

OHIO DEPARTMENT OF INSURANCE

**REPORT OF
MARKET CONDUCT EXAMINATION OF**

MEDICAL MUTUAL OF OHIO

NAIC # 29076

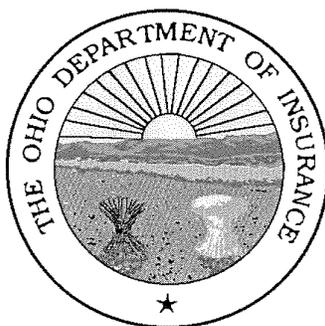
AND

MEDICAL HEALTH INSURING CORPORATION OF OHIO

NAIC # 95828

As Of

March 31, 2002





Bob Taft, Governor
Ann Womer Benjamin, Director

2100 Stella Court, Columbus, OH 43215-1067
(614) 644-2658 www.ohioinsurance.gov

Honorable Ann Womer Benjamin
Director of Insurance
Ohio Department of Insurance
2100 Stella Court
Columbus, Ohio 43215-1067

Director:

Pursuant to your instructions and in accordance with the powers vested under Title 39 of the Ohio Revised Code, a target market conduct examination was conducted on the Ohio business of:

Medical Mutual of Ohio
NAIC Company Code 29076

And

Medical Health Insuring Corporation of Ohio
NAIC Company Code 95828

The examination was conducted at the Company's headquarters located at:

2060 East Ninth Street, Cleveland, Ohio 44115-1355

A report of the examination is enclosed.

Respectfully submitted,

A handwritten signature in black ink that reads 'David R. Beck'.

David R. Beck
Chief, Market Conduct Division

8-23-2004
Date



Accredited by the National Association of Insurance Commissioners (NAIC)
Consumer Hotline: 1-800-686-1526 Fraud Hotline: 1-800-686-1527 OSHIIP Hotline: 1-800-686-1578

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FORWARD

This examination was conducted under the authority provided by Section 3901.011 of the Ohio Revised Code (ORC).

SCOPE OF EXAMINATION

This examination was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) and the Ohio Department of Insurance (the Department).

The scope of the examination was to determine if Medical Mutual of Ohio (MMO), and Medical Health Insuring Corporation of Ohio (MHICO), (the Companies) were processing claim denials in accordance with policy provisions and not in violation of any unfair trade practices as provided in section 3901-1-07 of the Ohio Administrative Code.

The examination period for this exam was October 1, 2001 through March 31, 2002. The on-site examination was conducted at the Company's offices in Cleveland, Ohio.

CLAIMS HANDLING

Prior to the review of denied claim files, the Companies provided a step-by-step tour of the mail handling process with emphasis placed on the efficiency of handling each claim, the accuracy of sorting and scanning each claim, and the Companies' claims adjudication process.

The claims handling process begins when mail is delivered from the United States Post Office at 5:30 AM and 7:30 AM, Monday thru Friday. The mail is manually opened, sorted, and physically delivered to the on-site Claims Distribution Center where all the claims are assigned a Julian date corresponding with the receipt date of the claim.

On average, the Claims Distribution Center receives 30,000 paper claims each day with two thirds of them processed through the Optical Character Recognition (OCR) system. The OCR system is a completely automated system that identifies the member, provider, corresponding policy, and assigns the Julian date based on specific fields of member

information provided on the claim. Claims that cannot be processed through this system due to illegibility and/or incorrect member information require manual entry and Julian date assignment. All paper claims are assigned a Julian date and imaged each day, even if they are returned to the submitter for missing or incorrect member information.

Once the claims have been aligned with active members, they are moved electronically to the Automated Claims Adjudication System for processing. Each claim passes through an automated progression of tests and edits before a disposition is reached and the claim is sent to disbursements for payment. If the claim fails one or more of the tests and edits, it is placed in a pended status and a request for additional information is sent to the appropriate party. When this occurs, these claims are defined by specific "pend" remark codes. Upon receipt of the requested information, the claim re-enters the adjudication process.

The claim payment system also has a more detailed level of review for claims with high dollar thresholds, specific error conditions, Medicare claims, and claims involving coordinated benefits with another carrier.

Claims for members that cannot be identified or processed are returned to the submitter with a claim number and a request for additional information and membership clarification. Depending on the response and the format of the *returned* information, the claim may re-enter the automated adjudication process or be assigned to a Claims Specialist for manual processing.

Test Methodology

The Department asked the Companies to provide a comprehensive list of Ohio health care claims closed, in whole or in part, between October 1, 2001 and March 31, 2002. Claims from capitated providers, self-funded plans, workers compensation, and Medicare, Medicare+Choice, Medicare Supplement and Medicaid claims were excluded. The Department pulled a random sample of 100 denied claims throughout the six-month exam period for Medical Mutual of Ohio. Medical Health Insuring Corporation of Ohio presented a smaller population for the exam period resulting in a sample of 50 denied claims. The examiners reviewed the specific denial reasons associated with each claim.

A second sample was pulled from the denied populations for the purpose of reviewing claims that were denied because of duplicate submissions. A sample of 100 Medical Mutual of Ohio claims denied as “duplicate” were pulled for review, and 50 claims for Medical Health Insuring Corporation of Ohio denied as “duplicate” were also reviewed.

A series of tests was designed and applied to the samples to determine the Companies level of compliance with Ohio insurance statutes and regulations. Specifically, the samples were reviewed for compliance with Ohio Administrative Code 3901-1-07, Ohio’s unfair trade practices regulation. These tests are described and the results are noted in this report. In any instance where the Examiners could not find sufficient documentation for the examination test, the claim file was considered incomplete and failed the test.

The Examiners used the NAIC standard of 7% error ratio to determine whether an apparent pattern or practice of non-compliance existed for each test. The results of each test are reported separately. The Examiners provided a list of exceptions to the Company. The Company’s response to this list was returned to the Examiners with notes as to whether the Company:

- Concurred with the findings, and/or
- Had additional information for the Examiners to consider, and/or
- Proposed remedial actions(s) to correct the apparent deficiency

Standard: Denied claims are handled in accordance with state law.

Test: Did the Company’s claim denial practices conform to Section 3901-1-07 (C) (1-16) of the Ohio Administrative Code?

Findings:

	Population	Sample	Yes	No	Standard	Findings
MMO	449,661	100	96	4	93%	96%
MHICO	75,390	50	46	4	93%	92%

The standard of compliance is 93%. MMO’s performance was above the minimum standard. MHICO was below the minimum standard.

Standard: Denied claims are handled in accordance with policy provisions.

Test: Did the Company's claim denial practices conform to the standards outlined within the provisions of the policy?

Findings:

	Population	Sample	Yes	No	Standard	Findings
MMO	449,661	100	96	4	93%	96%
MHICO	75,390	50	46	4	93%	92%

The standard of compliance is 93%. MMO's performance was above the minimum standard, MHICO was below the minimum standard.

Standard: Claims denied as a duplicate submission are handled in accordance with policy provisions and state law.

Test: Did the Company's claim denial practices conform to Section 3901-1-07 (C) (1-16) of the Ohio Administrative Code and were the settlement practices of the Company not forcing providers to resubmit claims repeatedly to reach final settlement?

Findings:

	Population	Sample	Yes	No	Standard	Findings
MMO	449,661	100	100	0	93%	100%
MHICO	75,390	50	49	1	93%	98%

The Standard of compliance is 93%. Both Companies performance was above the minimum standard.

Examiner Observations

MMO Claims:

- Of the 100 MMO claims reviewed within this section, 56 claims were submitted two times with the second submission being properly denied as a duplicate of the first submission.

MHICO Claims:

- Of the 50 MHICO claims reviewed within this section, 34 claims were submitted two times with the second submission being properly denied as a duplicate of the first submission.

ADDITIONAL FINDINGS

Throughout the review of the denied and duplicate claim files for both companies, the Examiners noted an apparent practice of claims being placed in a pended mode for workers' compensation clarification. The trigger for this particular "pended status" was linked to the specific ICD-9 code submitted by the provider for which treatment was rendered. Once the claim was pended, the Companies mailed a Workers' Compensation Questionnaire form to the member requesting clarification on whether the ailment for which treatment was sought was related to their employment. This process was followed regardless of how the provider responded to the workers' compensation-specific question on the HCFA-1500 form.

If the Workers' Compensation Questionnaire was completed and returned by the member, the claim was processed accordingly. If the member failed to return the Workers' Compensation Questionnaire, the Companies denied the claim for failure to respond to an inquiry.

When discussions with the Companies ensued regarding this apparent practice, the Companies admitted to having a specific list of ICD-9 codes often linked to employment injuries that would automatically trigger a Workers' Compensation pended status. This occurred even if the provider indicated that the injury was not related to the patient's employment. Since the discovery of this apparent practice, representatives from the Companies and the Department have engaged in lengthy discussions that resulted in a substantial alteration of this procedure. The Companies advised all claims with a clear indication of "not work related" are no longer pended for investigation and are subject to the normal adjudication process.

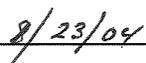
SUMMARY

The Companies' performance in the targeted compliance areas met or exceeded the minimum standard in three of the four samples tested. The claims that were identified as inappropriately denied were presented to the companies who agreed to reprocess and pay the claims in question.

This concludes the report of the Market Conduct Examination of Medical Mutual of Ohio and Medical Health Insuring Corporation of Ohio. The Examiners, Rodney Beetch and John Pollock, would like to acknowledge the assistance and cooperation provided by the management and employees of the Company.



Rodney Beetch
Examiner in Charge



Date