

THE COMMONWEALTH OF MASSACHUSETTS

Report to the Massachusetts Division of Insurance

*Report on the Targeted Market Conduct Examination
of the Readiness of*

*Fallon Community Health Plan, Inc.
and Fallon Health & Life Assurance Company, Inc.
Worcester, Massachusetts*

For Compliance with M.G.L. c. 176O Section 5A

For the Period September 1, 2011 through December 31, 2011

THE COMMONWEALTH OF MASSACHUSETTS

Report to the Massachusetts Division of Insurance

*Report on the Targeted Market Conduct Examination
of the Readiness of*

*Fallon Community Health Plan, Inc.
and Fallon Health & Life Assurance Company, Inc.
Worcester, Massachusetts*

For Compliance with M.G.L. c. 176O Section 5A

For the Period September 1, 2011 through December 31, 2011

Joseph G. Murphy
Commissioner of Insurance
Massachusetts Division of Insurance
1000 Washington Street, Suite 810
Boston, Massachusetts 02118-6200

Dear Commissioner Murphy:

Pursuant to your instructions and in accordance with Massachusetts General Laws, Chapter 175, Section 4 and Chapter 176G, Section 10, a targeted examination has been made of the market conduct affairs of

Fallon Community Health Plan, Inc.
and
Fallon Health & Life Assurance Company, Inc.

at its home office located at:

10 Chestnut Place
Worcester, MA, 01608

The following report thereon is respectfully submitted.

Table of Contents

PURPOSE AND SCOPE OF THE EXAMINATION.....	1
EXECUTIVE SUMMARY	1
EXAMINATION RESULTS.....	1
I. Chapter 305 – Payer-Provider Coding Status Report.....	1
II. Claims Review	12
ACKNOWLEDGMENTS	14

PURPOSE AND SCOPE OF THE EXAMINATION

Under authorization of the Division of Insurance ("Division"), pursuant to M.G.L. c. 175, § 4 and M.G.L. c. 176O, § 10 a targeted market conduct examination of Fallon Community Health Plan, Inc. and & Fallon Health & Life Assurance Company, Inc. (collectively known as the "Company" or "Fallon") was performed by Examination Resources, LLC. The scope period of this examination was September 1, 2011 through December 31, 2011 ("Examination Period"). The onsite examination began March 19, 2012 and ended March 29, 2012.

The purpose of the examination was to determine the status of the Company's compliance with M.G.L. c. 176O, § 5A, which requires insurance carriers to accept and recognize patient diagnostic information and patient care service and procedure information submitted pursuant to, and consistent with, the current Health Insurance Portability and Accountability Act ("HIPAA") compliant code sets; the International Classification of Diseases ("ICD"); the American Medical Association's Current Procedural Terminology ("CPT") codes, reporting guidelines and conventions; and the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System ("HCPCS"). Section 5 further requires insurance carriers to adopt the aforementioned coding standards and guidelines, and all changes thereto, in their entirety, which shall be effective on the same date as the national implementation date established by the entity implementing the coding standards. The examination also included review of the claims forms in use by the Company to determine if the Company uses the standardized claim formats for processing health care claims as adopted by the National Uniform Claim Committee and the National Uniform Billing Committee and implemented pursuant to the HIPAA.

In addition, the examination included a review of the Company's response to the required status reports pursuant to M.G.L. c. 176O, § 5A, which requires insurance carriers to submit quarterly detailed status reports of their compliance with certain identified coding issues. The coding issues are those issues for which compliance is required by M.G.L. c. 176O, § 5A, and as agreed upon by the Advisory Committee created by Chapter 305 of the Acts of 2008. For purposes of this examination, the status report submitted by the Company on November, 15, 2011 was reviewed by the examiners. In addition, the Company provided for review the most recent version of its compliance report, as of February 15, 2012.

In reviewing materials for this examination report, the examiners relied on records provided by the Company and personal observation by the examiners of processes and controls during the onsite examination. Testing was performed on both a sample basis and total population review on certain codes and/or modifiers, when feasible.

The National Association of Insurance Commissioners ("NAIC") Market Analysis Handbook allows the utilization of Audit Command Language ("ACL") for determining sample sizes and sampling. The 2011 version of the handbook was used. Samples sizes for this examination were calculated by entering a Confidence Level of 95%, an Upper Error Limit of 5% and an Expected Error Rate of 2%. ACL returned a sample size of 184 for the claims review.

EXECUTIVE SUMMARY

This summary of the targeted market conduct examination of the Company is intended to provide a high-level overview of the examination results. The body of the report provides details of the scope of the examination, tests conducted, findings, observations, recommendations and, if applicable, subsequent Company actions.

The examination included three areas of review: Processes and Controls, Review of Chapter 305 – Payer-Provider Coding Status Report and a Claims Sample Review.

The following is a summary of all substantive issues found, along with related recommendations and, if applicable, subsequent Company actions made, as part of the examination.

I. Chapter 305 – Payer-Provider Coding Status Report

Review of the Company's responses to each listed issue along with the sample of the claims review and/or review of the total population for a given code within the data file showed that the Company's responses were accurate.

However, with respect to Modifier 51, which is not to be used in facility claims, it was found that the Company adds this modifier to process the claim payment for facility claims. The issue with this approach is that it affects the accuracy and integrity of the data stored in the Company's system for reporting purposes.

II. Claims Sample Review

There were 184 claims, out of a total population of 966,651, reviewed which contained a total of 532 CPT/HCPCS codes, 89 Modifiers, and 408 ICD codes. There were no exceptions noted.

EXAMINATION RESULTS

I. Chapter 305 – Payer-Provider Coding Status Report

The quarterly detailed status report of the Company's compliance with certain identified coding issues, submitted as of November 15, 2011, was reviewed. The Company also provided the latest version of that report, as of February, 15, 2012, to the examiners.

The responses to each issue listed were reviewed and testing was performed either on a sample basis (claims sample review), review of the total population of a given code within the data files provided by the Company, or both. To augment the examiners' ability to confirm all responses, the participation of an IT Specialist was deemed necessary for this examination.

Issue 1

Bilateral procedures (Modifier 50) - There are concerns that certain payers would not accept the Bilateral Modifier 50 and require that the CPT Code be listed twice.

Company Response: The Company stated "it requires bilateral procedures to be billed on one line with Modifier 50 and one unit and it will systematically pay at 150% of the allowable."

Testing: No Modifier 50s were within the selected sample, however, the Data File shows that Modifier 50 is accepted as stated by the Company.

Results: No exceptions were noted.

Issue 2

Multiple Procedures (Modifier 51) (Physician Practice vs. Facility) - Per CPT coding conventions, this modifier should only be used for physician practices. There are concerns that certain payers have medical policies that do not distinguish this and may instruct hospitals to report Modifier 51 which is not for use in the hospital setting.

Company Response: The Company stated "it does not require Modifier 51 on facility claims. The Company's Provider Manual and Ambulatory Surgery Payment Policy indicate that when multiple surgical services are performed at the same session, the procedure with the highest intensity is reimbursed at full payment; others are reimbursed in accordance with CMS guidelines or pursuant to contractual agreement. Facility payment reductions are applied through our claim system and the Company appends Modifier 51 in order to reduce systematically."

Testing: There were two Modifier 51s that were noted in facility claims during the sample review. The examiners verified that the Provider Manual instructs providers that Modifier 51 is not used in facility claims. The Company stated they add Modifier 51 to facility claims in order to have the system pay subsequent charges at 50%.

Results: The approach used by the Company may permit certain claims to be handled even though not consistent with CPT guidelines and this affects the accuracy and integrity of the data stored in the Company's system for reporting purposes.

Issue 3

Reduced Services (Modifier 52) - There are concerns that certain payers require use of Modifier 73/74, and vice versa, for incomplete or reduced colonoscopy procedures (Physicians).

Company Response: The Company stated, "it requires providers to code the appropriate modifier according to CPT guidelines. Modifiers 73 and 74 are only to be used by facilities depending on when the procedure was terminated in regards to if anesthesia was or was not performed."

Testing: No Modifiers 73 or 74 appeared in the selected sample. There were 11 claims with Modifiers 73/74 noted in the data file, and none were from professional claims. Examiners verified that the Provider Manual instructs providers (in part) that "Due to extenuating circumstances or those that threaten the well being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation, but prior to the administration of anesthesia. Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of the Modifier 73 or Modifier 74."

Results: No exceptions were noted.

Issue 4

Distinct Procedures (Modifier 59) – There are concerns that payers vary in their instruction/recognition of Modifier 59 and do not clearly communicate any pertinent payment reduction/considerations to the providers.

Company Response: The Company stated "it communicates to our providers via the Provider Manual that we recognize Modifier 59 and instructs providers to use only if a more descriptive modifier is not available. Providers must also attach supporting documentation. The first procedure may be reimbursed at 100% of the billing physician's contracted rate. All subsequent procedures will be reviewed and payment may be affected."

Testing: Six claims were noted in the selected sample using Modifier 59 and were found to be processed properly. In addition, examiners noted that the provider manual does clearly instruct providers of the usage of Modifier 59.

Results: No exceptions were noted.

Issue 5

Repeat Clinical Diagnostic Lab Test (Modifier 91) - There are concerns regarding confusion associated with criteria to be used in the application of Modifier 91 and that certain payers do not recognize that Modifier 91 is to be used only for repeat lab tests and not other diagnostic test CPT code ranges.

Company Response: The Company stated "it accepts and recognizes this modifier."

Testing: No Modifier 91 codes were noted in the selected sample. The IT Specialist reviewed the Company's systems and determined that the Company's system did recognize Modifier 91, and that it was used for repeat laboratory tests.

Results: No exceptions were noted

Issue 6

Accepting multiple modifiers on the same line - There are concerns that payers vary in accepting the number of modifiers on the same line - some allow 2, 3 or 4. There are concerns that despite allowing more than one modifier on a line, certain payers only recognize the first modifier.

Company Response: The Company stated "it accepts and recognizes up to four modifiers. In some cases this is manual application of payment but is transparent to the provider."

Testing: The selected sample noted claims were accepted with multiple modifiers on the same line. As explained, claims are not rejected due to additional modifiers, but may be pending for manual review, depending on the diagnostic code preceding the modifier.

Results: No exceptions were noted.

Issue 7

V76.0-V76.9 - Screening for Malignant Neoplasms - There are concerns that for certain payers multiple claims are rejected because the V code is sequenced first and that IT issues exist for some payers that are unable to screen secondary diagnostic codes.

Company Response: The Company stated "it accepts and recognizes all diagnosis codes. The Company requires providers to indicate which diagnosis code applies to each service line billed using the diagnosis pointer."

Testing: The selected sample included 20 claim lines that included codes V76.11 (2), V76.12 (7), V76.2 (5), V76.44 (4), and V76.47 (2) and they were all processed properly.

Results: No exceptions were noted.

Issue 8

V57.0-V57.9 - Encounter for Rehabilitation. Services - There are concerns that certain payers will not accept the correct V Code sequencing (1st Listed) for Rehabilitation encounters and instruct providers to incorrectly sequence a medical condition first for Rehabilitation Therapy or Services.

Company Response: The Company stated "it accepts and recognizes all diagnosis codes. Providers are required to indicate which diagnosis code applies to each service line billed using the diagnosis pointer."

Testing: There were no V57.0 - V57.9 codes included in the selected sample. The IT Specialist observed claim records on the Company's system showing that it did recognize and pay claims with V57x codes in the secondary position.

Results: No exceptions were noted.

Issue 9

V67.0-V67.9 - Follow-up Examinations - There are concerns that certain payers instruct providers to omit the V code and list the code for the original condition or injury – even if resolved.

Company Response: The Company stated "it accepts and recognizes all diagnosis codes and does not instruct providers to bill specific diagnosis codes. We expect providers to bill according to guidelines."

Testing: There were no V67.0 - V67.9 codes included in the selected sample. The IT Specialist reviewed the company's systems and determined that the Company's system did recognize and pay claims with V67x codes as follow-up visits.

Results: No exceptions were noted.

Issue 10

V51-V58.9 - Encounter for Aftercare - There were concerns that certain payers do not process claims with this range of codes and instruct providers to submit the code for the initial injury or illness in the first position in order to process the claim. Some Specific

Aftercare V Codes within this range that trigger edits: V51-Plastic Surgery – Aftercare; V54.81-V54.9 – Orthopedic Aftercare; V58.0-Encounter for Radiation Therapy; V58.1-Encounter for Chemotherapy; V58.61-V58.61 – Long-term current use of medications (i.e. Coumadin); V55.3 –Attention to Colostomy- (i.e. Closure).

Company Response: The Company stated “it accepts and recognizes all diagnosis codes. Providers are required to indicate which diagnosis code applies to each service line billed using the diagnosis pointer.”

Testing: One claim from the selected sample contained three codes from this group and was processed properly.

Results: No exceptions were noted.

Issue 11

V30.00-V39.20 - Liveborn Infants – There were concerns that certain payers instruct providers to omit the V code as the first listed code on claims forms.

Company Response: The Company stated “it accepts and recognizes all diagnosis codes. Providers are required to indicate which diagnosis code applies to each service line billed using the diagnosis pointer.”

Testing: Two claims from the selected sample contained four codes from this group and were processed properly.

Results: No exceptions were noted.

Issue 12

V04.8 –Flu; V05.9 – Viral; V06.5-Tetanus Vaccinations – There were concerns that certain payers reject claims for those codes with the error message: Diagnosis incorrect for reimbursement.

Company Response: The Company stated “Fallon accepts and recognizes all diagnosis codes. Providers are required to indicate which diagnosis code applies to each service line billed using the diagnosis pointer.”

Testing: Only code V04.8 was included in the selected sample (four times) and was processed properly. The IT Specialist review showed that the Company's system did recognize and pay claims with codes V05.9 and V06.5 as well.

Results: No exceptions were noted.

Issue 13

Contraceptive V25.09-Mgt; V25.41-BCP Surveillance; V25.49-Surveillance - There are concerns that certain payers reject claims with the error message: Diagnosis incorrect for reimbursement.

Company Response: The Company stated "it accepts and recognizes all diagnosis codes. Providers are required to indicate which diagnosis code applies to each service line billed using the diagnosis pointer."

Testing: Only code V25.41 appeared (once) in the selected sample. The IT Specialist review showed that the Company's system did recognize and pay claims with these codes.

Results: No exceptions were noted.

Issue 14

V72.8x –Other Specified Exams – There were concerns that certain payers reject claims with first listed diagnosis of V Code for the Examination. Instructions are given to submit a medical condition (acute or chronic) rather than the V Code

Company Response: The Company stated "it accepts and recognizes all diagnosis codes. Providers are required to indicate which diagnosis code applies to each service line billed using the diagnosis pointer."

Testing: There were no claims in the selected sample with ICD V72.8x codes. The IT specialist reviewed the company's systems and data file and found that these codes are accepted and recognized.

Results: No exceptions were noted.

Issue 15

Timely ICD-9, CPT-4, HCPCS updates in system – There are concerns that providers are looking for the actual dates that the codes are adopted and the actual dates they are implemented/used for claims processing.

Company Response: The Company stated "Fallon accepts and updates new CPT and HCPCS codes by January 1st annually and ICD codes by October 1st annually. Fallon, however, does internal analysis to determine payment and benefit configuration which may delay processing of the claims. FCHP has a policy to support this and we communicate to providers in the provider newsletter."

Testing: The Company states the updates are performed timely. The IT Specialist was provided with the Company's Change Control document from the last change date and the review of these documents indicates that updates are tested and implemented timely.

Results: No exceptions were noted.

Issue 16

Physical Therapy ("PT")/Occupational Therapy ("OT") evaluation versus initial evaluation - PT and OT share many of the same CPT codes. Standard coding guidelines requires modifiers, but there are concerns that certain payers do not allow them and are also requiring inappropriate use of CPT codes by requiring OT to be billed using Evaluation or Re-Evaluation CPT codes, instead of the actual modalities that were performed.

Company Response: The Company stated "it accepts and recognizes all standard coding."

Testing: The IT specialist reviewed the Company's systems and data file and found that these modifiers are accepted and recognized.

Results: No exceptions were noted.

Issue 17

Canceled Procedures – V Code and Modifiers - Institutional Claims: Modifiers and ICD-9 codes exist to reflect cancellation of planned procedures. There are concerns that certain payers do not have clear-cut payer policies and recognition of modifiers to promote consistent capture and claims processing.

Company Response: The Company stated "it accepts and recognizes all standard coding."

Testing: The IT specialist reviewed the Company's systems and data file and found that these modifiers for cancellations of procedures are accepted and recognized.

Results: No exceptions were noted.

Issue 18

Canceled Procedures – V Code and modifier – Physician - Modifiers and ICD-9 codes exist to reflect cancellation of planned procedures. There are concerns that certain payers

do not have clear-cut payer policies and recognition of modifiers is needed in order to promote consistent capture and claims processing.

Company Response: The Company stated "it does not have a payment policy on cancelled procedures at this time. We do however, accept and recognize all standing coding."

Testing: There were no claims in the sample for these codes. The IT specialist reviewed the Company's systems and data file and determined that these modifiers for cancellations of procedures are allowed.

Results: No exceptions noted.

Issue 19

Total Number of diagnosis accepted and/or recognized - Institutional Claims – There were concerns that variation in the number of outpatient diagnostic codes accepted and recognized by certain payers.

Company Response: The Company stated "We accept and recognize all diagnosis codes billed but one primary (admitting diagnosis). The Company's system is basically unlimited for UB claims."

Testing: Selected sample shows usage of multiple ICD Codes. One claim included 7 ICD codes, the Company stated and demonstrated that they accept up to 10 or more ICD codes. During the QNXT demonstration the IT Specialist observed institutional claims with multiple diagnostic codes. The claims were automatically adjudicated and paid.

Results: No exceptions were noted.

Issue 20

Total Number of diagnosis accepted and/or recognized - physician level claims – There were concerns that variation in the number of outpatient diagnostic codes accepted and recognized by payers.

Company Response: The Company stated "We accept and recognize all diagnosis codes billed up to 8. Diagnosis pointer is required by provider indicating which diagnosis applies to service line."

Testing: The selected sample shows usage of multiple ICD Codes. One claim included 7 ICD codes, the Company stated and demonstrated that they accept up to 10 or more ICD codes. During the QNXT demonstration the IT Specialist observed physician claims with multiple diagnostic codes. The claims were automatically adjudicated and paid.

Results: No exceptions noted.

Issue 21

Medical Necessity Denials and Rejections - Code Recognition: Claims Denials and Rejections. There are concerns that certain payers are not consistently reading or recognizing additional 2nd, 3rd, 4th listed diagnoses codes pre-determined and documented medical necessity for the plan(s).

Company Response: The Company stated "We accept and recognize all diagnosis codes billed but one primary (admitting diagnosis). Diagnosis pointer required by provider. There are some codes (ex unlisted or NOS codes) that require documentation in order to process. The Company also publishes services that require prior authorization which entails a medical necessity review however this occurs prior to receipt of the claim."

Testing: There were no denials/rejections noted in the selected sample due to the Company not reading the 2nd, 3rd, etc diagnosis codes.

Results: No exceptions were noted.

Issue 22

Medical Necessity Denials and Rejections: Policy Coverage Logic - There were concerns that certain payers use 1. Payer Guidelines that fail to recognize official coding guidelines by requiring 1st listed/primary codes that are vague and/or should never be used as 1st listed diagnostic codes (examples: Late effect 900 codes) 2. Incorrect ICD-9-CM diagnostic codes listed for coverage. Failure of the payer to recognize the correct diagnoses codes (example: authorizing coverage for 996.52 complications for skin grafts vs. amputation flap complication code category range). 3. Policy Coverage Language that ensures coverage for high risk/family history conditions but fails to recognize Official Sequencing Guidelines for codes submitted. In other words, recognizes 1st listed code only.

Company Response: The Company stated "it is compliant and recognizes UB04 & HIPAA code sets, as well as official ICD-9-CM dx code set. The Company does not instruct providers what codes to use or in what position to use them. This is an expectation of the providers. We do require diagnosis pointers on the claims indicating which diagnosis applies to the service line (HCFA claims)."

Testing: There were no denials/rejections noted in the selected sample due to the Company not reading the 2nd, 3rd, etc diagnosis codes.

Results: No exceptions were noted

Issue 23

Medical Necessity Claims and Rejections: Outpatient Claims and Rejections – There were concerns that certain payers have 1. Medical Policy Language that Fails to Address Official Outpatient Coding Guidelines (example: Fetal Ultrasounds - Coverage Policy lists "coverage for suspected condition listing").

Company Response: The Company stated "it is compliant and recognizes UB04 & HIPAA code sets, as well as official ICD-9-CM dx code set. The Company does not instruct providers what codes to use or in what position to use them. This is an expectation of the providers. We do require diagnosis pointers on the claims indicating which diagnosis applies to the service line (HCFA claims)."

Testing: There were no denials/rejections noted in the selected sample due to the Company not reading the 2nd, 3rd, etc diagnosis codes.

Results: No exceptions were noted.

Issue 24

Unlisted CPT Procedure Codes – There were concerns that certain payers have Payer Rejections and Mandates for Hospital to "Change" the Unlisted Code to closest/similar CPT Code due to Payer IS/ Processing Constraints and/or lack of Medical Review Policies pertaining to unlisted CPT Codes.

Company Response: The Company stated "it requires operative notes on unlisted surgery codes and medical notes on other unlisted codes in order to determine pricing."

Testing: It is stated in the Provider Manual that procedures performed with unlisted codes need prior authorization, supporting documentation, and are subject to Medical Director review. There were no denials/rejections noted in the selected sample due to unlisted CPT codes.

Results: No exceptions were noted.

Issue 25

Unlisted CPT Procedure Codes - Errors in Assignment (Payer and Provider) - Payer/Provider Audit Discrepancies. There were concerns that certain payers had discrepancies in Multiple Payer Rejections of Unlisted CPT Procedure Codes leading to manual re-review, manual appeal, manual re-submission of supporting documentation.

Company Response: The Company stated "it accepts and recognizes unlisted codes. FCHP reimburses for unlisted procedures and services and requires plan prior authorization. Since unlisted procedure codes do not describe a specific procedure or service, claims must be submitted with supporting documentation and are subject to Medical Director Review. Similar codes to the unlisted code will be identified to determine reimbursement. Upon audit of surgical procedures, the Company does find that there are times when the provider bills an unlisted code but when the operative note is reviewed, we determine the unlisted code was not appropriate."

Testing: It is stated in the Provider Manual that procedures performed with unlisted codes need prior authorization and supporting documentation. There were no denials/rejections noted in the selected sample due to unlisted CPT codes.

Results: No exceptions were noted.

Issue 26

Retrospective Diagnosis Related Groups (DRG) and CPT Audits (Inpatient and Outpatient Provider) – There were the following concerns for certain payers –

1. Payer/Provider Discrepancies. Multiple Rejections of Initial DRG Assignment leading to manual re-review, manual appeal, manual re-submission of supporting documentation.
2. Auditors fail to quote and/or ignore Official ICD-9-CM and CPT Code Set Guidelines.
3. High Appeal/Over-turn Rates Upon Re-Review (35-40%).
4. Escalating Administrative Costs Associated with Payer's Failure to Recognize Official Code Set Guidelines.

Company Response: The Company stated "We conduct DRG audits and the results of the review are presented to the provider. The provider has the opportunity to review and appeal. As noted in the reporting of the DRG audits, historically our reviews and appeals to change DRG codes are very low in comparison to the volume of DRG claims processed."

Testing: Based on the selected sample review DRG claims were processed appropriately.

Results: No exceptions were noted.

II. Claims Review

The Company provided a data file containing 966,651 claims records. A total of 184 claims were randomly selected for review. The sample was reviewed to determine the Company's acceptance and recognition of information submitted pursuant to current coding standards and guidelines required, as well as use of standardized claim formats.

The Company uses standardized claim formats for processing health care claims as adopted by the National Uniform Claim Committee and the National Uniform Billing Committee and implemented pursuant to the HIPAA

The claim files reviewed included a total of 532 CPT/HCPCS codes, 89 Modifiers and 408 ICD codes.

Results:

No exceptions were noted.

ACKNOWLEDGMENTS

The courtesy and cooperation of the officers and employees of the Company during the examination are acknowledged and appreciated.

Victor M. Negron, AIE, FLMI, Joan McClain, AIE, FLMI, Ann McClain, CIE, FLMI, Stephen Lutz and Michael Morrissey, AES, CISA, CISSP participated in this examination.

Respectfully submitted,

Examination Resources, LLC