Aetna Health Inc.

NAIC # 95810

Response to Draft Market Conduct Examination Report Dated May 13, 2010

Missouri Market Conduct Examination #0612-45TGT and 0904-17-TGT

EXECUTIVE SUMMARY

The Department conducted a targeted market conduct examination of Aetna Health Inc. The contents of the examination report reflect the errors and violations that the examiners discovered during their review of the Company's records. The principal issues of concern found in this examination are as follows:

1. The Company wrongfully denied 11 emergency-room/ambulance claims without proper cause. Although the Company initially denied these claims, it subsequently reversed its position and paid the claims when the examination team requested it to reevaluate all denied claims that fell into this category.

Reference: Sections 354.400 (1), (5), and (6), and 375.1007 (4), RSMo.

Company's response:

After reviewing the errors cited in the report, we discovered there should have been 13 errors rather than 11. We note that all of the claims were reprocessed during the exam. Please refer to the response to A.1 Denied Ambulance/Emergency Room claims under Section A. Unfair Settlement of Claims for an explanation and supporting documentation.

2. The Company wrongfully denied eight Pap-smear claims. The denial reasons used by Aetna on these claims were not suitable exceptions to the Missouri mandate regarding pelvic and Pap-smear examinations.

Reference: Section 376.1250.1(1), RSMo.

Company's response:

The Company respectfully disagrees that the denial reasons on these claims were not suitable exceptions to the Missouri mandate regarding pelvic and Pap smear claims. The Company did reimburse for these services. The technical fee was paid to the laboratory and the professional fee was included in the reimbursement for the evaluation and management code billed by the attending physician. Please refer to the response to A.2 Denied Pap – Smear Claims under Section A. Unfair Settlement of Claims for an explanation and supporting documentation.

3. The Company wrongfully denied four cancer claims. The denial reasons used by Aetna on these claims were not suitable exceptions to the Missouri mandate regarding mammogram coverage.

Reference: Section 376.782, RSMo.

Company's response:

It appears that the reference to mammogram coverage in this finding is incorrect and should be changed to read "cancer coverage". In addition, the Company respectfully disagrees that the denial reasons used by Aetna on the cancer claims were not suitable exceptions to the Missouri mandate regarding cancer treatment. The Company did reimburse the hospital for these services. Please refer to A.3 Cancer Denied Claims under Section A. Unfair Settlement of Claims for an explanation and supporting documentation.

4. The Company wrongfully denied 63 child immunization claims without proper cause. Although the Company initially denied these claims, it subsequently reversed its position and paid the claims when the examination team requested it to reevaluate all denied claims that fell into this category.

Reference: Sections 376.1215 and 375.1007 (4), RSMo.

Company's response:

After reviewing the errors cited in the report, we believe the number of incorrectly denied child immunization claims should be changed from 63 to 36. Please refer to the response to A.4 Denied Child Immunization Claims under Section A. Unfair Settlement of Claims for an explanation and supporting documentation.

5. The Company improperly re-processed 11 claims that were initially denied due to referral issues, services deemed not medically necessary and timely filing. Although the Company wrongfully denied and improperly re-processed these claims, it subsequently reversed its position and properly paid the claims when the examination team requested it to reevaluate all claims that fell into this category.

Reference: Section 376.1218.4 and 376.383, RSMo.

Company's response:

The Company agrees.

EXAMINATION FINDINGS

I. COMPANY AUTHORIZATION

Missouri law determines which companies may sell insurance and the lines of insurance these companies may sell by requiring that each obtain the appropriate authority to transact the business of insurance. To protect the consumer, Missouri enacted laws and regulations to ensure that companies provide fair and equal treatment in its business dealings with Missouri citizens. An insurance company receives a Certificate of Authority that allows it to operate within the state only after it complies with certain application requirements regulated by the Department.

Aetna Health Inc., a Missouri corporation, has current authority to transact business in Missouri as a HMO carrier identified under Sections 354.400-354.636, RSMo.

II. CLAIMS PRACTICES

This section of the report is designed to provide a review of the Company's claims handling practices. Examiners reviewed how the Company handled claims to determine the accuracy of payment, adherence to contract provisions, and compliance with Missouri statutes and regulations.

To minimize the duration of the examination, while still achieving an accurate evaluation of claim practices, the examiners restricted the claim review process to only those claims denied by the Company. The review consisted of Missouri claims denied by the Company with a closing date from January 2004 through December 2005.

A claim file is determined in accordance with 20 CSR 100-8.040 and the NAIC *Market Regulation Handbook.* Error rates are established when testing for compliance with laws that apply a general business practice standard (e.g; Sections 375.1000-375.1018 and Section 375.445, RSMo) and compared with the NAIC benchmark error rate of seven percent (7%). Error rates in excess of the NAIC or statutory benchmark error rates are presumed to indicate a general business practice contrary to the law.
Errors indicating a failure to comply with laws that do not apply to the general business practice standard are separately noted as errors and are not included in the error rates.

For purposes of this targeted report, a claim error will include, but not be limited to, any of the following:

- An unreasonable or wrongful denial of a claim.
- A failure to calculate claim benefits correctly.
- A failure to comply with Missouri law regarding claim settlement practices.

Missouri statutes require the Company to disclose to first-party claimants all pertinent benefits, coverage or other provisions of an insurance policy under which a claim is presented. Claim denials must be given to the claimant in writing, and the Company must maintain a copy in its claim files.

A. <u>Unfair Settlement of Claims</u>

The examiners reviewed the Company's claim handling processes to determine compliance with contract provisions and adherence to unfair claims statutes and regulations. Whenever a claim file reflected that the Company failed to meet these standards, the examiners cited the Company for noncompliance.

The results of this review are as follows:

1. <u>Denied Ambulance/Emergency Room Claims</u>

Field Size:	1,274
Sample Size:	1,274
Type of Sample:	Census
Number of Errors:	11
Error Ratio:	.86%

The following errors were cited in this review:

Claim documentation indicates that the Company wrongfully denied the following 11 emergency-room/ambulance claims without proper cause. Although the Company initially denied these claims, it subsequently reversed its position and paid the claims when the examination team requested it to reevaluate all denied claims that fell into this category.

Reference: Sections 354.400 (1), (5), and (6), and 375.1007 (4), RSMo.

Claim Item	Date of Claim Adjustment	Claim Adjustment Amount
BBC9YD8B	11/09/2007	$176.11
BBCZJ68A	11/13/2007	$254.73
BBCZJ68A	11/02/2007	$125.43
BBL4YYNB	11/02/2007	$164.23
BBHS9ZBA	11/02/2007	$146.06
BBJ3JT6C	11/08/2007	$138.47
BBK2CTRB	11/05/2007	$45.48
BBKW7NNA	11/02/2007	$84.84
BBCZJ68A	11/02/2007	$125.43
BBL4YYNB	11/02/2007	$164.23
BBMKKO1A	11/08/2007	$495.03

Company's response:

The Company respectfully requests the report reflect the claim number as the Claim Item rather than the member's ID in order to protect the members' privacy. After reviewing the errors cited in the report, we discovered there should be 13 errors rather than 11 and the error ratio should be 1.02%. It appears there were some claims listed more than once and some claims were omitted from the report. Please refer to Attachment A for a listing of the claim numbers and our findings. We note that all of the claims were reprocessed during the exam; please see Attachment A for the explanation of benefits for each.

2. Denied Pap-Smear Claims

Field Size:	207
Sample Size:	207
Type of Sample:	Census
Number of Errors:	8
Error Ratio:	3.86%

The following errors were cited in this review:

Claim documentation indicates that the Company wrongfully denied the following eight Pap-smear claims. Aetna states that it will not pay for the profession component of obtaining the pap specimen, nor will it allow any payment to a physician unless the billing is marked with a "modifier 90" reference. This type of denial reason is not a suitable exception to the Missouri mandate regarding pelvic and pap-smear examination coverage.

Reference: Section 376.1250.1(1), RSMo.

Claim Item	Date Claim Denied	Billed Amount of Claim
050222E6010000	02/24/2005	$30.00
050202E2871500	02/03/2005	$30.00
05030711724400	03/17/2005	$10.00
050104Y9149608	01/14/2005	$21.00
05031430374700	03/24/2005	$10.00

Claim Item	Date Claim Denied	Billed Amount of Claim
050908E2513900	09/09/2005	$30.00
050512E1093100	05/13/2005	$103.00
050310E1446401	03/28/2005	$50.00

Company's response:
The Company respectfully disagrees the denial reasons used on these claims were not suitable exceptions to the Missouri mandate regarding pelvic and Pap smear claims. In all of the claims listed above, the charge at issue is the attending physician's charge for procedure code 88150. This CPT code is used to report the lab/physician interpretation of the Pap smear. This code is not payable to the physician obtaining the specimen because that physician does not interpret the test.

In these claims, the physician billed for 99214, which is the performance of the examination and collection of the specimen for the Pap smear. The physician also billed for 88150, which is for the interpretation of the Pap smear. We allowed payment for examination and collection of the specimen and considered the charge for 88150 as incidental to or inclusive with code 99214 with the following explanation:

> **"Charge is denied. Service/procedure is considered incidental/inclusive to the primary procedure and or OV/hosp consult fee."**

We note that since the charges for 88150 were billed by participating physicians, and so the member is not liable for the charges.

In addition, for all of the claims except claim # 050512E1093100, we received and paid the laboratory for the interpretation of the Pap smear. Aetna does not generally allow payment for more than one interpretation of the same laboratory or diagnostic test. Additional interpretations by the same or by a different provider are considered duplicative and not eligible for separate reimbursement. Please see Attachment B for copies of explanation of benefits or a copy of the claim history for the attending physician payment and laboratory payment for each claim with the exception of claim #050512E1093100, where we could not locate a payment to the laboratory.

3. Denied Mammogram Claims

Field Size: 390
Sample Size: 390

Type of Sample:	Census
Number of Errors:	0
Error Ratio:	0 %

No errors were cited in this review.

Company's response:
The Company agrees.

4. Denied Cancer Claims

Field Size:	173
Sample Size:	173
Type of Sample:	Census
Number of Errors:	4
Error Ratio:	2.31%

The following errors were cited in this review:

Claim documentation indicates that the Company wrongfully denied the following four cancer claims. Aetna states that it will not pay for the profession component for physician services rendered in relation to a cancer screening test. This type of denial reason is not a suitable exception to the Missouri mandates regarding cancer treatment.

Reference: Section 376.1250, RSMo.

Company's response:

The Company respectfully disagrees that the denial reasons applied were not suitable exceptions to the Missouri mandate regarding cancer treatment. In all of the claims listed above, the charges billed by the physicians were for procedure code 82270 billed with a modifier 26. A modifier 26 represents an additional professional component charge. For laboratory services (80000 CPT series), modifier 26 is only allowed in the following situations:

- **When the service is billed with one of the laboratory codes for which CMS provides payment or for specific laboratory codes that are deemed by Aetna to require direct clinical interpretation.**
- **When a provider contract provides for payment of Modifier 26.**

- **When services rendered by a non-participating provider are authorized/reimbursed at the in-network benefit level.**

Please see Attachment C for a listing of pathology codes that CMS determined are reimbursable when billed with modifier 26. Procedure code 82270 is not a listed code. The members associated with these claims were confined as inpatients at the time the services were rendered. The hospital billed for the laboratory expense for procedure code 82270 and that charge was included when the payment to the hospital was made. There are no Relative Value Units or payment amount for this code billed with a modifier 26 and therefore, no separate payment is made.

Claim Item	Date Claim Denied	Billed Amount of Claim
05050914868100	05/13/2005	$6.50
050602E0901102	06/06/2005	$2.00
050729E4526300	08/02/2005	$2.00
051205E1773400	12/07/2005	$12.00

5. Denied PSA (Prostate-Specific Antigen) Claims

Field Size:	207
Sample Size:	207
Type of Sample:	Census
Number of Errors:	0
Error Ratio:	0%

No errors were cited in this review.

Company's response:

The Company agrees.

6. Denied Child Immunization Claims

Field Size:	356
Sample Size:	356
Type of Sample:	Census
Number of Errors:	63
Error Ratio:	17.70%

The following errors were cited in this review:

Claim documentation indicates that the Company wrongfully denied the following 63 child immunization claims without proper cause. Although the Company initially denied these claims, it subsequently reversed its position and paid said claims when the examination team requested it to reevaluate all denied claims that fell into this category.

Reference: Sections 376.1215 and 375.1007 (4), RSMo.

Claim Item	Date of Claim Adjustment	Claim Adjustment Amount
BBKXKL9F	12/05/2007	$53.90
RZZPPO4O	11/29/2007	$10.01
BBJW9ZZC	11/29/2007	$10.06
BBDN157D	11/29/2007	$10.02
BB618TMB	11/29/2007	$9.81
BBG15HWB	11/29/2007	$9.86
BBKM9MRD	11/29/2007	$10.00
BBGCZFYB	11/29/2007	$9.96
BBKXZR9B	11/29/2007	$9.84
BBH37QPE	11/30/2007	$9.74
BBG15HWB	11/29/2007	$9.86
BBKM9MRD	11/29/2007	$10.00
BBGCZFYB	11/29/2007	$9.96
BBKXZR9B	11/29/2007	$9.84
BBLN3WDD	11/29/2007	$1.25
BBLT59KB	11/29/2007	$9.85
BBLWXFRC	11/29/2007	$19.73
BBW9SSTC	11/02/2007	$39.34
BBW7536B	11/29/2007	$2.45
BBLWXFRC	11/29/2007	$19.73

Claim Item	Date of Claim Adjustment	Claim Adjustment Amount
BBM9SSTC	11/29/2007	$39.34
BBWG5ZQB	11/29/2007	$19.69
BBNDL35F	11/29/2007	$39.39
RZZPP040	11/29/2007	$10.01
BBJW9ZZC	11/29/2007	$10.06
BBDN167D	11/29/2007	$10.02
BBG18TMB	11/29/2007	$9.81
VNXPQ050	12/03/2007	$9.87
BBD9VFOE	11/29/2007	$29.27
BBFDLQ2D	12/03/2007	$10.54
BBKMGFPC	12/04/2007	$10.08
BBM6FJ9C	12/03/2007	$9.88
BBM4ZOMC	11/29/2007	$10.00
BBKXKL9F	11/29/2007	$10.00
RZZPPO4O	11/29/2007	$10.01
BBJW9ZZC	11/29/2007	$10.06
BBDN167D	11/29/2007	$10.02
BBG18TMB	11/29/2007	$9.81
BBG15HWB	11/29/2007	$9.86
BBKM9MRD	11/29/2007	$10.00
BBGCZFYB	11/29/2007	$9.96
BBKXZR9B	11/29/2007	$9.84
BBH37QPE	11/30/2007	$9.74
BBG15HWB	11/29/2007	$9.86
BBKM9MRD	11/29/2007	$10.00
BBGCZFYB	11/29/2007	$9.96
BBKXZR9B	11/29/2007	$9.84

Claim Item	Date of Claim Adjustment	Claim Adjustment Amount
BBLN3WDD	11/29/2007	$1.25
BBLT59KB	11/29/2007	$9.85
BBLWXFRC	11/29/2007	$19.73
BBM9SSTC	11/29/2007	$39.34
BBWG5ZQB	11/29/2007	$19.69
BBNDL35F	11/29/2007	$39.39
RZZPPO4D	11/29/2007	$10.01
BBJW9ZZC	11/29/2007	$10.06
BBDW167D	11/29/2007	$10.02
BBG18TWB	11/29/2007	$9.81
VMXPQO5O	12/03/2007	$9.87
BBD9VFOE	11/29/2007	$29.27
BBFDLQ2D	12/03/2007	$10.54
BBM104YE	10/12/2005	$8.00
BBKMGFPC	12/04/2007	$10.08
BBM6FJ9C	12/03/2007	$9.88

Company's response:

The Company respectfully requests the report reflect the claim and line number as the Claim Item rather than the member's ID in order to protect the members' privacy.

The Company agrees that some childhood immunization claims were incorrectly denied. After reviewing the errors cited in the report, we discovered there should be 36 errors rather than 63 and the field and sample size should be 373 rather than 356. The error ratio should 9.65%. It appears there were some claims were listed more than once and some claim lines were omitted from the report. Please refer to Attachment D for a listing of the claim and line numbers and our findings. We note that all of the claims were reprocessed and copies of the EOBs for these payments are included as Attachment D.

7. Denied "First-Step" Claims

Field Size:	1,783
Sample Size:	1,783
Type of Sample:	Census
Number of Errors:	11
Error Ratio:	.62%

The following errors were cited in this review:

Claim documentation indicates that the Company improperly re-processed 11 claims that were initially denied due to referral issues, services deemed not medically necessary, and timely filing.

The Company explains that it encountered claim payment issues in the beginning of the examination period. Once the Company started processing claims and issuing checks, Covansys notified the Company that the checks were made payable to the incorrect payee, and therefore, returned the checks to the Company to be reissued. The Company encountered provider matching issues related to the Missouri Tax Identification Number (TIN). The Company worked with Covansys to correct the check payee issue and to void and reissue all checks to the correct payee. This issue was resolved in May 2007.

While the Company worked with Covansys, the examiners discovered that claims were being denied inappropriately for lack of referral, services not medically necessary, timely filing, etc. The Company identified that the pending code was not set correctly which resulted in claims not pending appropriately, and therefore, being incorrectly denied. The pending code issue was corrected approximately January 2008. The Company worked with Covansys to have the inappropriately denied claims reprocessed.

Although the Company wrongfully denied and improperly re-processed these claims, they subsequently reversed their position and properly paid the claims when the examination team requested it to reevaluate all claims that fell into this category.

Reference: Sections 376.1218.4 and 376.383, RSMo.

Claim Item	Date of Claim Adjustment	Claim Adjustment Amount
080612E2101500	02/17/2010	$36.16
080612E1491500	02/17/2010	$17.04
080612E0875800	02/17/2010	$39.42
080612E2713600	02/17/2010	$56.31
080612E0262300	02/17/2010	$39.42
080612E0262400	02/17/2010	$39.42
080612E0875900	02/17/2010	$56.31
080612E2713700	02/17/2010	$39.42
070301E9220001	02/17/2010	$10.28
080719E1179000	02/17/2010	$27.88
081122E2122900	02/17/2010	$26.84

Company's response

The Company agrees.

B. General Handling Practices

Apart from the review of determining those claims that were improperly denied, reduced or delayed by the Company, the examination staff reviewed the carrier's procedures for maintaining proper control over the usage of Coordination of Benefits (COB), deductible and coinsurance provisions.

There were no errors noted in this review.

Company's response:

The Company agrees.

III. COMPLAINTS

This section of the report is designed to provide a review of the Company's complaint handling practices. Examiners reviewed how the Company handled complaints to ensure it was performing according to its own guidelines and Missouri statutes and regulations.

Section 375.936(3), RSMo, requires companies to maintain a registry of all written complaints received for the last three years. The registry must include all Missouri complaints, including those sent to the DIFP and those sent directly to the Company.

The examiners verified the Company's complaint registry, dated January 1, 2003, through December 31, 2005. The registry contained a total of 222 complaints. They reviewed all 31 complaints that went through DIFP and all 191 complaints that did not come through the Department, but went directly to the Company.

The review consisted of an evaluation of the nature of each complaint, the disposition of the complaint, and the time taken to process the complaint as required by Section 375.936(3), RSMo, and 20 CSR 300-2.200(3)(D) (As amended 20 CSR 100-8.040, effective 1/30/09).

There were no errors noted in this review.

Company's response:

The Company agrees.

IV. CRITICISM AND FORMAL REQUEST TIME STUDY

This study is based upon the time required by the Company to provide the examiners with the requested material or to respond to criticisms. Missouri law requires companies to respond to criticisms and formal requests within 10 calendar days. Please note that in the event an extension was requested by the Company and granted by the examiners, the response was deemed timely if it was received within the time frame granted by the examination team. If the response was not received within that time period, the response was not considered timely.

The amount of time taken by the Company to respond is noted below.

A. Criticism Time Study

Calendar Days	Number of Criticisms	Percentage
Received within time limit, including any extensions.	5	100.0%
Received outside time-limit, including any extensions.	0	0%
No Response:	0	0%
Total:	5	100%

In this review, the Company responded to all criticisms within a timely manner.

Reference: Section 374.205.2(2), RSMo, and 20 CSR 100-8.040

B. Formal Request Time Study

Calendar Days	Number of Criticisms	Percentage
Received within time limit, including any extensions.	14	100.0%
Received outside time-limit, including any extensions.	0	0%

No Response:	0	0%
Total:	14	100%

In this review, the Company responded to all formal requests within a timely manner.

Reference: Section 374.205.2(2), RSMo, and 20 CSR 100-8.040

Company's response:

The Company agrees.

EXAMINATION REPORT SUBMISSION

The examination report of Aetna Health Inc. is respectfully submitted to the Director of Insurance, Financial Institutions and Professional Registration; State of Missouri.

The courteous cooperation of the officers and employees of the Company is hereby acknowledged.

In addition to the undersigned, John Korte-CIE, David Pierce-CIE, and John Clubb-CIE participated in the examination.

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E. Jack Baldwin
Examiner-In-Charge

Date: _____

SUPERVISION

The examination process has been monitored and supervised by the undersigned. The examination report (#s 0612-45-TGT & 0904-17-TGT) of Aetna Health Inc., NAIC # 95810 and supporting work papers have been reviewed and approved. Compliance with NAIC procedures and guidelines as contained in the Market Regulation Handbook has been confirmed.

_____ _____

James E. Mealer Date

Market Conduct Chief-Missouri Department of
Insurance, Financial Institutions and
Professional Regulation