Report to the
Massachusetts Division of Insurance

on the Targeted Market Conduct Examination of
the Readiness of

Network Health, LLC.

101 Station Landing, Medford, MA 02155

for Compliance with M.G.L. c. 176O, §5A

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

May 7, 2012

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The Honorable 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, a targeted examination has been made of the market conduct affairs of:

Network Health, LLC
("The Company")

at their home office located at:

101 Station Landing
Medford, MA 02155

The following report thereon is respectfully submitted.

FOREWORD

This report on the market conduct examination of the Company is provided pursuant to the *NAIC Market Regulation Handbook*. Some practices, procedures and files subject to review during the examination were omitted from the report if no improprieties were noted.

The Commonwealth of Massachusetts conducted a series of targeted examinations to determine insurance company compliance with Massachusetts General Law (M.G.L.) Chapter (c.) 176O, § 5A. In accordance with that section, insurers are required to meet the following criteria no later than July 1, 2012:

1. Implementation of HIPAA compliant codes and forms;
2. Acceptance of standardized claim formats; and
3. Utilization of standardized code sets.

These examinations measured the companies' readiness to achieve 100 percent compliance with these requirements by July 1, 2012.

INS Regulatory Insurance Services, Inc. (INS) was engaged by the Division of Insurance ("Division") to conduct this series of targeted examinations, including the examination of Network Health, LLC. In order to measure the Company's compliance with these impending requirements, INS engaged in the following:

- INS sent interrogatories to the Company which posed a series of questions regarding reports and information that demonstrate the Company's current level of compliance with M.G.L. 176O, § 5A.
- The Company provided responses to the interrogatories that included policies, procedures and reports illustrating their current level of compliance with the law.
- INS collected data samples from the Company, which were analyzed using ACL ® software.
- INS selected representative samples of claim data submissions and reviewed the same in an on-site visit to the Company.

PROFILE

Network Health, LLC is a non-profit Massachusetts Health Maintenance Organization (HMO) with contracts to provide managed care benefits to enrollees with the Massachusetts Executive Office of Health and Human Services (EOHHS), the Commonwealth Health Insurance Connector Authority (Connector) and the Massachusetts Department of Unemployment Assistance (DUA). Tufts Associated Health Maintenance Organization, Inc. is the sole member of Network Health, LLC. On November 1, 2011, Network Health, LLC became operational, purchasing all of the assets of Network Health, Inc. and receiving an HMO license from the Massachusetts Division of Insurance. Prior to this transaction, Network Health, Inc. had been in operation for over 10 years.

EOHHS is the state agency responsible for administering the Medicaid MassHealth program. Network Health contracts with this agency to provide comprehensive health care coverage to MassHealth Members.

Connector is a public instrumentality of The Commonwealth of Massachusetts responsible for the administration of the Commonwealth Care Health Insurance Program. Network Health contracts with the Connector to provide comprehensive health care coverage to eligible individuals to be identified by the Connector.

Network Health contracts with DUA to provide comprehensive health care coverage to individuals who are eligible for unemployment insurance benefits and their families.

SCOPE OF EXAMINATION

The Division conducted an examination of the Company's status to be fully compliant with M.G.L. c. 176O § 5A as of July 1, 2012. Data was collected from the Company from the period of October 1, 2011 through December 31, 2011 (the "Examination Period"). Based on the submitted data, information was analyzed and sample files selected for review. The files were reviewed during an onsite visit, and the review included group and individual health insurance, but did not include disability income, long-term care, short-term travel, accident only, limited policies (including dental, vision, pharmaceutical policies, or specified disease policies) or policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act (Medicare). Only data for fully insured plans were included; self-insured or Administrative Services Only contracts were not included in the review.

EXAMINATION RESULTS

The following is a summary of examiner findings, along with related recommendations and required actions and, if applicable, subsequent Company actions made, as part of the targeted market conduct examination of the Company.

The Company identified a universe of 4,277 lines of claims with modifier codes 50, 51, 52, 59 and 91 that were reported during the Examination Period. A random sample of 109 claims was requested, received and reviewed. The claims were reviewed to verify compliance with M.G.L. c. 176O, § 5A.

No exceptions were noted.

The Company identified a universe of 93,234 lines of claims with a V diagnosis code reported during the Examination Period. A random sample of 109 claims was requested, received and reviewed. The claims were reviewed to verify compliance with M.G.L. c. 176O, § 5A.

No exceptions were noted.

The Company identified a universe of 61,175 denied claims reported during the Examination Period. A random sample of 109 claims was requested, received and reviewed. The files were reviewed to verify compliance with M.G.L. c. 176O, § 5A.

No exceptions were noted.

The Company identified a universe of 385,787 paid claims reported during the Examination Period. A random sample of 109 claims was requested and received. Of the 109 claims, 60 were reviewed to verify compliance with M.G.L. c. 176O, § 5A.

No exceptions were noted.

Finding(s):

In response to the interrogatory, the Company indicated that:

"Network Health uses the seven listed codes and formats exclusively, making our level of compliance 100%. Network Health participated in a correct coding work group with other health plans and the DOI, which confirmed for us that we complied with correct coding initiatives. We have not done internal audits given that we use the codes and formats listed above exclusively."

During the on-site phase of the examination the Company demonstrated that they have implemented HIPAA compliant codes and forms, acceptance of standardized claim formats and utilization of standardized code sets.

Recommendation(s):

Based on a review of Network Health, LLC's responses, it appears that the Company is in compliance with Massachusetts General Law Chapter 1760 § 5A, and no recommendations are warranted at this time to address any identified compliance issues.

Observation 1:

The Company's responses to Interrogatories required additional follow up. The Company responses below were noted:

<u>Company Response to IR1</u>

Network Health uses the existing Uniform Coding and Billing Compliance Report to identify deficiencies in configured code sets. See attachments Chapter 305 denials

PayerProviderCodingGrid 20120201, Uniform Coding and Billing Compliance report 2012 and UniformCodingSummary2012.

Company Responses to IR2

Network Health has currently loaded 100% of the coding updates per files received from Ingenix. This includes ICD-9, CPT, HCPCS and Revenue Codes, as well as CPT and HCPCS modifiers.

The Configuration team begins the diagnosis code update process in early September each year to ensure adequate testing so they code updates are available in our production claims system by October 1.

Update of the CPT, HCPCS and Revenue codes and their modifiers begins in early November to ensure production readiness by January 1. We also purchase quarterly update files which are loaded upon receipt.

As we talked about, we do not currently maintain a daily internal audit that monitors compliance with MA1760 5A.

The Company responses to the requests indicated the Company is using the existing compliance report only to identify code processing deficiencies and noncompliance with M.G.L. Chapter 176O § 5A. The Company does not perform any scheduled internal audit or oversight of rejected claims or codes.

Recommendation(s)

It is recommended that the Company perform scheduled internal reviews of rejected claims or codes and measure compliance with M.G.L. c. 176O, § 5A.

Observation 2:

Upon conclusion of the four (4) claims samples reviewed during the on-site portion of the examination, the following issues were noted:

Modifier Code Identified Claims

Sample 104 –*An initial claim was received on 11/2/11 which denied on 11/20/11 for medical records. The provider resubmitted a paper claim with medical records as a new claim to our PO Box on 12/16/11. Once entered in our system, this second claim was treated as correspondence which resulted in the first claim being adjusted on 1/26/12 and finalized/posted on 1/29/12. Although the initial claim was adjusted as a result of the second claim submission, no further action was taken on the second claim and it remained "pending". The correct process should have been to delete the second claim and treat it as correspondence. The second claim has been deleted and the notes on the initial claim have been updated to reflect the actual resolution.*

Denied Claims

Sample 9 – This claim was received on 12/9/11 and finalized on 12/29/11 with a denial for services not authorized. A new claim was received on 1/31/12 and paid on 2/12/12. Upon review during the audit it was determined that the initial claim was denied incorrectly. The claim was denied incorrectly by a newly hired reviewer.

Sample 80 – This claim was received on 10/17/11 and finalized on 10/23/with a denial for services not authorized. The claim was originally being reviewed for third party liability, but the TPL reviewer overlooked the ER place of service and denied it with the incorrect reason. Customer Service received a call from the provider on 11/16/11 which resulted in the claim being reprocessed and denied for MVA (Motor Vehicle Accident) PIP (Personal Injury Protection) must be exhausted.

In both cases, re-training was provided to eliminate future inappropriate denials.

Sample 20 – This claim was received on 11/20/11 and paid on 12/4/11. This one line for CPT code 86305 was denied as "Invalid procedure code for this DOS". The code appears to be valid for the DOS, although the system doesn't currently reflect that. A request has been submitted to update that, and the claim will be adjusted when the change is made.

Samples 102 & 103 – This claim was received on 10/21/11 and finalized on 10/31/11 with a denial for services not authorized. Customer Service received a call from the provider on 11/2/11 which resulted in the claim being reprocessed to pay as an appropriately referral was found for these services.

Sample 30 – The claim was received on 10/3/11 and finalized on 11/6/11 with a denial for Invalid Modifier for CPT code (S9485 – HE). Prior authorization was previously given for S9485 with modifier TG. The incorrect denial was used for this service. The correctly denial should have been "service not authorized as billed".

Recommendation(s):

It is recommended that the Company provide additional training to claim processors to ensure appropriate and accurate processing.

REPORT SUBMISSION

This report of examination is hereby respectfully submitted.

Examiners:
INS Regulatory Insurance Services, Inc.

Sean Connolly, MCM Examiner
Frank Kyazze , EIC, Examiner in Charge
Shelly G. Schuman, Supervising Insurance Examiner

APPENDIX

The following summarizes the data analysis conducted during the examination. All analyses were conducted utilizing ACL ® software. Duplicate claims were removed.

Total Number of Claims	533,814
Total Number of Paper Claims (claims submitted in hard copy form)	65,855
Total Number of Electronic Claims	467,959
Top 5 Reasons for Denial	
1. Payment included in global rate	24.11%
2. Member not eligible on date of service	11.65%
3. Incidental procedure	9.9%
4. Filing limit exceeded	8.21%
5. Service not authorized	7.98%
Percentage of Claims Paid	72.27%
Percentage of Claims Denied	11.46%
Time to Process Claims	
1-15 Days	88.71%
15-30 Days	6.60%
30-45 Days	3.66%
Over 45 Days	1.03%