THE COMMONWEALTH OF MASSACHUSETTS

Report to the
Massachusetts Division of Insurance

Report on the Targeted Market Conduct Examination of
the Readiness of

Tufts Associated Health Maintenance Organization, Inc.
and
Tufts Insurance Company

Watertown, Massachusetts

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

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

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June 24, 2012

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

Tufts Associated Health Maintenance Organization, Inc.
and
Tufts Insurance Company

at its office located at:

705 Mt. Auburn Street
Watertown, Massachusetts 02472

The following report herein is respectfully submitted.

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 Tufts Associated Health Maintenance Organization, Inc. and Tufts Insurance Company (collectively known as the "Company" or "Tufts Health Plan") 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 26, 2012 and ended April 6, 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. Processes and Controls

The review of the processes and controls along with the sample of the claims review and total population review of certain codes indicates that system edits are working as expected, with one exception noted in the claims review. The review of the Company's processes and controls required the use of an Information Technology ("IT") Specialist. The work performed by the IT Specialist included an analysis of a questionnaire completed by the Company, conducting interviews of key personnel, performing walk-throughs of the Company's systems, and assisting the examiners, as deemed necessary. The Company has indicated that it is undergoing a system enhancement to ensure full compliance with the uniform coding requirements by July 1, 2012.

The Company provided a copy of the Tufts Health Plan SSAE16 covering the period from November 1, 2010 through October 31, 2011. This report, prepared by an independent auditor, includes control documentation and testing of security, change management and system processes (including those for claims and payments). A review of the SSAE16 by the IT Specialist did not identify any significant control weaknesses.

II. Chapter 305 – Payer-Provider Coding Status Report

Review of the Company's responses to each listed issue along with the claims sample review and/or review of the total population of a given code within the data file (1,295,662 claim records) showed that the Company's responses were accurate.

III. Claims Sample Review

The sample of 184 claim files reviewed included a total of 387 CPT/HCPCS codes, 52 Modifiers and 303 ICD codes. A total of 75 instances were found to be not in compliance with the uniform coding guidelines. These are broken down as follows:

1. There were 72 instances where the ICD Codes were not used for adjudication.

2. There were two instances where multiple modifiers were not used for adjudication.

3. There was one instance in which the CPT code was incorrect.

IV. Additional Issue Referral

The Division requested the examiners review an issue with the Company's practice of recoding properly submitted test codes into a panel code when not all tests required under the panel were performed. The examiners determined that although the practice is done for payment processing, it affects the accuracy and integrity of the data stored in the Company's system for reporting purposes.

EXAMINATION RESULTS

I. Processes and Controls

Claims are submitted either electronically or on paper. The Company states that about 90% of claims are submitted electronically. Electronic claims are submitted in HIPAA 837 format and paper claims are submitted on the standard UB04 and 1500 forms.

Electronic data interchange ("EDI") is a way providers can submit electronic transactions to Tufts Health Plan. This commonly refers to claim, referral and eligibility transactions, but also can be applied to other transaction types. Tufts Health Plan supports a number of EDI methods for claims, including:

- Direct submission (ANSI X12N 837 claim format) Reference the HIPAA 837 Companion Document for Direct Submitters for additional information.

Submissions from a variety of external clearinghouse sources, including:

- Capario/MedAVANT- Statlink (professional only)
- Emdeon (WebMD) - Healthwire, Claim Master, and others (professional and institutional)
- McKesson/RelayHealth
- Allscripts

The date of receipt for the claim is defined as the day the claim is processed at Tufts Health Plan and a Tufts Health Plan claim number is assigned to the claim. Proof of receipt is supported by the EDI acceptance report or paper Statement of Account ("SOA").

The Company states that about 80% of the claims are auto-adjudicated. There are two levels of edits. The first level reviews basic information and after the claim passes the first level it goes to the second level of edits which includes review of the codes. If a claim is rejected, a report is sent to the provider explaining the reason for the rejection, so the provider can resubmit the corrected claim if necessary.

Paper claims come through the mail. The mail room staff delivers it to the claims operations where clerical staff sorts the claims by different types of claims (professional, outpatient, inpatient, etc.) and also by different categories (with documentation, without documentation, single code or multiple codes, etc.) and are set in batches. Scanner operators will scan the documents and the OCR software will read the documents and enter them into the system automatically. The "date of receipt" of paper claims is the earlier of:

The date indicated on a receipt of delivery signed by a Tufts Health Plan representative when paper claims are sent via hand delivery, registered mail, or some other means requiring a signed receipt. The provider must maintain a log that clearly identifies all claims included in each filing which require a signed receipt. Such log must be available for inspection by Tufts Health Plan upon reasonable notice to the provider.

OR

The date the claim is recorded as received by Tufts Health Plan or three business days after the day that the claim is recorded by the provider as sent to Tufts Health Plan when claims are not sent by a means requiring a signed receipt. Such recording must be completed by means of a written log or patient account ledger maintained by the provider in the ordinary course of business. Such log or patient account ledger must be available for inspection by Tufts Health Plan upon reasonable notice to the provider.

The process thereafter is similar to electronic claims.

The Company stated it reviews all claims with a dollar amount of $100,000 and over. The Company also stated internal audit routinely reviews claims for payment and coding accuracy. Edits are set into the system to ensure proper codes are being used. The Company stated, "Tufts Health Plan consistently promotes the importance of providing the correct diagnosis and procedure codes on all claims so that we are able to process claims appropriately and efficiently. Payment policies are consistently updated to promote accurate coding and policy clarification. Annually and quarterly, HIPAA medical code sets undergo revisions. Revisions typically include adding, deleting or redefining the description or nomenclature of new HCPCS, CPT procedure and ICD-9 diagnosis codes. As these revisions are made public, Tufts Health Plan will update its system to reflect these changes."

The Company has initiated many system changes and upgrades during the last two years to ensure it is fully compliant with the uniform coding requirements by July 1, 2012. At the time of this examination, these changes and upgrades were still underway; however, the Company stated it will be fully compliant by the July 1, 2012 deadline and it is the opinion of the examiners that the Company's system changes are expected to bring the Company into compliance by July 1, 2012.

II. 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 will not accept the Bilateral Modifier 50 and require that the CPT Code be listed twice.

Company Response: The Company stated "it is compliant and that required provider notification was done in 2008."

Testing: The selected sample and data file review shows that Modifier 50 is allowed and recognized 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 "based on the Bilateral and Multiple Surgical Procedures Facility Payment Policy, the Company requires Modifier 51 be appended to all surgical procedures that are billed in addition to the primary surgical codes (reimbursement rates listed in published payment policy)." The Company further stated that it would "update the Multiple Surgical Procedures Facility Payment Policy to reflect the appropriate guidelines."

Testing: The Company's facility payment policy refers the provider to the modifier payment policy and instructs to use of industry standard coding. Review of the data file shows over 300 facility claims using Modifier 51, however that modifier is not used for processing the claim payment.

Results: The Company's system accepts the incorrect modifier, but that modifier is not being used to process the claim. The issue with this approach is that any required reporting would not be fully accurate as it would report the modifier that has been stored in the system.

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 accepts all three Modifiers 52, 73 and 74 (reimbursed rates vary according to published payment policy)."

Testing: Review of the data file shows three Professional claims with Modifier 74. One of the claims was for a colonoscopy procedure. The examiners reviewed these three claims and it was determined that one of the claims was denied for improper modifier. The second claim was processed and paid as system edit was added to the system after the claim was processed, so in the future it would be properly denied as the claim above. The third claim had the modifier in secondary lines, so it was not used. However, based on the examiners observations, the issues identified are being resolved with the Company's July 1, 2012 system enhancements.

Results: It is the examiners' opinion that this should no longer be an issue with July 1, 2012 system enhancements.

Issue 4

Distinct Procedures (Modifier 59) - There are concerns that certain 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 "its Modifier Payment Policy indicates procedure codes appended with Modifier 59 are reimbursed at the Company's Fee Schedule/Amount Allowed listed in published payment policy. Operative notes not required. The Company is in the process of making system level changes to comply with uniform coding and billing requirements set forth in Chapter 305 of the Acts of 2008, including the acceptance and recognition of multiple modifiers submitted on a claim. Expected completion by July 1, 2012."

Testing: The selected sample and data file review shows that the Company accepts Modifier 59, however, multiple modifiers were not recognized. It appeared from an

overview of system changes provided to the IT Specialist that the changes were appropriate.

Results: It is the examiners' opinion that this should no longer be an issue with July 1, 2012 system enhancements.

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 "Tufts Health Plan accepts all industry standard modifiers - however 91 is not included in the payment policy as a modifier that is utilized for payment processing purposes. Tufts Health Plan is in the process of making system level changes to comply with uniform coding and billing requirements set forth in Chapter 305 of the Acts of 2008, including the acceptance and recognition of multiple modifiers submitted on a claim. Expected completion by July 1, 2012."

Testing: Review of the data file showed that Modifier 91 is accepted by the Company; however, it is not used for payment processing. It appeared from an overview of the system changes provided to the IT Specialist that the changes were appropriate.

Results: It is the examiners' opinion that this should no longer be an issue with July 1, 2012 system enhancements.

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 currently accepts multiple modifiers however it will only process one modifier per procedure code submitted (documented on modifier payment policy). The Company requires modifiers that impact claims payment be placed in the primary field. The Company publishes a modifier priority table. Tufts Health Plan is in the process of making system level changes to comply with uniform coding and billing requirements set forth in Chapter 305 of the Acts of 2008, including the acceptance and recognition of multiple modifiers submitted on a claim. Expected completion by July 1, 2012."

Testing: The selected sample and data file review showed that the Company accepts multiple modifiers on a line, however, it processes one modifier. Overview of system changes provided to the IT Specialist was deemed appropriate.

Results: It is the examiners' opinion that this should no longer be an issue with July 1, 2012 system enhancements.

Issue 7

V76.0-V76.9 - Screening for Malignant Neoplasm - There are concerns that for certain payers multiple claims are rejected because the V code is sequenced first, and that Information Systems ("IS") issues exist for certain payers that are unable to screen secondary diagnostic codes.

Company Response: The Company stated "it currently accepts multiple diagnoses on submitted claims but requires specific sequencing (per published payment policies) for reimbursement. Tufts Health Plan is in the process of making system level changes to comply with uniform coding and billing requirements set forth in Chapter 305 of the Acts of 2008, including the acceptance and recognition of multiple diagnoses submitted on a claim. Expected completion by July 1, 2012."

Testing: The selected sample and data file review showed claims with V76.x diagnostic codes are accepted, but require specific sequencing. It appeared from an overview of the system changes provided to the IT Specialist that the changes were appropriate.

Results: It is the examiners' opinion that this should no longer be an issue with July 1, 2012 system enhancements.

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 currently accepts multiple diagnoses on submitted claims but requires specific sequencing (per published payment policies) for reimbursement. Tufts Health Plan is in the process of making system level changes to comply with uniform coding and billing requirements set forth in Chapter 305 of the Acts of 2008, including the acceptance and recognition of multiple diagnoses submitted on a claim. Expected completion by July 1, 2012."

Testing: Review of the data file review showed claims with V57.x diagnostic codes are accepted, but require specific sequencing as stated by the Company. It appeared from an

overview of the system changes provided to the IT Specialist the changes were appropriate.

Results: It is the examiners' opinion that this should no longer be an issue with July 1, 2012 system enhancements.

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 currently accepts multiple diagnoses on submitted claims but requires specific sequencing (per published payment policies) for reimbursement. Tufts Health Plan is in the process of making system level changes to comply with uniform coding and billing requirements set forth in Chapter 305 of the Acts of 2008, including the acceptance and recognition of multiple diagnoses submitted on a claim. Expected completion by July 1, 2012."

Testing: Review of the data file review showed claims with V67.x diagnostic codes are accepted, but require specific sequencing. It appears from an overview of the system changes provided to the IT Specialist that the changes were appropriate.

Results: It is the examiners' opinion that this should no longer be an issue with July 1, 2012 system enhancements.

Issue 10

V51-V58.9 - Encounter for Aftercare - There are concerns that certain payers will 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 currently accepts multiple diagnoses on submitted claims but requires specific sequencing (per published payment policies) for reimbursement. Tufts Health Plan is in the process of making system level changes to comply with uniform coding and billing requirements set forth in Chapter 305 of the Acts of 2008, including the acceptance and recognition of multiple diagnoses submitted on a claim. Expected completion by July 1, 2012."

Testing: Review of the data file review showed claims with V5x diagnostic codes are accepted, but require specific sequencing. It appears from an overview of system changes provided to the IT Specialist that the changes were appropriate.

Results: It is the examiners' opinion that this should no longer be an issue with July 1, 2012 system enhancements.

Issue 11

V30.00-V39.20 - Liveborn Infants - There are 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 currently accepts multiple diagnoses on submitted claims but requires specific sequencing (per published payment policies) for reimbursement."

Testing: Review of the data file, shows that V30-V39.20 ICD codes are being allowed. V codes are not being omitted, but require specific sequencing. It appears from an overview of system changes provided to the IT Specialist that the changes were appropriate.

Results: It is the examiners' opinion that this should no longer be an issue with July 1, 2012 system enhancements.

Issue 12

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

Company Response: The Company stated "it currently accepts multiple diagnoses on submitted claims but requires specific sequencing (per published payment policies) for reimbursement. Tufts Health Plan is in the process of making system level changes to comply with uniform coding and billing requirements set forth in Chapter 305 of the Acts of 2008, including the acceptance and recognition of multiple diagnoses submitted on a claim. Expected completion by July 1, 2012."

Testing: Review of the data file review showed claims with V04.8 –Flu; V05.9 – Viral; V06.5-Tetanus Vaccinations diagnostic codes are accepted, but require specific sequencing. It appears from an overview of system changes provided to the IT Specialist was deemed appropriate.

Results: It is the examiners' opinion that this should no longer be an issue with July 1, 2012 system enhancements.

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 currently accepts multiple diagnoses on submitted claims but requires specific sequencing (per published payment policies) for reimbursement. Tufts Health Plan is in the process of making system level changes to comply with uniform coding and billing requirements set forth in Chapter 305 of the Acts of 2008, including the acceptance and recognition of multiple diagnoses submitted on a claim. Expected completion by July 1, 2012."

Testing: Review of the data file review showed claims with Contraceptive V25.09-Mgt; V25.41-BCP Surveillance; V25.49-Surveillance diagnostic codes are accepted, but require specific sequencing. It appears from an overview of system changes provided to the IT Specialist that the changes are appropriate.

Results: It is the examiners' opinion that this should no longer be an issue with July 1, 2012 system enhancements.

Issue 14

V72.8x –Other Specified Exams - There are 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 currently accepts multiple diagnoses on submitted claims but requires specific sequencing (per published payment policies) for reimbursement. Tufts Health Plan is in the process of making system level changes to comply with uniform coding and billing requirements set forth in Chapter 305 of the Acts of 2008, including the acceptance and recognition of multiple diagnoses submitted on a claim. Expected completion by July 1, 2012."

Testing: Review of the data file review showed claims with V72.8x diagnostic codes are accepted, but require specific sequencing. It appears from an overview of the system changes provided to the IT Specialist that the changes are appropriate.

Results: It is the examiners' opinion that this should no longer be an issue with July 1, 2012 system enhancements.

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 "it updates their systems within 30 days of the annual or quarterly release dates."

Testing: Updates are installed once available. Company has processes in place to update IDC-9, CPT and HCPCS codes and performs testing prior to implementation. The IT Specialist reviewed the change management procedures as documented in the SSAE16 and concluded that controls are in place to ensure accurate and properly authorized updates. In addition, the Company provided formally documented guidelines stating that the Company "loads all industry standard code sets to its systems on or before the day preceding a code's effective date. In the event that codes are instituted retroactively, the codes will be loaded on an emergency basis as soon as [Tufts Health Plan] is notified. Typically, codes are loaded well in advance of the effective date to allow other relevant system updates to be conducted in a timely fashion. Updates are conducted on both an annual and quarterly basis"

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 requires providers to bill in the following manner for OT services: 97003 for evaluation and 97004 for all subsequent visits. The Company will accept modifiers, however they do not impact claims payment. Tufts Health Plan is in the process of making system level changes to comply with uniform coding and billing requirements set forth in Chapter 305 of the Acts of 2008, including the ability to accept the use of occupational therapy modality codes and modifiers. Expected completion by July 1, 2012."

Testing: Review of the data file review showed claims with multiple modifiers, but currently recognizes the first. It appears from an overview of the system changes provided to the IT Specialist that the changes are appropriate.

Results: It is the examiners' opinion that this should no longer be an issue with July 1, 2012 system enhancements

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 currently accepts multiple diagnoses on submitted claims but requires specific sequencing (per published payment policies) for reimbursement. Tufts Health Plan is in the process of making system level changes to comply with uniform coding and billing requirements set forth in Chapter 305 of the Acts of 2008, including the acceptance and recognition of multiple diagnoses submitted on a claim. Expected completion by July 1, 2012."

Testing: Review of the data file review showed claims with canceled procedures diagnostic codes are accepted, but require specific sequencing. It appears from an overview of the system changes provided to the IT Specialist that the changes are appropriate.

Results: It is the examiners' opinion that this should no longer be an issue with July 1, 2012 system enhancements.

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 currently accepts multiple diagnoses on submitted claims but requires specific sequencing (per published payment policies) for reimbursement. Tufts Health Plan is in the process of making system level changes to comply with uniform coding and billing requirements set forth in Chapter 305 of the Acts of 2008, including the acceptance and recognition of multiple diagnoses submitted on a claim. Expected completion by July 1, 2012."

Testing: Review of the data file review showed claims with canceled procedures diagnostic codes are accepted, but require specific sequencing as stated by the Company. It appears from an overview of the system changes provided to the IT Specialist that the changes are appropriate.

Results: It is the examiners' opinion that this should no longer be an issue with July 1, 2012 system enhancements.

Issue 19

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

Company Response: The Company stated "it currently accepts multiple diagnoses on submitted claims but requires specific sequencing (per published payment policies) for reimbursement. Tufts Health Plan is in the process of making system level changes to comply with uniform coding and billing requirements set forth in Chapter 305 of the Acts of 2008, including the acceptance and recognition of multiple diagnoses submitted on a claim. Expected completion by July 1, 2012."

Testing: Review of the data file review showed claims with multiple diagnostic codes are accepted, but require specific sequencing. It appears from an overview of the system changes provided to the IT Specialist that the changes are appropriate.

Results: It is the examiners' opinion that this should no longer be an issue with July 1, 2012 system enhancements.

Issue 20

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

Company Response: The Company stated "it currently accepts multiple diagnoses on submitted claims but requires specific sequencing (per published payment policies) for reimbursement. Tufts Health Plan is in the process of making system level changes to comply with uniform coding and billing requirements set forth in Chapter 305 of the Acts of 2008, including the acceptance and recognition of multiple diagnoses submitted on a claim. Expected completion by July 1, 2012."

Testing: Review of the data file review showed claims with multiple diagnostic codes are accepted, but require specific sequencing. It appears from an overview of the system changes provided to the IT Specialist that the changes are appropriate.

Results: It is the examiners' opinion that this should no longer be an issue with July 1, 2012 system enhancements.

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 "it currently accepts multiple diagnoses on submitted claims but requires specific sequencing (per published payment policies) for reimbursement. Tufts Health Plan is in the process of making system level changes to comply with uniform coding and billing requirements set forth in Chapter 305 of the Acts of 2008, including the acceptance and recognition of multiple diagnoses submitted on a claim. Expected completion by July 1, 2012."

Testing: Review of the data file review showed claims with multiple diagnostic codes are accepted, but require specific sequencing. It appears from an overview of the system changes provided to the IT Specialist that the changes are appropriate.

Results: It is the examiners' opinion that this should no longer be an issue with July 1, 2012 system enhancements.

Issue 22

Medical Necessity Denials and Rejections: Policy Coverage Logic - 1. There are concerns that certain payer's Payer Guidelines 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 by the payer 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 currently accepts multiple diagnoses on submitted claims but requires specific sequencing (per published payment policies) for reimbursement. Tufts Health Plan is in the process of making system level changes to comply with uniform coding and billing requirements set forth in Chapter 305 of the Acts of 2008, including the acceptance and recognition of multiple diagnoses submitted on a claim. Expected completion by July 1, 2012."

Testing: Review of the data file review showed claims with multiple diagnostic codes are accepted, but require specific sequencing. It appears from an overview of the system changes provided to the IT Specialist that the changes are appropriate.

Results: It is the examiners' opinion that this should no longer be an issue with July 1, 2012 system enhancements.

Issue 23

Medical Necessity Claims and Rejections: Outpatient Claims and Rejections - There are 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 "its billing guideline is based on standards set by the American College of Obstetrics which is considered an industry standard source. Tufts Health Plan is in the process of making system level changes to comply with uniform coding and billing requirements set forth in Chapter 305 of the Acts of 2008, including the acceptance and recognition of multiple diagnoses and multiple modifiers submitted on a claim. Expected completion by July 1, 2012."

Testing: Review of the data file review showed claims with multiple diagnostic codes are accepted, but require specific sequencing. It appears from an overview of the system changes provided to the IT Specialist that the changes are appropriate.

Results: It is the examiners' opinion that this should no longer be an issue with July 1, 2012 system enhancements.

Issue 24

Unlisted CPT Procedure Codes - There are concerns that certain payers have 1. 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 "its practice is to 'level' the submitted codes with others that are of a similar nature/quantity of work and/or supplies, however they do require supporting documentation to determine the level of payment appropriate, which is done by a medical director."

Testing: The selected sample showed the use of unlisted codes was handled appropriately. The Company's procedures for processing claims with unlisted codes are appropriate.

Results: No exceptions were noted.

Issue 25

Unlisted CPT Procedure Codes - Errors in Assignment (Payer and Provider) - Payer/Provider Audit Discrepancies. There are concerns that certain payers have 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 does not 'reject' unlisted CPT codes. The Company stated that they will automatically deny unlisted codes if they are submitted without supporting documentation."

Testing: See above issue 24.

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 "its auditors may find issues on claims that require resubmission of information, but should be in compliance with ICD9 & CPT guidelines."

Testing: The selected sample review showed that all DRG Claims were handled properly.

Results: No exceptions were noted.

Recommendation

In light that most coding issues could not be fully tested due to the fact that the Company's systems enhancements are scheduled for completion by July 1, 2012, it is recommended that a follow-up examination be conducted at a later date to ensure all system enhancements are working as expected.

III. Claims Review

The Company provided a data file containing 1,295,662 claim 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 387 CPT/HCPCS codes, 52 Modifiers and 303 ICD codes.

Results:

A total of 75 instances were found to not be in compliance with the uniform coding guidelines. These are broken down as follows:

1. There were 72 instances where the ICD Codes were not used for adjudication. This issue should be resolved with the system enhancements to be completed by July 1, 2012.

2. There were two instances where multiple modifiers were not used for adjudication. This issue should be resolved with the system enhancements to be completed by July 1, 2012.

3. There was one instance in which the CPT code was incorrect. The CPT code submitted was a code specific to patients of ages 3 to 18. In this case, the patient was over 50 years old. The Company system does not have an edit in place to reject these issues. The Company stated that it processes these instances as it does not affect the payment amount and to not deny or delay the claim unnecessarily. The issue with this approach is that it affects the integrity and coding accuracy stored in the Company's system.

IV. Additional Issue Referral

Overview

Panel Code(s) includes multiple laboratory testing but one code is reported. These panels are tests that are routinely performed together as a group. In order to report the panel code(s), Official CPT Coding Guidelines require that all the tests contained within the one panel code be performed in order to assign the panel code. Example: General Health Panel CPT Code: 80050 – all of the tests listed within the panel (CBC, Comprehensive Metabolic Panel, TSH) must be performed/included in order to consolidate/use the 80050 code only. If the tests listed within the panel are not all performed, then each of the tests that are actually performed are coded separately. For instance, if they performed everything except for the TSH, it would be incorrect to use the one code 80050.

It was communicated to the examiners that the Company's practice is to change correct codes submitted for multiple laboratory testing and re-code them to a panel (one code) in certain instances when the actual testing performed does not constitute a panel code assignment according to the official CPT guidelines/code set definition.

The Company stated that "for the purposes of reimbursement, when multiple laboratory procedure codes are submitted, Tufts Health Plan will assign a laboratory panel code based on the appropriateness of the procedure codes submitted. This allows Tufts Health Plan to assign the appropriate level of reimbursement based on the contract with the provider."

The examiners confirmed the Company does accept the CPT codes submitted by the provider; however, to process the claim they re-code and assign the panel code to reimburse the provider based on their payment policy and contract with its provider. When processing the claim, the Company shows the submitted codes as denied and adjudicates the claim under the newly added panel code.

The Company's payment policy contains a section that indicates the following:

> Edits may recode procedures based on the appropriateness of the code selection. For example, if 80048 (basic metabolic panel), 84443 (TSH) and 85025 (CBC) are billed on the same date of service, the more appropriate code 80050 (General health panel) will be substituted for 84443.

The Company provided documentation in support of its interpretation of the law and further based its position in the section of M.G.L. c. 176O, § 5A that states:

> *Except for the requirements for consistency and uniformity in coding patient diagnostic information and patient care service and procedure information, this section shall not modify or supersede a carrier's or its*

> *subcontractor's payment policy, utilization review policy or benefits under a health benefit plan. Nothing in this section shall further preclude a carrier or a subcontractor thereof from adjudicating a claim pursuant to its billing guidelines, payment policies, provider contracts or health benefit plans.*

After review of the documentation provided by the Company, the examiners concluded that although this practice may be allowed under M.G.L. c. 175, § 5A, there remains the concern that the accuracy and integrity of the data stored in the Company's system for reporting purposes would not be 100% accurate as not every test was actually performed by the provider.

Regarding the applicability of any reporting requirements, the Company stated that "it sees no basis for this expansive interpretation of the statute. All of the stated purposes of the statute center on the submission and processing of health care claims. If, in enacting Chapter 176O, § 5A, the Legislature had intended these additional purposes, it would presumably have said so."

The examiners disagree with this statement, as the statute does include wording related to reporting:

> *…for the purposes of processing claims for health care services submitted by a health care provider and to provide uniformity and consistency in* ***the reporting*** *of patient diagnostic information, patient care service and procedure information as it relates to the submission and processing of health care claims,…*

M.G.L. c. 176O, § 5A (emphasis added).

Recommendation

It is recommended the Company modify its current payment policy, to ensure proper and accurate codes are maintained in its system for reporting purposes.

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, Timothy Nutt, CIE, and Michael Morrissey, AES, CISA, CISSP, participated in this examination.

Respectfully submitted,

Examination Resources, LLC