

**MARKET CONDUCT EXAMINATION REPORT  
PROMPT PAY**

**of**

**BCBSD, Inc.**

**as of**

**June 30, 2006**

I, Matthew Denn, Insurance Commissioner of the State of Delaware, do hereby certify that the attached REPORT ON MARKET CONDUCT EXAMINATION, made as of JUNE 30, 2006 of the

**BCBSD, INC.**

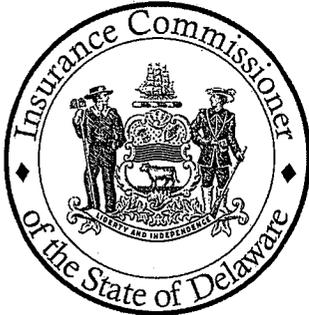
is a true and correct copy of the document filed with this Department.

ATTEST BY:

*Antoinette Handy*

DATE: 24 APRIL 2007

*In Witness Whereof,* I HAVE HEREUNTO SET MY HAND AND AFFIXED THE OFFICIAL SEAL OF THIS DEPARTMENT AT THE CITY OF DOVER, THIS 24TH DAY OF APRIL 2007.



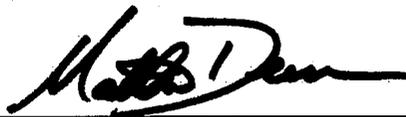
*Matthew Denn*

Insurance Commissioner

**REPORT ON MARKET CONDUCT EXAMINATION-PROMPT PAY**  
OF THE  
**BCBSD, INC.**  
AS OF  
**JUNE 30, 2006**

Consideration has duly been given to the comments, conclusions, and recommendations of the examiners regarding the status of the Company as reflected in the Report.

This Report is hereby accepted, adopted, and filed as an official record of this Department.



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MATTHEW DENN  
INSURANCE COMMISSIONER

DATED this 24TH day of APRIL, 2007.

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**BCBSD, Inc.**

March 7, 2007

Honorable Matthew Denn  
Insurance Commissioner  
State of Delaware  
841 Silver Lake Boulevard  
Dover, Delaware 19904

Dear Commissioner Denn:

In compliance with instructions contained in Certificate of Examination Authority Number 06.722, and pursuant to statutory provisions, a limited scope, single state, target market conduct examination has been conducted of the affairs and practices of:

**BCBSD, Inc.**

hereinafter referred to as the “Company”. The Company is incorporated under the laws of the State of Delaware. This examination reviewed the operations of the Company as they impact residents, policyholders, providers, and members residing in the State of Delaware or serving Delaware members of the Company. This examination focused on compliance with Delaware prompt pay laws, regulations and the Company’s limitations on physical therapy claims and treatment of Current Procedural Terminology (CPT) code modifier “25”.

This report is as of June 30, 2006. It covers the period from January 1, 2006 through June 30, 2006.

The report of examination thereon is respectfully submitted.

## **EXECUTIVE SUMMARY**

This executive summary addresses areas of concern identified as a result of the examination team's review of the Company's performance measured against the nine (9) examination standards authorized by Certificate of Examination Authority Number 06.722. The examination standards are based on NAIC methodology. The scope of the market conduct examination was limited to verification of compliance with 18 Del. Admin. Code 1310 Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care Services [Formerly Regulation 80], review of practices related to the Company's treatment of claims that include CPT modifier 25 and review of the Company's policies and procedures regarding physical therapy benefits.

**Prompt Payment Standards 1-7:** The examiners found three (3) areas of concern resulting in failure of the Company to comply with Standards 1, 2, 3 and 6. The issues identified were:

- The Company's records of claims that were rejected as "unclean," are maintained in a manner that is inadequate for independent verification that the entire population of clean claims has been identified and available for review. Therefore, the examination team was unable to do a complete review and testing of the Company's compliance with requirements of 18 Del. Admin. Code 1310.
- Review of the sample of claims adjudicated in excess of 30 days after receipt by the Company resulted in a finding that 40 of the 100 claims were clean claims that were not adjudicated timely, and therefore, not processed in compliance with 18 Del. Admin. Code 1310 § 6.1. The number of instances found exceed the permissible threshold of three

instances in 36 months as specified in 18 Del. Admin. Code 1310 § 7.0, substantiating an unfair practice in violation of 18 Del.C. §2304.

- In some instances, the documentation received by the Company as a result of a request for additional information is maintained in a manner which is inadequate for independent verification of the Company's compliance with the requirements of 18 Del. Admin. Code 1310.

**Modifier "25" Standard 8:** The examiners did not identify any concerns or issues of non-compliance.

**Physical Therapy Limitations Standard 9:** The examiners did not identify any concerns or issues of non-compliance.

### **SCOPE OF EXAMINATION**

The principal focus for this examination were standards for the review of Delaware prompt payment laws, the Company's treatment of claims with Current Procedural Terminology modifier "25" and limitations on physical therapy payments. The standards and work plan utilized in this examination were approved by the Delaware Insurance Department.

This target examination tested for compliance with the provisions of 18 Del. Admin. Code 1310 relating to the timely payment of clean claims, the Company's treatment of claims with CPT modifier "25" and limitations on physical therapy payments.

## **BCBSD, Inc.**

The issues generating this examination include complaints from a number of providers concerning untimely payment of claims and claim denials.

### **HISTORY AND PROFILE**

BCBSD, Inc. was originally incorporated in Wilmington, Delaware under the name of Group Hospital Service, Incorporated by the filing of a Certificate of Incorporation with the Delaware Secretary of State on August 16, 1935. The Company has been operating as a private not-for-profit corporation and does not have the authority to issue capital stock.

Since 1968, when DE adopted Chapter 63 of the Delaware Code regulating Health Service Corporations, the Company has been regulated as such by the Delaware Insurance Department.

The management structure of BCBSD has remained stable throughout the period of examination.

### **METHODOLOGY**

This examination is based on standards approved by the Department, which are based on applicable Delaware Statutes, Rules, and Regulations as referenced herein and testing based on the NAIC Market Conduct Examiners Handbook.

Some standards are measured using a single type of review, while others use a combination of the types of review. The types of review used in an examination fall into three general categories. The types of review are Generic, Sample, and Electronic. Random samples were used in this examination.

A "Generic" review indicates that a standard was tested through an analysis of general data gathered by the examiner, or provided by the examinee in response to queries by the examiner.

A "Sample" review indicates that a standard was tested through direct review of a random sample of files using sampling methodology described in the NAIC Market Conduct Examiners Handbook.

An "Electronic" review indicates that a standard was tested through use of a computer program or routine applied to a download of computer records of the examinee. This type of review typically reviews 100% of the records of a particular type.

Standards were measured using tests designed to adequately measure how the examinee met each standard. Each standard tested is described and the result of testing is provided under the appropriate standard. Only standards tested are shown in this report.

Each Standard is accompanied by a "Comment" describing the purpose or reason for the Standard. The "Result" is indicated and the examiner's "Observations" are noted. In some cases a "Recommendation" is made. Comments, Results, Observations, and Recommendations are recited with each Standard.

- A. COMPANY OPERATIONS/MANAGEMENT**
- B. COMPLAINTS/GRIEVANCES**
- C. MARKETING AND SALES**
- D. NETWORK ADEQUACY**
- E. PRODUCER LICENSING**
- F. POLICYHOLDER SERVICE**
- G. UNDERWRITING AND RATING**

*Comments: The series of standards for the above were not tested in this examination.*

**H. CLAIMS**

*Comments:* The evaluation of standards in this business area is based on Company responses to information requested by the examiner, discussions with the Company's staff, electronic testing of claim databases, and the review of claim files. This portion of the examination is designed to provide a view of how the company treats claimants and whether that treatment is in compliance with applicable statutes, rules, and regulations.

Services provided to the subscribers of the Company do not typically result in a claim by the recipient of care as is usually seen in an indemnity scenario. Claims to the Company usually arise from the provider who delivers services to a subscriber of the Company.

The following Standards were developed to test compliance with Delaware statutes, rules and regulations.

## Prompt Payment Standard 1

**The Company is using the Department's standards with regard to required elements for a clean claim when processing claims.**

18 Del. Admin. Code 1310 § 4.0

*Comments:* This standard was designed and implemented to determine if the Company is properly identifying clean claims and if their definition of a "clean claim" is in compliance with 18 Del. Admin. Code 1310 § 4.0. Review methodology for this standard is generic and sample. The examiners reviewed the Company's procedures, training manuals, and internal communications. The examiners also interviewed claims personnel and did a walk-through of the claims processing department and mailroom. A sample of adjudicated claims was reviewed by examiners.

*Results:* FAIL

The Company's records of claims that were rejected as "unclean," are maintained in a manner that is inadequate for independent verification that the entire population of clean claims has been identified and available for review. Therefore, the examination team was unable to do a complete review and testing of the Company's compliance with requirements of 18 Del. Admin. Code §1310.

*Observation:* Reviews, interviews, and testing indicate the Company is using the Department standards and definitions to identify clean claims. However, the walk-through of the claims processing department and the mailroom along with subsequent interviews with Company personnel and documentation provided by the Company, indicate that the Company returns paper

claims it considers unclean with a request for additional information. The Company's reasons for returning a claim as unclean are not recorded or tracked. Therefore, the examiners could not verify that the "rejected" claims were appropriately rejected as unclean claims. When originally submitted, claims may or may not be entered into the claim system. Claims that are not entered into the system are not otherwise tracked. Although the originally submitted claims are microfilmed when received and assigned a claim number, when the claim is returned with the requested information it is assigned a "new" claim number and again microfilmed. However, the original claim submission is not linked to the "new" claim. This practice may not be a violation of Delaware Insurance Laws. However, it is important to note that the Company's failure to link resubmitted claims to their original submission precludes a complete review of the Company's timeliness and accuracy of claims processing. The examiners could not verify that all clean claims were included in the population.

***Recommendations:* It is recommended that the Company maintain records of its "rejected" claims in a manner that allows for independent verification of the Company's compliance with requirements of 18 Del. Admin. Code 1310.**

### **Prompt Payment Standard 2**

**The Company is correctly processing claims that include unspecified, unclassified, or miscellaneous codes or data elements when an appropriate descriptive narrative is included.**

18 Del. Admin. Code 1310 § 4.7

*Comments:* This standard was designed and implemented to determine if the Company is correctly processing claims which include unspecified, unclassified, or miscellaneous codes or data elements when an appropriate descriptive narrative is included and in compliance with 18 Del. Admin. Code 1310 §4.7. Review methodology for this standard is generic and sample. The

**BCBSD, Inc.**

examiners reviewed the Company's procedures, training manuals, and internal communications. The examiners also interviewed claims personnel. A sample of adjudicated claims was reviewed by examiners.

*Results: FAIL*

The Company's records of claims that were rejected as "unclean," are maintained in a manner that is inadequate for independent verification that the entire population of clean claims has been identified and available for review. Therefore, the examination team was unable to do a complete review and testing of the Company's compliance with requirements of 18 Del. Admin. Code §1310.

*Observation:* Reviews, interviews, and testing from available claims indicate the Company is processing claims in a manner that complies with this standard. However, the examiners could not verify that all clean claims were included in the population.

***Recommendations:* It is recommended that the Company maintain records of its "rejected" claims in a manner that allows for independent verification of the Company's compliance with requirements of 18 Del. Admin. Code §1310.**

**Prompt Payment Standard 3.**

**The Company's clean claim processing is timely and in compliance with applicable statutes, rules and regulations.**

18 Del. C. §2304, 18 Del. Admin. Code 1310 §6.0 and 7.0

*Comments:* This standard was designed and implemented to determine if the Company processes clean claims on a timely basis and in compliance with 18 Del. Admin. Code 1310 § 6.0, which requires adjudication within 30 days and 18 Del. Admin. Code 1310 §7.0, which states “Within a 36 month period, three instances of a carrier’s failure to comply with Section 6 of this Regulation shall give rise to a rebuttable presumption that the carrier has engaged in an unfair practice in violation of 18 Del.C. §2304.” Review methodology for this standard is generic, sample, and electronic. The examiners reviewed the Company's procedures, training manuals and internal communications and interviewed claims personnel. A random sample of 100 claims that were adjudicated in excess of 30 days of receipt was reviewed by examiners.

*Results:* FAIL

The examiners identified the following two reasons for failure.

- (1) Review of the sample of claims adjudicated in excess of 30 days after receipt by the Company resulted in a finding that 40 of the 100 claims were clean claims that were not adjudicated timely, and therefore, not processed in compliance with 18 Del. Admin. Code 1310 §6.1. The number of instances found exceed the permissible threshold of three

instances in 36 months as specified in 18 Del. Admin. Code 1310 §7.0, substantiating an unfair practice in violation of 18 Del. C. §2304.

(2) The Company's records of claims that were rejected as "unclean," are maintained in a manner that is inadequate for independent verification that the entire population of clean claims has been identified and available for review. Therefore, the examination team was unable to do a complete review and testing of the Company's compliance with requirements of 18 Del. Admin. Code 1310.

*Observation:* The Company adjudicated 461,164 claims during the period examined. Of those claims, 26,197 or 6% were adjudicated in excess of 30 days of receipt. A random sample of 100 claims was selected from the claims adjudicated in excess of 30 days. Review of the sample indicated that 40 of the 100 claims were clean claims and adjudicated untimely. Extrapolated to the total population, this indicates 2.4% of clean claims were not adjudicated timely.

In addition, the examiners could not verify that all clean claims were included in the population.

***Recommendations:* It is recommended that the Company ensure all claims are adjudicated within the time requirements of 18 Del. Admin. Code 1310 §6.0.**

**It is also recommended that the Company maintain records of their "rejected" claims in a manner which allows for independent verification of the Company's compliance with requirements of 18 Del. Admin. Code 1310.**

**Prompt Payment Standard 4.**

**Proper payment is made on clean claims.**

18 Del. Admin. Code 1310 §6.1.1 and 6.1.2

*Comments:* This standard was designed and implemented to determine: 1) if, at the time the Company determines an entire claim is payable, it pays the total allowable amount; and 2) to determine if, when only a portion of the claim is deemed payable, it pays the allowable portion in compliance with 18 Del. Admin. Code 1310 §6.1.1 and 6.1.2. Review methodology for this standard is generic and sample. The examiners reviewed the Company's procedures, training manuals and internal communications, and interviewed claims personnel. A random sample of 100 claims that were adjudicated in excess of 30 days of receipt and a random sample of 100 claims from the entire population were reviewed by examiners.

*Results:* PASS

*Observation:* Review of the sample of claims indicated the Company is either making complete allowable payment or partial allowable payment as indicated.

**Prompt Payment Standard 5**

**The Company sends proper notification to the provider or claimant when either the entire claim or a portion of a claim will not be paid.**

18 Del. Admin. Code 1310 §6.1.2 and 6.1.3

*Comments:* This standard was designed and implemented to determine if, when the Company concludes an entire claim or a portion of a claim will not be paid, it sends proper notification to the provider or policyholder in compliance with 18 Del. Admin. Code 1310 §6.1.2 and 6.1.3.

**BCBSD, Inc.**

Review methodology for this standard is generic and sample. The examiners reviewed the Company's procedures, training manuals and internal communications, and interviewed claims personnel. A random sample of 100 claims that were adjudicated in excess of 30 days of receipt and a random sample of 100 claims from the entire population were reviewed by examiners.

*Results:* PASS

*Observation:* Review of the sample of claims indicate the Company is sending proper written notification to either the provider or policyholder when either an entire claim or portion of a claim will not be paid.

**Prompt Payment Standard 6**

**The Company makes additional information requests for determination of propriety of payment in accordance with statutes, regulations, and rules.**

18 Del. Admin. Code 1310 § 6.1.4, 6.2 and 6.3

*Comments:* This standard was designed and implemented to determine if the Company is making proper requests for additional information to assure that claims are not inappropriately denied. 18 Del. Admin. Code 1310 §6.1.4 states “if the carrier needs additional information from a provider or policyholder who is submitting the claim to determine the propriety of payment of a claim, the carrier shall request in writing that the provider or policyholder provide documentation that is relevant and necessary for clarification of the claim.” 18 Del. Admin. Code 1310 §6.2 states in part, “A carrier who requests information under this subsection shall take action... within 15 days of receiving properly requested information.” 18 Del. Admin. Code 1310 §6.3

**BCBSD, Inc.**

limits requests to one per claim except for coordination of benefits information and to determine if a claim is a duplicate.

Review methodology for this standard is generic and sample. The examiners reviewed the Company's procedures, training manuals, and internal communications. The examiners also interviewed claims personnel. A random sample of 100 claims that were adjudicated in excess of 30 days of receipt and a random sample of 100 claims from the entire population were reviewed by examiners.

*Results:* FAIL

*Observation:* When the Company requires additional information to determine the propriety of payment, the Company denies the claim and requests additional information concurrently. The denial is a full denial affording the subscriber all rights normally associated with a denial. If the Company receives additional information, the claim is re-adjudicated based on the information received. The Company considers this a "soft denial." Once received, information used to determine re-adjudication of the claim is imaged in monthly batches, but not directly linked to the claim. Documentation of receipt, such as date stamping, which would allow examiners to determine timely adjudication, may or may not be captured. The manner in which the Company maintains their records does not allow for independent verification of the Company's compliance with the requirements of 18 Del. Admin. Code 1310.

***Recommendations:* It is recommended that the Company maintain records, which should include, but not be limited to, documentation of receipt date of requested information used**

to re-adjudicate claims in a manner which allows for independent verification of the Company's compliance with requirements of 18 Del. Admin. Code 1310.

#### Prompt Payment Standard 7

**The Company makes interest payments on claims where appropriate and so ordered in compliance with statutes, rules, and regulations.**

18 Del. Admin. Code 1310 §8.0

*Comments:* This standard was designed and implemented to determine if the Company made proper interest payments when so ordered. Review methodology for this standard is generic.

*Results:* PASS

*Observation:* No interest payments on claims have been ordered to date.

#### Modifier "25" Standard 8

**The company policy and practice for payment of claims with Current Procedural Terminology (CPT) code modifier 25 comply with statutes, rules, regulations, and contract provisions.**

*Comments:* Review methodology for this standard is generic. The Current Procedural Terminology (CPT) is the list maintained by the American Medical Association (AMA) to provide unique billing codes for services rendered. CPT modifier 25 is a specific code designated to indicate that a separate, significant physician evaluation and management (E/M) work that went above and beyond the physician work normally associated with a preventive medicine service or a minor surgical procedure was provided and should be additionally billable. The examiners were requested to review the Company's processing of claims, which included

**BCBSD, Inc.**

CPT modifier 25 to ensure compliance with related statutes, rules, regulations, and contract provisions. The examiners reviewed the Delaware Insurance Statutes and Regulations and found that they do not provide specific restrictions or guidance regarding the use of CPT codes. The examiners also reviewed information regarding the Company's policies and procedures regarding claims involving CPT modifier 25, along with the rationale supporting such policies and procedures. Provider contracts and benefit booklets were also reviewed.

*Results: PASS*

*Observation:* Several years ago the Company faced the issue of providers billing multiple medical services on the same day. This conflicted with their contractual limitation which provides for one service per day by a professional provider. However, they allowed for exceptions resulting in additional payments when justifiable appeals were submitted. Currently, the Company processing system captures the CPT modifier 25 but does not consider it as a payment determinant. Instead, it pays the greatest value service regardless of the CPT modifier 25, except for some specifically coded exceptions such as immunizations, chiropractic services, acupuncture, etc.

The Company analyzed the use of the CPT modifier 25 and discovered the following. (1) The use of the CPT modifier 25 was more prevalent than they had anticipated. (2) The modifier was apparently being submitted routinely, not just for situations involving same day multiple medical services. (3) It was submitted with surgical, diagnostic (lab & imaging), and machine testing services billed in conjunction with the E&M code. (This is not the intended use of the modifier.)

**BCBSD, Inc.**

(4) They also noted that some providers were not billing the CPT modifier 25 when it appeared appropriate to do so. Therefore, the Company decided not to use CPT modifier 25 as a systematic payment determinant.

The Company does systematically deny some of the multiple medical service claims, paying the service that generates the higher allowance, per its contract language. However, those claims are open to appeal by the providers. Company claims processing and systems do allow for payment of multiple services when appropriate by processing standardized contract exceptions without the requirement of an appeal.

Based on the above information, the examiners concluded that the Company's contract provisions limiting coverage to one service per day by a professional provider allows for the denial of secondary procedures submitted with or without a CPT modifier 25. Delaware insurance law does not appear to prohibit this practice. Additionally, the Company has established policies and procedures for processing standardized exceptions to this contract provision without necessitating an appeal. Based on the examiners' review, the Company's practices related to its processing of claims submitted by providers with a CPT modifier 25 does not appear to result in non-compliance with Delaware insurance laws.

**Physical Therapy Limitations Standard 9**

**The Company pays or denies claims for physical therapy in accordance with policy provisions and in compliance with the applicable statute, rules, and regulations.**

18 Del. Admin. Code 1304 §6.6.1-12

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*Comments:* This standard was designed and implemented to determine if the Company policies and procedures related to payment or denial of physical therapy claims are in compliance with applicable statutes, rules, and regulations, as well as, in accordance with complying policy provisions. Review methodology for this standard is generic and sample. The review of the Delaware Insurance Statutes and Regulations revealed that with the exception of mandated Basic and Standard plans for small employer groups, the state does not have any specific statutory or regulatory requirements mandating the coverage of physical therapy. The examiners reviewed a representative sample of the Company's individual, large group and small group contracts, and provider contracts.

*Results:* PASS

*Observation:* Subscribers are notified of limitations on physical therapy benefits, in that, all subscriber contracts provided for our review contained the following language in regard to Physical Therapy:

“80% Covered for up to 60 consecutive days per acute condition,  
beginning on the first day of treatment.”

The Company communicates these limitations to providers by giving them a CD containing a “Provider Manual” when they accept a contract with BCBS. The primary objective of the manual is to offer providers a reference tool to assist in the administration of health care services. The provider manual contains a general overview of coverages and protocols for payments. Under the physical therapy portion of Section

**BCBSD, Inc.**

8, it states: “In general ...programs limit coverage to physical therapy services provided within 60 days... from the first date of physical therapy treatment...” “...please confirm member’s available coverage with the Provider Services Department.”

Additionally, providers are contractually required to have internet access to the Company’s Health Benefit Policies. The provider can download the Health Benefit Policies or can request a hard copy of the policies at any time.

The Health Benefit Policies contain detailed information regarding the Company’s payment guidelines. The text regarding the 60-day limitation per acute condition has not been modified since inception in September of 1997. Although the referenced Health Benefit Policy was effective for other BlueCross BlueShield Association members, it did not become effective for BCBSD, Inc. until July 15, 2005. Even though the official Health Benefit Policy was not adopted until July 2005, its adoption did not represent a change in the consumer’s contract language or in the administration of the physical therapy benefits.

The Company has established policies and procedures to ensure the consistent application of its contract provisions relating to physical therapy. The Company is processing claims in accordance with the applicable physical therapy contract provisions.

### **SUMMARY**

The Company is a Delaware domiciled health insurer that provides health care coverage in the commercial and individual markets.

**BCBSD, Inc.**

This examination focused on compliance with Delaware prompt pay laws, regulations and the Company's limitations on physical therapy claims and treatment of CPT modifier 25.

Recommendations have been made to address the areas of concern noted during the examination. These are summarized below.

### **LIST OF RECOMMENDATIONS**

It is recommended that the Company maintain records of its "rejected" claims in a manner that allows for independent verification of the Company's compliance with requirements of 18 Del. Admin. Code 1310 (pgs. 7, 8, 10)

It is recommended that the Company ensure that all claims are adjudicated within the time requirements of 18 Del. Admin. Code 1310 §6.0. (p. 10)

It is recommended that the Company maintain records, which should include but not be limited to, documentation of receipt date of requested information used to re-adjudicate claims in a manner that allows for independent verification of the Company's compliance with requirements of 18 Del. Admin. Code 1310 (p. 13)

### **CONCLUSION**

The examination was conducted by the undersigned and respectfully submitted,



Market Conduct Examiner-in-Charge

Delaware Insurance Department