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

OF

UNITED HEALTHCARE INSURANCE COMPANY
MARKET CONDUCT EXAMINATION REPORT

MARKET CONDUCT EXAMINATION REPORT

DATE OF EXAMINATION:	July 20, 2009 through August 28, 2009
EXAMINATION OF:	United Healthcare 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
EXAMINERS:	Shelly Schuman Dennis Shoop

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I. SUMMARY

1. United Healthcare 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 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.

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

United Healthcare Insurance Company (the "Company") is a Connecticut domiciled life, accident and health insurance company specializing in the group accident and health line of business. The Company is a wholly-owned subsidiary of UHIC Holdings, Inc. with the ultimate parent company being UnitedHealth Group Incorporated. The Company also owns five (5) insurance companies including United Healthcare Insurance Company of Illinois. The Company operates in 49 states, the District of Columbia and four (4) US territories.

The Company serves individuals, small, middle and national commercial market segments. The majority of its business is derived from the small to middle market PPO and point of service business. The contract with the members of the American Association of Retired Persons ("AARP") represents the second highest generator of the direct premiums revenue for the Company which includes Medicare supplement and hospital indemnity and preferred provider organization ("PPO") products. The third largest generator of the company premiums revenue is generated contracts with Medicare and Medicaid Services ("CMS.") The Company also offers a variety of related health care management services and products such as Medicare supplement insurance, Medicaid products, behavioral health and utilization review services, disease management and specialized provider networks, health information and employee assistance programs, knowledge and information services and administrative services.

In October 2007 it was announced that UnitedHealth's contract with AARP was extended to 2014. This partnership with AARP includes Medicare Advantage, Part D and Medicare Supplement products across all markets.

The Company's 2008 Annual Statement reflects $452,496,028 in Illinois direct Group Health insurance policy. The Company's 2009 Annual Statement reflects $521,076,190 in Illinois Group Health insurance policy direct premiums.

The Company's Illinois Policy Count Report indicates that it had in force 4,435 insurance policies in 2008. The Company's Illinois Policy Count Report indicates that it had in force 4,354 insurance policies in 2009.

IV. METHODOLOGY

This limited scope Market Conduct Examination was designed to assess compliance with the 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 responded with coordinator information on June 25, 2009. The primary coordinator was Jeff Jones and the secondary coordinator was Tonja Donato.

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

The Company does not have any underwriting guidelines to automatically decline a group if there is an applicant with autism and the Company does not decline coverage to individual applicants within a group. In addition, the Company does not offer individual health insurance policies in Illinois other than conversion from a group policy. Underwriting does not take place prior to the issuance of the conversion policy.

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

Year	Number of Applicants Denied due to Autism
2008	0
2009	0

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 has taken the following steps to meet the requirements of 215 ILCS 356z.14:

- Following the legislation being signed, the Company's Legislation Implementation Engagement workgroup met to discuss the actions required on 12/17/08. The Illinois Department of Insurance published its initial "fact sheet" on 12/19/09 and the Legislation Implementation Engagement workgroup reviewed the "fact sheet" and discussed actions that may be required. The Illinois Department of Insurance published a revised "fact sheet" and the workgroup reviewed the revised "fact sheet" on 2/10/09 to discuss actions that may be required.
- In February, 2009 the Company educated its customer service staff via a customer care bulletin assist when members called.
- The Company has revised the tool used by Customer Services staff for Small Group (PASS system) and Large Group (BAAG) verifying benefits.
- An amendment to the certificate of coverage (2001 and 2007 versions) was filed in April with the Illinois Department of Insurance.

- The large group claims platform (UNET TOPS) was updated 5/13/09. As a result, new and renewing large groups as of 7/1/09 were set up to handle claims per the requirements of 215 ILCS 356z.14. The small group claims platform (PRIME TOPS) was updated 7/10/09. As a result new and renewing small groups as of that day were set up to handle claims per the requirements of 215 ILCS 356z.14.

The Company is taking the following actions as it relates to groups that were new or renewed after 12/12/08 and prior to the updates being made to the claims platforms as described above:

- Claims data extracts were run by diagnosis code and reviewed with criteria. There were 22 claims that were improperly denied and are being adjusted to pay.

The Company will run an extract of claims on a monthly basis to identify any claims improperly denied. These claims will be adjusted to pay. The Company will continue this process until it is notified by the case/group install department that all cases have been properly installed.

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 has taken the following steps to meet the requirements of 215 ILCS 356z. 12:
   - An amendment to the certificate of coverage (2001 and 2007 versions) was filed with Illinois Department of Insurance on 11/12/08.
   - On 3/13/09, the policy masters were updated that sets up eligibility controls to meet requirements of 215 ILCS 356z. 12.
   - Small Group (PASS system) and Large Group (IBAAG) customer service benefit tools were updated on 3/13/09.
   - Notices required by 215 ILCS 356z. 12 were mailed to members on 5/22/09. The second notice has been added to the larger annual compliance mailer "1009 Annual Rights and Resources Booklet" which will be mailed out no later than October of 2009.
   - Communication bulletin provided electronically to brokers/producers on 6/9/09 along with Illinois fact sheets.
   - Communication bulletin provided electronically to employer groups on 6/16/09 along with Illinois fact sheets.
   - Developed procedures for eligibility customer service staff.

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 initially failed to submit data in accordance with the Examination Warrant and request submitted on June 18, 2009. After repeated requests by the examiners and by Department representatives, the Company did provide information that permitted the examination to proceed. However, the data was not provided in the format provided with the Warrant. The data was also provided too late for the examiners to conduct an onsite review of claim files. The data that was submitted by the Company is insufficient to analyze proper benefit payment in accordance with 215 ILCS 356z.14.

The Company submitted a total of 701 transactions involving 16 policyholders. These 16 policyholders had had at least one (1) claim for autism submitted during the examination period. However, the majority of the 701 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 701 transactions was $156,548.56. Of this amount, the Company paid in full $41,260.14 transactions. There were 185 denied claims for an amount billed of $29,946.62 and 136 partially denied claims for an amount of 29,946.19. The examiners did review a sample of claims. The Company provided the reasons why transactions denied or partially denied were not paid. The examiners selected and reviewed a sample of claim files for compliance with 215 ILCS 356z.14.

Additional information on the 701 claim transactions may be found in Appendix D.

VI. FINDINGS/RECOMMENDATIONS

The Company provided the examiners with documentation, information and materials to support their position that they have developed processes and procedures designed to maintain compliance with Insurance Coverage for Autism and Young Adult Dependent Coverage requirements. When asked to define what system modifications have been made to support the requirements, the Company responded that it had implemented a manual process. The company did report activities for compliance with the Autism and Young Adult Dependent Coverage legislation, and these changes were initiated as early as when the legislation was signed, however, the Company did not implement system changes until May 13, 2009.

The Company's internal process for identification of claims eligible under 215 ILCS 356z.14 is limited to those claims with an autism diagnosis code. Since some claims are eligible for payment under the Illinois statute and may be submitted without the autism codes, the Company should adjust their process. The process should capture all claims submitted for an individual that has had at least one (1) claim with an autism diagnosis code. The examiners find the Company is not able to affirm compliance with 215 ILCS 356z.14.

The Company should audit all claims for an individual that had at least one (1) autism code since the effective date of 215 ILCS 356z. 14. Results of the Company's audit should be submitted to the Illinois Department of Insurance.

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 (1) 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 (1) claim may include separate bills for the medical visit, physical therapy and equipment. In this instance, the one (1) 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: denied, paid or partially paid.

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 copayments 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 (1) 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.

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

Appendix D
Claims Payment Information

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

Table 1 (Claim Status by Transaction)

Claim Status	Claim Count	Amount Billed (Source Charged)	Partial Denied Count	Partial Denied Billed
Closed w/o payment	116	25,738.60	0	0.00
Denied	185	29,946.62	0	0.00
Paid	400	100,863.34	136	37,798.19
Totals	701	156,548.56	136	37,798.19

Summary of Table 1 (Claim Status by Transaction)

According to the company during the time period under review there were a total 701 claim transactions. 57% of all the claims submitted were paid. One hundred thirty-six (136) of those claims were partially denied in the amount of $37,798.19. Claims denied totaled 185 or less than 26% of the total claim transactions for an amount totaling $29,946.00.

Table 2 (Claim Payment Breakdown)

Claim Status	Claim Count	Amount Paid	Paid to Source	Amount Billed (Source Charged)	Paid by Patient	Discount	Amount Allowed	CoPay	Deductible
Closed w/o payment	116	0.00	0.00	25,738.60	0.00	352.80	0.00	0.00	0.00
Denied	185	469.03	469.03	29,946.62	0.00	60.09	0.00	0.00	0.00
Paid	400	41,791.11	41,791.11	100,863.34	13,560.23	38,385.77	55,351.34	3,779.40	5,619.27
Totals	701	42,260.14	42,260.14	156,548.56	13,560.23	38,798.66	55,351.34	3,779.40	5,619.27

Summary of Table 2 (Claim Payment Breakdown)

The total amount billed for all of these claims was $156,548.56, with $55,351.34, or 35% of that being the maximum allowable amount covered by the policy. The amount listed as patient's responsibility is $13,560.23, plus a copayment amount of $3,779.40 and a deductible amount of $5,619.27 for a total of cost to the consumers of $22,958.90 or 15% of the total amount billed.

There were 185 transactions denied. The reason for the 185 transactions that were denied in full is included in the following table.

Table 3 (Reason for the Denial)

Explanation for Denial Reason	Count	Amount Billed
This is not a separately reimbursable service or supply.	20	1,210.30
Please submit records of the benefits paid by your basic group insurance policy so we can determine major medical benefits.	20	2,713.60
This service was performed in a facility setting. This code, when accompanied by a facility place of service, is not eligible for reimbursement to the physician.	15	512.00
According to our records, we did not receive notifications for this service, as required by your plan.	15	2,722.10
The number of units reported for this procedure code that exceed the typical frequency per day are not being considered. If the provider has additional documentation, please send it to us for consideration.	13	1,628.20
Our records show we have already processed this charge.	10	2,617.70
We do not show coverage for you at this time. If you are on COBRA and made the premium payment, please contact the claim office. We apologize for any delay and inconvenience you may experience.	7	558.00
These charges are services provided after this patient's coverage was cancelled, therefore, they are not covered.	6	1,680.00
This service is not covered for this physician when the same service has been previously submitted by a reference laboratory.	6	943.59
We asked your provider to send us more information. We will process the claim when we receive this information.	6	677.60
This claim cannot be processed because it was not submitted within the contracted timeframe or did not provide reprocessing details. You cannot be billed for any amount over your copay, coinsurance or deductible. Your provider can resubmit.	6	2,363.38
This code is used for an adjustment transaction related to another line entry and does not appear on the EOB.	5	(710.30)
This code is used for an adjustment transaction related to another line entry and does not appear on the EOB.	5	469.05

Explanation for Denial Reason	Count	Amount Billed
Your plan does not cover travel or transportation expense, even though prescribed by a physician.	5	46.66
According to your plan, psychiatric and substance abuse services not authorized by perspectives are subject to a $500 calendar year maximum.	5	231.30
Charges cannot be considered because services billed are not documented as performed.	5	686.40
Your plan does not cover acupuncture.	4	219.60
The documentation we received does not support the codes that were billed. Benefits are limited to documented services; therefore, benefits are not available.	4	560.00
Based on the info provided, this service is unproven and is not covered, therefore, no benefits are payable for this expense. In order for this service to be considered for coverage, you must submit scientific evidence.	4	25.00
This service is not covered for the diagnosis listed on the claim.	3	420.00
The reported diagnosis codes are inconsistent with the service rendered, and are not eligible for reimbursement.	3	1,066.00
Our records show we have already processed this charge.	3	280.60
Your plan does not cover this non-medical or personal item or service.	2	2,681.60
These charges are considered an integral part of the primary procedure and not eligible for separate reimbursement.	2	91.40
Our records show these services have been previously submitted by another physician or health care provider.	2	54.50
Our records show that we already processed an identical procedure for this date of service. The only change we see is a different billed amount. Since we have not received any supporting documentation for reconsideration, no benefits are being allowed.	1	1,824.00
Corrected billing or additional late charges has been considered. The contracted amount for this claim was previously allowed and has been issued. No further payment is due. The patient is not responsible for the charges.	1	105.00

Explanation for Denial Reason	Count	Amount Billed
Thank you for using a network physician or other health care professional. We have applied the contracted fee. The patient is not responsible for the difference between the amount charged by the physician or health care professional and the amount allowed by the contract.	1	1,483.74
This service code is not separately reimbursable in this setting.	1	150.00
The number of units reported for this service appears	1	201.60
We have requested additional information to properly process your claim.	1	255.00
This procedure code and modifier are the same as or equivalent to another procedure code and modifier previously submitted by another health care provider. No further benefits are available for this service.	1	1,824.00
This claim has already been processed and the allowable amount was applied to the yearly deductible.	1	105.00
Routine exams and/or related services are not a covered expense under your group health plan unless the services were performed by a network provider.	1	250.00
Totals	185	29,946.62

Summary of Table 3 (Reason for Denial)

Of the 185 transactions that were denied, the majority of these denials (20) occurred because either the service or supply is not reimbursable, for an amount of $1,210.30 or an average of $60.52, per transaction or because there was a request for additional information about the basic group plan benefit coverage for an amount of $2,713.60 or an average of $135.68 per transaction. The second largest amount of denials (15) occurred because either the service was performed in a facility setting for an amount of $512.00 or an average of $34.13 per transaction or because the company did not receive notifications for this service, as required by the plan for an amount of $2,722.10 or an average of $181.47 per transaction. The highest amount per transaction denied was for $1,824.00 which included two transactions one defined as this procedure code and modifier are the same as or equivalent to another procedure code and also another transaction for the same amount defined as our records show that we already processed an identical procedure for this data of service.

Table 4 Autism Only Claims

Claim Status	Record Count	Amount Billed	Partially Denied Count	Partial Denied Amount
Closed w/o payment	23	3,400.00	0	0
Denied	56	10,967.78	0	0
Paid	118	18,234.90	53	8,356.6
Totals	197	36,263.06	53	8,356.66

Summary of Table 4 (Autism Only Claims)

Of the original 701 claim transactions reported, 197 or 28% of those transactions were specifically coded with an autism related diagnostic code. Of the 197 autism specific claim transactions, 118 were paid in the amount of $18,234.90 with 56 claim transactions being denied in the amount of $10,967.78. There were 53 partially denied claims in the amount of $8,356.66.

Table 5 (Reason for the Denial-Autism Only)

Explanation of Denial Reason	Count	Amount Billed (Source Charged)
According to our records, we did not receive notification for this service, as required by your plan.	13	2,400.00
Please submit records of the benefits paid by your basic group insurance policy so we can determine major medical benefits.	9	1,665.00
This service is not covered for this physician when the same service has been previously submitted by a reference laboratory.	5	792.60
The number of units reported for this procedure code that exceed the typical frequency per day are not being considered. If the provider has additional documentation, please send it to us for consideration.	5	985.00
Our records show we have already processed this charge.	4	1,987.00

Explanation of Denial Reason	Count	Amount Billed (Source Charged)
Your plan does not cover travel or transportation expenses, even though prescribed by a physician.	4	42.50
Based on the information provided, this service is unproven and is not covered. Therefore, no benefits are payable for this expense. In order for this service to be considered for coverage, you must submit scientific evidence.	4	25.00
This code is used for an adjustment transaction related to another line entry and does not appear on the EOB.	3	381.68
We do not show coverage for you at this time. If you are on COBRA and made the premium payment, please contact the claim office. We apologize for any delay and inconvenience you may experience.	3	452.00
These charges are services provided after this patient's coverage was cancelled, therefore, they are not covered.	2	231.00
This service code is not separately reimbursable in this setting.	1	150.00
The reported diagnosis codes are inconsistent with the service rendered, and are not eligible for reimbursement.	1	931.00
This claim cannot be processed because it was not submitted within the contracted timeframe or did not provide reprocessing details. You cannot be billed for any amount over your copay, coinsurance or deductible. Your provider can resubmit.	1	675.00

Explanation of Denial Reason	Count	Amount Billed (Source Charged)
Routine exams and/or related services are not a covered expense under your group health plan unless the services were performed by a network provider.	1	250.00
Total	56	10,967.78

Summary of Table 5 (Reason for Denial)

The 56 autism specific claim transactions reported as having been denied, the top listed the reasons include: 13 – According to our records, we did not receive notification for this service, as required by your plan $2,400.00, 9 – Please submit records of the benefits paid by your basic group insurance policy so we can determine major medical benefits, for an amount totaling $1,665.00, 5 – This service is not covered for this physician when the same service has previously been submitted for an amount of $792.60, 5 – The number of units reported for this procedure code that exceed the typical frequency per day for an amount of $985.00, 4 – Our records show we have already processed this charge for an amount of $1,987.00, 4 – Your plan does not cover travel or transportation expenses, even though prescribed by a physician for an amount of $42.50, 4 – Based on the information provided, this service is unproven and is not covered therefore no benefits are for an amount of $25.00.