NORTH CAROLINA
DEPARTMENT OF INSURANCE

MARKET REGULATION DIVISION

COORDINATOR'S HANDBOOK

Examination
of
Health Maintenance Organization Line of Business

of

Insurance Company Inc.

Prepared for:

Ms/Mr. [name of Exam Coordinator]
Manager, Regulatory Compliance
Insurance Company, Inc.

NC DEPARTMENT OF INSURANCE
MIKE CAUSEY • COMMISSIONER

MARKET REGULATION
Tel 919.807.6899 Fax 919.807.6858

Date XX, 201X

[Exam Coordinator Name]
Manager, Regulatory Compliance
Insurance Company, Inc.
Mailing address
City, North Carolina 27560

Re: Market Conduct Examination - North Carolina Operations Only
Insurance Company Inc.
- Health Maintenance Organization Operations

Dear Ms/Mr. [Exam Coordinator's name]:

Thank you for responding to our examination call letter dated [Date XX, 201X]. It is the goal of the Market Regulation Division to perform examinations as quickly and efficiently as possible. The Handbook is designed to provide procedural guidelines for the Company. The Handbook includes general information regarding the examination process and includes a checklist of items required of the Company and is not all-inclusive.

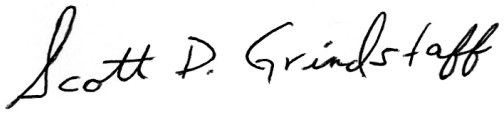
We will conduct a pre-examination conference with the Company prior to the submission of any information or data at a mutually agreeable date and time. The purpose of this conference is to discuss the information outlined in the handbook as well as establish lines of communication. All issues and concerns are encouraged for discussion at this time.

We ask that the Company include in the meeting those members of management and/or other personnel who have daily contact with North Carolina operations for each listed area of examination, particularly utilization management, marketing, underwriting, policyholder/member services and claims. **Personnel from the Management Information Systems Department, responsible for creating the electronic policy and claim data file submissions, must also be in attendance.**

The timely receipt of complete and accurate policy and claim data is an integral part of the examination process. The failure of the Company to provide such data as outlined and requested in the Coordinator's Handbook could result in a violation of North Carolina General Statute 58-2-185, 58-2-131 through 58-2-134, and Title 11 of the North Carolina Administrative Code (NCAC) Chapter 19 Section 0106. The Company may not be afforded the opportunity to submit revised data within 60 days prior to the commencement date of the examination.

We encourage you to distribute copies of the handbook to appropriate Company personnel involved in the examination. If you have any questions concerning the above, please contact Scott D. Grindstaff, Examiner-In-Charge, at 919-807-6879.

Sincerely yours,



Scott D. Grindstaff, MHP,HIA,MCM
Examiner-In-Charge
Market Regulation Division
Scott.Grindstaff@ncdoi.gov

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I. EXAMINATION AUTHORITY

The Market Regulation Division (the "Division") and the National Association of Insurance Commissioners have identified a series of items required for an examination. Pursuant to North Carolina General Statutes (NCGS) 58-2-131 through 58-2-134, 58-2-185, 58-2-200, and 58-67-100 the North Carolina Commissioner of Insurance requests that the Company make specified items available to the Department's authorized representatives. The requested items will reference transactions occurring during the examination period. The examination periods are as follows, unless agreed to otherwise by the Department and the Company at the Pre-Examination conference:

January 1, 2015 through December 31, 2017

The following pages identify examination protocol to which the Company must adhere in order for the Division to conduct an efficient and thorough examination. It is the Company's responsibility to review this information thoroughly and make sure its personnel are familiar with and understand the requirements it sets forth. Questions regarding this handbook, exam protocol or the examination process should be directed to the following Examiner-In-Charge:

Scott D. Grindstaff, Examiner-In-Charge at (919) 807-6879

II. EXAMINATION CHRONOLOGY

1. NOTICE OF EXAMINATION

The Division provides notice of examination to the Company's President.

2. EXAMINATION COORDINATOR AND REQUIREMENTS

a. Delivery of Coordinator's Handbook
b. Scheduling of the Pre-Examination
c. Completion of Interrogatories

3. PRE-EXAMINATION CONFERENCE

The Pre-Examination Conference is held to discuss examination requirements and establish lines of communication. This conference is normally scheduled at least 60 to 120 days prior to commencement of Phase I and/or the Off-site portion of the examination.

4. PHASE I AND/OR OFF-SITE PORTION OF EXAMINATION

The Examination Team reviews the information and materials at the Division's office in Raleigh, North Carolina. This review may be referred to as the Phase I and/or Off-Site portion of the examination, as opposed to the Phase II or On-Site Examination, which is conducted at the Company's location.

5. PHASE II AND/OR ON-SITE EXAMINATION

Phase II and/or the On-Site Examination will continue in the Market Regulation Division's office in Raleigh, North Carolina and at the Company's office if deemed necessary by the Department. If the examination is conducted at the Company's office, all information requested for Phase II and/or the on-site portion of the examination must be available in the conference room assigned to the examiners upon arrival on the first day of the examination. The Examination Team conducts an open examination and encourages discussion of any relevant issues between representatives of the Company and the Examination Team.

6. WRAP-UP CONFERENCE

A Wrap-Up Conference is conducted by the EIC upon completion of the examination. The Company is encouraged to include all affected management in this conference. The Examination Team will summarize their findings and discuss pertinent issues that will appear in the examination report.

7. EXAMINATION REPORT DRAFTING

Upon completion of the examination, the Examination Team begins preparation of the Report on Examination at the office of the Division. This process is normally completed in two weeks.

8. INTERNAL REPORT REVIEW

The Report is reviewed and approved at various levels within the Division and requires approval by the Deputy Commissioner and the Senior Deputy Commissioner of the Company Services Group. Pursuant to NCGS §58-2-132, the Report will be submitted to the Company within 60 days of the official closing date of the examination by certified or electronic mail.

9. COMPANY REVIEW AND ACCEPTANCE OF REPORT

Pursuant to NCGS §58-2-132, the Company has 30 days following receipt of the Report to review the Report. The Report will become a public document if the Market Regulation Division does not receive a written response from the Company by the end of the 30-day period.

10. FORMAL ACCEPTANCE OF REPORT

If, upon review of the Report, the Company accepts its contents, it must provide the Division all of the following:

a. formal, written acceptance of the Report;
b. a Statement of Corrective Actions for each violation identified in the Report, including for each item the person(s) responsible and the expected completion date;
c. a signed statement from each member of the Company's Board of Directors acknowledging that he/she has read and is familiar with the contents of the Report; and
d. the original Report and one bound (stapled) photocopy of the Report.

11. WRITTEN SUBMISSIONS OR REBUTTALS

Pursuant to NCGS 58-2-132, at the end of 30 days, the Commissioner shall fully consider and review the Report together with any written submissions or rebuttals and enter an order either,

a. adopting the examination Report as filed, or with modifications or corrections;
b. rejecting the examination report with directions to the examiner to obtain additional data; or
c. calling for an investigatory hearing with no less than 20 days notice to the insurer.

12. INFORMAL CONFERENCE

If all issues relating to the Report cannot otherwise be resolved, the Department may request an informal, private conference at the office of the Division in Raleigh, North Carolina. The Company must submit its issues in writing at the conference as well as discussing them during the meeting.

13. REGULATORY ACTION

Final regulatory disposition will be determined by the Commissioner of Insurance for the State of North Carolina.

III. COORDINATOR'S ROLE

The Company's Examination Coordinator plays an essential role in the examination process and should have knowledge of all operational areas of the Company. The examination will require a great deal of the Coordinator's time; therefore, the Company may consider limiting his/her other work assignments during the examination. Coordinator is expected to be available to the examiners continuously during the exam The Coordinator's responsibilities include, but are not limited to the following:

- Collecting, coordinating and submitting off-site materials;
- Coordinating the availability of documents and records and making sure all requested documentation and records are available immediately upon the examiners' arrival
- Providing a schedule of the availability of the contact person for each operational area of the Company for the duration of the examination;
- Assisting the examination team in scheduling interviews with contact persons for each operational area; and
- Disseminating MC-1s and MC-2s to the appropriate contact person and officer and returning them back to the EIC when due.

IV. FACILITY REQUIREMENTS

The Company must designate adequate private, secure work space and facilities for approximately seven examiners, including a telephone and a separate computer modem telephone line for each examiner. The examination room should have appropriate electrical outlets for the examiners' laptop computers. Access to a photocopier and facsimile machine must also be provided. It is the responsibility of the Company to assure security for the examiners' computer equipment during Phase II and/or the On-Site Examination.

The Company is required to provide in writing the following logistical information:

a. the Company's core business hours;
b. locations of relevant Company operations and programs;
c. telephone directory of examination contact persons for each operational area;
d. directions and parking information for examination sites;
e. arrangement for temporary access to the Company's offices (security cards, keys, etc.);
f. access to computers, microfiche and other equipment used by the Company for records retention and maintenance; and
g. access to television and video cassette recorder in order to view the Company's advertisements.
h. Supplies:
    - Three-Hole punch
    - Two reams of paper (printer paper)
    - Stapler/staples & staple removers
    - Scotch tape
    - Scissors
    - One set of In and Out baskets
    - White-out (1 bottle)
    - Post-it notes (small)
    - 1 Dozen Manila folders
    - 6 #2 pencils & pens (please include red, black, and blue pens)
    - Expandable File Folders
    - Medical Dictionary/ ICD-9 & CPT Code Reference Books
    - Calculator (minimum 14 digit capacity)
    - Rubber bands (various sizes)
    - Dictionary
    - Highlighters (various colors)
    - Rulers
    - Paperclips (small and large)
    - Laser jet Printer

V. EXAMINATION PROTOCOL

The examination team will review the information provided in order to determine compliance with North Carolina statutes, regulations and standards. This will be achieved through statistical sampling, interviews with designated representatives from each operational area and a thorough review of the documentation provided.

If additional documentation is needed or a violation is identified, the following procedures and protocol will be adhered to:

Informal Request

If an examiner needs additional information or clarification of information obtained from a Company file, the examiner may request the designee from the applicable operational area to meet in a designated area to go over the file in detail.

Formal Request

1. When additional information is required, the Examiner-In-Charge will submit an official request to the Coordinator via an MC-1 form via electronic mail or hard copy in the event that electronic mail is not available.

2. The Coordinator will deliver the MC-1 to the representative of the appropriate operational area.

3. If clarification of the request is needed, the Coordinator should request to meet with the Examiner-In-Charge immediately.

4. The requested information must be provided to the examination team as soon as reasonably possible, but no later than seven calendar days after delivery of the MC-1. If information is stored off-site, the Coordinator must work out a specific timeframe with the Examiner-In-Charge. The Examiner-In-Charge will make the final determination regarding deadlines and due dates.

5. The additional information must be complete. Partial information will not be accepted.

Confirmation Request

1. An MC-2 form is issued to document a factual finding or a deemed violation identified during the examination. This form is provided to the Company as a courtesy in an effort to keep the Company informed with respect to major examination findings. The form can document the following:

    a. Factual findings include, but are not limited to:
        i. Confirmation that the Company has not established policies and procedures; and
        ii. Confirmation that the Company was unable or failed to provide documentation.

b. A deemed violation is noted where the documentation and information provided by the Company indicates that the Company has not operated in compliance with North Carolina General Statutes and/or Regulations.

2. The Examiner-In-Charge will issue an MC-2 to the Coordinator. If the Company requests a file review after receiving an MC-2 related to deemed violations based on samples reviewed by the Department, the Examiner-In-Charge and the Coordinator will schedule a meeting for the review. During this meeting the following will occur:

   a. The Coordinator discusses any additional questions with the Examiner-In-Charge. The Coordinator then completes the form and returns it to the Examiner-In-Charge.

   b. If the Company can provide additional information to dispel the findings of the MC-2, the Coordinator shall notify the Examiner-In-Charge immediately and arrange a time frame to provide the additional information. If such information is relevant and is found to be satisfactory by the Examiner-In-Charge, the MC-2 may be updated accordingly.

3. If the deemed violation listed on the MC-2 either in whole or in part may have multi-jurisdictional impact that would affect membership in other States, the Department will also request that the company evaluate this violation to determine impact in jurisdictions beyond North Carolina by marking the checkbox indicating that a multi-jurisdictional response is required. The results of this evaluation must be provided to the Examiner-In-Charge in writing as an attachment to the MC-2.

4. If the Coordinator still does not concur with the findings, the Coordinator may document this on the form and return it to the Examiner-In-Charge. The Company will complete the form and return it to the Examiner-In-Charge no later than seven calendar days after receipt, unless the Examiner-In-Charge has established an alternate deadline and communicated that deadline to the Company in writing.

VI. GENERAL PROCEDURES/REQUIREMENTS

In an effort to streamline the examination process and to remain cost conscious, the examination team will be conducting some of the review at the company's location(s), and some at the Market Regulation Division's home office in Raleigh, North Carolina. This process yields less interruption in the company's daily operation during the several-week review process. You will be notified in advance when the team plans to be on-site at the Company's home office, and when the team will be working at the Division's office.

Attached you will find two comprehensive lists outlining the material to be provided to the examination teams for both the Off-site and On-site (Attachment A) reviews. Also attached is the format for the required data files (Attachment B). The material to be examined off-site should be shipped to: 1201 Mail Service Center, Raleigh, North Carolina 27699-1201. **The examination team must receive this shipment no later than 30 days prior to on-site review.**

The materials listed for the on-site portion of the exam must be available **in the conference room on the first day of the examination and** must remain in the room at all times during the examination.

If any of the functions subject to examination are located apart from company headquarters, the examiners may visit those sites. In addition, the examiners may require access to the offices of subcontractors.

VII. ERROR THRESHOLDS

It is the Department's practice to cite companies in apparent violation of a statute or rule when the results of a sample show errors/non-compliance at or above the following levels:

- 0 percent tolerance level for timeliness of utilization review, member appeal and grievance acknowledgement and determination letters; listing of a provider/facility in the directory prior to being fully credentialed; use of unapproved underwriting methodology and factors.

- 7 percent tolerance level is applied for notification letter content of utilization reviews, member appeals and grievances; claims processing; and credentialing errors.

- 10 percent tolerance level is applied for all other underwriting errors.

When errors are detected in a sample, but the error rate is below the applicable threshold for citing an apparent violation, the Department issues a reminder to the company.

*** ATTACHMENT A ***

ON-SITE AND OFF-SITE EXAM MATERIALS
GENERAL - HMO LINE OF BUSINESS

Please forward the examination materials listed on the following pages to the address below no later than [Date XX, 201X], so that we may begin the off-site portion of the General Examination as scheduled:

North Carolina Department of Insurance
Market Regulation Division
1201 Mail Service Center
Raleigh, North Carolina 27699-1201
Attention: Scott D. Grindstaff, Examiner-In-Charge

A. GENERAL ADMINISTRATION

1. Articles of Incorporation and bylaws and any amendments thereto
2. Minutes of the meetings of the Board of Directors with applicable attachments
3. Minutes of the meetings of the shareholders with applicable attachments
4. Minutes of the board's standing and ad hoc committee meetings with applicable attachments
5. Historic abstract of the Company including organizational history, product offerings and current activities
6. Organizational charts illustrating the departmental structure of the Company
7. Corporate chart showing the Company and any affiliated companies
8. Copies of all management contracts and exclusive contracts and approval letters from the Department, in accordance with NCGS 58-67-30
9. List of current officers and board members, including business addresses
10. Description or overview of Management Information System
11. Job description of individual responsible for risk management activities
12. Copies of notices to the Department of changes to the members of the Board of Directors, trustees, officers or any entity maintaining at least 10 percent ownership in the Company, in accordance with 11 NCAC 20.0602
13. Copies of notices to the Department of any application made in any other state for licensure as an HMO, insurance company or any other type of managed care organization, in accordance with 11 NCAC 20.0602
14. Copies of notices to the Department of any application made in North Carolina or any other state to engage in business arrangements involving Medicare, Medicaid, CHAMPUS or Workers Compensation, in accordance with 11 NCAC 20.0602
15. Copies of Department approval letters for service area expansions and product lines, in accordance with 11 NCAC 20.0601
16. Copies of any notice to the Department of intent to engage in any arrangement through which the Company owns or controls or manages any operations of another HMO in any other state, in accordance with 11 NCAC 20.0601
17. Data/Hardware protection plan
18. Disaster recovery plan
19. Antifraud Plan and related policies & procedures detailing the Company's proactive efforts to combat fraud and respond to incidents of fraud
20. Data/information confidentiality policies and confidentiality statements
21. Risk management policies and procedures
22. Premium collected and total member months for each calendar year of the examination period by the following categories (chart is an example – please provide data for the entire exam period):

	Member Type					
	Commercial Insured	**Medicare**	**Medicaid**	**Federal Employees**	**Total Insured**	**Self Funded**
[Year] Members at December 31 Premiums Collected Member Months						
[Year] Members at December 31 Premiums Collected Member Months						
[Year] Members at March 31 Premiums Collected Member Months						

In addition, the Company must provide the examination team access to the following:

23. Risk management files and records

B. DELIVERY SYSTEM AND PROVIDER RELATIONS

1. Provider relations staffing plans
2. Organizational chart of the Provider Relations Department(s) illustrating current structure and staffing
3. Provider Administrative Manual
4. Number of additions and deletions to the provider network by calendar year for the examination period by provider type (i.e. family practice, internist, ENT, cardiologist, ancillary, hospital, pharmacy, facility, etc.). Indicate the number of voluntary provider deletions and the number of involuntary provider deletions each year.
5. Provider availability standards (methodology and guidelines used for determining appropriate network for membership) in accordance with 11 NCAC 20.0301
6. Provider accessibility standards, in accordance with 11 NCAC 20.0302
7. Description of all components of the delivery system, including the number of providers by type and reimbursement. (i.e. family practice, internist, ENT, cardiologist, ancillary, hospital, pharmacy, facility, etc.).
8. Copies of any notice made to the Department regarding reductions in the number of providers that exceed 10 percent of the total number of providers in a particular service area, in accordance with 11 NCAC 20.0602
9. Contract management policies and procedures
10. Provider contract templates and approval letters from the Department, in accordance with NCGS 58-67-10 and 11NCAC 20.0202.
11. Provider relations policies and procedures, including availability and accessibility policies
12. Provider directories and periodic updates, if applicable
13. Provider survey forms and summary of results for each year during the examination period
14. Provider availability and accessibility monitoring reports
15. Out of area/out of network payment policies and procedures

In addition, the Company must provide the examination team access to the following:

16. Executed provider contracts

C. UTILIZATION MANAGEMENT

1. Written description or overview of the UM Department's responsibilities, activities conducted, staffing and reporting structures
2. Organizational chart of the UM Department illustrating current structure and staffing
3. UM Plan(s) used during the examination period
4. Minutes of UM Committee meetings with appropriate attachments, if not provided above
5. Annual evaluations of committee activities
6. Job descriptions of UM Management and Medical Director(s)
7. List of physician (provider) advisors which indicates specialty type
8. Actual staffing ratios for each year of the examination period (member to staff ratio and member to clinical staff ratio), if applicable (chart is an example – please provide data for the entire exam period).

Staffing Ratios	[Year]	[Year]	[Year]
Staff to member ratio	[x]: [x]	[x] : [x]	[x] : [x]
Clinical staff to member ratio	[x]: [x]	[x] : [x]	[x] : [x]

9. Copies of UM staff licenses, as applicable. Include information regarding the frequency of monitoring UM staff licenses to ascertain they are current and in good standing.
10. Description of telephone system and call monitoring system, including the normal business hours phones are staffed and a description of how calls received after hours are handled. If a nurse hotline is used, please indicate if member calls are tracked and forwarded to the Company for review.
11. Telephone accessibility standards
12. Monthly telephone reports used to monitor telephone accessibility standards for the examination period
13. Written description of review criteria and length of stay tables utilized. Include a description of the process for reviewing and updating, when necessary, the medical criteria utilized.
14. Policies and procedures for handling precertification, concurrent, and retrospective review requests. Include a copy of all form letters used as notification to members during the examination period
15. Policies and procedures for handling noncertification appeals. Include a copy of the noncertification form letter(s) used as notification to members during the exam period.
16. Policies and procedures for obtaining medical records
17. Additional UM policies and procedures not addressed in items C-14 through C-15
18. Written description of computer system capabilities with regard to UM program, including security protections and clearance levels as well as any integration existing between authorizations/referrals and the claims processing system.
19. Annual reports of UM activities filed with the Department, in accordance with statutory and regulatory requirements.
20. Average length of stay for maternity admissions separated by vaginal deliveries and cesarean section deliveries for each year during the examination period. Use the following chart to illustrate the number of and average length of stay for maternity admissions experienced by the Company during the examination period (chart is an example – please provide data for the entire exam period):

Maternity Length of Stay				
Year	Vaginal Delivery		Cesarean Delivery	
	Admissions	Avg. LOS	Admissions	Avg. LOS
[Year]		[x days]		[x days]
[Year]		[x days]		[x days]
[Year]				

* Period _____

21. Report of all maternity admissions during the examination period illustrating the length of stay experienced for each admission. Distinguish each admission by type (vaginal delivery vs. cesarean section delivery)
22. UR Activity Summaries - for each type of transaction listed below provide the total number of transactions processed during the exam period and provide a breakdown for the transactions handled each calendar year of the exam period and for transactions handled by delegated entities. Do not include data for federal programs, self-funded groups, or non-NC business. The year by year totals should reconcile with the non-HEDIS submission (see table following list of UR items).
    - ❑ Precertification Reviews (authorization given prior to treatment/visit).
    - ❑ Concurrent Reviews (utilization review conducted during a patient's hospital stay or course of treatment).
    - ❑ Retrospective reviews (utilization review of medically necessary services and supplies that is conducted after services have been provided).
    - ❑ Reconsiderations
    - ❑ Standard Noncertification Appeals (authorization denied based on medical necessity and subsequently contested)
    - ❑ Expedited noncertification appeals
    - ❑ 2nd-level Grievances (UR-related only)

Breakdown of UR Activity Performed by Plan/Delegated Entity (Do for each type of UR Activity)

	[Year]	[Year]	[Year]	**Totals for Exam Period**
Plan (in-house)				
Delegated Entity 1				
Delegated Entity 2				
Delegated Entity 3				
Totals by Year				
Totals per Annual Filing				

23. UR Activity Data Files - for each of the components listed in the immediately preceding item, provide an electronic file containing a list of transactions. Only include transactions processed by the plan. Do not include transactions handled by delegated entities. Use the layout in Attachment B, Table 1.
24. Noncertification Appeals Data Files - provide an electronic file of transactions processed by the plan. Do not include transactions handled by delegated entities. Follow the layout in Attachment B, Tables 2 - 3.
25. Internal or external reviews of the UM program
26. Additional UM form letters not provided with off-site materials
27. Signed confidentiality/conflict of interest statements of staff and committee members

In addition, the Company must provide the examination team access to the following:

28. Review criteria sets/length of stay tables
29. Precertification, retrospective review, concurrent review and noncertification appeals files

D. QUALITY MANAGEMENT

1. Written description or overview of the QM Department's responsibilities, activities conducted, staffing and reporting structures
2. Organizational chart of QM Department illustrating current structure and staffing
3. QM plan(s) and annual workplans used during the examination period
4. Minutes of QM Committee meetings with appropriate attachments, if not provided above
5. Annual evaluations of committee activities
6. Job descriptions of QM Department staff and Clinical Director(s)
7. Copies of QM staff licenses, as applicable
8. Minutes of departmental and interdepartmental staff meetings, with appropriate attachments
9. Quality of care and quality of service standards and the mechanisms utilized to determine if those standards are being met.
10. Description or summary of QM activities conducted each year during the examination period
11. Provider sanctions plan
12. Policies and procedures for handling written complaints/grievances with quality of care or quality of service implications
13. Written description of computer system capabilities with regard to QM program
14. Number of written quality of care complaints received from **January 1, 2015 through December 31, 2017**.
15. Number of quality of care complaints received each calendar year of the examination period. Indicate the number of quality of care/service complaints received in each year in the following categories: access, provider attitude, quality of care, referral management. Refer to Attachment B (Table 8) for the required format for this data submission.
16. Written QM confidentiality policy
17. Written QM conflict of interest policy
18. QM policies and procedures
19. Internal or external reviews of QM program
20. Quality of care/service complaint summary and analysis reports
21. Internal audit plan

In addition, the Company must provide the examination team access to the following:

22. QM studies and other activities relating to standards
23. Corrective action plans relating to sanctioned providers
24. Reports of adverse actions taken against participating providers
25. QM files, including quality of care complaint documentation

E. PROVIDER CREDENTIALING

1. Written description of overview of the Credentialing Department's responsibilities, types of credentialing conducted, staffing and reporting structures
2. Organizational chart of Credentialing Department illustrating current structure and staffing
3. Written Credentialing Plan
4. Credentialing Committee minutes, with appropriate attachments
5. Annual evaluation of committee activities
6. Job descriptions of Credentialing Department staff and Clinical Director(s)
7. Policies and procedures related to provider credentialing and recredentialing
8. Flowchart of the provider credentialing and recredentialing process
9. Provider credentialing and recredentialing application forms
10. Provider credentialing and recredentialing checklists
11. Provider office site visit checklists and forms
12. Recredentialing form used by staff to obtain information from other operational areas, if applicable
13. Written credentialing confidentiality policy
14. Total number and a numbered list of providers contracted from the period **January 1, 2015 through December 31, 2017**. Exclude duplicate listings and providers credentialed by delegated entities. This list should include providers which were active at some point during the examination period but are currently terminated. Refer to Attachment B (Table 4) for the required format for this data submission.
15. Total number and a numbered list of facilities contracted from the period of **January 1, 2015 through December 31, 2017**. Exclude duplicate listings, facilities credentialed by delegated entities and facilities for which individual credentialing activities are not conducted (i.e. secondary facilities which are covered under the same license, accreditation, insurance, etc. as a primary facility and for which, separate credentialing activities would not be conducted.) Refer to Attachment B (Table 5) for the required format for this data submission.
16. Total number and a numbered list of excluded network applications not requiring a review that were received by the Company from **January 1, 2015 through December 31, 2017**. Refer to Attachment B (Table 6) for the required format for this data submission.
17. Internal or external reviews of the credentialing program

The following information must be made available on-site:

18. Sample provider profile
19. Signed confidentiality statements of staff and committee members

In addition, the Company must provide the examination team access to the following:

20. Credentialing files and records
21. Reports of completed provider office site visits
22. Completed provider profiles
23. Terminated provider files
24. Excluded network application files

F. CLAIMS PRACTICES

1. Written description or overview of the Claims Department's responsibilities, staffing and reporting structures
2. Target staffing ratios for each year of the examination period, if applicable
3. Actual staffing ratios for each year of the examination period (member to staff ratio)
4. Minutes of departmental and interdepartmental staff meetings, with appropriate attachments
5. Claims administration flowcharts, including adherence to Prompt Pay Law
6. Written description of computer system with regard to claims processing
7. List of claims reports and time frames when they are produced
8. Sample explanation of benefits form
9. Sample remittance advice form
10. Sample denial letter, as required by NCGS 58-3-225
11. Describe how the company rescinds or cancels policies for material misrepresentation and/or reforms policy premiums for medical misrepresentation. Please provide sample rescission/cancellation and/or premium reformation letters for each product applicable in this examination, and copies of all policies and procedures related to rescissions/cancellations for material misrepresentation and reformations for medical misrepresentation.
12. Total number of rescinded/cancelled policies for material misrepresentation and/or reformed policy premiums for medical misrepresentation from **January 1, 2015 through December 31, 2017**. Do not include self-funded or any federal program policies in the total number. (From this population, the Department will generate a list of random numbers which must be matched to corresponding claims. Please maintain, in diskette format, the method by which this claims population number was obtained.)
13. List of rescinded/cancelled policies for material misrepresentation and/or reformed policy premiums for medical misrepresentation for the preceding item (F-12). Refer to Attachment B (Table 12) for the required format for this data submission.
14. Total number of claim line items processed (including paid, denied and pended claims) from **January 1, 2015 through December 31, 2017**. Do not include capitated claims, self-funded or any federal program claims in the total number. (From this population, the Department will generate a list of random numbers which must be matched to corresponding claims. Please maintain, in diskette format, the method by which this claims population number was obtained.)
15. List of claim line items – provide an electronic file containing a list of transactions from the preceding item (F-14). Do not include transactions handled by delegated entities. Refer to Attachment B (Table 7) for the required format for this data submission.
16. Claims processing standards for timeliness and accuracy, and any monitoring results.
17. Dollar amount of reimbursement, subcategorized by capitation and fee-for-service, for each calendar year during the examination period. Do not include self-funded or any federal program reimbursements in these figures (chart is an example – please provide data for the entire exam period).

Medical Expenses	[Year]	[Year]	[Year]
Total	$[x]	$[x]	$[x]
Type of Payment:			
• Fee for Service	[x]%	[x]%	[x]%
• Capitated	[x]%	[x]%	[x]%

18. If the claims unit has a dedicated telephone line, standards for average speed of answer and abandonment rate and **monthly** reports measuring the results, if applicable.
19. Prompt pay policies and procedures

The following information must be made available on-site:

20. Claims administration policies and procedures
21. Claim lag reports for the examination period
22. Internal or external audit reports

In addition, the Company must provide the examination team access to the following:

23. Individual claims filed
24. Claims processing system
25. Physician fee schedules and member benefit information on-line
26. Rescinded/cancelled policy files

G. POLICYHOLDER TREATMENT

1. Written description or overview of the Member Services Department's responsibilities, activities conducted, staffing and reporting structures
2. Job descriptions of member services staff
3. Minutes of departmental and interdepartmental staff meetings, with appropriate attachments
4. Description of automated telephone system, including normal business hours phones are staffed and description of how calls received after hours are handled
5. Telephone accessibility standards
6. Employer group enrollment guidelines
7. Description of the enrollment process
8. Flowchart of the enrollment process
9. Late enrollee enrollment guidelines
10. Late enrollee form letter and approval letter from the Department, in accordance with NCGS 58-39-55
11. Sample member identification cards used during the examination period
12. Member handbooks used during the examination period
13. Member complaint and grievance policy and procedures
14. Flowchart of the member complaint and grievance resolution process
15. List of categories utilized to categorize complaints and grievances
16. Please provide the number of complaints received by telephone as categorized by the Company's definitions in the following chart (chart is an example – please provide data for the entire exam period):

Complaint Type	**Number of Telephone Calls**		
(Company Definitions)	**[Year]**	**[Year]**	**[Year]**
[General medical coverage/Lack of coverage]			
[Company materials]			
[Company service]			
[Managed care concept/Referrals]			
[Mental health]			
[Pharmaceutical service]			
[Physician access]			
[Physician care/Services (Quality issues)]			
[Claims processing]			
[Media related]			
[Other]			
Total telephone calls			

17. Statement of member rights and responsibilities
18. Target staffing ratios, if applicable
19. Actual staffing ratios for each year of the examination period (member to staff ratio)
20. Number of members added and deleted during each calendar year of the examination period by the following categories (i.e. commercial insured, Medicare, Medicaid, federal employees, self-funded). Indicate the reasons for member deletion, if available. At a minimum, indicate whether the member deletion was a result of the employer group's option or the member's option.
21. Number of member grievances, excluding quality of care/service complaints reported in the QM section, noncertification appeals reported in the UM section,

data from self-funded or federal programs and any nocertification appeals reviewed by a delegated entity, received during the period January 1, 2015 through December 31, 2017. Refer to Attachment B (Table 8) for the required format for this data submission.

22. Number of grievances per one thousand members by calendar year
23. Member services policies and procedures
24. Member brochures, information sheets, mailouts
25. Member newsletters
26. Member information materials
27. Member satisfaction survey form and summary of results for each year during the examination period
28. Provider specific member satisfaction survey form and summary of results for each year during the examination period, if applicable
29. Member disenrollment survey form and summary of results for each year during the examination period, if applicable
30. Other member survey form and summary of results for each year during the examination period, if applicable
31. Telephone reports which measure actual performance against standards
32. Summary reports of member complaints
33. A copy of the North Carolina Consumer Complaint Record (register). This register should include complaints closed from the North Carolina Department of Insurance and those complaints received directly on behalf of North Carolina consumers during the examination period.
34. Complaint corrective action reports, if applicable
35. Privacy disclosure notices and any applicable policies and procedures as required by NCGS 58-39-25, 58-39-26 and 58-39-27.

In addition, the Company must provide the examination team <u>access</u> to the following:

36. Member videos and equipment for viewing such videos
37. Completed member surveys
38. Complaint files

H. MARKETING AND UNDERWRITING

1. Written description or overview of the Marketing Department's responsibilities, staffing and reporting structure
2. Written description or overview of the Underwriting Department's responsibilities, staffing and reporting structure
3. Flowchart of the solicitation process, including formulation of the rate quotation
4. Job descriptions of marketing staff
5. Job descriptions of underwriting staff
6. Minutes of departmental and interdepartmental staff meetings, with appropriate attachments
7. Number and list of all agents and brokers appointed in accordance with NCGS 58-33-40 during the period of **January 1, 2015 through December 31, 2017**. Indicate the National Producer Number of the agent/broker and the date of appointment. Refer to Attachment B (Table 9) for the format for this data submission.
8. Number and list of all agents and brokers terminated in accordance with NCGS 58-33-55 and NCGS 58-33-56 during the period of **January 1, 2015 through December 31, 2017** (NCGS 58-33-55 repealed 7/1/02 and replaced with NCGS 58-33-56, effective 7/1/02). Indicate the National Producer Number of the agent/broker and the date of termination. Refer to Attachment B (Table 10) for the format for this data submission.
9. Sales staff training schedules, agenda and syllabi
10. Sales training materials provided to brokers
11. Copies of all forms (Master Group Contracts, Evidences of Coverage, enrollment applications, change forms, etc.) used during the examination period and the approval letters from the Department
12. Plan descriptions
13. Benefit plan summaries (Summary of Benefits) used during the examination period. Please indicate the effective time period for each summary.
14. Broker kits
15. Enrollment kits
16. Direct marketing materials
17. Agent field manual, if applicable
18. Description or overview of sales presentation monitoring activities
19. Annual certificates of compliance filed with the Department, in accordance with 11 NCAC 12.0534
20. Total number and numbered list of employer groups which were sold or renewed during the examination period. Refer to Attachment B (Table 11) for the format for this data submission.
21. Number of employer groups added and deleted each calendar year during the examination period. Indicate the reasons for deletion, if available.
22. Annual premium rate filings and approval letters from the Department
23. Premium rate setting methodologies
24. For each rating methodology filed with the Department, a written example and explanation of how the rate was derived manually for both large and small groups. Include an example employer group for each methodology, all factors utilized from the approved rate filings and calculations done to arrive at the rate sold to that employer group.
25. Underwriting guidelines
26. Marketing plans for the examination period

27. Marketing Department policies and procedures
28. Policies and procedures for developing and approving marketing materials

The following information must be made available on-site:

29. Marketing and promotional materials

In addition, the Company must provide the examination team access to the following:

30. Sales and broker staff's files and records
31. Employer group marketing files
32. Executed Master Group Contracts
33. Responses to Requests for Proposal
34. Advertising file
35. Employer group underwriting files

I. DELEGATED OVERSIGHT

1. List of intermediary organizations with which the Company contracts or has contracted during the examination period as well as the operational functions delegated to each intermediary organization. Using the format below, indicate the name, effective date, termination date and the delegated function of each intermediary contract.

Name of Intermediary	Effective Date of Contract	Termination Date of Contract (if applicable)	Function Delegated

2. List of contract organizations (organization contracted to provide operational functions, but which does not supply a provider network as does an intermediary organization) with which the Company contracts as well as the operational functions delegated to each contract organization. Using the format below, indicate the name, effective date of the contract, termination date of the contract and the function delegated to each contract organization.

Name of Contract Organization	Effective Date of Contract	Termination Date of Contract (if applicable)	Function Delegated

3. Form contracts with intermediary organizations and approval letters from the Department, in accordance with 11 NCAC 20.0204
4. Copies of certifications filed with the Department regarding intermediary organizations, in accordance with 11 NCAC 20.0204
5. Form contracts with contract organizations and approval letters from the Department, in accordance with NCGS 58-67-30
6. Executed contracts with intermediary organizations
7. Executed contracts with contract organizations
8. Copies of any notice made to the Department of the addition of an intermediary, in accordance with 11 NCAC 20.0601
9. Copies of any notice made to the Department of the deletion of an intermediary, in accordance with 11 NCAC 20.0601
10. Provider contract templates of intermediary organizations
11. Audit mechanism established for reviewing intermediary organizations' provider contracts, including any policies and procedures used during the exam period.
12. Availability standards of the intermediary organizations', if applicable
13. Accessibility standards of the intermediary organizations', if applicable
14. Intermediary organizations' provider availability and accessibility monitoring reports, if applicable
15. List of Third Party Administrators with which the Company contracts. Using the format below, indicate the name, effective date of the contract and termination date of the contract, if applicable.

Name of Third Party Administrator	Effective Date of Contract	Termination Date of Contract (if applicable)

16. Third Party Administrator audit policies and procedures, in accordance with NCGS 58-56-26
17. Results of reviews of intermediary organizations' provider contracts
18. Intermediary organizations' provider availability and accessibility monitoring reports, if applicable
19. Oversight reports regarding intermediary organizations' and/or contract organizations' operations and activities. Include documentation of oversight activities, including audits, follow-up activities, joint committees, reports submitted by delegated entities', etc. regarding all delegated activities, including utilization management, quality management, credentialing and member services. Please include any policies and procedures used during the exam period which address monitoring of any delegated activities.
20. Third Party Administrator audit reports
21. Intermediary organizations' utilization and claims payment reports, if applicable (refer to 11 NCAC 20.0204)
22. Documentation regarding financial monitoring of intermediary organizations', if applicable (refer to 11 NCAC 20.0204)

ATTACHMENT B – INSTRUCTIONS FOR PREPARING ELECTRONIC FILES

The attached file layouts are to be used for building the electronic files/records to be sent to the North Carolina Department of Insurance (Department). Please only submit data subject to this examination.

Files may be submitted via compact disc or e-mail (if the size of the attachment is less than 1 MB). If employing a WINZIP® compatible data compression tool on any attachments greater than 100KB, please submit via compact disc. Do not submit 'backed-up' files.

The data must be formatted as ASCII Fixed Length (plain text).

All files/records must correspond to the appropriate layout definition exactly as prescribed herein.

All records must contain data only. Do not include any column titles/field names, blank records, header or trailer records, total or subtotal records, etc.

With the exception of a leading dash in the first position of the field to represent a negative amount, numeric fields must not contain any punctuation (decimal points, commas, dollar signs, etc.).

Numeric fields must be right justified; alphanumeric fields must be left justified.

If there are any fields that you are unable to populate, please advise the Department, in writing, as soon as possible. These fields need to be accounted for in the file through the use of blank fill. Do NOT use Tab characters.

The company will be supplied with a list of the records selected as a representative sample of the total population submitted for each specific examination item. The selected records will be reviewed, in detail, by the Department's examiners; therefore, the associated company files must be made available to the examiners for their use in verifying data submitted electronically.

Please forward the files as they are completed. Do not wait until all files are complete to start sending. Electronic Data Files not received in good order by the Department at least 60 calendar days prior to the commencement of the examination will be deemed in violation.

Address all diskettes and CDs to the attention of the Examiner in Charge of your examination at the following address:

North Carolina Department of Insurance
Market Regulation Division
1201 Mail Service Center
Raleigh, North Carolina 27699-1201

1. UM Activity

Submit 3 files: All Prospective Reviews. Name the file: Prospective.txt
All Concurrent Reviews. Name the file: Concurrent.txt
All Retrospective Reviews. Name the file: Retrospective.txt

Field Name	Start	Length	Type	Dec	Description
List #	1	8	N	0	Number of records, 1 – last record
Received Date	9	8	N	0	YYYYMMDD
Timing	17	5	A		Prospective, Concurrent, Retrospective
Additional Info Requested	22	8	N	0	If applicable, YYYYMMDD
Additional Info Received	30	8	N	0	If applicable, YYYYMMDD
Notification Date	38	8	N	0	YYYYMMDD
UR Decision	46	8	A		Approved, denied, etc.…
Product Type	54	8	A		Should only include NC commercial business
ID #	62	25	A		Enough detail for plan personnel to pull the applicable record
Company Name	87	50	A		Plan's Name
NAIC #	137	5	A		Plan's NAIC Number

Total Record Length: 141

2. UM 1st and 2nd Level Noncertification Appeals

INCLUDE ALL 1ST LEVEL APPEALS RECEIVED WITHIN THE SPECIFIED TIME PERIOD AND ANY 2ND LEVEL APPEALS RECEIVED WITHIN THE SPECIFIED TIME PERIOD FOR WHICH A CORRESPONDING 1ST LEVEL APPEAL WAS NOT RECEIVED.

Name the file: Appeals.txt

Fields	Start	Length	Type	Dec	Description
List #	1	8	N	0	Number of records, 1 - last record
Received Date	9	8	N	0	YYYYMMDD
Notification Date	17	8	N	0	YYYYMMDD
Decision Date	25	8	N	0	YYYYMMDD
ID #	33	25	A		Enough detail for plan personnel to pull the applicable record
Company Name	58	50	A		Plan's Name
NAIC #	108	5	A		Plan's NAIC Number

Total Record Length: 112

3. UM Expedited Appeals

Name the file: AppealsExp.txt

Fields	Start	Length	Type	Dec	Description
List #	1	8	N	0	Number of records, 1 - last record
Received Date	9	8	N	0	YYYYMMDD
Additional Info Requested	17	8	N	0	If applicable, YYYYMMDD
Additional Info Received	25	8	N	0	If applicable, YYYYMMDD
Decision Date	33	8	N	0	YYYYMMDD
ID #	41	25	A		Enough detail for plan personnel to pull the applicable record
Company Name	66	50	A		Plan's Name
NAIC #	116	5	A		Plan's NAIC Number

Total Record Length: 120

4. Provider Credentialing

Name the file: CredProv.txt

Fields	Start	Length	Type	Dec	Description
List #	1	8	N	0	Number of records, 1 - last record
Credentialing Application Received Date/ Re-credentialing Review Date	9	8	N	0	YYYYMMDD
Sign-Off/ Approval Date	17	8	N	0	YYYYMMDD
Type of Review	25	1	A		I = Initial credentialing, R = Re-credentialing
Provider Name	26	25	A		Identifier
Company Name	51	50	A		Plan's Name
NAIC #	101	5	A		Plan's NAIC Number

Total Record Length: 105

5. Facility Credentialing

Name the file: CredFac.txt

Fields	Start	Length	Type	Dec	Description
List #	1	8	N	0	Number of records, 1 - last record
Credentialing Application Received Date/ Re-credentialing Review Date	9	8	N	0	YYYYMMDD
Sign-Off/ Approval Date	17	8	N	0	YYYYMMDD
Type of Review	25	1	A		I = Initial credentialing, R = Re-credentialing
Provider Name	26	25	A		Identifier
Company Name	51	50	A		Plan's Name
NAIC #	101	5	A		Plan's NAIC Number

Total Record Length: 105

6. Excluded Network Applications Not Requiring a Review

Name the file: CredExcl.txt

Fields	Start	Length	Type	Dec	Description
List #	1	8	N	0	Number of records, 1 - last record
Application Received Date	9	8	N	0	YYYYMMDD
Written Notification Date	17	8	N	0	YYYYMMDD
Provider / Facility Name	25	25	A		Identifier
Company Name	50	50	A		Plan's Name
NAIC #	100	5	A		Plan's NAIC Number

Total Record Length: 104

7. Claims Administration

INCLUDE ONLY CLAIMS FOR NORTH CAROLINA COMMERCIAL BUSINESS. DO NOT INLCUDE CAPITATED CLAIMS, DUPLICATE CLAIMS, SELF-FUNDED CLAIMS OR ANY FEDERAL PROGRAM CLAIMS.

Submit 2 files. **All Paid claims. Name the file: Claimspaid.txt**
All Denied claims. Name the file: Claimsdenied.txt

Fields	Start	Length	Type	Dec	Description
List #	1	8	N	0	Number of records, 1 - last record
Claim #	9	20	A		Plan's claim identifier
Line Item #	29	4	A		Claim line item number, if applicable
Special Area Review	33	20	A		Special area review: • General • Emergency • OB/GYN • Pharmacy • Provider • Student • Other (Explanation)
Member ID #	53	15	A		Member's identification number
Provider Name	68	18	A		Provider's name as it appears in the claims system, if last name is a separate field, report last name only
Provider Number	86	15	A		Provider's identification number
Service Date	101	8	N	0	YYYYMMDD
Received Date	109	8	N	0	YYYYMMDD
Adjudication Date	117	8	N	0	Process date, YYYYMMDD
30 Day Letter Date	125	8	N	0	Initial correspondence, YYYYMMDD
Status	133	1	A		The status of the claim line: P = Paid, D = Denied
CPT/Revenue Code	134	8	A		CPT or Revenue code
Diagnosis Code	142	8	A		Diagnosis Code
Product Type	150	1	A		Commercial Business Only: H = HMO, P = PPO
Copay	151	8	N	2	
Deductible	159	8	N	2	
Billed Amount	167	8	N	2	
Allowed Amount	175	8	N	2	
Discount Amount	183	8	N	2	
Coinsurance Amount	191	8	N	2	
Withhold Amount	199	8	N	2	
Net Paid Amount	207	8	N	2	
Date check generated	215	8	N	0	Date the check was cut, YYYYMMDD
Date check mailed	223	8	N	0	Date the check was mailed, YYYYMMDD
Amount of interest paid	231	8	N	2	
Place of Service	239	3	A		Place of Service code
Company Name	242	50	A		Plan’s Name
NAIC #	292	5	A		Plan's NAIC number

Total Record Length: 296

8. Grievance Data

Non-Quality of Care Grievances. Name the file: Grievance.txt
Quality of Care Grievances. Name the file: QCGrievance.txt

Fields	Start	Length	Type	Dec	Description
List #	1	8	N	0	Number of records, 1 - last record
Received Date	9	8	N	0	YYYYMMDD
Decision Date	17	8	N	0	YYYYMMDD
Type of Grievance	25	10	A		Plan definition
Product Type	35	10	A		Should only include NC commercial business
ID #	45	25	A		Enough detail for plan personnel to pull the applicable record
DOI Complaint	70	1	A		Was grievance initiated as a result of a consumer complaint to DOI? Y = Yes, N = No
Received Date of DOI Complaint	71	8	N	0	YYYYMMDD (Date company received the complaint from the DOI)
Company Response Date to Consumer Complaint	79	8	N	0	YYYYMMDD (Date company responded in writing to the Department regarding consumer complaint)
Company Name	87	50	A		Plan's Name
NAIC #	137	5	A		Plan's NAIC Number

Total Record Length: 141

9. Appointed Agents

Name the file: AgentAppt.txt

Fields	Start	Length	Type	Dec	Description
List #	1	8	N	0	Number of records, 1 - last record
Producer Name	9	50	A		Writing Producer's Name
National Producer #	59	9	A		Writing Producer's National Producer Number
Producer's Appoint Date	68	8	N	0	Writing Producer's Appointment Date (YYYYMMDD)
Company Name	76	50	A		Plan's Name
NAIC #	126	5	A		Plan's NAIC Number

Total Record Length: 130

10 Terminated Agents

Name the file: AgentTerm.txt

Fields	Start	Length	Type	Dec	Description
List #	1	8	N	0	Number of records, 1 - last record
Producer Name	9	50	A		Writing Producer's Name
National Producer #	59	9	A		Writing Producer's National Producer Number
Producer's Termin Date	68	8	N	0	Writing Producer's Termination Date (YYYYMMDD)
Company Name	76	50	A		Plan's Name
NAIC #	126	5	A		Plan's NAIC Number

Total Record Length: 130

11. Employer Groups

Name the file: EmployerGrps.txt

Fields	Start	Length	Type	Dec	Description
List #	1	8	N	0	Number of records, 1 - last record
Sold/Renewed Date	9	8	N	0	YYYYMMDD
Employer Group Name	17	25	A		Employer Group Name
Company Name	42	50	A		Plan's Name
NAIC #	92	5	A		Plan's NAIC Number

Total Record Length: 96

12. Policy Rescissions

Name the file: PolRescissions.txt

Fields	Start	Length	Type	Dec	Description
List #	1	8	N	0	Number of records, 1 - last record
Insured Name	9	50	A		Insured's Name
Policy #	59	20	A		Policy number
Policy Issue Date	79	8	N	0	Date Policy Issued (YYYYMMDD)
Claim Receipt Date	87	8	N	0	Date Claim Received (YYYYMMDD)
LOB	95	20	A		Line of Business – Valid values are: Health-HMO Health-PPO Health-POS
Rescission/Cancellation Date	115	8	N	0	Date Policy Rescinded/Cancelled (YYYYMMDD)
Reason for Rescission/Cancellation	123	100	A		Plan Definition
Diagnosis Code 1	223	8	A		Diagnosis Code 1
Diagnosis Code 2	231	8	A		Diagnosis Code 2
Diagnosis Code 3	239	8	A		Diagnosis Code 3
Diagnosis Code 4	247	8	A		Diagnosis Code 4
Diagnosis Code 5	255	8	A		Diagnosis Code 5
Premium Amount	263	8	N	2	Premium Amount
Refund Amount	271	8	N	2	Amount Refunded
Refund Date	279	8	N	0	Date Refund Issued (YYYYMMDD)
Company Name	287	50	A		Plan's Name
NAIC #	337	5	A		Plan's NAIC Number

Total Record Length: 341

XI. FORMAT OF EXAMINATION REPORT

I. GENERAL ADMINISTRATION

II. DELIVERY SYSTEM AND PROVIDER RELATIONS

III. UTILIZATION MANAGEMENT

IV. QUALITY MANAGEMENT

V. PROVIDER CREDENTIALING

VI. CLAIMS PRACTICES

VII. POLICYHOLDER TREATMENT

VIII. SALES AND MARKETING

IX. UNDERWRITING PRACTICES

X. DELEGATED OVERSIGHT

XI. SUMMARY

XII. TABLE OF STATUTES AND RULES

XIII. CONCLUSION

XII. GENERAL SAMPLING GUIDELINES

The examination team uses guidelines established by the National Association of Insurance Commissioners (NAIC) to determine the number of records requested for review. A random sample of 131 will be reviewed from the population of records (119 for Underwriting files). If the population is less than 131 for any given area of review (less than 119 for Underwriting), all records will be reviewed.

1. Samples requested for review by the examination team should not include any self-funded or federal data, including the State Health Plan.

2. The samples should not include any duplicate or delegated records.

3. The Coordinator should maintain all documentation that identifies the manner in which the sample was selected.

4. Any records or claims that the Company is not able to retrieve and which, therefore will not be provided to the examination team should be identified immediately.

5. Any applicable documentation relevant to the review of the record should be included in the file. If any documentation relevant to verification of a record is to be viewed on-line, notification of this fact should be communicated to the EIC in the off-site materials.

6. All samples requested prior to the commencement of the examination must be available for review on the first day of the examination.

A. UTILIZATION REVIEW SAMPLES

Pre-Certification Review

1. The EIC will request precertification samples based on the total number of precertification reviews conducted by the Company during the examination period. The EIC uses a computer program to determine the specific precertification records to be retrieved.

2. The Coordinator will make available any logs or computer spreadsheets used to match the records to the sample.

3. The Coordinator must ensure that the sample does not include concurrent or retrospective records.

4. Any documentation relevant to the review should be included in the file. This may include but is not limited to, precertification logs, medical information and correspondence to the provider and/or member regarding the request.

Concurrent Review

Same process as stated above, however the sample should exclude prospective and retrospective reviews

Retrospective Review

Same process as stated above, however the sample should exclude prospective and concurrent reviews.

Appeals of Noncertification

1. The EIC will request a sample of appeals regarding utilization review noncertifications based on the total number of appeals conducted by the Company for the examination period.

2. The EIC will use a computer program to determine the specific appeal records to be retrieved.

3. The Coordinator will make available any logs or computer spreadsheets used to match the records to the sample.

4. The Coordinator must verify that the sample only contains records relevant to appeals for utilization management noncertifications. Self-funded, federal or requests for reconsideration should not be included.

5. Any documentation relevant to the appeal, which is maintained in another area such as quality management or member services, must be included with the record.

6. Effective January 1, 1998, second level appeal information must be available for review. The first and second level appeal will be reviewed as one record.

B. QUALITY MANAGEMENT SAMPLE GUIDELINES

1. The EIC will request the total number of written quality of care complaints/grievances received by the Company for the examination period.

2. The EIC will use a computer program to determine the specific quality of care complaint records to be retrieved.

3. The Coordinator will make available any logs or computer spreadsheets used to match the records to the sample.

4. The Coordinator must verify that the sample only contains records relevant to quality of care complaints.

5. Any documentation relevant to initiation of the complaint and resolution of the complaint/grievance that is maintained in another area such as member services must be included with the record.

C. CREDENTIALING SAMPLES

1. The EIC will request a current Provider Directory and a numbered list of providers from the Coordinator. Due to the length of the examination period, this may include providers that do not participate currently.

2. The EIC will verify the total number of individual providers in the directory and/or list. If the Company conducts credentialing for facilities, pharmacies or other ancillary providers separate and apart from individual physicians the Coordinator will provide a list of each of these providers by category.

3. The network information provided should not include duplicate information (i.e., a physician who is both a primary care provider and a specialist should only be included once.)

4. Credentialing functions which have been delegated to an intermediary and for which the Company does not maintain the files should not be included in the sample.

5. The EIC will use a computer program to determine the specific credentialing records to be retrieved.

6. The Coordinator will make available any logs or computer spreadsheets used to match the records to the sample.

7. Any credentialing plans, criteria, procedures and/or guidelines used to credential providers should be provided to the examination team if not provided with the off-site materials. If a Company has separate credentialing criteria for specific types of providers, all criteria must be provided to the examination team.

8. If documentation which is part of the credentialing process is maintained in another area, this documentation must be provided to the examination team with each credentialing file (i.e., provider profiles, provider contract etc.)

D. CLAIMS SAMPLING GUIDELINES

1. The EIC will request a total claims population of claims received (including paid and denied as well as claims not entered into the system yet) for the examination period, from the Coordinator or designee. The Coordinator will save the program used to identify this information.

2. Using a computer generated formula; the EIC will forward a random sample of record numbers to the Coordinator.

3. The Coordinator will then have the necessary claims records retrieved and available for review on the first day of the examination. It is the responsibility of the Company to establish a numbering system to use to match the population number to the claim record. Additionally, the Coordinator must save any information related to matching the sample to the actual claim record.

4. The random sample should be broken down by line item for each claim.

5. Duplicate claims should be excluded from the sample. Self-funded and federal claims should also be excluded.

6. The examination team will need access to two computer terminals that will allow the examination team to review processed claims.

7. The examination team will need all documentation relevant to claims adjudication, which shall include but not be limited to the following:

    a. member eligibility information
    b. benefit plan information
    c. provider payment schedules
    d. IC-D9 code information

Denied Claims

1. The EIC will request a report of all claims denied during the examination period as well as the reason for the denial. It is the responsibility of the Company to establish a numbering system to use to match the population number to the claim record. Additionally, the Coordinator must save any information related to matching the sample to the actual claim record.

2. Using a computer generated formula; the EIC will forward a random sample of record numbers to the Coordinator.

3. The Coordinator will then have the necessary denied claims retrieved and available for review on the first day of the examination.

4. The examination team will need all documentation relevant to the claim, which shall include but not be limited to the following:

    a. member eligibility information
    b. benefit plan information
    c. provider payment schedules
    d. denial code explanation key

E. POLICYHOLDER TREATMENT SAMPLE GUIDELINES

1. The EIC will request a member grievance samples based on the total number written grievances reviewed by the Company (do not include delegated records) for the examination period. The EIC will use a computer-generated sample to request the specific complaint records to be retrieved.

2. The Coordinator will make available any logs or computer spreadsheets used to match the records to the sample.

3. The Coordinator must assure the sample does not include any self-funded or federal complaints. However, the sample should include state employee complaint/grievance files.

4. Any documentation relevant to the review, which may be maintained in another operational area, should be provided with the file.

5. If the Company has multiple levels of review, all information relevant to each level of the review should be included in the file. Effective 1/1/98, first and second level grievances will be reviewed. This will be considered one record.

6. If complaints are categorized by type, any directory identifying the categories should be provided with the sample.

F. MARKETING SAMPLING GUIDELINES

Employer Group Files

1. The EIC will request a list of the Company's employer groups sold or renewed during the examination period.

2. The EIC will use a computer-generated sample to request the specific employer group files to be retrieved.

3. The Coordinator will make available any logs or computer spreadsheets used to match the records to the sample.

4. Documentation usually found in the employer group files includes but is not limited to:

    a. rate quotation proposal
    b. request for proposal (if applicable)
    c. master group contract
    d. small group disclosure forms (if applicable)
    e. general correspondence between the Company and the employer group

5. If documentation such as master group contracts is maintained separately, these must be made available to the examination team.

Advertising Files

1. The Company may escort the examination team to the appropriate operational area where the advertising file is maintained. All advertisements should be centrally located.

2. The examination team will review all advertisements in use by the Company during the examination period. The file should contain all print, television, radio and outdoor advertisements.

3. If radio and television advertisements are maintained on cassette or videotape, the Company must have a tape cassette recorder, television and video cassette player available to the examination team.

Producer Files

1. The Examiner-In-Charge will request a list of all agents and brokers used by the Company during the examination period. The list should state the name and social security number of the agent.

2. The EIC will request a list of all agents appointed and terminated during the examination period.

3. The EIC will use a computer-generated sample to request the specific agent and broker files to be retrieved.

4. The Coordinator will make available any computer program, logs or computer spreadsheets used to match the records to the sample.

G. UNDERWRITING PRACTICES AND PREMIUM RATE SAMPLE GUIDELINES

1. The EIC will use the same employer groups selected in the marketing sample for the underwriting sample.

2. The Coordinator should request that all underwriting files used to generate rate quotations for each employer group selected be retrieved.

3. All documentation relevant to the development of the rate quotation should be available in these files.

4. For **each** rating methodology filed with and approved by the Department, the Company must provide the following:

    a. A written example of how the rate was derived manually for both large and small groups; the example should be a group that was sold; provide all documentation necessary to demonstrate compliance.
    b. any tables used to assist the examiner in developing the rate such as industry code tables; and
    c. any benefit plan information, which may have had both benefits and rates, approved in the same filing.

XIII. SCHEDULE AND STAFF PROJECTION

NORTH CAROLINA
MARKET CONDUCT EXAMINATION

OF

INSURANCE COMPANY INC.

This examination has been scheduled for the following dates:

Commencement Date: Date XX, 20XX
Estimated Completion Date: Date XX, 20XX

The following analysts have been assigned to this examination:

	Phone Number	E-Mail Address
HMO and PPO Team		
Scott Grindstaff Examiner-In-Charge	919-807-6879	scott.grindstaff@ncdoi.gov

The Examination Team can be reached by telefax at (919) 807-6858.

There will be charges levied to the Company for this examination.

Any comments about the examination process that cannot be addressed by the Examiner-In-Charge should be addressed to:

Teresa Knowles, ACS, MCM
Deputy Commissioner
Market Regulation Division
1201 Mail Service Center
Raleigh, North Carolina 27699-1201
(919) 807-6886