

**STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
COMPLIANCE EXAMINATION
STATUTORY DEPENDENT COVERAGE AND
AUTISM SPECTRUM DISORDERS LEGISLATION**

OF

**HUMANA INSURANCE COMPANY
MARKET CONDUCT EXAMINATION REPORT**

MARKET CONDUCT EXAMINATION REPORT

DATE OF EXAMINATION: July 20, 2009 through August 28, 2009

EXAMINATION OF: Humana Insurance Company

LOCATION OF EXAMINATION: INS Offices in Philadelphia, PA and
Kansas City, MO

PERIOD COVERED BY EXAMINATION: December 12, 2008 through June 11, 2009

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I. SUMMARY

1. Humana Insurance Company (the "Company") was subject to a limited scope Market Conduct Examination designed to assess compliance with two (2) pieces of legislation 215 ILCS 5/356z.14, Autism Spectrum Disorders, and 215 ILCS 5/356z.12, Dependent Coverage. The Autism Spectrum Disorder legislation was effective December 12, 2008. Its text is attached as Appendix A. The Dependent Coverage legislation was effective June 1, 2009. Its text is attached as Appendix B.

The Company was required to submit information on its underwriting practices to assess compliance with the provisions of 215 ILCS 5/356z.14, Autism Spectrum Disorders.

The Company was required to submit claims information data for all group insurance and individual insurance claims received between December 12, 2008 and June 11, 2009 if an insured had at least one (1) claim for autism submitted during the examination period. Standard industry diagnostic codes commonly referred to as ICD-9 Codes (*International Classification of Diseases, ninth revision*) were used to determine what qualified as an autism claim. Claim information was to be provided regardless of whether autism was listed as a primary or secondary diagnosis in connection with the treatment for which the claim was submitted. For example, claim information relating to an injury suffered by a passenger in an automobile accident which occurred in May 2009 would have been obtained if the injured passenger had had an autism related claim submitted in January 2009. Submitted data was analyzed to review basic statistical information and trends related to claim payment, claim denials, additional information requests and other dispositions.

The Company was required to submit information on the steps the company had taken to implement processes and procedures to meet the requirements of 215 ILCS 356z.12, Dependent Coverage.

It should be noted that the examination was limited to the Company's activities relating to its insurance business. The examination did not involve a review of the Company's, or any of its affiliates' activities as a claims administrator of ERISA qualified self funded plans. ERISA qualified self funded plans are not subject to the provisions of either the Autism Spectrum Disorders legislation or the Dependent Coverage legislation. ERISA qualified self-funded plans are subject to oversight by the US Department of Labor. A significant number of Illinois residents obtain health care coverage through ERISA qualified self funded plans.

II. BACKGROUND

This examination reflects the Illinois insurance activities of the Company, specifically as it relates to the Company's implementation of legislation regarding coverage for individuals with autism and coverage for adult dependent children. The examination was conducted on behalf of the Illinois Department of Insurance by INS Regulatory Insurance Services, Inc. It should be noted that the examination was limited to the Company's activities relating to its insurance business. The examination did not involve a review of the companies, or any of its affiliates,' activities as a claims administrator of ERISA qualified self funded plans. ERISA qualified self funded plans are not subject to the provisions of either the Autism Spectrum Disorders legislation or the Dependent Coverage legislation. ERISA qualified self-funded plans are subject to oversight by the US Department of Labor. A significant number of Illinois residents obtain health care coverage through ERISA qualified self funded plans.

Project Description

A review of autism related claim information was selected from the Company utilizing ACL[®] software which provides a general evaluation of the payment, denial, pending and other claims handling practices related to claims under review.

Fields to be Collected

The fields selected for inclusion in the data request were extracted from the NAIC *Market Regulation Handbook* Standardized Data Calls. The fields include information designed to provide a snapshot of the numbers of claims received, paid and denied during the examination period.

Specific Information Collected

The Company was sent a letter with two (2) attachments requests along with an examination warrant. The first attachment to this letter was a request for data that included the fields identified for submission in the Company's data file. The second attachment was a series of interrogatories designed to extract information from the Company about its compliance with the recently enacted legislation.

III. COMPANY HISTORY AND ILLINOIS PREMIUM VOLUME

Humana Insurance Company, Inc. (Company) was originally incorporated as Classified Life Insurance Corporation. In 1977, the Company's name was changed to Wisconsin Employers Health Insurance Company. The name Fireman's Fund Employers Insurance Company was assumed in 1983 and the Company name was changed to Employers Health Insurance Company in 1986.

From 1986 through 1994, the Company was a wholly-owned subsidiary of Lincoln Financial Insurance Company (LFL). LFL subsequently formed EMPHESYS Financial Group as the holding company for the Company and its related affiliates. A subsequent initial public offering reduced LNL's interest in Employers Health to 29% and the outstanding stock retained by LNL was later transferred to its property and casualty division, American States Insurance Company. In 1995, all outstanding stock of EMPHESYS was purchased by Humana Inc. Then, on December 31, 2001, Humana Insurance Company merged into Employers Health Insurance Company and the name of this Company was changed to Humana Insurance Company, Inc.

The Company is domiciled in the state of Wisconsin. The company writes primarily Individual Accident and Health Insurance, followed by Group Accident and Health, Group Life Insurance and a small amount of Ordinary Life Insurance.

The Company's 2008 Annual Statement reflects \$376,603,073 in Illinois direct group health insurance policy premiums and \$44,414,131 in Illinois individual health insurance policy premiums. The Company's 2009 Annual Statement reflects \$407,224,187 in Illinois group health insurance policy direct premiums and \$52,102,862 in Illinois individual health insurance policy premiums.

The Company's Illinois Policy Count Report indicates that it had in force 698 Large Group Comprehensive Major Medical insurance policies with 12,474 certificate holders and 5,587 Small Group Comprehensive Major Medical insurance policies with 35,874 certificate holders in 2008. The Company's Illinois Policy Count Report indicates that it had in force 2,420 Large Group Comprehensive Major Medical insurance policies with 18,039 certificate holders and 5,255 Small Group Comprehensive Major Medical insurance policies with 39,028 certificate holders in 2009.

IV. METHODOLOGY

This limited scope Market Conduct Examination was designed to assess compliance with a recently implemented Autism Spectrum Disorders law and the Dependent Coverage law. A two-fold approach to the examination included (1) interrogatories and (2) analysis of data submissions.

Interrogatories

There were a total of five (5) questions included in the interrogatories.

The first question related to the identification of the project coordinator.

The second and third questions were designed to determine whether autism was one of the criteria used when underwriting new individual health insurance applications. (Group health insurance policies are not allowed to refuse enrollment based on health status.) In addition, specific data regarding the numbers of applications that were denied coverage was collected.

The fourth question was designed to determine whether the Company was taking necessary actions to implement the requirements of the Autism Spectrum Disorders law.

The fifth question was designed to determine whether the Company was taking necessary actions to implement the requirements of the Dependent Coverage law. This law prohibits termination of individual or group health insurance coverage for dependents prior to their 26th birthday, regardless of the dependent's health status. (Note this legislation is not limited to dependents with autism).

Interrogatory questions are listed below along with the Company's response.

- 1. Please provide the name of the individual that is the company coordinator for this project along with telephone and email. This information should be submitted no later than June 25, 2009**

The Company identified Paulette Boulder and Craig Zimanek as coordinators.

- 2. Do the company's underwriting guidelines take into consideration autism?**

Large Group Underwriting (100+people) – No
Small Group Underwriting (2-99 people) – Yes
HumanaOne (Individual Coverage) – Yes

3. Provide the number of applicants denied for each 2008 and 2009 due to autism.

Year	Number of Applicants Denied due to Autism
2008	2
2009	1

While the Company reported it denied the above applicants due to autism, it has since modified the underwriting procedures. Autism is no longer a factor which disqualifies an applicant from coverage.

4. Please explain what steps the company has taken to implement processes and procedures to meet the requirements of 215 ILCS 356z.14. Provide copies of procedures or bulletins issued to comply with this statute.

The Company reported that it has implemented processes and procedures for Insurance Coverage for Autism requirements of 215 ILCS 356z.14.

Claims Processing Policies

Humana created claims policies to support a process to manually adjudicate claims outside of its automated claim processing system until the claim system is modified.

Implementation activities for autism were coordinated with implementation activities related to the requirements of the new Federal Mental Health Parity law effective on October 3, 2009.

There are two (2) major systems impacted by the changes, the Metavance (MTV) system and the Claims Administration System (CAS).

Illinois State Specific Policy

- Completion Dates: Metavance (MTV) System - 6/30/2009; Claims Administration System (CAS) – 7/14/2009

Supporting Claims Work-Around Process – MTV only

- Completion Date – 6/30/2009

Comprehensive Autism and Pervasive Developmental Disorder Grid

- Developed for behavioral health provider (LifeSynch)/ UM
- Completion Date – 2/18/2009

Clinical Autism Policy

- Completion Date – 6/3/2009

Physical Therapy (PT)/Occupational Therapy (OT)/Speech Therapy Policy

- Completion Date – 7/9/2009

The following supplemental materials support the Companies documentation developed for compliance:

- An Illinois Autism Manual – *Medical Claims Legislations* - identified scope, impacted platforms, legislative definitions, eligibility requirements/mandates, detailed claim processing information, procedures to meet the guidelines using the electronic systems, contact centers for further inquiries, procedural request forms and other information.
- Pending Code Manual - *National Education and Policy Development (Review of Autism)* - included an overview of the coding definition for claims processed in states with special autism statutes.
- IL Autism and Pervasive Developmental Disorder Comprehensive Grid - includes a grid of the impacted codes, definition of behavioral analysis and tips for billing coders to decipher between cognitive behavior vs. cognitive functioning.
- IL Autism Mandated Coverages - includes a list of information for Nurse Advisors to use when conducting service requests related to the treatment of autism services in accordance with the Illinois regulatory requirements.
- OrthoNet Illinois Autism Mandate Policy - a document used for authorization for service requests related to the treatment of autism and ensuring services are allowed in accordance with Illinois regulatory requirements.

5. Please explain what steps the company has taken to implement processes and procedures to meet the requirements of 215 ILCS 356z.12. Provide copies of procedures or bulletins issued to comply with this statute.

The Company provided a series of documents to support its position that it has implemented processes and procedures designed to comply with the Young Adult Dependent Coverage requirements. The following supplemental materials support the Companies documentation developed for compliance:

- An Illinois State Regulation Manual - *National Education and Policy Development (Dependent Limiting Age)* - included an overview of the statute changes.
- An Illinois Dependent Coverage Manual-*Medical Claims Legislations* - identified scope, impacted platforms, legislative definitions, eligibility requirements/mandates, detailed claim processing information, procedures to meet the guidelines using the electronic systems, contact centers for further inquiries, procedural request forms and other information.
- *HumanaOne Sales Call Center Training Manual* - containing underwriting guidelines, eligibility, step-by-step process for completing applications.
- Draft letter for consumers regarding Illinois Dependent Eligibility Guidelines
- Proof of submittal to the System for Electronic Rate and Form Filing (SERFF) for an Illinois Rider for dependent coverage changes.

V. DATA ANALYSIS

Analysis of Company Data

A summary of the Company data analysis is listed below. The analysis was conducted using ACL[®] software.

The Company submitted a total of 591 transactions involving 56 policyholders. These 56 policyholders had had at least one (1) claim for autism submitted during the examination period. However, the majority of the 591 transactions were not autism specific claims. The Autism Spectrum Disorders legislation mandates coverage for a number of different treatments and services which are not unique to individuals with autism, such as psychiatric care, psychological care, counseling and speech and behavioral therapies. Accordingly, claim information was to be provided regardless of whether autism was listed as a primary or secondary diagnosis in connection with the treatment for which the claim was submitted. For example, claim information relating to an injury suffered by a passenger in an automobile accident which occurred in May 2009 would have been obtained if the injured passenger had had an autism related claim submitted in January 2009. This broader set of claims was chosen to ensure that coverage was not being denied to any individual with autism for any mandated treatment or service.

The total amount billed on these 591 transactions was \$368,262.20. Of this amount, the Company paid in full \$178,455.15. The Company provided the reasons why billed amounts were not paid. The examiners selected and reviewed a sample of claim files, 153 claim lines, for compliance with 215 ILCS 356z.14. A number of the reviewed claims were denials for duplicate claim submission or coding errors.

Additional information on the 591 claim transactions may be found in Appendix D.

VI. FINDINGS/RECOMMENDATIONS

The Company provided the examiners with documentation, information and materials to support its position that it has developed processes and procedures designed to maintain compliance with 215 ILCS 5/356z.14, Autism Spectrum Disorders and 215 ILCS 5/356z.12, Adult Dependent Coverage. The examiners reviewed this documentation, information and material. The Company also provided the examiners with data and information on all claims submitted by any individual who had had submitted at least one claim with an autism related diagnosis during the examination period. The examiners analyzed this data and reviewed the information as well as a sample of claim files. The examination and sample files did not identify any instances in which the Company was in material non-compliance with the provisions of 215 ILCS 5/356z.14, Autism Spectrum Disorders or 215 ILCS 5/356z.12, Dependent Coverage.

Humana indicated it has implemented a work around process for compliance with the Insurance Coverage for Autism requirements. The work around process is expected to be utilized until November 2011. The system changes will be implemented in 2010, however, all groups will need to be renewed for the changes to impact the group. When asked how the Company selects claims for the work around process, it responded, "We use all diagnosis codes in the 299 - 29991 range to suspend Illinois claims for autism." This means the Company is separating out these claims from the automated claim payment processing to manually determine the eligibility for payment.

The examiners recommend that the Company modify its work around procedures to ensure claims for individuals diagnosed with autism that are not coded in the 299-29991 range also be included in the process. For instance, 784.5 (Other Speech Disturbance) would be eligible for payment consideration in accordance with the Statute but would not be in the code range for the work around process. The Company should complete the automation of requirements to comply with the Illinois autism mandate rather than continued reliance on manual processing of those claims.

The Company provided information to support its position that it implemented procedures for the Young Adult Dependent Coverage requirements. The Company stated that the procedures would not affect claims until 2010. When asked to explain this statement, the Company referenced the pre-existing limitations available via the Young Adult Dependent Coverage question and answer document. Since HIPAA provides for creditable coverage, the Company's response may not be accurate in instances where an individual had prior coverage before moving into the group. The examiners recommend the Company further review its practices to ensure they are appropriately handling pre-existing coverage limitations and creditable coverage for newly added dependents in accordance with 215 ILCS 356z.12.

Appendix A
Insurance Code Section 356z.14
Autism Spectrum Disorders

(215 ILCS 5/356z.14)

(Text of Section from P.A. 95-1005)

Sec. 356z.14. Autism spectrum disorders.

(a) A group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 95th General Assembly must provide individuals under 21 years of age coverage for the diagnosis of autism spectrum disorders and for the treatment of autism spectrum disorders to the extent that the diagnosis and treatment of autism spectrum disorders are not already covered by the policy of accident and health insurance or managed care plan.

(b) Coverage provided under this Section shall be subject to a maximum benefit of \$36,000 per year, but shall not be subject to any limits on the number of visits to a service provider. After December 30, 2009, the Director of the Division of Insurance shall, on an annual basis, adjust the maximum benefit for inflation using the Medical Care Component of the United States Department of Labor Consumer Price Index for All Urban Consumers. Payments made by an insurer on behalf of a covered individual for any care, treatment, intervention, service, or item, the provision of which was for the treatment of a health condition not diagnosed as an autism spectrum disorder, shall not be applied toward any maximum benefit established under this subsection.

(c) Coverage under this Section shall be subject to copayment, deductible, and coinsurance provisions of a policy of accident and health insurance or managed care plan to the extent that other medical services covered by the policy of accident and health insurance or managed care plan are subject to these provisions.

(d) This Section shall not be construed as limiting benefits that are otherwise available to an individual under a policy of accident and health insurance or managed care plan and benefits provided under this Section may not be subject to dollar limits, deductibles, copayments, or coinsurance provisions that are less favorable to the insured than the dollar limits, deductibles, or coinsurance provisions that apply to physical illness generally.

(e) An insurer may not deny or refuse to provide otherwise covered services, or refuse to renew, refuse to reissue, or otherwise terminate or restrict coverage under an individual contract to provide services to an individual because the individual or their dependent is diagnosed with an autism spectrum disorder or due to the individual utilizing benefits in this Section.

(f) Upon request of the reimbursing insurer, a provider of treatment for autism spectrum disorders shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued medical

treatment is medically necessary and is resulting in improved clinical status. When treatment is anticipated to require continued services to achieve demonstrable progress, the insurer may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated.

(g) When making a determination of medical necessity for a treatment modality for autism spectrum disorders, an insurer must make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under the policy, including an appeals process. During the appeals process, any challenge to medical necessity must be viewed as reasonable only if the review includes a physician with expertise in the most current and effective treatment modalities for autism spectrum disorders.

(h) Coverage for medically necessary early intervention services must be delivered by certified early intervention specialists, as defined in 89 Ill. Admin. Code 500 and any subsequent amendments thereto.

(i) As used in this Section:

"Autism spectrum disorders" means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

"Diagnosis of autism spectrum disorders" means one or more tests, evaluations, or assessments to diagnose whether an individual has autism spectrum disorder that is prescribed, performed, or ordered by (A) a physician licensed to practice medicine in all its branches or (B) a licensed clinical psychologist with expertise in diagnosing autism spectrum disorders.

"Medically necessary" means any care, treatment, intervention, service or item which will or is reasonably expected to do any of the following: (i) prevent the onset of an illness, condition, injury, disease or disability; (ii) reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury, disease or disability; or (iii) assist to achieve or maintain maximum functional activity in performing daily activities.

"Treatment for autism spectrum disorders" shall include the following care prescribed, provided, or ordered for an individual diagnosed with an autism spectrum disorder by (A) a physician licensed to practice medicine in all its branches or (B) a certified, registered, or licensed health care professional with expertise in treating effects of autism spectrum disorders when the care is determined to be medically necessary and ordered by a physician licensed to practice medicine in all its branches:

- (1) Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.
- (2) Psychological care, meaning direct or consultative services provided by a licensed psychologist.
- (3) Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs,

including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual. As used in this subsection (i), "applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

(4) Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas: (i) self care and feeding, (ii) pragmatic, receptive, and expressive language, (iii) cognitive functioning, (iv) applied behavior analysis, intervention, and modification, (v) motor planning, and (vi) sensory processing.

(j) Rulemaking authority to implement this amendatory Act of the 95th General Assembly, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 95-1005, eff. 12-12-08.)

Appendix B
Insurance Code Section 356z.12
Dependent Coverage

215 ILCS 5/356z.12)

Sec. 356z.12. Dependent coverage.

(a) A group or individual policy of accident and health insurance or managed care plan that provides coverage for dependents and that is amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 95th General Assembly shall not terminate coverage or deny the election of coverage for an unmarried dependent by reason of the dependent's age before the dependent's 26th birthday.

(b) A policy or plan subject to this Section shall, upon amendment, delivery, issuance, or renewal, establish an initial enrollment period of not less than 90 days during which an insured may make a written election for coverage of an unmarried person as a dependent under this Section. After the initial enrollment period, enrollment by a dependent pursuant to this Section shall be consistent with the enrollment terms of the plan or policy.

(c) A policy or plan subject to this Section shall allow for dependent coverage during the annual open enrollment date or the annual renewal date if the dependent, as of the date on which the insured elects dependent coverage under this subsection, has:

- (1) a period of continuous creditable coverage of 90 days or more; and
- (2) not been without creditable coverage for more than 63 days.

An insured may elect coverage for a dependent who does not meet the continuous creditable coverage requirements of this subsection (c) and that dependent shall not be denied coverage due to age.

For purposes of this subsection (c), "creditable coverage" shall have the meaning provided under subsection (C)(1) of Section 20 of the Illinois Health Insurance Portability and Accountability Act.

(d) **Military personnel.** A group or individual policy of accident and health insurance or managed care plan that provides coverage for dependents and that is amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 95th General Assembly shall not terminate coverage or deny the election of coverage for an unmarried dependent by reason of the dependent's age before the dependent's 30th birthday if the dependent (i) is an Illinois resident, (ii) served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States, and (iii) has received a release or discharge other than a dishonorable discharge. To be eligible for coverage under this subsection (d), the eligible dependent shall submit to the insurer a form approved by the Illinois Department of Veterans' Affairs stating the date on which the dependent was released from service.

(e) Calculation of the cost of coverage provided to an unmarried dependent under this Section shall be identical.

(f) Nothing in this Section shall prohibit an employer from requiring an employee to pay all or part of the cost of coverage provided under this Section.

(g) No exclusions or limitations may be applied to coverage elected pursuant to this Section that do not apply to all dependents covered under the policy.

(h) A policy or plan subject to this Section shall not condition eligibility for dependent coverage provided pursuant to this Section on enrollment in any educational institution.

(i) Notice regarding coverage for a dependent as provided pursuant to this Section shall be provided to an insured by the insurer:

(1) upon application or enrollment;

(2) in the certificate of coverage or equivalent document prepared for an insured and delivered on or about the date on which the coverage commences; and

(3) in a notice delivered to an insured on a semi-annual basis.

(Source: P.A. 95-958, eff. 6-1-09.)

Appendix C
Claims Data Analysis
Definitions

Prior to reviewing the analysis of the data submitted by the company, it may be useful to review the definitions of the terminology used in this report. The following information provides definitions for the headers used to explain the analysis of the data received by and from the Company.

Claim – A notification to an insurance company requesting payment of an amount due under the terms of the policy. One claim may contain multiple transactions or lines of payment requests.

Transaction/Line – A single electronic exchange to request payment for medical visit, product or service. Claims may contain more than one (1) transaction/line. (For example: one claim may include separate bills for the medical visit, physical therapy and equipment. In this instance, the one claim would be comprised of three (3) individual transactions or lines.) Transactions/Lines are often assigned distinct numbers.

Claim Status – The status of the transaction that is currently being processed. The various statuses for claims/transactions according to this Company include: undefined, closed without payment, denied, paid or pending.

Amount Billed – The fees or charges billed by the provider.

Partial Denied Count – A partially denied count is the number of transactions where a portion of the amount billed by the provider or insured was denied. This may include certain transactions/lines within a claim without denying the entire claim.

Partial Denied Billed – A partially denied billed transaction is a transaction where a portion of the amount billed by the provider or insured was denied. There may be contractual reasons for a partial denial such as co-payments or coinsurance requirements or payments may be reduced as a result of contracted benefit payments arrangements made with the provider. Partial denials may also occur if the policy's maximum benefit for a period of time has been reached. One example of a maximum benefit may be seen where a policy has limits on the number of outpatient visits for mental/nervous disorders in a calendar quarter.

Uncategorized Transaction Status – A transaction that is unidentified in the electronic payment system as not being paid, pending, denied or closed without payment. Generally, the uncategorized transactions are identified as “informational lines” or “adjustment lines” which are inadvertently inserted in a claim. The “informational lines” can cause the sample to be skewed if they are not identified in a population to be studied. The inadvertent selection of these lines will dilute the sample as they contain no actual claim payment information. The examiners needed to review an entire “Claim Event” in order to determine if certain lines were informational only and could be disregarded or if the claim contained any “Lines” that contained treatment codes corresponding to autism treatment even where the event may not appear to be autism related. An example of an uncategorized claim would be for the use of general anesthesia related to simple dental procedures. Normally the procedure would be performed with local dental anesthesia but in the case of an autistic child, more extensive treatment may have been necessary.

Closed Without Payment Transaction Status – A transaction that is closed without any payment.

Denied Transaction Status – A transaction that has been denied for payment. Denial for transactions could be for a number of reasons, such as the policy doesn’t cover that type of transaction, the provider is not authorized to bill for that type of transaction or the coverage was terminated at the time this expense was incurred.

Pending Transaction Status – A transaction that has not been paid, denied or closed without payment. Examples of pending transactions may include those that are currently in process or where more information has been requested before payment is considered.

Paid Amount – Actual amount paid by an insurance company during a specified time interval.

Amount Billed – The amount billed to the insurance company for the claim or transaction.

Patient’s Responsibility – The amount of a claim or transaction which is to be paid by the insured. These amounts may apply to deductibles, coinsurance or other provisions in the insurance contract.

Provider Discount – Negotiated discount for services. These provider discounts are agreed to in contracts between the providers and insurance company or other affiliated network.

Maximum Allowable – The maximum amount payable per the contract.

Co-Pay (Copayment) – The copayment is an amount the insured pays in accordance with their insurance contract. This amount may be a flat dollar amount such as \$25 per office visit or may be a percentage of the billed amount such as 20% of the amount billed.

Deductible – A deductible is the amount of expenses that must be paid out of pocket before an insurer will cover certain benefits or expenses.

COB – Coordination of Benefits – A group policy provision which helps determine the primary carrier when an insured is covered by more than one policy. This provision prevents claims overpayments.

EOB - Explanation of Benefits- A document that is explains the claim and its charges and discounts. The EOB identifies any copay or coinsurance owed, the amount have paid toward a deductible and any network discounts.

Appendix D
Claims Payment Information

The Company submitted a total of 591 transactions in response to the data request involving 56 different policies. Humana provided data with claims in one (1) of three (3) status definitions: Closed Without Payment, Denied and Paid.

Table 1 (Claim Status by Transaction)

<u>Claim Status</u>	<u>Claim Count</u>	<u>Amount Billed</u>	<u>Partial Denied Count</u>	<u>Partial Denied Billed</u>
Closed w/o payment	179	283,412.97	0	0.00
Denied	203	34,390.26	0	0.00
Paid	209	50,458.97	51	20,846.44
Totals	591	368,262.20	51	220,846.44

Summary of Table 1 (Claim Status by Transaction)

Of the 591 transactions, 209 were paid claims totaling \$50,458.97, 51 of those claims were partially denied in the amount of \$20,846.44. An additional 79 claims were Closed without Payment and 203 claims were denied.

Table 2 (Claim Payment Breakdown)

<u>Claim Disposition</u>	<u>Count</u>	<u>Paid Amount</u>	<u>Amount Billed</u>	<u>Patient's Responsibility</u>	<u>Provider Discount</u>	<u>Maximum Allowable</u>	<u>Co Pay</u>	<u>Deductible</u>
Closed w/o payment	179	0.00	283,412.97	16,986.54	266,088.19	12,301.89	0.00	12,301.89
Denied	203	0.00	34,390.26	12,478.95	938.45	0.00	0.00	0.00
Paid	209	178,455.15	50,458.97	9,232.70	(137,228.88)	187,225.33	2,835.00	3,775.82
Totals	591	178,455.15	368,262.20	38,698.19	129,797.76	199,527.22	2,835.00	16,077.71

Summary of Table 2 (Claim Payment Breakdown)

The total amount billed for all of these claims was \$178,455.15. The amount listed as the patient's responsibility is \$38,698.19, plus a copayment amount of \$2,835.00 and a deductible amount of \$16,077.71 for a total of cost to the consumers of \$57,610.90 or 15.6% of the total amount billed.

The reason for denial in the 203 files that were denied in full is included in the following table.

Table 3 (Reason for the Denial)

<u>Explanation of Denial Reason</u>	<u>Count</u>	<u>Billed</u>
This service is not covered under your plan	53	7,255.30
The diagnosis code must be billed to the highest level of specificity using the 4th and 5th digits	36	5,192.96
This charge is a duplicate of a service that was previously processed	22	4,035.50
This charge was a duplicate of a service that was submitted and is currently pending	21	4,725.00
Your outpatient therapy benefit has been met; therefore no additional benefits are available under your plan	19	3,643.00
Professional interpretation charge is not allowed separately for automated lab tests.	16	296.00
A coding error was detected. This claim contains an inappropriate number of units for the billed procedures.	14	4,022.25
Submit a description of service and/or CPT or a valid HCPC code.	7	1,292.79
We detected a coding error. The diagnosis is not compatible with procedure billed. We relied on internal criteria to make this determination.	3	1,805.00
The diagnosis billed for this service is invalid for the date of service billed. We relied on internal criteria to make this determination.	3	1,225.00
This procedure is not allowed separately, as it is part of a more global code. We relied on internal criteria to make this determination.	3	40.46
This procedure is not allowed because the primary procedure has not been processed, received or allowed.	1	150.00
The provider's contractual obligation was not met. The amount is not the patient's responsibility/liability.	1	175.00
Claim has been denied as the requested information for prior dates of service was not received from the provider. This claim will be reconsidered upon receipt of the requested information.	1	286.00
This claim has been denied until information that was previously requested is received concerning other insurance information.	1	130.00

<u>Explanation of Denial Reason</u>	<u>Count</u>	<u>Billed</u>
This service/procedure is not reimbursed separately. Charges for this service were included with the primary procedure. You, as the member, are not responsible for this charge.	1	36.00
This is a duplicate charge or billing error. The member is not responsible for this charge.	1	80.00
	<u>203</u>	<u>34,390.26</u>

Summary of Table 3 (Reason for Denial)

Of the 203 transactions that were denied, the majority of these denials (53) occurred because the service is not covered under the plan, for an amount of \$7,255.30 or an average of \$136.89, per transaction. The second largest amount of denials (36) occurred because the diagnosis code must be billed to the highest level of specificity using the 4th and 5th digits, for an amount of \$5,192.96, for an average amount of \$144.25 per transaction. The highest amount per transaction denied was for the three (3) denied transactions where a coding error was detected (the diagnosis is not compatible with the procedure billed) for an average amount of \$601.67 per transaction.

Table 4 (Autism Only Claims)

<u>Claim Status</u>	<u>Claim Count</u>	<u>Amount Billed</u>	<u>Partially Denied</u>	<u>Partial Denied Billed</u>
Closed w/o payment	82	14,487.19	0	0
Denied	114	21,315.26	0	0
Paid	129	25,332.71	36	9,724.00
Totals	<u>325</u>	<u>61,135.16</u>	<u>36</u>	<u>9,724.00</u>

Summary of Table 4 (Autism Claim Totals)

Of the 591 claim transactions, there were 325 reported claims with autism related diagnostic codes. Of the 325 autism claims, 82 or 25% were closed without payment for an amount of \$14,487.19. There were 114 or 35% of the 325 total autism transactions denied for the 59 policyholders. There were 129 or 40% of the 325 claims paid for a total amount of \$61,135.16 and another 36 partially paid for an amount of \$9,724.00.

A summary of the claim payment break downs are included in Table 5.

Table 5 (Reasons for Denial-Autism Only)

<u>Summary of Denial Code</u>	<u>Count</u>	<u>Amount Billed</u>
The diagnosis code must be billed to the highest level of specificity using the 4th and 5th digits	31	4,592.96
This charge was a duplicate of a service that was submitted and is currently pending	19	4,425.00
Your outpatient therapy benefit has been met; therefore no additional benefits are available under your plan	19	3,643.00
This charge is a duplicate of a service that was previously processed	16	3,110.50
A coding error was detected. This claim contains an inappropriate number of units for the billed procedures.	7	1,466.25
Submit a description of service and/or CPT or a valid HCPC code.	6	1,232.79
This service is not covered under your plan. Please refer to the limitations and exclusions portion of your Benefit Plan Document.	6	372.30
We detected a coding error. The diagnosis is not compatible with procedure billed. We relied on internal criteria to make this determination.	3	1,805.00
This procedure is not allowed separately, as it is part of a more global code. We relied on internal criteria to make this determination.	3	40.46
The provider's contractual obligation was not met. The amount is not the patient's responsibility/liability.	1	175.00
Claim has been denied as the requested information for prior dates of service was not received from the provider. This claim will be reconsidered upon receipt of the requested information.	1	286.00

<u>Summary of Denial Code</u>	<u>Count</u>	<u>Amount Billed</u>
This claim has been denied until information that was previously requested is received concerning other insurance information.	1	130.00
This service/procedure is not reimbursed separately. Charges for this service were included with the primary procedure. You, as the member, are not responsible for this charge.	1	36.00
Totals	114	21,315.26

Summary of Table 5 (Reason for Denial-Autism Claims)

The Company's data indicates it denied 114 or 35% of the 325 autism claims for an amount of \$21,315.26. The top five (5) reason codes for denial of these autism claims include: The diagnosis code must be billed to the highest level of specificity using the 4th and 5th digits (31) for a total amount of \$4,492.96 or an average of \$148.16 per claim; This charge was a duplicate of a service that was submitted and is currently pending (19) for a total amount of \$4,425.00 or an average of \$232.89 per claim; Your outpatient therapy benefit has been met; therefore, no additional benefits are available under your plan (19) for a total amount of \$3,643.00 or an average of \$191.74 per claim; This charge is a duplicate of a service that was previously processed (16) for a total amount of \$3,110.50 or an average of \$194.41 per claim; coding errors were found (7) for a total amount of \$1,466.25 or an average of \$209.46 per claim. The highest amount per transaction denied was for the three (3) denied transactions where a coding error was detected (the diagnosis is not compatible with the procedure billed) for an average amount of \$601.67 per transaction.