Texas Department of Insurance

EXAMINATION REPORT

UNICARE LIFE & HEALTH INSURANCE COMPANY

PLANO, TEXAS

As of October 31, 2001

STATE OF Texas §

COUNTY OF Travis §

Steven B. Carter, being first duly sworn, upon his oath deposes and says:

That he is an examiner appointed by the Commissioner of Insurance of the State of Texas;

That an examination was made of the affairs of Unicare Life & Health Insurance Company, Plano, Texas, as of October 31, 2001;

That the following pages numbered one to five, consecutively, constitute the report thereon to the Commissioner of Insurance of the State of Texas;

And that the statements, exhibits, and data therein contained are true and correct to the best of his knowledge and belief.

Steven B. Carter

Steven B. Carter, AIE, CFE
Examiner in Charge

Subscribed and sworn to before me this 23rd day of July, 2002.

MaryAnn Cortez
(Signature)

MaryAnn Cortez Notary Public
(Print Name)

in and for the State of Texas

My commission expires 10-12-03

MARY ANN CORTEZ
Notary Public State of Texas
My Commission Expires
OCTOBER 12 2003

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Plano, Texas
December 10, 2001

Honorable José Montemayor
Commissioner of Insurance
State of Texas
Austin, Texas

Commissioner:

Pursuant to the provisions of Articles 1.15 and 21.21, Section 5 of the Texas Insurance Code (Code), an examination was made of the conduct, performance, and practices of

UNICARE LIFE & HEALTH INSURANCE COMPANY

hereinafter referred to as the "Company," with its home office located at 1 WellPoint Way, Thousand Oaks, California, as of October 31, 2001 (covering the preceding fifteen months).

SCOPE OF EXAMINATION

This was a limited scope market conduct examination with primary focus on the process and procedures for claims adjudication and verification of restitution paid on clean claims paid after 45 days, nonpayment of restitution on unclean claims, physician and/or provider complaints, and training procedures provided by the Company to its physicians and/or providers.

The purpose of the examination was to verify compliance with the Texas Insurance and Administrative Codes and to the Texas Department of Insurance (Department) Consent Order dated September 6, 2001, and to determine if operations were consistent with the public interest.

CLAIMS PRACTICES

During the course of the examination, paid claim files on which restitution was paid and on which restitution was not paid were reviewed, for compliance with Article 3.70-3C § 3A(c) of the Code and 28 TAC § T, Submission of Clean Claims.

The following table reflects the type, population, and sample size of randomly selected claim files reviewed:

Type of Claim	Population	Sample Size
Restitution Paid	505	61
Restitution Not Paid	10,231	220

The initial report provided to the Department of claims paid over 45 days, on which restitution was not paid, indicated 21,077 claims were paid to physician/providers without restitution during the first quarter of 2001. During the pre-examination meeting with Company officials, the claim data provided by the Company reflected only 10,231 claims paid without restitution for the period August 1, 2000 through September 1, 2001.

For explanation, the Company stated that the data initially supplied included parameters not related to clean claims, which included the following:

- California Blue Cross claims
- Claims with dates of service prior to 8-1-2000
- Adjustment to claims previously submitted

The adjustments made to claims were excluded to preclude them from being counted twice. Adjustments the Company excluded included:

- A deficient claim rejected for information (when reopened the claim is an adjustment and calculates from the original date of receipt)*
- Provider contract renegotiations that change the fee schedule causing a claim to be reopened
- Overpaid claims
- Information provided that changes a claim i.e. payment of outstanding premium due by the member, changes in a medical decision, a submitted appeal, or an administrative override

* A deficient claim was included in the original count submitted to the Department, however, when the claim was reopened for adjudication, the computer system counted this a second time.

The Company reported to the Department that 280 clean claims were paid over 45 days during the second quarter of 2001. The Company had initially reported all claims that were paid over 45 days when their report was submitted to the Department for the first quarter of 2001. The change in the Company's reporting methodology for the second quarter of 2001 was the reason the number of claims reported as being paid over 45 days substantially decreased.

Late Clean Claims-Restitution Paid

Individual, small and large group claims identified as clean claims that were paid late were reviewed to determine that the Company paid the appropriate restitution. The review revealed that all of the claims reviewed were paid restitution based on the difference between the billed charges and the negotiated rate.

Claims Paid after 45 Days-No Restitution Paid

Company officials indicated, and reports verified, that the Company pays claims that have enough information for proper adjudication within 45 days of receipt without making a determination of whether the claims are clean or deficient. Claims paid after the 45th day from the date of receipt of the claim require a determination as to whether the claim is clean or deficient. The department recommends that a deficiency notice be sent if a deficient claim is paid after the 45th day from the date of receipt.

Examiners reviewed 63 large group and 157 individual and small group claims identified as deficient claims. The large group claims were appropriately designated by the Company as not clean and were correctly denied restitution payment. The review of individual and small group claims revealed 150 unclean claims paid correctly, but late, with no restitution owed and one claim that was incorrectly identified by the Company as not clean for which restitution should have been paid. On December 6, 2001, the Company processed a restitution penalty payment as follows:

Customary and reasonable charge for service	$897.00
Less member co-pay	100.23
Less amount previously paid	400.90
Penalty Amount Paid	$395.87

Of the claims reviewed six were submitted using form UB92's that were not signed in field 85; however, a representative had typed in a name. The examiners requested the Company run a report on claims denied with a field 85 deficiency as the basis for not paying restitution. The report indicated that 48 claims were not paid restitution based on a deficiency in field 85. Examiners requested that the Company identify claims denied restitution for field 85 to determine the number that had a typed name or were left blank. The Company stated that in accordance with 28 TAC § 21.2803 (b)(2)(AA) a signature of a provider representative or a notation that a signature is on file with the HMO or preferred provider carrier is an essential field for an institutional claim. The Company considers a typed name in field 85 as a valid deficiency and that a typed name is neither a signature nor notation that a signature is on file and does not meet the necessary requirement for this field. The Company has indicated that they have no hospital representative's signatures on file.

The examination also revealed that the Company instituted an automated procedure to begin notifying providers, on claims which could not be adjudicated without additional information, within 45 days of receipt of the claim approximately February 1, 2001. The Company had used a manual process to notify providers of additional information that was needed from August 1, 2000 through January 31, 2001.

Current Claims Data

Claims data for September and October 2001 were reviewed for compliance with the clean claim rules. The Company's present policy is to continue the adjudication and payment of deficient (unclean) claims if they can be processed without additional information in order to assure providers are paid timely. While the Company is paying many unclean claims within 45 days the Company is not notifying the physician or provider of the deficiency. Providers filing deficient claims, which can not be adjudicated without additional information, are sent a notification requesting information required to process the claim. If the requested information is not received before the 45th day, the claim is denied and the provider is sent a follow-up notification requesting the required information. The Company reported six claims that were paid over 45 days in which restitution was paid during these two months.

The Company provided reports and claims that were verified by examiners, evidencing that an audit process is in place and utilized. The Company audited 96 claims and made the required 85 percent payment with the additional 15 percent paid on all eligible claims within 180 days. Aged unpaid claim reports from the Company indicated that the oldest claim was 20 days.

Company Provider Training Initiatives

The Company is taking several approaches to educate its network providers regarding the submission of clean claims. A Company newsletter included articles to providers in August 2000, February 2001, and intends to issue another in February 2002.

In October of 2001 and January of 2002, the Company mailed additional clean claim requirements to network physicians. An annual conference held during 2000 and 2001 included presentations on clean claims and

legislative sessions. The conference scheduled for 2002 will include sessions for provider claim representatives with hands-on instructions for the submission of clean claims.

In January 2001, the Company hired a hospital services representative to act as a liaison and monitor claim payments between network hospital billing staff and Company claims operations. Hospital billing personnel are able to contact the service representative directly to address claim issues.

Provider manuals are supplied to network providers with additional clean claim requirements required by the Company.

The Company has developed a specific form entitled "TCC Penalty Payment Inquiry Form" for a contracted provider to complete when inquiring about a possible restitution payment owed on a claim. The "TCC Form" requests the provider to review the initial claim submission to determine if the claim was in fact submitted clean, and requires the provider to supply additional information as well as to resubmit a hard copy of the initial claim before the claim will be reevaluated by the Company for possible restitution payment. The use of the TCC Inquiry Form as presently designed by the Company places too heavy of a burden on the provider when they desire to request the Company review a specific claim for possible restitution payment. It is our recommendation that the Company reconsider the requirements it places on the providers to request a review of a claim for possible restitution payment.

CONSUMER COMPLAINTS/INQUIRIES

During the course of the examination, the Company's complaint files were reviewed to ensure compliance with the provisions of Article 20A.12 and Title 2 Subtitle A § 38.001 of the Code and 28 TAC §§11.205(a)(20) and 21.2501-21.2507.

The Company was only able to furnish Department complaints from August 1, 2000 through March 31, 2001. Complaints that did not originate through the Department could not be provided. Effective on April 1, 2001, the Company established revised procedures to maintain the complaint record pursuant to 28 TAC.

Company records indicated 176 Department complaints from physician/providers during the period August 1, 2000 through March 31, 2001. The Company complaint record indicated 588 physician/provider complaints received during the period of January 1, 2001 through September 1, 2001 and 218 were recorded during the period of September 1, 2001 through November 30, 2001.

The following complaint analysis gives a description of the type, number and percentage of the complaints reviewed:

	Complaint Analysis	
Description	Number	Percentage
Claims:		
Claim delays	38	64%
Denial of claim	11	19
Unsatisfactory settlement	10	17
Totals	59	100%

The complaint review revealed that the Company had appropriately paid restitution to the physician or provider when a clean claim was paid over 45 days.

CONCLUSION

Cady Crismon, RN, MSN, Director, and Debra Diaz-Lara, Insurance Specialist, of HMO Quality Assurance, and Mark Richter, Investigator, Legal, participated in this examination.

Respectfully submitted,

Steven B. Carter, AIE, CFE
Market Conduct Examiner