DEPARTMENT OF
Managed
Health Care

Edmund G. Brown Jr., Governor
State of California
Business, Transportation and Housing Agency

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Via Federal Express and E-mail
In Reply Refer to File No.: 933 0303

April 12, 2011

Pam D. Kehaly, President
BLUE CROSS OF CALIFORNIA
1 Wellpoint Way
Thousand Oaks, CA 91362

RE: FINAL REPORT OF THE ROUTINE EXAMINATION OF BLUE CROSS OF CALIFORNIA'S (DBA: ANTHEM BLUE CROSS) CLAIMS SETTLEMENT PRACTICE AND PROVIDER DISPUTE RESOLUTION MECHANISM

Dear Ms. Kehaly:

Enclosed is the Final Report of the routine examination of Blue Cross of California's ("the Plan") claims settlement practice and provider dispute resolution mechanism for the three-month period ending September 30, 2008. The examination was conducted by the Department of Managed Health Care (the "Department") pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975 ("Act").[1] The Department issued a Preliminary Report to the Plan on October 29, 2010. The Department accepted the Plan's electronically filed response on January 4, 2011.

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

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

Please indicate within ten (10) days whether the Plan requests the Department to append its January 4, 2011 response to the Final Report. If so, please indicate which portions of the Plan's response shall be appended, and electronically file copies of those portions of the Plan's response

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

exclusive of information held confidential pursuant to Section 1382 (c), no later than ten (10) days from the date of the Plan's receipt of this letter.

If the Plan requests the Department to append a brief statement summarizing the Plan's response to the Preliminary Report or wishes to modify any information provided to the Department in its January 4, 2011 response, please provide the filed documentation no later than ten (10) days from the date of the Plan's receipt of this letter through the eFiling web portal.

Please file this addendum electronically via the Department's eFiling web portal https://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select "eFiling".
- From the eFiling (Home) menu, select "File Documents".
- From the File Documents Menu for:
  1) File Type; select "Amendment to prior filing";
  2) Original Filing, select "Filing No. 20082628" assigned by the Department; and
  3) Click "create filing".
- From the Original Filing Details Menu, click "Upload Amendments"; select # of documents; select document type: "Plan addendum response to Final Report (FE5)"; then "Select File" and click "Upload".
- Upload all documents then upload a cover letter as Exhibit E-1 that references to your response.
- After upload, please select "Complete Amendment", complete "Execution" and then click "complete filing".

As noted in the attached Final Report, the Plan's January 4, 2011 response was not fully responsive to the deficiencies raised in the Preliminary Report issued by the Department on October 29, 2010. Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any request for additional corrective action contained within the attached Final Report, within 30 days after receipt of the report, unless an earlier date is requested. If the Plan fails to fully respond and/or resolve the deficiencies addressed in the Final Report, then a referral will be made to the Office of Enforcement for appropriate administrative action for any remaining, unresolved deficiencies.

Please file the Plan's response electronically via the Department's eFiling web portal https://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select "eFiling".
- From the eFiling (Home) menu, select "File Documents".
- From the File Documents Menu for:
  1) File Type; select "Amendment to prior filing";
  2) Original Filing, select the "Filing No. 20082628" assigned by the Department; and
  3) Click "create filing".

- From the Original Filing Details Menu, click "Upload Amendments"; select # of documents; select document type: "Plan's Response to Final Report (FE10)"; then "Select File" and click "Upload".
- Upload all documents then upload a cover letter as Exhibit E-1 that references to your response.
- After upload, please select "Complete Amendment", complete "Execution" and then click "complete filing".

Questions or problems related to the electronic transmission of the above responses should be directed to Rita Ultreras at (916) 255-2443 or email at rultreras@dmhc.ca.gov. You may also email inquiries to wpso@dmhc.ca.gov.

The Department will make the attached Final Report available to the public in ten (10) days from the Plan's receipt of this letter. The report will be located at the Department's web site at www.dmhc.ca.gov.

If there are any questions regarding this report, please contact me.

Sincerely,

Original Signed By

JANET NOZAKI
Supervising Examiner
Office of Health Plan Oversight
Division of Financial Oversight

tr:jn

cc: G. Lewis Chartrand, Assistant Secretary, Blue Cross of California
Maureen McKennan, Assistant Deputy Director, Office of Health Plan Oversight
Dennis Balmer, Acting Chief, Division of Financial Oversight
Marcy Gallagher, Chief, Division of Plan Surveys
Susan Miller, Examiner, Division of Financial Oversight
Steven Alseth, Senior Examiner, Division of Financial Oversight
Katie Coyne, Staff Counsel, Division of Licensing

DEPARTMENT OF
Managed
Health Care

STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

DIVISION OF FINANCIAL OVERSIGHT

BLUE CROSS OF CALIFORNIA

FILE NO. 933-0303

DATE OF FINAL REPORT: APRIL 12, 2011

OVERSIGHT EXAMINER: JANET NOZAKI

EXAMINER-IN-CHARGE: SUSAN J. MILLER

FINANCIAL EXAMINERS:

GALAL GADO
NED GENNAOUI
CANDICE HAW
JENNIFER LUM
THOMAS ROEDL

BACKGROUND INFORMATION FOR BLUE CROSS OF CALIFORNIA

Date Plan Licensed:	January 7, 1993
Organizational Structure:	The Plan is a wholly owned subsidiary of WellPoint, Inc. On April 1, 2008, Blue Cross of California and Blue Cross of California Partnership Plan, Inc. ("BCCPP") changed its "doing business as" name to Anthem Blue Cross and Anthem Blue Cross Partnership Plan, respectively. The Plan has a wholly owned subsidiary, BCCPP, which is also licensed under the Knox-Keene Act and was formed to facilitate the implementation of the quality improvement fee imposed by the Department of Health Care Services, effective July 1, 2005 through September 30, 2009. Pursuant to intercompany administrative services agreements, the Plan receives from its affiliates and provides to its affiliates services such as health plan services, claims processing, provider contract services, and other financial management and administrative support, including computer data processing services.
Type of Plan:	The Plan is a for-profit, full service health care plan offering a variety of health services, including specialty managed care networks (i.e., dental, behavioral). These services are provided to individuals, small and large groups, seniors, and state-sponsored programs.
Provider Network:	The Plan contracts with participating medical groups ("PMG") to provide health care services (such as primary care, specialty care and some ancillary services) and compensates them on a capitated basis. The Plan also contracts with hospitals to provide hospital services on a capitated, per diem, case rate, or other basis. The Plan contracts with a number of skilled nursing facilities, home health agencies, and freestanding ambulatory surgical centers. Specialty care is provided by the PMG through contracted specialists. Enrollees access primary and specialty care through their selected medical groups. The Plan also contracts with physicians statewide to provide services to its preferred provider organization (PPO) enrollees.
Plan Enrollment:	3,972,996 enrollees as of the quarter ended September 30, 2008, including 1,259,036 PPO enrollees.
Service Area:	All major counties within the State of California
Date of Last Final Report for Routine Examination:	October 11, 2010

FINAL REPORT OF THE ROUTINE EXAMINATION OF BLUE CROSS OF CALIFORNIA'S (DBA: ANTHEM BLUE CROSS) CLAIMS SETTLEMENT PRACTICE AND PROVIDER DISPUTE RESOLUTION MECHANISM

This is the Final Report of a routine examination of Blue Cross of California's ("the Plan") claims settlement practice and provider dispute resolution mechanism for the three month period ending September 30, 2008. The examination was conducted by the Department of Managed Health Care (the "Department") pursuant to Section 1382 of the Knox-Keene Health Care Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on October 29, 2010. The Department accepted the Plan's electronically filed response on January 4, 2011.

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

Our findings are presented in this report as follows:

Section I.	Compliance Issues
Section II.	Non-Routine Examination

Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any requests for additional corrective action contained within this report, within 30 days after receipt of this report, unless an earlier date is requested.

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

SECTION I. COMPLIANCE ISSUES

A. PROVIDER DISPUTE VIOLATIONS

Rule 1300.71.38 (m) (2) states that the failure of a plan to comply with the requirements of a fast, fair and cost-effective dispute resolution mechanism shall be a basis for disciplinary action against the plan.

The Department's examination found that the Plan failed to comply with the requirements of a fast, fair and cost-effective dispute resolution mechanism for the three month period ending September 30, 2008 as summarized in the table below:

Deficiency	Total Claims in the Sample Population	Total Claims in the Sample	Number of Deficiencies Found	% of Compliance
Provider disputes were not resolved within 45 working days.	37,976	50	7	86%
Determination letters for provider's disputes were not accurate or not complete.	"	"	3	94%
Provider disputes were not acknowledged within 15 working days.	"	"	5	90%
Unnecessary request for medical records.	"	"	4	N/A

On July 19, 2010, the Plan filed a signed acknowledgement with the Department that stated the following:

"The Plan acknowledges that it has deficiencies in its provider dispute resolution procedures, operations and related finalization processes which have resulted in untimely processing of provider disputes, inaccurate or incomplete written determination letters of pertinent fact(s); untimely acknowledgement of the disputes; requests for additional information that was unnecessary or the Plan had the information on an unacceptable number of provider disputes. The Plan has requested that the Department discontinue its testing of provider disputes in light of the Plan's acknowledgement of these deficiencies and the Plan acknowledges that the Department agreed to do so in reliance upon this document. The Plan further acknowledges its commitment to correcting these deficiencies in accordance with requirements stated in all Department reports, including examination reports, issued in connection with this routine examination.

The Plan acknowledges that these deficiencies have resulted in its violations of California Code of Regulations, Title 28, and section 1300.71.38. For purposes of assessing a penalty for these violations, the Plan agrees that the deficiency rates of 14 percent for untimely processing of provider disputes; 6 percent for inaccurate or incomplete determinations letters; 10 percent for

untimely acknowledgement of provider disputes; and 8 percent for requesting unnecessary information found in the sample of 50 provider disputes are conclusive evidence of the percentage of deficiencies present in the entire universe of provider disputes adjudicated during the time frame defined by the Department's examination, specifically July 1, 2008 through September 30, 2008."

The following details the provider dispute resolution mechanism violations found during our examination:

1. UNTIMELY RESOLUTION OF DISPUTES

Rule 1300.71.38 (f) requires a plan to issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days after the date of receipt of the provider dispute.

Rule 1300.71 (a)(8) defines a "demonstrable and unjust payment pattern" or "unfair payment pattern" as any practice, policy or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims. Subsection (S) describes one of the payment patterns as the failure to comply with the Time Period for Resolution and Written Determination enumerated in Rule 1300.71.38 (f) at least 95% of the time over the course of any three-month period.

The Department's examination found that seven (7) out of 50 provider disputes reviewed were not resolved timely (a compliance rate of 86%). They included the following provider dispute samples:

PDR Sample No.	Date Dispute Received by Plan	Date of Determination Letter	Number of Days Beyond the 45 Working Days
2	08/11/08	01/22/09	100
3	05/03/08	07/09/08	3
17	06/14/08	08/29/08	12
20	07/22/08	09/26/08	1
27	06/23/08	08/30/08	4
32	06/19/08	08/29/08	7
44	06/21/08	08/29/08	5

The Department's analysis of the provider disputes determined during the three-month period ended September 30, 2008 revealed that twelve percent of provider disputes were not resolved timely as required by Rule 1300.71.38(f). As a result, the Plan demonstrated an unjust payment pattern pursuant to Rule 1300.71 (a)(8)(S).

The above violation was referred to the Department's Office of Enforcement for appropriate administrative action. The enforcement action resulted in a $900,000 fine being assessed against the Plan.[2]

The Plan was required to state the corrective action implemented to ensure that the Plan complies with Rule 1300.71.38 (f). A copy of these revised policies and procedures were to be submitted with the Plan's response to the preliminary report. The Plan was also required to provide the date of implementation, the management position(s) responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure continued compliance with this Rule.

The Plan responded that its Grievances and Appeals PDR Policy and Procedures documentation has been revised to a standardized format which reflects the 45-day turnaround timeframe and the fact that any monies owed to the provider will be paid within a 5-day turnaround timeframe from the issuance of the written final determination. This revised document was implemented on December 30, 2010.

The Plan stated that it has implemented daily, weekly, monthly, quarterly, and annual reporting to monitor the PDR inventory and timeliness. It also included monitoring criteria within its auditing tool to ensure that PDRs are timely and any claims adjustments are done accurately and fairly.

The Plan identified the Regulatory Compliance Director, who reports to the Plan President, as the individual responsible for monitoring ongoing compliance of this corrective action on a quarterly basis.

The Department finds that the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required.

2. INACCURATE OR INCOMPLETE DETERMINATION LETTERS

Rule 1300.71.38 (f) requires a plan to issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days after the date of receipt of the provider dispute.

The Department's examination found that three (3) out of 50 provider disputes reviewed have determination letters that were inaccurate or incomplete (a compliance rate of 94 percent). They included provider dispute sample numbers 30, 43, and 44.

The above violation was referred to the Department's Office of Enforcement for appropriate administrative action. The enforcement action resulted in a $900,000 fine being assessed against the Plan.

[2] Letter of Agreement dated November 29, 2010 regarding Enforcement matter number 10-002.

The Plan was required to revise its policies and procedures to ensure that written determinations include the pertinent facts and reasons for the determination in compliance with the above Rule. A copy of these revised policies and procedures were to be submitted with the Plan's response to the preliminary report. The Plan was also required to provide the date of implementation, the management position(s) responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure continued compliance with this Rule.

The Plan replied that it included monitoring criteria within its PDR auditing tool to ensure that PDR determination letters are accurate and complete. The Plan provides a monthly PDR Audit Roll Up Report to its management team that includes all audit results and findings.

The Plan responded that its Grievances and Appeals PDR Policy and Procedures documentation has been revised to a standardized format that reflects that all written determinations include the pertinent facts and reasons for the Plan's determination in compliance with the regulation. This revised document was implemented on December 30, 2010.

The Plan identified the Regulatory Compliance Director as the individual responsible for monitoring ongoing compliance of this corrective action on a quarterly basis.

The Department finds that the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required.

3. UNTIMELY ACKNOWLEDGEMENT OF DISPUTES

Rule 1300.71.38 (e)(2) requires a plan to issue a provider dispute acknowledgement within fifteen (15) working days from the date of receipt of the written provider dispute by the office designated to receive provider disputes.

Rule 1300.71 (a)(8) defines a "demonstrable and unjust payment pattern" or "unfair payment pattern" as any practice, policy or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims. Subsection (R) describes one of the payment patterns as the failure to acknowledge the receipt of at least 95% of the provider disputes it receives consistent with section 1300.71.38 (e) over the course of any three-month period.

The Department's examination found that five (5) out of 50 provider disputes reviewed were not acknowledged timely (a compliance rate of 90 percent). They included the following disputes:

PDR Sample No.	Date Dispute Received	Date of Acknowledgement Letter	Number of Days Beyond the 15 Working Days
1	05/21/08	06/16/08	5
23	05/12/08	06/07/08	5
27	06/23/08	08/29/08	46
30	06/16/08	07/29/08	22
44	06/21/08	07/22/08	10

The Department's analysis of the provider disputes determined during the three-month period ended September 30, 2008 revealed that 9 percent of provider disputes were not acknowledged as required by Rule 1300.71.38 (e). As a result, the Plan demonstrated an unjust payment pattern pursuant to Rule 1300.71 (a)(8)(R).

The above violation was referred to the Department's Office of Enforcement for appropriate administrative action. The enforcement action resulted in a $900,000 fine being assessed against the Plan.

The Plan was required to revise its policies and procedures to ensure the timely acknowledgement of disputes. A copy of these revised policies and procedures were to be submitted with the Plan's response to the preliminary report. The Plan was also required to provide the date of implementation, the management position(s) responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure continued compliance with this Rule.

The Plan replied that its Grievances and Appeals PDR Policy and Procedures documentation has been revised to a standardized format which reflects the 15-day turnaround timeframe and the fact that any monies owed to the provider will be paid within a 5-day turnaround timeframe from the issuance of the written final determination. This revised document was implemented on December 30, 2010.

The Plan stated that it has implemented daily and monthly reporting to monitor the timeliness of PDR acknowledgements. It also included monitoring criteria within its auditing tool to ensure that PDRs are timely and any claims adjustments are done accurately and fairly.

The Plan identified the Regulatory Compliance Director as the individual responsible for monitoring ongoing compliance of this corrective action on a quarterly basis.

The Department finds that the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required.

4. UNNECESSARY REQUESTS FOR MEDICAL RECORDS

Rule 1300.71 (a)(8)(H) sets forth practices, policies and procedures that may constitute a basis for finding that the plan has engaged in a "demonstrable and unjust payment pattern", if it fails to establish that requests for medical records more frequently than in three percent (3%) of the claims submitted to the Plan by all providers over any 12-month period were reasonably necessary to determine payor liability for those claims consistent with section (a)(2). The calculation of the 3% threshold and the limitation on requests for medical records does not apply to those claims involving emergency or unauthorized services or those cases where the plan has reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices

The Department's examination found that the Plan failed to establish that requests for medical records were reasonably necessary for four (4) out of 50 provider disputes reviewed (a non-compliance rate of 8%). They included provider dispute sample numbers 8, 21, 29 and 46.

The above violation was referred to the Department's Office of Enforcement for appropriate administrative action. The enforcement action resulted in a $900,000 fine being assessed against the Plan.

The Plan was required to implement policies and procedures to ensure that requests for medical records are reasonable in compliance with Rule 1300.71 (a)(8)(H). A copy of these policies and procedures were to be submitted with the Plan's response to the preliminary report. The Plan was also required to provide the date of implementation, the management position(s) responsible for compliance, and a description of the monitoring system implemented to ensure continued compliance with this Rule.

The Plan replied that it included monitoring criteria within its PDR auditing tool to ensure that medical records are requested appropriately. The Plan provides a monthly PDR Audit Roll Up Report to its management team that includes all audit results and findings.

The Plan responded that its Grievances and Appeals PDR Policy and Procedures documentation has been revised to a standardized format which reflects that medical records are only requested when necessary and are reasonable in compliance with the regulation. This revised document was implemented on December 30, 2010.

The Plan identified the Regulatory Compliance Director as the individual responsible for monitoring ongoing compliance of this corrective action on a quarterly basis.

The Department finds that the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required.

5. INTEREST ON LATE CLAIMS PAYMENTS RESULTING FROM PROVIDER DISPUTES – *REPEAT DEFICIENCY*

Rule 1300.71.38 (g) states that if the provider dispute or amended provider dispute involves a claim and is determined in whole or in part in favor of the provider, the plan or the plan's capitated provider shall pay any outstanding monies determined to be due, and all interest and penalties required under Sections 1371 and 1371.35 and Rule 1300.71, within five (5) working days of the issuance of the written determination.

Section 1371.37 (a) states each plan is prohibited from engaging in an unfair payment pattern. Section 1371.37 (c)(4) defines an "unfair payment pattern," as failing on a repeated basis to automatically include the interest due on claims pursuant to Section 1371.

The failure of the Plan to pay interest correctly on late claim payments resulting from provider disputes was noted in the Final Report of the prior provider dispute resolution mechanism examination, dated August 17, 2005. In response to the Preliminary Report for that examination, the Plan described various corrective actions which included policy and procedure changes, system enhancements and the remediation of interest and penalties for the time periods specified in the report. However, further efforts are needed to ensure sustainable compliance with the requirements of a fast, fair and cost-effective resolution mechanism for providers.

The examination found that four (4) out of 50 provider disputes reviewed had no interest paid or interest was underpaid (a compliance rate of 92%). The failure to pay interest correctly was due to the Plan using the date the provider dispute was received, or other incorrect receipt date, instead of the date a "complete claim" as defined by Rule 1300.71 (a)(2) was met.

The following table identifies the claims where interest was not paid or interest was underpaid:

PDR Sample No.	Line of Business	Receipt Date Used to Calculate Interest	Receipt Date of a "Complete Claim"	Interest Paid by the Plan	Correct Interest Due	Penalty Due	Amount of Interest Underpaid Including Penalty
21	HMO	N/A	07/24/08	$0	$15.06	$10.00	$25.06
35	PPO	06/23/08	04/15/08	$0	$31.37	$10.00	$41.37
40	HMO	06/19/08	06/30/07	$0	$21.29	$10.00	$31.29
46	HMO	06/23/08	05/30/08	$82.84	$108.48	$10.00	$35.64

The Plan's repeated failure to comply with the interest requirements was referred to the Department's Office of Enforcement for appropriate administrative action. The enforcement action resulted in a $900,000 fine being assessed against the Plan.

The Plan was required to state the reasons why its compliance efforts have not achieved the necessary levels of compliance with the Act and Regulations cited.

In addition, the Plan was required to submit a Corrective Action Plan ("CAP") to address the deficiency cited above. The CAP was to include the following:

a. Training procedures to ensure that claim processors have been properly trained on interest and penalty requirements regarding additional payments resulting from provider disputes due to incorrect payment of the initial claim.

b. Audit procedures to ensure that the Plan is monitoring correct payment of interest and penalties on late adjusted claim payments resulting from provider disputes.

c. Identification of all late claims resulting from provider disputes for which interest and penalties were not correctly paid from July 1, 2007 through the date corrective action was implemented by the Plan.

d. Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in the paragraph immediately above. This evidence was to include an electronic data file (Excel or Access) or schedule that identified the following:

- Claim number
- Date of service
- Date original claim received
- Date new information received (date claim was complete)
- Total billed
- Total paid
- Paid date
- Interest amount paid
- Date interest paid
- Penalty amount paid
- Additional Interest amount paid if applicable
- Date additional interest paid if applicable
- Check number for additional interest and penalty paid amount
- Provider name
- ER or Non-ER indicator
- Line of Business (HMO or PPO)
- Number of late days used to calculate interest

The data file was to include the total number of claims and the total additional interest and penalty paid, as a result of remediation.

e. Revised policies and procedures implemented to ensure that payments of late adjusted claims resulting from provider disputes include interest and penalty, if applicable, in compliance with the above Sections and Rules.

f. Date the revised policies and procedures were implemented, the management position(s) responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

If the Plan was not able to complete the CAP or portions of the CAP within 45 calendar days of receipt of the preliminary report, the Plan was required to submit a timeline (that did not exceed 180 calendar days from the receipt of the preliminary report) with its response. If the Plan was not able to meet this timeframe, it was to justify the reason for the delay. The Plan was also required to submit monthly status reports until the CAP is completed.

In response to the Department's finding that PDR sample 21 was not paid sufficient interest, the Plan stated that it used a received date of January 20, 2009, as that was the date the corrected claim was received, and the claim was paid on January 27, 2009.

The Plan replied that it would provide refresher training to appropriate staff. The training was to be completed by January 31, 2011.

The Plan added that it has made changes to its claims process, including criteria to ensure that adjustments and interest payments are made in a timely and accurate manner during the audit process. The revised audit tool was implemented on December 30, 2010.

The Plan responded that its Grievances and Appeals PDR Policy and Procedures documentation has been revised to a standardized format which reflects that payments of late adjusted claims resulting from provider disputes include any applicable interest and penalties, in compliance with the regulation. This revised document was implemented on December 30, 2010.

The Plan stated that it has implemented daily and monthly reporting to monitor the accuracy of interest payments. It also included monitoring criteria within its auditing tool to ensure that PDRs are timely and any claims adjustments are done accurately and fairly.

The Plan identified the Regulatory Compliance Director as the individual responsible for monitoring ongoing compliance of this corrective action on a quarterly basis.

The Department finds that the Plan's compliance efforts are not fully responsive to the deficiencies cited and the corrective actions required.

The Plan failed to provide a data set that identified all late claims resulting from provider disputes for which interest and penalties were not correctly paid from July 1, 2007 through the date corrective action has been implemented by the Plan. The Plan also failed to provide evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in paragraph "c" above.

The Plan is requested to submit the information required in "c" and "d" above by April 27, 2011. If the Plan is not able to comply with this due date, it must file a timeline by April 27, 2011 (broken down monthly showing the expected percentage of completion)

with a specific date when its CAP will be completed. Furthermore, the Plan is required to submit monthly status reports with the information requested in "d" above starting May 15, 2011 until its CAP is fully completed.

B. OTHER PROVIDER DISPUTE RESOLUTION DEFICIENCIES

The following details other provider dispute resolution deficiencies found during the Department's examination:

1. UNTIMELY RESOLUTION OF PHARMACY DISPUTES

Rule 1300.71.38 (f) requires a plan to issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days after the date of receipt of the provider dispute.

Rule 1300.71 (a)(8) defines a "demonstrable and unjust payment pattern" or "unfair payment pattern" as any practice, policy or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims. Subsection (S) describes one of the payment patterns as the failure to comply with the Time Period for Resolution and Written Determination enumerated in Rule 1300.71.38 (f) at least 95% of the time over the course of any three-month period.

The Department's examination found that five (5) out of 35 pharmacy disputes reviewed were not resolved timely (a compliance rate of 86%). They included pharmacy dispute sample numbers 3, 7, 8, 26, and 27.

The Plan was required to revise its policies and procedures to ensure the timely resolution of pharmacy disputes. A copy of these revised policies and procedures were to be submitted with the Plan's response to the preliminary report. The Plan was also required to provide the date of implementation, the management position(s) responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure continued compliance with this Rule.

The Plan replied that its Grievances and Appeals PDR Policy and Procedures documentation has been revised to a standardized format which reflects the 45-day turnaround timeframe and the fact that any monies owed to the provider will be paid within a 5-day turnaround timeframe from the issuance of the written final determination. This revised document was implemented on December 30, 2010.

The Plan stated that it has implemented daily, weekly, monthly, quarterly, and annual reporting to monitor the PDR inventory and timeliness. It also included monitoring criteria within its auditing tool to ensure that PDRs are timely and any claims adjustments are done accurately.

The Plan identified the Regulatory Compliance Director as the individual responsible for monitoring ongoing compliance of this corrective action on a quarterly basis.

The Department finds that the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required.

2. INACCURATE OR INCOMPLETE PHARMACY DETERMINATION LETTER

Rule 1300.71.38 (f) requires a plan to issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days after the date of receipt of the provider dispute.

The Department's examination found that three (3) out of 35 pharmacy disputes reviewed had determination letters that were not accurate or not complete (a compliance rate of 91%). They included pharmacy dispute sample numbers 4, 16, and 23.

The Plan was required to revise its policies and procedures to ensure that written pharmacy determinations include the pertinent facts and reasons for the determination in compliance with the above Rule. A copy of these revised policies and procedures were to be submitted with the Plan's response to the preliminary report. The Plan was also required to provide the date of implementation, the management position(s) responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure continued compliance with this Rule.

The Plan responded that it has included monitoring criteria within its PDR auditing tool to ensure that PDR determination letters are accurate and complete. The Plan stated it provides a monthly PDR Audit Roll Up Report to its management team that includes all audit results and findings.

The Plan replied that its Grievances and Appeals PDR Policy and Procedures documentation has been revised to a standardized format which reflects that all written determinations include the pertinent facts and reasons for the Plan's determination in compliance with the regulation. This revised document was implemented on December 30, 2010.

The Plan identified the Regulatory Compliance Director as the individual responsible for monitoring ongoing compliance of this corrective action on a quarterly basis.

The Department finds that the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required.

3. UNTIMELY ACKNOWLEDGEMENT OF PHARMACY DISPUTES

Rule 1300.71.38 (e)(2) requires a plan to issue a provider dispute acknowledgement within fifteen (15) working days from the date of receipt of the written provider dispute by the office designated to receive provider disputes.

Rule 1300.71 (a)(8) defines a "demonstrable and unjust payment pattern" or "unfair payment pattern" as any practice, policy or procedure that results in repeated delays in the adjudication

and correct reimbursement of provider claims. Subsection (R) describes one of the payment patterns as the failure to acknowledge the receipt of at least 95% of the provider disputes it receives consistent with section 1300.71.38(e) over the course of any three-month period.

The Department's examination found that four (4) out of 35 pharmacy disputes reviewed were not acknowledged timely (a compliance percentage of 89%). They included pharmacy dispute sample numbers 2, 3, 5, and 26.

The Plan was required to revise its policies and procedures to ensure the timely acknowledgement of pharmacy disputes. A copy of these revised policies and procedures were to be submitted with the Plan's response to the preliminary report. The Plan was also required to provide the date of implementation, the management position(s) responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure continued compliance with this Rule.

The Plan replied that its Grievances and Appeals PDR Policy and Procedures documentation have been revised to a standardized format which reflects the 15-day turnaround timeframe and the fact that any monies owed to the provider will be paid within a 5-day turnaround timeframe from the issuance of the written final determination. This revised document was implemented on December 30, 2010.

The Plan stated that it has implemented daily and monthly reporting to monitor the timeliness of PDR acknowledgements. It also included monitoring criteria within its auditing tool to ensure that PDRs are timely and any claims adjustments are done accurately and fairly.

The Plan identified the Regulatory Compliance Director as the individual responsible for monitoring ongoing compliance of this corrective action on a quarterly basis.

The Department finds that the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required.

4. PHARMACY CLAIMS - DATE OF RECEIPT OF PROVIDER DISPUTES

Rule 1300.71.38 (a)(3) defines the "date of receipt" as the working day when the provider dispute or amended provider dispute, by physical or electronic means, is first delivered to the plan's designated dispute resolution office or post office box.

Our review disclosed that the Plan did not record the correct "date of receipt" for seven (7) out of the 35 pharmacy claims disputes reviewed (a non-compliance rate of 20%). They included pharmacy dispute sample numbers 1, 2, 3, 5, 26, 27, and 35.

The Plan was required to state the corrective action implemented to ensure that a claim processor uses the correct receipt date to calculation interest. The Plan was also required to provide the date of implementation, the management position(s) responsible for overseeing

the corrective action, and a description of the monitoring system implemented to ensure continued compliance.

The Plan replied that its Grievances and Appeals PDR Policy and Procedures documentation has been revised to a standardized format to reflect that the correct receipt date be accurately entered into the system. This revised document was implemented on December 30, 2010.

The Plan responded that it included monitoring criteria within its PDR auditing tool to ensure that the corporate receipt date is entered accurately into the system. The Plan stated that it provides a monthly PDR Audit Roll Up Report to its management team that includes all audit results and findings.

The Plan identified the Regulatory Compliance Director as the individual responsible for monitoring ongoing compliance of this corrective action on a quarterly basis.

The Department finds that the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required.

5. PHARMACY CLAIMS - BUNDLING OF PROVIDER DISPUTES

Rule 1300.71.38 (k)(2) requires each plan to submit an "Annual Plan Claims Payment and Dispute Resolution Mechanism Report" in compliance with Rule 1300.71 (q). The report is required to be based upon the date of receipt of the provider dispute and shall include a summary of the disposition of all provider disputes. Disputes contained in a bundled submission should be reported separately as individual disputes. Information may be submitted in an aggregate format so long as all data entries are appropriately footnoted to provide full and fair disclosure.

The Department's examination found that provider disputes that are submitted in a bundled group of substantially similar multiple claims are not individually numbered. Therefore, the number of provider disputes was understated on the Plan's annual report submitted to the Department. They included pharmacy dispute sample numbers 1, 7, 8, 10, 11, and 12.

The Plan was required to implement a policy and procedures to individually report pharmacy disputes submitted in a bundled group of substantially similar claims or other contractual disputes in compliance with Rule 1300.71.38 (k)(2). The Plan was also required to provide the date of implementation and the management position(s) responsible for ensuring compliance.

The Plan replied that it has made the following corrections:

For 2010: The Plan will use a manual process to capture bundled and multiple provider disputes and will report them within a footnote to the report.

For 2011: The Plan will modify its reporting capabilities to ensure that all disputes, including bundled and multiple disputes, are accounted for and reported separately.

The Plan identified the Regulatory Compliance Director as the individual responsible for monitoring ongoing compliance of this corrective action on a quarterly basis.

The Department finds that the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required.

6. MANUAL PROCESSING ERRORS RELATED TO PROVIDER DISPUTES

Rule 1300.71 (a)(8)(K) describes one unfair payment pattern as the failure to reimburse at least 95% of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period.

The examination found that the Plan did not routinely perform reworks to identify all claims for a provider whose claim was not paid correctly due to manual processing errors. This deficiency was noted in provider dispute sample numbers 2, 21, 35, 40 and 46. It was also noted in pharmacy dispute sample numbers 1, 2, and 13.

The Plan was required to submit the following:

a. Evidence that correct payments were made to the providers associated with the claims identified above, including interest and penalties, as appropriate. This evidence was to include an electronic data file/schedule (Excel or dBase) that identified the following:

- Claim number
- Date of service
- Date original claim received
- Date new information received (date claim was complete)
- Total billed
- Total paid
- Paid date
- Interest amount paid
- Date interest paid
- Penalty amount paid
- Additional Interest amount paid if applicable
- Date additional interest paid if applicable
- Check number for additional interest and penalty paid amount
- Provider name
- ER or Non-ER indicator
- Line of Business (HMO or PPO)
- Number of late days used to calculate interest

The data file was to provide the detail of all claims remediated; and, to include the total number of claims and the total additional interest and penalty paid, as a result of remediation.

b. Revised policies and procedures implemented to ensure that reworks are routinely performed for a provider when manual processing errors are identified.

c. Date the revised policies and procedures were implemented, the management position(s) responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

If the Plan was not able to complete the CAP or portions of the CAP within 45 calendar days of receipt of the preliminary report, the Plan was required to submit a timeline (that did not exceed 180 calendar days from the receipt of the preliminary report) with its response. If the Plan was not able to meet this timeframe, it was to justify the reason for the delay. The Plan was also required to submit monthly status reports until the CAP is completed.

The Plan replied that the claims identified by the Department were not paid incorrectly due to problems in its claims payment system. The Plan stated that its review did not disclose any systemic problems. The Plan added that it routinely reworks sets of similar claims when error trends are identified through their internal audit process

The Plan responded that a monthly report is provided to the Plan's management team that includes all findings from such audits.

The Plan identified the Regulatory Compliance Director as the individual responsible for monitoring ongoing compliance of this corrective action on a quarterly basis.

The Department finds that the Plan's compliance efforts are not fully responsive to the deficiencies cited and the corrective actions required.

The Plan failed to provide a data set to demonstrate that correct payments were made to the providers associated with the claims identified above, including interest and penalties, as appropriate. The Plan also failed to submit evidence to support its position that these manual errors were not systemic. Systemic issues may arise in the manual processing of claims, especially if one or more claims processors continue to make similar errors when processing similar claims.

Furthermore, the Plan failed to include revised policies and procedures implemented to ensure that reworks are routinely performed for a provider when manual processing errors are identified.

The Plan is requested to submit the information required in "a" above by April 27, 2011. If the Plan is not able to comply with this due date, it must file a timeline by April 27, 2011 (broken down monthly showing the expected percentage of completion) with a specific date when its CAP will be completed. The Plan is also required to submit monthly status reports with the information requested in "a" above starting May 15, 2011 until its CAP is fully completed.

Furthermore, the Plan is requested again to submit the information required in "b" above with its response to this report.

C. CLAIM SETTLEMENT PRACTICES – "UNFAIR PAYMENT PATTERN"

Section 1371.37 (a) prohibits a health care service plan from engaging in an unfair payment pattern. Subsection (c) includes the following claim settlement practices as "unfair payment patterns":

(1) Engaging in a demonstrable and unjust pattern, as defined by the department, of reviewing or processing complete and accurate claims that result in payment delays.

(2) Engaging in a demonstrable and unjust pattern, as defined by the department, of reducing the amount of payment or denying complete and accurate claims.

(3) Failing on a repeated basis to pay the uncontested portions of a claim within the timeframes specified in Section 1371, 1371.1, or 1371.35.

(4) Failing on a repeated basis to automatically include the interest due on claims pursuant to Section 1371.

Rule 1300.71 (a)(8) defines a "demonstrable and unjust payment pattern" or "unfair payment pattern" as any practice, policy or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims.

The Department's examination found that the Plan engaged in "unfair payment patterns" as summarized in the following table:

Deficiency	Type of Claim	Total Claims in the Sample Population	Total Claims in the Sample	Number of Deficiencies Found	% of Compliance
Failure to reimburse claim accurately, including paying interest and penalty.	Late WGS	72,757	25	6	76%
Failure to reimburse claim accurately, including paying interest and penalty.	Late ISG	26,306	25	2	92%
Failure to reimburse claim accurately, including paying interest and penalty.	Non-Contracted Emergency ISG	15,062	50	4	92%
Failure to provide accurate or clear written denial explanations.	Denied WGS	1,063,358	50	5	90%

Failure to reimburse claims accurately. Incorrect claim denial.	"	"	"	3	94%
Date of receipt not entered correctly into system for timeliness and accurate interest calculation.	Emergency ISG	81,818	50	25	50%
Date of receipt not entered correctly into system for timeliness and accurate interest calculation.	Non-Contracted Emergency WGS	78,656	50	10	80%
Date of receipt not entered correctly into system for timeliness and accurate interest calculation.	Non-Contracted Emergency ISG	15,062	50	9	82%
Date of receipt not entered correctly into system for timeliness and accurate interest calculation.	Emergency WSG	240,202	50	6	88%

On October 6, 2010, the Plan filed a signed acknowledgement with the Department that stated the following:

Claim Payment Accuracy

"Blue Cross of California (the "Plan") acknowledges that it has deficiencies in its claims payment procedures, operations and related finalization processes which have resulted in the Plan incorrectly denying and incorrectly paying on an unacceptable number claims as described below. The Plan has requested that the Department of Managed Health Care (the Department) discontinue its testing on late ISG and WGS claims, denied WGS claims, and non-contracted emergency ISG claims in light of the Plan's acknowledgement of these deficiencies and the Plan acknowledges that the Department agreed to do so in reliance upon this document. The Plan further acknowledges its commitment to correcting these deficiencies in accordance with requirements stated in all Department reports, including examination reports, issued in connection with this routine examination.

The Plan acknowledges that these deficiencies have resulted in its violations of Health and Safety Code sections 1371, 1371.35, 1371.37 and 1371.8; and California Code of Regulations, Title 28, sections 1300.71(a)(8), 1300.71(i) and 1300.71(j). For purposes of assessing a penalty for these violations, the Plan agrees that there was a deficiency rate of 24 percent found in the sample of 25 late WGS claims, 8 percent found in the sample of 25 late ISG claims, 6 percent found in the sample of 50 denied WGS claims, and 8 percent found in the sample of 50 non-contracted emergency ISG claims that are evidence of the percentages of deficiencies present in the entire universe of late claims, denied WGS claims, and non-contracted emergency IGS [sic] claims that were manually adjudicated during the time frame defined by the Department's examination, specifically July 1, 2008 to September 30, 2008."

Date of Receipt

"The Plan acknowledges that it has certain deficiencies in its claims payment procedures, operations and related finalization processes which have resulted in the recording of incorrect dates of receipt on a number of emergency claims as described below. The Plan has requested that the Department discontinue its testing on emergency claims in light of the Plan's acknowledgement of this deficiency and the Plan acknowledges that the Department agreed to do so in reliance upon this document. The Plan further acknowledges its commitment to correcting this deficiency in accordance with requirements stated in all Department reports, including examination reports, issued in connection with this routine examination.

The Plan acknowledges that this deficiency has resulted in its violations of California Code of Regulations, Title 28, and section 1300.71(a)(6). For purposes of assessing a penalty for this violation, the Plan agrees that the deficiency rates of 50 percent found in the sample of 50 emergency ISG claims, 18 percent found in the sample of 50 non-contracted emergency ISG claims, 20 percent found in the sample of 50 non-contracted emergency WGS claims, and12 percent found in the sample of 50 emergency WGS claims are conclusive evidence of the percentages of deficiencies present in the entire universe of emergency ISG claims and emergency WGS claims received between 2:01 pm and 1:59 pm Pacific Standard time and adjudicated during the time frame defined by the Department's examination, specifically July 1, 2008 through September 30, 2008."

Accurate Written Explanation

"The Plan acknowledges that it has deficiencies in its claims payment procedures, operations and related finalization processes which have resulted in the lack of adequate or complete written explanation of denial for a number of denied WGS claims as described below. The Plan has requested that the Department discontinue its review of denied WGS claims in light of the Plan's acknowledgement of these deficiencies and the Plan acknowledges that the Department agreed to do so in reliance upon this document. The Plan further acknowledges its commitment to correcting this deficiencies in accordance with requirements stated in all Department reports, including examination reports, issued in connection with this routine examination.

The Plan acknowledges that this deficiency has resulted in its violation of California Code of Regulations, Title 28, section 1300.71 (a)(8)(F) and 1300.71 (d)(1). For purposes of assessing a penalty for this violation, the Plan agrees that the deficiency rates of 10 percent found in the sample of 50 denied WGS claims is conclusive evidence of the percentages of deficiency present in the entire universe of misdirected claims mailed back to the medical group for processing and adjudication during the time frame defined by the Department's examination, specifically July 1, 2008 through September 30, 2008."

The following details the unfair payment practices and other claim settlement deficiencies found during our examination:

1. PAYMENT ACCURACY OF CLAIMS – *REPEAT DEFICIENCY*

Section 1371 requires a health care service plan to reimburse uncontested claims no later than 45 working days after the date of receipt of the claim by the plan. This section also requires that if an uncontested claim is not reimbursed within 45 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 45 working day period.

Section 1371 and Rule 1300.71 (j) require that all interest that has accrued shall be automatically included in the claim payment. The penalty for failure to comply with this requirement shall be a fee of ten ($10) dollars paid to the claimant.

Rule 1300.71(a)(8)(K) describes one unfair payment pattern as the failure to reimburse at least 95% of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period.

Rule 1300.71 (g)(1) requires a health care service plan that maintains a PPO line of business to reimburse all claims relating to or arising out of non-HMO lines of business within thirty (30) working days.

The failure of the Plan to pay interest correctly on additional late claim payments was noted in the Final Report of the prior non-routine examination, dated October 13, 2006. In response to the Preliminary Report for that examination, the Plan described various corrective action plans which included additional training and audit procedures and the remediation of interest and penalties for the time periods specified in the report.

This examination disclosed that the Plan's compliance efforts have not achieved the necessary levels of compliance with the claim settlement requirements in the following respect:

INDIVIDUAL AND SMALL GROUP (ISG)

The Department's examination found that two (2) out of the twenty-five (25) late ISG claims had interest that was not paid or was underpaid (a compliance rate of 92%). The incorrect payment of interest was the result of the Plan not selecting the correct date of receipt of a complete claim to calculate the number of days used in determining the amount of interest payable on these late claims.[3] Therefore, the Plan demonstrated an unfair payment pattern according to Section 1371.37 (c)(4) for failing to automatically include the interest due on late claims payments during the three-month period ending September 30, 2008.

They included the following late claim samples:

[3] The Department's examination also found that interest was overpaid on six (6) out of the twenty (25) late STAR claims reviewed.

ISG Late Claim Sample No.	Product	Date of Receipt	Number of Days Late for Calculating Interest	Interest Paid by Plan	Interest That Should Have Been Paid	Penalty	Amount of Interest Underpayment Including Penalty
LP-7	PPO	04/30/08	60	$.11	$.28	$10.00	$10.17
LP-14	PPO	05/10/06	822	$121.64	$1,072.56	$10.00	$960.92

WELLPOINT GROUP SYSTEM (WGS)

The Department's examination found that six (6) out of the 25 late claims reviewed had interest that was not paid or was underpaid (a compliance rate of 76%). The incorrect payment of interest was the result of the Plan not selecting the correct date of receipt of a complete claim to calculate the number of days used in determining the amount of interest payable on these late claims.[4]

Therefore, the Plan demonstrated an unfair payment pattern according to Section 1371.37 (c)(4) for failing to automatically include the interest due on late claims payments during the three-month period ending September 30, 2008.

Examples included the following late claim samples:

WGS Late Claim Sample No.	Product	Date of Receipt	Number of Days Late for Calculating Interest	Interest Paid by Plan	Interest That Should Have Been Paid	Penalty	Amount of Interest Underpayment Including Penalty
LP-3	HMO	11/13/07	191	$0.00	$13.43	$10.00	$23.42
LP-8	HMO	4/12/08	19	$0.00	$0.15	$10.00	$10.15
LP-9	PPO	11/2/07	259	$0.00	48.26	$10.00	$58.26
LP-11	PPO	12/12/07	184	$0.00	$17.96	$10.00	$27.96
LP-14	HMO	1/30/07	484	$0.00	$28.67	$10.00	$38.67
LP-25	HMO	12/29/07	210	$0.00	$140.02	$10.00	$150.02

The Plan's repeated failure to comply with the requirements of Sections 1371 and Rule 1300.71 was referred to the Office of Enforcement for appropriate administrative action. The enforcement action resulted in a $900,000 fine being assessed against the Plan.

The Plan was required to state the reasons why its compliance efforts have not achieved the necessary levels of compliance with the Act and Regulations cited.

In addition, the Plan was required to submit a Corrective Action Plan ("CAP") to address the deficiency cited above. The CAP was to include, for each system, the following:

[4] The Department's examination also found that interest was overpaid on three (3) out of the twenty-five (25) late WGS claims reviewed.

a. Training procedures to ensure that claim processors have been properly trained on interest and penalty requirements.

b. Audit procedures to ensure that the Plan was monitoring correct payment of interest and penalties on late and late adjusted claims payments.

c. Identification of all late claims for which interest and penalties were not correctly paid from July 1, 2007 through the date corrective action has been implemented by the Plan.

d. Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in the paragraph immediately above. This evidence was to include an electronic data file (Excel or Access) or schedule that identifies the following:

- Claim number
- Date of service
- Date original claim received
- Date new information received (date claim was complete)
- Total billed
- Total paid
- Paid date
- Interest amount paid
- Date interest paid
- Penalty amount paid
- Additional Interest amount paid if applicable
- Date additional interest paid if applicable
- Check number for additional interest and penalty paid amount
- Provider name
- ER or Non-ER indicator
- Line of Business (HMO or PPO)
- Number of late days used to calculate interest

The data file was to include the total number of claims and the total additional interest and penalty paid, as a result of remediation.

e. Revised policies and procedures implemented to ensure that payments of late adjusted claims include interest and penalty, if applicable, in compliance with the above Sections and Rules.

f. Date the revised policies and procedures were implemented, the management position(s) responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

If the Plan was not able to complete the CAP or portions of the CAP within 45 calendar days of receipt of the preliminary report, the Plan was required to submit a timeline (that did not exceed 180 calendar days from the receipt of the preliminary report) with its response. If the Plan was not able to meet this timeframe, it was to justify the reason for the delay. The Plan was also required to submit monthly status reports until the CAP is completed.

The Plan replied that its current audit procedures are not sufficient. Therefore, it has initiated a focus group of operations experts to improve its prompt pay calculations, and revise procedures accordingly. The Plan is also exploring the possibility of an automated audit tool and stronger oversight.

The Plan stated that it is updating and implementing additional training materials, policies, and procedures. These updates are targeted to be completed by March 31, 2011.

The Plan added that it has made changes to its claims process, including criteria to ensure that adjustments and interest payments are made in a timely manner during the audit process.

The Plan responded that its audit procedures have been increased to better monitor compliance. This includes creating a report, which is intended to show all paid claims without interest payments when the claim has been completed beyond the interest timeframe. The target date for completing this report is April 1, 2011.

The Plan has identified 1,680,428 claims with interest payments that it will need to review.

The Plan provided an estimated timeline to complete its CAP that ranged from 90 to 365 calendar days based on estimated staffing of 650 to162, respectively.

The Plan identified the claims operations director as being responsible for the CAP and the Regulatory Compliance Director as the individual responsible for monitoring ongoing compliance of this corrective action on a quarterly basis.

The Department finds that the Plan's compliance efforts are not responsive to the deficiencies cited and the corrective actions required.

The Plan failed to submit evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in the "c" above.

The Plan is requested to submit the information required in "c" and "d" above by April 27, 2011. If the Plan is not able to comply with this due date, it must file a timeline by April 27, 2011 (broken down monthly showing the expected percentage of completion) with a specific date when its CAP will be completed. The Plan is also required to submit monthly status reports with the information requested in "d" above starting May 15, 2011 until its CAP is fully completed.

Furthermore, the Plan is requested again to submit the information required in "a", "b" and "e" above with its response to this report.

2. PAYMENT ACCURACY OF EMERGENCY CLAIMS

Section 1371.35 and Rule 1300.71 (i), which refers to claims for emergency services, require that if an uncontested claim is not reimbursed within 45 working days after the date of receipt of the claim by the plan, the plan shall automatically include the greater of $15 for each 12-month period or portion thereof on a *non-prorated basis*, or interest at the rate of 15% per annum for the period of time that the payment is late.

Rule 1300.71(a)(8)(K) describes one unfair payment pattern as the failure to reimburse at least 95% of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period.

The examination found that four (4) out of 50 non-contracted emergency ISG claims were not paid correctly (a compliance rate of 92%). They included emergency ISG claim sample numbers PD-12, PD-14, PD-33, and PD-42.

The above violation was referred to the Department's Office of Enforcement for appropriate administrative action. The enforcement action resulted in a $900,000 fine being assessed against the Plan.

The Plan was required to submit a Corrective Action Plan ("CAP") to address the deficiency cited above. The CAP was to include the following:

a. Identification of non-contracted ISG emergency claims that were not paid correctly from July 1, 2007 through the date corrective action has been implemented by the Plan.

b. Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in the paragraph immediately above. This evidence was to include an electronic data file (Excel or Access) or schedule that identifies the following:

- Claim number
- Date of service
- Date original claim received
- Date new information received (date claim was complete)
- Total billed
- Total paid
- Paid date
- Interest amount paid
- Date interest paid
- Penalty amount paid
- Additional Interest amount paid if applicable
- Date additional interest paid if applicable

- Check number for additional interest and penalty paid amount
- Provider name
- Line of Business (HMO or PPO)
- Number of late days used to calculate interest

The data file was to include the total number of claims and the total additional interest and penalty paid, as a result of remediation.

c. The Plan was required to submit its revised policy and procedures for ensuring that non-contracted emergency claim are paid correctly pursuant to the above Rule. The Plan was required to indicate the date of implementation, the management position responsible for compliance, and the controls implemented for monitoring continued compliance.

If the Plan was not able to complete the CAP or portions of the CAP within 45 calendar days of receipt of the preliminary report, the Plan was required to submit a timeline (that did not exceed 180 calendar days from the receipt of the preliminary report) with its response. If the Plan was not able to meet this timeframe, it was to justify the reason for the delay. The Plan was also required to submit monthly status reports until the CAP is completed.

The Plan has identified 202,886 ISG emergency claims with interest payments that it will need to review.

The Plan provided an estimated timeline to complete its CAP that ranged from 90 to 365 calendar days based on estimated staffing of 650 to162, respectively.

The Plan replied that it was updating and implementing policies and procedures. The target date for completion is April 15, 2011.

The Plan added that it has made changes to its claims process, including criteria to ensure that adjustments and interest payments are made in a timely manner during the audit process.

The Plan identified the claims operations director as being responsible for the CAP and the Regulatory Compliance Director as the individual responsible for monitoring ongoing compliance of this corrective action on a quarterly basis.

The Department finds that the Plan's compliance efforts are not fully responsive to the deficiencies cited and the corrective actions required.

The Plan failed to submit evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in the "a" above.

The Plan is requested to submit the information required in "a" and "b" above by April 27, 2011. If the Plan is not able to comply with this due date, it must file a timeline by April 27, 2011 (broken down monthly showing the expected percentage of completion) with a specific date when its CAP will be completed. The Plan is also required to

submit monthly status reports with the information requested in "b" above starting May 15, 2011 until its CAP is fully completed.

Furthermore, the Plan is requested again to submit the information required in "c" above with its response to this report.

3. INCORRECT CLAIM DENIALS

Rule 1300.71 (a)(8)(K) describes one unfair payment pattern as the failure to reimburse at least 95% of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period.

Rule 1300.71(d) states that a plan or a plan's capitated provider shall not improperly deny, adjust, or contest a claim.

The Department's examination found that three (3) out of 50 WGS denied claims were not paid correctly (a compliance rate of 94%). They included denied WGS claim sample numbers D-9, D-21, and D-23.

The above violation was referred to the Department's Office of Enforcement for appropriate administrative action. The enforcement action resulted in a $900,000 fine being assessed against the Plan.

The Plan was required to submit a detailed Corrective Action Plan ("CAP") to bring the Plan into compliance with the above Section and Rule that should include, but not be limited to, the following:

a. Identification of all claims processed from July 1, 2007 to the present that were incorrectly denied.

b. Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in paragraph "a" above. This evidence was to include an electronic data file/schedule (Excel or dBase) that identified the following:

- Claim number
- Date of service
- Date original claim received
- Date new information received (date claim was complete)
- Total billed
- Total paid
- Paid date
- Interest amount paid
- Date interest paid
- Penalty amount paid
- Additional Interest amount paid if applicable

- Date additional interest paid if applicable
- Check number for additional interest and penalty paid amount
- Provider name
- ER or Non-ER indicator
- Line of Business (HMO or PPO)
- Number of late days used to calculate interest

The data file was to provide the detail of all claims remediated; and, to include the total number of claims and the total additional interest and penalty paid, as a result of remediation.

c. Policies and procedures implemented to ensure that claims are paid in compliance with the above Section and Rules.

d. Date the policies and procedures were implemented, the management position responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

If the Plan was not able to complete the CAP or portions of the CAP within 45 calendar days of receipt of the preliminary report, the Plan was required to submit a timeline (that did not exceed 180 calendar days from the receipt of the preliminary report) with its response. If the Plan was not able to meet this timeframe, it was to justify the reason for the delay. The Plan was also required to submit monthly status reports until the CAP is completed.

The Plan has identified 12,238 claims denied for eligibility that it will need to review.

The Plan provided an estimated timeline to complete its CAP that ranged from 90 to 365 calendar days based on estimated staffing of 650 to162, respectively.

The Plan replied that it was updating and implementing policies and procedures. The target date for completion is April 15, 2011.

The Plan added that it has made changes to its claims process, including criteria to ensure that adjustments and interest payments are made in a timely manner during the audit process.

The Plan identified the claims operations director as being responsible for the CAP and the Regulatory Compliance Director as the individual responsible for monitoring ongoing compliance of this corrective action on a quarterly basis.

The Department finds that the Plan's compliance efforts are not fully responsive to the deficiencies cited and the corrective actions required.

The Plan failed to submit evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in the "a" above.

The Plan is requested to submit the information required in "a" and "b" above by April 27, 2011. If the Plan is not able to comply with this due date, it must file a timeline by April 27, 2011 (broken down monthly showing the expected percentage of completion) with a specific date when its CAP will be completed. The Plan is also required to submit monthly status reports with the information requested in "b" above starting May 15, 2011 until its CAP is fully completed.

Furthermore, the Plan is again requested to submit the information required in "c" above with its response to this report.

4. CLEAR AND ACCURATE DENIAL EXPLANATION

Rule 1300.71 (d) states that a plan shall not improperly deny, adjust, or contest a claim. For each claim that is either denied, adjusted or contested, the plan shall provide an accurate and clear written explanation of the specific reasons for the action taken within the timeframes specified in sections (g) and (h).

The examination found that five (5) out of 50 denied WGS claims reviewed had denial explanations that were not clear or not accurate (a compliance rate of 90%). They included denied WGS claim sample numbers D-7, D-11, D-24, D-26, D-28, and D-37.

The above violation was referred to the Department's Office of Enforcement for appropriate administrative action. The enforcement action resulted in a $900,000 fine being assessed against the Plan.

The Plan was required to submit a revised policy and procedures for ensuring that the providers of denied claims are given a clear and accurate denial reason in accordance with Section 137.71(d). A copy of these revised policies and procedures were to be submitted with the Plan's response to this report. The Plan was also required to provide the date of implementation, the management position(s) responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure continued compliance with this Rule.

The Plan replied that it was updating and implementing policies and procedures. The target date for completion is April 15, 2011.

The Plan added that it has made changes to its claims process, including criteria to ensure that adjustments and interest payments are made in a timely manner during the audit process.

The Plan identified the claims operations director as being responsible for the CAP and the Regulatory Compliance Director as the individual responsible for monitoring ongoing compliance of this corrective action on a quarterly basis.

The Department finds that the Plan's compliance efforts are not fully responsive to the deficiencies cited and the corrective actions required.

The Plan failed to file its revised policies and procedures for ensuring that the providers of denied claims are given a clear and accurate denial reason.

The Plan is requested again to submit the information required above with its response to this report.

5. RECEIPT DATE OF CLAIMS

Rule 1300.77.4 requires all plans to institute procedures whereby all claims received by the Plan are maintained and accounted for in a manner which permits the determination of the date of receipt of any claim, the status of any claim, the dollar amount of unpaid claims at any time and the rapid retrieval of any claim.

Rule 1300.71 (a)(6) defines the date of receipt as the working day when a claim is delivered to either the plan's specified claims payment site, post office box, or to its designated claims processor.

The Department's examination found that the Plan did not record the correct receipt date which can cause timeliness and interest to be incorrect calculated. Incorrect receipt dates were identified in the follow samples:

- 25 out of 50 emergency ISG claims reviewed (a compliance rate of 50%). They included emergency ISG claim sample numbers PD-5, PD-7, PD-8, PD-11, PD-12, PD-13, PD-15, PD-16, PD-18, PD-21, PD-25, PD-28, PD-30, PD-31, PD-32, PD-34, PD-37, PD-39, PD-43, PD-44, PD-46, PD-47, PD-48, PD-49 and PD-50.

- 10 out of 50 non-contracted emergency WGS claims reviewed (a compliance rate of 80%). They included non-contracted emergency WGS claim sample numbers PD-3, PD-14, PD-16, PD-24, PD-26, PD-38, PD-40, PD-45, PD-46, and PD-47.

- 9 out of 50 non-contracted emergency ISG claims reviewed (a compliance rate of 82%). They included non-contracted emergency ISG claim sample numbers PD-3, PD-14, PD-16, PD-18, PD-28, PD-29, PD-32, PD-36 and PD-39.

- 6 out of 50 emergency WGS claims reviewed (a compliance rate of 88%). They included paid claim samples PD-29, PD-36, PD-38, PD-43, PD-45, and PD-46.

The above violation was referred to the Department's Office of Enforcement for appropriate administrative action. The enforcement action resulted in a $900,000 fine being assessed against the Plan.

The Plan was required to submit a description of its process to ensure that the correct claim receipt date is being captured in compliance with Rule 1300.71(a)(6). The Plan was also required to provide the management position(s) responsible for compliance and a description of the monitoring system implemented to ensure continued compliance with this Rule.

The Plan replied that it was analyzing its claims processing system; the Plan anticipates that the work would be completed in the third quarter of 2011.

The Plan identified the claims operations director as being responsible for the CAP and the Regulatory Compliance Director as the individual responsible for monitoring ongoing compliance of this corrective action on a quarterly basis.

The Department finds that the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required.

D. OTHER CLAIM SETTLEMENT DEFICIENCIES

The following details other claim settlement deficiencies found during the Department's examination:

1. ACCURATE AND CLEAR EXPLANATION OF PAYMENT

Rule 1300.71 (a)(8)(F) defines an unfair payment pattern as "the failure to provide a provider with an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim consistent with section (d)(1) at least 95% of the time for the affected claims over the course of any three-month period.

The Department's examination found that the Plan failed to clearly state that a "goodwill" payment was made and no interest was being paid on two (2) out of 25 late ISG claims (a compliance rate of 92%). This issue was identified in late ISG claim sample numbers LP-3 and LP-17.

The Plan was required to revise its policies and procedures to ensure that the written explanations of goodwill payments clearly state that no interest is being paid. A copy of these revised policies and procedures were to be submitted with the Plan's response to this report. The Plan was also required to provide the date of implementation, the management position(s) responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure continued compliance with this Rule.

The Plan submitted its revised language used in notifying payees of goodwill payments and revised its policies and procedures; these were to be completed by February 1, 2011.

The Plan identified the claims operations director as being responsible for the CAP and the Regulatory Compliance Director as the individual responsible for monitoring ongoing compliance of this corrective action on a quarterly basis.

The Department finds that the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required.

2. REWORKS FOR MANUAL PROCESSING ERROR RELATED TO CLAIMS

The Department's examination found that the Plan failed to routinely perform reworks to identify all claims for a provider whose claim was not paid correctly due to manual processing errors. This issue was noted in denied ISG claim sample numbers D-8 and D12. It was also noted in denied WGS claim sample number D-23.

The Plan was required to submit the following:

a. Evidence that correct payments were made to the providers associated with the claims identified above, including interest and penalties, as appropriate. This evidence was to include an electronic data file/schedule (Excel or dBase) that identifies the following:

- Claim number
- Date of service
- Date original claim received
- Total billed
- Total paid
- Paid date
- Interest amount paid
- Date interest paid
- Penalty amount paid
- Additional Interest amount paid, if applicable
- Date additional interest paid if applicable
- Check Number for additional payment, interest and penalty paid
- Provider name
- Line of Business
- ER or Non-ER indicator
- Number of Late Days used to calculate interest

b. The data file was to provide the detail of all claims remediated; and, to include the total number of claims and the total additional interest and penalty paid, as a result of remediation

c. Revised policies and procedures implemented to ensure that reworks are routinely performed for a provider when manual processing errors are found.

d. Date the revised policies and procedures were implemented, the management position(s) responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

If the Plan was not able to complete the CAP or portions of the CAP within 45 calendar days of receipt of the preliminary report, the Plan was required to submit a timeline (that did not exceed 180 calendar days from the receipt of the report) with its response. If the Plan was

not able to meet this timeframe, it was to justify the reason for the delay. The Plan was also required to submit monthly status reports until the CAP is completed.

The Plan has identified 866,611 denied claims it will need to review.

The Plan provided an estimated timeline to complete its CAP that ranged from 90 to 365 calendar days based on estimated staffing of 650 to162, respectively.

The Plan replied that it was updating and implementing policies and procedures. The target date for completion is April 15, 2011.

The Plan added that it will create a monthly report to capture any potential claims denied in error. It will also create and implement a policy and procedure to explain the report and how to utilize it. The target date for completion is April 15, 2011.

The Plan identified the claims operations director as being responsible for the CAP and the Regulatory Compliance Director as the individual responsible for monitoring ongoing compliance of this corrective action on a quarterly basis.

The Department finds that the Plan's compliance efforts are not fully responsive to the deficiencies cited and the corrective actions required.

The Plan failed to submit evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in the "a" above.

The Plan is requested to submit the information required in "a" and "b" above by April 27, 2011. If the Plan is not able to comply with this due date, it must file a timeline by April 27, 2011 (broken down monthly showing the expected percentage of completion) with a specific date when its CAP will be completed. The Plan is also required to submit monthly status reports with the information requested in "a" above starting May 15, 2011 until its CAP is fully completed.

Furthermore, the Plan is again requested to submit the information required in "c" above with its response to this report.

SECTION II. NON-ROUTINE EXAMINATION

The Plan is advised that the Department will conduct a non-routine examination, in accordance with Rule 1300.82.1, to verify representations made to the Department by the Plan in response to this report. The cost of such examination will be charged to the Plan in accordance with Section 1382 (b).

No response was required to this Section.

Anthem. Blue Cross

Laura Reno
State Regulatory Compliance Director

April 22, 2011 **Transmitted via E-Mail, E-File and Postal Service**

Janet Nozaki, Supervising Examiner
Office of Health Plan Oversight Division of Financial Oversight
DEPARTMENT OF MANAGED HEALTH CARE
320 West Fourth Street, Suite 880
Los Angeles, CA 90013

RE: FINAL REPORT OF THE ROUTINE EXAMINATION OF BLUE CROSS OF CALIFORNIA'S (DBA: ANTHEM BLUE CROSS) CLAIMS SETTLEMENT PRACTICE AND PROVIDER DISPUTE RESOLUTION MECHANISM

Dear Ms. Nozaki:

We have received the Department's Final Report of the routine examination of the Blue Cross of California ("Anthem") claims settlement practice and provider dispute resolution mechanism for the three-month period ending September 30, 2008.

In accordance with Section 1382(d) of the Knox-Keene Health Care Service Plan Act, **Anthem wishes to append its January 4, 2011 response to the Final Report with the attached Letter of Agreement between the Department and Anthem dated November 29, 2010.**

Please note that in addition to the administrative burden and cost associated with reprocessing claims back to July 1, 2007, which Anthem addressed in its previous response letter, we would like to direct the Department to the attached Settlement Letter of Agreement releasing Anthem of all findings in the Preliminary Report.

Please contact me with any questions or comments. Thank you.

Sincerely,

Laura Reno

Laura Reno

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DEPARTMENT OF
Managed
Health Care

Arnold Schwarzenegger, Governor
State of California
Business, Transportation and Housing Agency

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November 29, 2010

DELIVERED VIA FAX AND U.S. MAIL

Karen Francolini
Vice President and Counsel
Legal Department
Blue Cross of California
dba Anthem Blue Cross
21555 Oxnard Street, First Floor
Woodland Hills, CA 91367

RE: ENFORCEMENT MATTER NUMBER 10-002

LETTER OF AGREEMENT

Dear Ms. Francolini:

The Department of Managed Health Care ("Department") has concluded its investigation of Blue Cross of California dba Anthem Blue Cross (the "Plan"). The focus of the Department's investigation was the Plan's failure to comply with the Knox-Keene Act governing claims payment, provider disputes, and unfair payment patterns, including but not limited to California Health and Safety Code Sections 1371, 1371.35 and California Code of Regulations, title 28, sections 1300.71, 1300.71.38

The Department has completed its audit of these issues and determined that a penalty is warranted based on the violations found. Pursuant to the Department's authority under California Health and Safety Code Section 1386, the Department assessed an administrative

penalty against the Plan in the amount of $900,000. The Department will suspend $400,000 of the penalty amount contingent upon the next financial examination demonstrating Blue Cross' full compliance with the claims payment and PDR provisions of the Knox-Keene Act for which the Plan has acknowledged violations. At that time, the Plan can petition the Department for a complete waiver of the suspended $400,000 penalty. Should the Plan fail to meet this goal, the Department may reinstate the penalty in whole, or in part, at its discretion. The Plan has agreed to these terms and will pay $500,000 of the penalty amount immediately for the purpose of resolving this action. The parties agree this agreement fully and completely settles all matters related to the subject matter herein, including all findings in the Department's Preliminary Report dated October 29, 2010.

Sincerely,

Michael D. McClelland
Assistant Deputy Director
Office of Enforcement

Accepted by BLUE CROSS OF CALIFORNIA

Dated: 11/30/2010

Pam D. Kehaly
President
Blue Cross of California dba Anthem Blue Cross