined that the Plan's method for processing and recording claims into their database does not ensure that all claims eligible for interest payment are identified. An examination of the claims history for the period of 4/01/2001 to 3/31/2003 was conducted to determine the Plan's timeliness of claims processing. It was determined that due to the Plan's method of processing and recording of claims data, an accurate determination of payment timeliness could not be made through an examination of the recorded received and paid dates associated with a claim. The Plan records a received date that the claim was first received. In Northern California, this date is not usually imprinted onto a scanned copy of the claim form. There is an "alternate received" date field that is also available for the recording the date additional information regarding the claim is received. This field is not consistently used. The claims system also records a paid date, recording when the claim was finally processed and paid. In an uncontested or "clean" claim, the received date and paid dates are enough to determine a turn-around time (TAT). However, when the Plan processes pended claims, the received date and paid dates creates problems with TAT determination because the claims system does not have a field to record the date a letter is sent to the provider and the member informing them that a claim is pended for additional information. The result is an artificially high TAT if examining just the system recorded date of receipt and paid date.

Also, we determined the system does not have the data field to record the date the additional information may be received allowing final adjudication of the claim. Instead, Plan staff use

the “notepad” feature to annotate information about the pend status of the claim. A claim that had been pended may therefore appear in the system as having a TAT of over 45 working days, but in reality, may have been pended for a period of time between initial receipt and payment and ultimately processed in a timely manner. The Plan would have to individually examine all claims to ensure timely processing of claims.

The Preliminary Report required that the Plan respond as follows:

7. The Plan should consider having their claims processing system print the received date on the claim form in order to provide hard-copy documentation of the received date. The system currently only records the received date in the claims processing system.
8. The Plan should consider re-evaluating their method of processing pended claims. The system currently cannot account for the time between notification of the provider and member that a claim has been pended, and the subsequent receipt of information that will allow for the adjudication of the claim.

The Plan’s response to the Preliminary Report was as follows:

Issue Number 7

The Plan stated that the NCCA has begun the following corrective action to ensure that the receipt date is stamped on the hard copy of the claim. NCCA will implement a new document scanning system. The National EDI and Imaging Workflow System (NIEWS) modifies the existing software so that the dating “slug” will imprint each document with the document control number (DCN) that includes a concatenated number consisting of the scanner identification (ID), year, julian date of receipt, and sequential document ID. The new scanners with the DCN application will be installed and functional by April 30, 2004. At that time, the scanned documents and the hard-copy documents will show the receipt date. The Plan stated that the monitoring of this process will occur with the monthly audits performed by NCCA and the annual audits performed by Health Plan Regulatory Services. The Plan stated that the responsible party is the NCCA Claims Operational Leader.

Issue Number 8

The Plan stated that the NCCA adjudication system, CATS, does provide a field for the entry of the alternate receipt date. CATS is programmed to apply interest to claims using the original or alternate receipt date field if an entry has been made. The Plan stated that adjudicators have been re-trained on the use of the alternate date field during orientation and that the “Alternate Receipt Date” policy (included in the Plan’s response) delineates how to manage this field. The Plan stated that the current audit tools for NCCA will be revised to include an indicator that monitors the entry to this field and that NCCA will also monitor this entry from weekly production reports on claims paid beyond the regulatory timeframes. The Plan stated that the claims identified in the report will be audited and, if interest is due, it will be paid along with applicable penalties. When the audit indicates interest is not due because the claim was pended with a request for information, the alternate receipt date filed will be properly edited to reflect the

date the additional information was received, and notations made in the claim notepad of this entry. The Plan stated that this report and the audits will begin March 2004. The Plan stated that the monitoring of this process will occur with the monthly audits performed by NCCA and the annual audits performed by Health Plan Regulatory Services. The Plan stated that the responsible party is the NCCA Claims Operational Leader.

The Plan's compliance efforts, as described above, are responsive to the corrective action required.

C. EMERGENCY SERVICES AND CARE

At the time of our review, no exceptions were identified with the Plan's compliance with Section 1371.4.

(1) The Plan has adequate processes in place for members to obtain emergency services and authorizations.

Summary of Issue

The Plan currently does not require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition or active labor. This policy will change on 01/01/04. 24-hour access for enrollees and providers to obtain timely authorization for medically necessary care is provided. This authorization is accessed through a telephone access number printed on the enrollee's membership card. A physician and surgeon are available for consultation and to resolve disputed requests for authorization.

The Plan reimburses providers for emergency services and care provided to its enrollees until the care results in the stabilization of the enrollee. A provider is not required to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.

If there is a disagreement between the Plan and the provider regarding the need for necessary medical care following stabilization of the enrollee, the Plan assumes responsibility for the care of the enrollee either by having medical personnel contracting with the Plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with the Plan agree to accept the transfer.

SECTION IV: CLAIMS PROCESSING ENVIRONMENT

EMERGENCY CLAIMS PROCESS

ER CLAIMS RECEIPT AND PROCESSING

(1) At the time of our review, no significant exceptions were identified with the Plan’s claims receipt processing for emergency claims.

Summary of Issue

Kaiser North located at 1800 Harrison Street, Oakland, California conducts all claims processing for emergency room claims for the Northern California region. ER claims are received from providers directly or can come from anywhere in the world for Plan members that needed emergency room treatment. These claims are referred to by the Plan as “ER claims” and “out of area” emergent care claims. The Plan receives the ER claims via a dedicated post office box number 12923. They receive between 12,000 to 15,000 claims weekly.

The mailroom, located at the same address, 1800 Harrison Street receives incoming ER claim forms, including medical information, and other assorted claim documentation. Up to three mail clerks sort ER claims based on a number of categories. Some of the major categories include:

- (1) Super bills – those claims submitted on something other than a HCFA form.
- (2) Foreign Claims.
- (3) Vendor – W-9s. (TIN numbers are usually needed so that claims could be paid)
- (4) Red Simplex claims, forms with red single lines.
- (5) Red Duplex claims, forms with red double lines.
- (6) Drug prescription claims

Mail clerks sort the claims in batches of 250. A batch cover sheet is prepared that records the date the mail was received and the date the mail was sorted. There is no quality assurance procedure that verifies that the receipt date entered on the batch form is the actual receipt date of the claim. The batch of claims is forwarded to the Scan Room for digital imaging. At the time of our review on July 1, 2003, claims received on June 28, 2003 were being scanned.

The scan room uses an electronic scanning/optical character recognition system called Cardiff. The receipt date recorded on the batch form is entered into the scanning software application. This records the date received for each claim scanned. There is no verification process implemented by Plan management that ensures that the receipt date entered into system is actual date recorded on the batch form. The clerk will then load the batch of 250 claims into the scanning machine which will then scan each individual claim into the system. The scanner will then display the claims on her desktop monitor to check whether the print can be viewed and to ensure that the scanned pages are not upside down or skewed in any way. Original claims forms scanned are stored temporarily in boxes on site until destroyed.

As a result of scanning technology, the claims information is fed into a workflow management system called I-File. I-File creates a workflow folder based on a member’s medical record number. If the system identifies multiple records with same record number and similar dates of service and similar diagnosis, the claims are combined into an episode of care. The I-File system also distributes work to individual examiners. The system identifies claims by the age

of the claim and subsequent higher priority claims rise in the work queue for claims to be processed by staff. Generally, the logic table that is used is the “first in, first out” criteria.

Scanned claims are reviewed through a verification process that checks the accuracy and completeness of the data scanned into I-File. Optical character recognition (OCR) software highlights data that it doesn’t believe has at least an 80% accuracy confidence, but some data fields on the claim form are subject to editing on all claims, such as procedure amounts, codes, and claim amount, including member name and member number. If the system has accurately captured data from the claim form, the edit check is such that it will accept the claim. For questionable claims, Plan staff, called verifiers, will review scanned claims to make sure that the scanned data is accurate. For data that the verifiers know is incorrect, the verifier will change the data by entering new data in the OCR software application. Generally, incorrect data stems from providers who make mistakes completing the claim form. The Plan has over a dozen permanently employed verifiers and about six additional temporary workers.

Upon completion of the verification process, the claims are forwarded to another room to validate the information on the ER claims and thus, to validate whether the ER claims is a valid emergency claim according to Plan policy. The Plan uses the prudent layperson criteria cited under California Health and Safety Code Section 1317(b) to identify valid emergency claims.² At the time of our review, Plan staff was observed contacting a provider listed on the emergency claim form to verify the provider’s address. The Plan employee also asked whether the provider was a chiropractor. Upon an affirmative response, the Kaiser employee recorded the information on the claim, which was subsequently flagged for denial because it did not meet the Plan’s prudent layperson criteria. The claim in question was related to a Plan member

² Under California Health and Safety Code section 1317.1(b), an emergency medical condition is defined as: [A] medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) Placing the patient's health in serious jeopardy. (2) Serious impairment to bodily functions. (3) Serious dysfunction of any bodily organ or part. See Cal. Health & Safety Code § 1317.1(b).

Active labor is defined as:

[A] labor at a time at which either of the following would occur:

- (1) There is inadequate time to effect safe transfer to another hospital prior to delivery.
- (2) A transfer may pose a threat to the health and safety of the patient or the unborn child.

See Cal. Health & Safety Code § 1317.1(c).

For Medicare and Medicaid, an emergency medical condition is defined as follows:

The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in -

- (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- (ii) serious impairment to bodily functions, or
- (iii) serious dysfunction of any bodily organ or part.

See 42 U.S.C. § 1395w-22(d)(3)(B) and 42 U.S.C. § 1396u-2(b)(2)(C), respectively.

Under EMTALA, an emergency medical condition is defined as:

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in -

- (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- (ii) serious impairment to bodily functions, or
- (iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant women [sic] who is having contractions -

- (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
- (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

having acute back pain. Plan management staff explained that this verification process is necessary because many providers will try to submit claims under emergency status because otherwise “non-emergency” services provided by non-Plan providers would not generally be covered under a member’s contract. Plan management further explained that it is through this verification process that bona-fide ER claims are identified.

ER claims deemed bona-fide are processed through CATS, or Claims Adjudication Tracking System. The CATS system contains the price mechanism that helps determine how much a provider should be reimbursed. Generally, these are usual and customary charges, Medicaid and Medicare reimbursement rates, and other reimbursement rates such as from provider contracts. Where no contract exists for the ER facility, the claim is sent to the Medical Audit unit where the claim would be priced.

Within the CATS system, there is another software system that reviews the reasonableness of procedural coding. Generally, claims that meet certain demographic characteristics or exceed dollar thresholds allowed for the provider are routed into clinical review to assure medical necessity, clinical appropriateness and that the denial of claims meet regulatory compliance for prudent layperson criteria. Claim denial letters are subsequently generated through Aurora DS software which is driven by denial code and includes all dispute and resolution language.

(2) Kaiser North’s Claim processing system does not accurately identify claims eligible for interest expense.

While the Plan reports that system reviews have been performed to check for data reliability and accuracy, the Plan has not been able to provide documentation supporting that electronic data processing reviews have been performed to ensure system controls are in place to provide data integrity and reliability. The results of our testing of claims show that the Plan’s system does not effectively identify claims eligible for interest expense and that its reporting functions cannot produce pending and denied information.

The Preliminary Report for Issue 9 required that the Plan, in addition to implementing the recommendations pertaining to correcting the system related problems previously discussed in this report, Kaiser North should undertake a more comprehensive electronic data processing review that evaluates the integrity, reliability and accuracy of its claims processing information management systems.

The Plan’s response to Issue 9 stated that NCCA will develop a process to assure mail received at the main mailroom is appropriately identified with the date received. This will be done via a batch cover sheet to be developed and which will accompany the mail from the main mailroom through the CCA mail scanning process. The Plan stated that the policies and procedures for this process will be developed and implemented on or before May 1, 2004.

The Plan stated that the Quality Audit Department will begin a monthly manual random audit (effective May 1, 2004) of NCCA Mailroom Operations to include:

- 1. Selection of a completed mail batch from the mailroom.*

2. Verification that the batch form is completed appropriately and is attached to the batched documents.
3. Validation that the mail receipt date entered to the system matches the mail receipt date contained on the batch form.

The Plan stated that the responsible party is the NCCA Claims Operational Leader.

The Plan stated that NCCA currently employs staff known as verifiers. On a daily basis, the Verifier performs the task known as “job QC” (job quality control) on each batch of scanned claims. The purpose of “job QC” is to monitor and validate that the batches are scanned correctly, are legible, and that the batch is of the document type indicated in the scan (i.e.-UB-92 or CMS 1500 claim form). The Plan stated that corrective action is taken if the verifiers identify issues that may include, but is not limited to, rescanning a document and staff education. The Plan stated that the monitoring of this process will occur with the monthly audits performed by NCCA and the annual audits performed by Health Plan Regulatory Services. The Plan stated that the responsible party is the NCCA Claims Operational Leader.

The Plan stated that NCCA has pay and suspend rules built into the CATS that direct the adjudicator to forward the claim for clinical review. Clinical reviews the claim for the application of the prudent layperson standard and directs the claims adjudicator of their determination. CATS is linked to the member benefits. Chiropractic care is a capitated benefit administered through another health plan, American Specialty Health Plan (ASHP). The Plan stated that this is true whether the chiropractic care is related to an emergency condition or not. Chiropractic services are processed by ASHP. NCCA has provided the revised policies and procedures on chiropractic care (included in the Plan’s response) to reflect the routing of misdirected chiropractic service claims to ASHP within 10 working days of receiving such a misdirected claim (the Plan included the procedures in its response). These policies will be approved in the 2nd quarter 2004. The Plan stated that the monitoring of this process will occur with the monthly audits performed by NCCA and the annual audits performed by Health Plan Regulatory Services. The Plan stated that the responsible party is the NCCA Claims Operational Leader.

The Plan’s compliance efforts, as described above, are not fully responsive to the corrective action required. The Plan was required to undertake a more comprehensive electronic data processing review that evaluates the integrity, reliability and accuracy of its claims processing information management systems. The Plan did not file documentation that demonstrates the Plan has implemented this more comprehensive review. The Plan’s response mainly addresses mailroom procedures and not the integrity of data as it is further input and flows through the claims processing information management systems. The Plan is required to file documentation demonstrating that it has undertaken a more comprehensive electronic data processing review that evaluates the integrity, reliability and accuracy of its claims processing information management systems.

ER CLAIMS REFERRAL AND AUTHORIZATION

(3) At the time of our review, no exceptions were noted with the Plan’s process of ER Claims referral and authorization.

Summary of Issue

Most of the referral offices for Kaiser North are located in the 15 regional hospital locations. Referrals are made for all contracted services, or providers are prepared contracts as the referral is processed by the Plan. Emergency room authorizations are provided by physician in charge at each facility. Facility coordinators at each referral location will batch claims and send them to the regional office for review of quality and final authorization. There is a five to 10 day turn-around time for authorizing referrals.

ER CLAIMS PAYING AND POSTING

(4) At the time of our review, no other exceptions were noted with the Plan’s process for preparing claim payment checks.

Summary of Issue

For all approved claims processed by the claims processors, the claims are electronically routed to the claims payable system. The Plan reports a two-day lag between claim payment approval and the actual paid date of the claim. Kaiser North issues checks continuously throughout the month. The check stock is kept at the Finance Division. All claim checks are electronically generated.

The receipt date Kaiser is using to determine compliance with turn-around times depends on the claim. For example, if someone submits a claim and it has insufficient information, it is given a denied/pended status until additional info is received. When the supplemental information is received, a new receipt date is supposed to be used. As discussed in the previous sections, this process does not always identify claims needing interest or late fees.

SAFEGUARDING OF ER CLAIMS

(5) At the time of our review no exceptions were noted in the physical security of claims.

Summary of Issue

Original claims that are scanned in the system are boxed and placed into storage for safekeeping for 30 days on-site. The claim forms are destroyed in 30 days and other adjustment and legal document are sent out to offsite storage for seven years. Plan staff was unaware of the destruction date of the claims. Plan employees have various types of access to the claims system and the appropriate personnel have full access to the system. All doors entering the claims processing area are kept locked at all times to prevent unauthorized access.

Plan IT staff maintain the CATS system. If the logic is changed, the IT staff will change the associated tables. If the rate is to be changed, there are two persons with access to change the

rate. We noted that the CATS system had sufficient edit checks in place to identify duplicate claims. These edit checks can be overwritten by an appropriate manager or supervisor.

ER CLAIMS PROCESSING STAFF SKILLS AND ABILITIES

(6) At the time of our review, no exceptions were noted in the skills and abilities in staff.

Summary of Issue

Kaiser North employs several dozen verifiers and processors with varying degrees of experience. Upon hiring, Kaiser provides routine training on Plan operations, the I-File system, CATS system, referral system, provider contracts, and conducts hands-on training to processors. In addition, feedback from quality assurance audits are provided to claims supervisors who subsequently inform claims processing staff. The claims examiners do not enter any financial data or perform any financial calculations, thus at the time of our review, claims processing staff appear to have sufficient expertise and knowledge of their roles and responsibilities because staff were responsive to questions asked, and responded to various scenarios presented. Further, for new claims processing, audits are conducted for all claims processed.

ER CLAIMS QUALITY ASSURANCE FUNCTION

(7) The Plan had sufficient independent oversight of quality assurance activities.

Summary of Issue

Kaiser North performs three types of reviews. The first type of review will review claims for financial accuracy. The second type of review is a retrospective review that checks for claims processing accuracy. For each examiner, 5 percent of all claims finalized per month by each examiner are reviewed. The third type of review is called a focused audit to determine whether claims were appropriately denied and meet regulatory compliance issues. This type of quality assurance audits identified error trends in claims processing. The results are not provided in formal reports, but are addressed in weekly meetings with corrective actions being implemented. These meetings also address training opportunities and discuss system enhancement. Quality assurance auditors will also individually contact claims supervisors or managers to discuss claim errors.

For denied claims, a claims examiner cannot initially deny a claim for medical reasons. These claims are forwarded to medical audit for review by a clinical review team.

ER CLAIMS REPORTING

(8) The Plan had sufficient reporting mechanisms to provide oversight of claims processing activities.

Summary of Issue

The I-File system produces various reports to allow management to review various aging and inventory reports. For example, the Plan uses six reports to review claims aging statistics. These reports are used to monitor the lag time of claims received and prioritize those that need processing. Other reports, such as compliance report is received daily, including override and production reports.

END STAGE RENAL DIALYSIS (ESRD) CLAIMS PROCESS

ESRD CLAIMS RECEIPT AND PROCESSING

(9) At the time of our review, no exceptions were identified with the Plan's claims receipt and processing for ESRD claims.

Summary of Issue

All claims are received and processed at 950 Franklin Street, Oakland. The Plan does not use a separate post office box for the receipt of the End Stage Renal Dialysis (ESRD) claims. They are received on the 16th floor of the ESRD unit and manually sorted when opened. About half of the ESRD claims received arrive via mail and about half through electronic data interface. Few claims are received by facsimile. About 800 ESRD claims are received weekly via the U.S. mail.

ESRD processes claims for dialysis, labs, physician, hospitalization and pre-transplant. All claims are from contracted facilities. The Plan ended the receipt of capitation claims on 4/1/03. Up to that point, only about four percent of claims received were capitation encounter forms.

Claims are date stamped upon opening. There is no backlog of mail waiting to be date stamped. Claims may have multiple date stamps on them if they had been previously received and subsequently returned to the provider for corrected or additional information. According to ESRD processing staff, about 75 percent of claims received are returned to the provider to collect additional information about the claim.

A daily log of the number of claims received is kept. Claims are batched into lots of 50, and placed into a file of claims waiting to be processed.

Claims processors will pull from the file cabinet on a first in, first out basis, taking the oldest claims first. As of our review date of 7/1/03, there was a three-week backlog of claims waiting to be processed, or about 4,720 ESRD claims. The oldest claim had a receipt date of 6/9/03.

In addition to the ESRD claims, there are several other categories of claims received and processed in the office. These are for transplant claims and those from two hospital alliances (Alta Bates and Mount Diablo). Processors will assign the claims to themselves, taking the oldest claims from the drawer. The office goal is for the processor to administer 100 claims per day.

Claims must be entered manually into the AOMS system, but as of June 1, 2003, the office started using the I-File document imaging and character recognition system.

Claims may be pended in the AOMS system if they are determined to be “unclean”. That is, they are received with insufficient information to process. The claim information is entered and a DP (denied-pending) status is applied to the claim. At this point, a claim number has not been assigned to the claim. It must be matched to an authorization before a claim number can be assigned. A letter is generated manually to the provider notifying them of the pended status of the claim and the additional information that is needed. Generally, the original processor will be responsible for the continued processing of a pended claim. The claim may go to another processor if the person originally responsible for the claim is absent. Claims that have been resubmitted for processing having been previously pended and returned to the provider will go to the top of the queue for processing.

The Plan does not maintain a tracking system to follow-up on pended claims. Similar to the processing of SNF claims, the Plan does not issue a follow-up letter requesting the additional information. If no updated information is received within 90 days, the claim enters a DF (denied-final) status. No letter is sent to the provider notifying them of the claim entering a denied-final status.

If a claim is to be denied upon review, it can be denied by the CATS system where a denial letter will be sent out. If the denied claim is re-submitted, it is not given a new number.

Upon completion of initial claims processing, the claims are sent to medical billing examiners who review the claims and then release them for payment. No claims are processed manually.

ERSD CLAIMS REFERRAL AND AUTHORIZATION

(10) At the time of our review, no exceptions were noted with the ERSD referral and authorization process.

Summary of Issue

A plan member will receive authorization for services from their doctor. The physician who will coordinate the services needed sends an authorization request to a referral coordinator. The referral coordinator will enter the information into the AOMS (Authorized Outside Medical Services) system and an authorization number will be generated. The authorization number is sequential in nature and does not refer to a calendar date. Claims subsequently received are matched to the appropriate authorization.

ESRD CLAIMS PAYING AND POSTING

(11) At the time of our review, no exceptions were noted with claims payment.

Summary of Issue

Rate determination is set within the provider contracts or based upon Medi-Cal rates, and customary and reasonable rates for physician services. All hospital bills are from contracted providers.

The plan's AOMS system automatically determines if a claim needs a further medical review audit if charges exceed normal and customary amounts allowed. The system also checks whether the claim has been processed within the allowable timeframe according to Section 1371 or 1371.35. The system also calculates the interest owed and sends the information to the accounts payable system that will pay the interest in combination with the claim reimbursement amount. No checks are manually prepared out of the ERSD office.

The AOMS system is over 10 years old and was developed in-house. The system contains edit checks for reasonableness and to check for duplicates. Only the edit check for a duplicate claim can be overridden. On all others, the medical bill examiners would have to take action.

SAFEGUARDING OF ESRD CLAIMS

(12) At the time of our review, no exceptions were noted with the safeguarding of ESRD claims.

Summary of Issue

The AOMS system contains historical information going back over 10 years. Copies of the claims forms are kept on microfiche and kept indefinitely.

If a processor does not complete the claims they have assigned themselves within the day, the claims remain the responsibility of the processor.

ESRD CLAIMS PROCESSING STAFF SKILLS AND ABILITIES

(13) At the time of our review, no exceptions were noted in the skills and abilities of staff.

Summary of Issue

The office has seven full-time processors who have completed Kaiser processor training and have prior medical experience. Prior claims processing experience is not a requirement. All processors are trained to handle all types of claims seen within the office. There have been no major changes to the processing procedures or the adjudication procedures.

SKILLED NURSING FACILITY (SNF) CLAIMS PROCESS

SNF CLAIM RECEIPT AND PROCESSING

Summary of Issue

(1) At the time of our review, no exceptions were identified with the Plan's claims receipt and processing for SNF claims.

The processing locations for Skilled Nursing Facilities (SNF) claims we visited – Modesto, Sacramento, and Stockton - receive claims from facilities on contract with the Plan. They also

could variously receive claims for lab, DME, x-ray, therapy, mental health, podiatry and other ancillary services. In Modesto, the DME claims are sent over to an adjacent building for processing. At all of the facilities, no encounter forms are received or processed.

The Modesto office receives about 1,950 claims daily, but only about eight of them are SNF claims. Claims are received once per day via the mail service and may also be received via fax and EDI interfaces. Approximately 90 percent of claims are received via mail, five percent by fax, and five percent are received electronically via EDI. In Modesto, a dedicated post office box is used which is located on Baines Road and delivered to the location by courier.

In Sacramento, the facility receives approximately 2,000 claims per month or 500 per week. Claims are received daily by mail or by fax. Approximately 90 percent of claims are received via mail, 5 percent by fax, and 5 percent are hand delivered by the providers. No claims are received via EDI. A dedicated post office box is not used.

In Stockton, about 300 to 350 claims are received monthly.

The SNF claims are date stamped upon opening at the three facilities we visited and there were no backlog of SNF claims waiting to be date stamped. Manual logs were kept on the count of claims received daily.

At the three facilities, a claim that is received and lacks sufficient information to process will be returned to the provider for additional information. The claim will have a DP status code (denied-pending) and secondary code RV (returned to vendor). A note will be maintained in the system as to why the claim was returned. Two cover sheets accompany the claim back to the provider and contain information on the areas that need to be completed. When all information is obtained, the claims are batched in groups of 50 and placed on a shelf from oldest to newest. If a claim is received with insufficient information to process completely, it is placed into a DP (denied-pending) status and is returned to the provider with a letter outlining the information needed. No follow-up letter is sent in the Modesto and Sacramento facilities. However, in the Stockton facility, a second letter for the request for information is sent in accordance with AOMS policies and desk procedures. At all of the facilities, if after 90 days, no further information is received, the claim enters into DF (denied-final) status. No letter is sent out informing the provider of the claim being placed into the DF status.

For SNF claims, initial claims processing occur in Kaiser facilities located in Fresno, Union City, Modesto, Walnut Creek, Redwood City, Sacramento, San Francisco, San Rafael, Santa Clara, San Jose, Stockton, and Vallejo.

Claim processors review claims from the oldest to the newest. Each processor maintains a count log of the number of claims processed.

At the time of our review on 7/8/03, the oldest claim waiting to be processed was dated 6/10/03, but this included all claims processed by the facility. However, there were no SNF claims waiting to be processed. In Sacramento, as of our review date of 7/2/03, the oldest SNF

claim waiting to be processed was dated 6/10/03. In Stockton, the SNF processor was working on a claim dated 6/23/03, which was approximately 2 ½ weeks old.

The SNF claims are entered manually into the AOMS system and matched to an authorization number. The claim number assigned to the claim uses the authorization number and a sequential bill number. All SNF claims have been preauthorized, thus they are rarely denied for payment.

The determination of interest being owed and the amounts of the interest is not done on the local facility level. The AOMS system makes the determination and calculates the amounts automatically and sends information to the AP system for payment. The regions receive a monthly interest report from the Oakland office, but this is after the fact. There are also no aging reports that are run locally.

The AOMS system has the ability to edit claims and identifies those that need more information or where the appropriateness of the claim is in question. Claims processors can override some edits dealing with Denied Final (DF) codes. If a claim is denied by the processor for coverage or other reasons, a denial letter is generated manually and sent to the provider.

Once the claims are initially processed at the local facility, the claims are sent to the Oakland facility for final review by medical bill examiners and payment. Typically, SNF claims have up to a 10-day turn-around time for payment.

SNF CLAIMS REFERRAL AND AUTHORIZATION

(2) No exceptions were noted in referral and authorization procedures at the three facilities we visited.

Summary of Issue

Authorizations are generated when a member is determined to need care in a skilled nursing facility. This is usually generated by a patient being in an acute care facility and needs to be transferred to a SNF facility. The authorization documents are received from the doctors and processed and checked for items, such as member eligibility, timing, and COB. A sequential authorization number is then assigned by AOMS. If it is determined that a member is ineligible for SNF coverage, they are notified via letter outlining reason for denial of authorization. Patients would only be denied authorization if they did not meet skilled nursing criteria developed by Medicare.

SNF CLAIMS PROCESSING STAFF SKILLS AND ABILITIES

(3) No exceptions were noted in the staffing or training among the three facilities we visited.

Summary of Issue

The Modesto facility has one dedicated processor for SNF claims. There are 14 permanent employees to handle all of the types of claims received by the facility. Staff have at least 1 to 7 years of experience.

Claims processors receive training on both the processing of authorizations and the processing of claims. Employees attend training with the referral coordinator and then attend training on the AOMS system in Oakland. On an annual basis, Oakland has a referral coordinator conference to discuss training and also conducts quarterly teleconference training. In addition, monthly meetings take place to highlight deficiencies found in internal audit reports. For new staff, every coordinator reviews claims processed before medical review for accuracy.

SNF CLAIMS REPORTING

(4) No exceptions were noted in the reporting activities among the three facilities we visited.

Summary of Issue

The SNF facilities use various reports to help monitor claim processing. These reports include weekly reports that show a denied pending list on all claims; a monthly accounts payable report, and weekly count sheets that show the age of claims waiting to be processed.

On the local level, reports on pended claims and denied claims are not generated unless audits are conducted.

The types of reports variously used by the three facilities are as follows:

- Denied pended report
- Inventory report
- Production report (daily and weekly summary)
- Quarterly reports (retrospective audits on coordinator)
- Medical Bill Examination report (As the occurrence happens) – Fax cover sheet; director to the correct it
- Compliance report
- Override report

DURABLE MEDICAL EQUIPMENT (DME) CLAIMS PROCESS

DME CLAIM RECEIPT AND PROCESSING

(1) At the time of our review, no exceptions were identified with the Plan's claims receipt and processing for DME claims.

Summary of Issue

Two durable medical equipment claims processing facilities that we reviewed – Modesto and Sacramento—receive up to 15 fee-for-service (FFS) claims per day via mail, facsimile or

courier services. In Stockton, the DME facility receives 30 authorization requests and about 40 claims per month. In Sacramento and Stockton, DME claims are generally date stamped the same day they are received. In Modesto, claims are generally received by fax, which serves as the received date of the claim. In Modesto and Sacramento DME facilities, claim logbooks are not maintained onsite.

The DME processing office will facilitate the ordering of prescribed DME as well as the initial processing claims for reimbursement. DME facilities work with up to three capitated providers – APRIA, NATIONAL, and SHIELD. Other capitated providers are used but the providers are contracted on a FFS basis. Some claims are not capitated and for these, contracts are kept in a binder for manual adjudication. For the most part, contracts are programmed into the system so that auto adjudication can take place. For Mini-Medi, there is a pricing list. The contracts that are not loaded in the system commonly involve Healthcare Compliance Packaging Council (HCPC) codes that have multiple items. But for the most part, the contracts are loaded. For invoices that are not auto-adjudicated, staff use a binder that contains the contract.

Upon entering the invoice/authorization into the DOTS (DME Ordering and Tracking System), it is electronically transferred to AOMS, the forms are batched and sent to Kaiser's Oakland office. On our walkthrough date of 7/8/03, there was a reasonable backlog of claims of about two weeks. The oldest claims waiting to be processed were received 6/25/03. Claims and authorizations are entered into the systems manually, but once the fields are entered, the system auto adjudicates the claims.

DME CLAIMS REFERRAL AND AUTHORIZATION

(2) No exceptions were noted in referral and authorization procedures at the three facilities we visited.

Summary of Issue

At each of the 3 DME facilities we visited – Modesto, Sacramento, and Stockton - all DME claims are generated by authorization requests, which are received by fax, courier, or mail. DME staff will review the completeness of the authorization request such as signature, height and weight of the member. Authorization requests are generally returned for additional information on the prescription for the equipment. DME staff will review the claim for member eligibility. If members are eligible to receive the equipment under their plan, then staff will determine whether medical review is necessary. The Chief of the Utilization Management, who is a physician, will come daily to the department to approve or deny authorization requests based on clinical formulary criteria that establishes medical necessity. For some items, specialty review committees are used, when it is requested, usually for pulmonary issues. The committee makes a joint decision on whether equipment should be provided. DME clinical formulary criteria were revised in March 2003. However, DME staff will provide the initial recommendation to approve or deny the request. If the authorizations are denied, a general denial letter is sent. All denied letters are administratively reviewed to ensure that it makes sense to the average person. Letters are mailed on a daily basis. All denials for reimbursement

occur at the authorization stage and it is rare that a claim would be denied after authorization. If it is approved, staff will call the vendor and the doctor and if warranted, the family.

When a member is authorized for DME, the prescription/authorization request is received by the DME office, which enters the information into DOTS. The ordering of the material is then facilitated either through one of the capitated providers or FFS providers if the material it is not part of the capitated providers contract. Upon delivery of the equipment to the member, the provider will submit an invoice (claim) to the plan for reimbursement.

DME CLAIMS PROCESSING STAFF SKILLS AND ABILITIES

(3) No exceptions were noted in the staffing or training among the three facilities we visited.

Summary of Issue

The various DME offices visited have sufficient staff expertise in DME offices. Most had multiple years of experience. For new DME claims processors, the Plan provides training on the AOMS system, claims processing procedures, and hands on training by the area Plan managers. Also, DME claim management participates in monthly conference calls with QA to review audit reports.

DME CLAIMS REPORTING

(4) No exceptions were noted in the reporting activities among the three facilities we visited.

Summary of Issue

The DME facilities receive timeliness and interest reports on a monthly basis. Other reports used include:

- Capitated reports
- DOTS system (web based system March 18th): DME Departmental activity report.
- Utilization reports

SECTION V: SUMMARY OF RECOMMENDATIONS

1. The Plan should either re-evaluate their methodology for calculation of SNF and ESRD IBNR liability, or add a conservancy factor to the amount booked. The adjusted methodology should be re-evaluated periodically to ensure sufficiency.
2. The Plan should evaluate their DME expenses for northern California and if material, establish an appropriate reserve.
3. The Plan should examine their claim system edits to properly identify claims falling outside of the appropriate TAT. Issues were noted with the pending of claims that may have caused errors in identifying proper TATs.
4. The Plan should institute a company-wide policy on the payment of interest or late fees associated with the late payment of a claim. Emergency claims that were examined, in most cases, paid at the 15% per annum rate, instead of the greater of 15% per annum or \$15 per year non-prorated.
5. The Plan should examine their internal process of denial and pend letter generation in order to ensure that all denial and pend letters are sent to providers and members in a timely manner. The maintenance and storage of these documents should also be a priority because without the hard-copy documentation, there is not a proper substantiation of notification.
6. The Plan's system edits and processing should be examined to identify methods of applying member co-pays and registration fees to a single episode of care (or as defined by the member's contract).
7. The Plan should consider having their claims processing system print the received date on the claim form in order to provide hard-copy documentation of the received date. The system currently only records the received date in the claims processing system.
8. The Plan should consider re-evaluating their method of processing pended claims. The system currently cannot account for the time between notification of the provider and member that a claim has been pended, and the subsequent receipt of information that will allow for the adjudication of the claim.
9. The Plan should undertake a more comprehensive electronic data processing review that evaluates the integrity, reliability and accuracy of its claims processing information management systems.

APPENDIX

Methodology

MCG's examination of the Plan's fiscal and administrative affairs included several phases. First, MCG staff assessed the Plan's claims processing environment by conducting a walkthrough of the Plan's claim processing facilities, and reviewing policies and procedures related to claims processing, referral and financial accounting. This was mainly focused upon the Plan's processing of emergency claims and those other claims associated with the Plan's commercial health plan (ESRD, SNF, DME and Ambulance). Second, MCG requested claims database information from the Plan for the period of 4/1/01 to 3/31/03 and performed a series of statistical analysis on the database. The Plan's claim database for the period was tested to evaluate a turn-around time (TAT) calculation. TAT is usually determined by calculating the number of days between the receipt date and the paid date for an entire claim. The Plan's claim database was also analyzed to determine claims accuracy by testing a sample of claims processed and paid. Claims accuracy testing is based upon a point in time; therefore the tested sample accuracy is based upon whether the claim was paid correctly on the date the sampled claim was processed. For this reason, any claim that is subsequently reprocessed and corrected at a later date is still considered to be in error.

Using the stratified random sampling technique for emergency claims, the paid claims were selected randomly within each of the three strata listed below. A sample size of 33 for each stratum was selected to provide total claims sample of 99.

The claims were stratified based upon paid amount per claim. Stratification levels were selected to provide an even distribution of claims between strata.

\$0.01 - \$99.99

\$100.00 - \$299.99

\$300.00 +

A limited review of claims was also conducted for the ESRD, SNF, DME, and ambulance claims categories, but a standard random selection method was used.

Terms

Financial Accuracy – Calculated by dividing the net of the total tested dollars minus the gross dollars in error by the total tested dollars.

Payment Accuracy – Calculated by dividing the net of the number of tested claims paid correctly by the number of tested claims audited.

Non-Payment Error – Errors that do not affect the payment amount of a claim. These errors include the recorded date of receipt, date of service, paid date, amount claimed.

Non-Payment Accuracy – Calculated by dividing the number of tested claims without non-payment errors by the number tested claims audited.

Turn-around Time (TAT) – TAT is the number of days needed to process a claim. The calculation covers the period from the day the claim is received to the day the claim payment is made, suspended or denied.